

The University of Minnesota Hospital and Clinic

Board of Governors

April 23, 1986

PLEASE NOTE THAT THE BOARD MEETING WILL BE HELD IN 555 DIEHL HALL.

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OTHER ATTACHMENTS

1986-87 Preliminary Operating Budget

Interface

**The University of Minnesota Hospital and Clinic
Board of Governors**

April 23, 1986
1:30 P.M.
555 Diehl Hall

AGENDA

- | | | |
|------|---|-------------|
| I. | <u>Approval of March 26, 1986 Minutes</u> | Approval |
| II. | <u>Chairman's Report</u>
- Ms. Barbara O'Grady | Information |
| III. | <u>Hospital Director's Report</u>
- Mr. C. Edward Schwartz | Information |
| IV. | <u>Committee Reports</u> | |
| | A. <u>Planning and Development Committee Report</u>
- Mr. Robert Latz | |
| | 1. Parking Ramp Tunnel Construction | Approval |
| | B. <u>Joint Conference Committee Report</u>
- Ms. Phyllis Ellis | |
| | 1. Medical Staff-Hospital Council Report | Information |
| | 2. UMHC End Stage Renal Disease Program | Approval |
| | C. <u>Finance Committee Report</u>
- Mr. Robert Nickoloff | |
| | 1. Report of Operations for the Period
July 1, 1985 through March 31, 1986 | Information |
| | 2. 1985-86 Third Quarter Bad Debts | Approval |

MINUTES

Board of Governors

The University of Minnesota Hospital and Clinic

March 26, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the March 26, 1986 meeting of the Board of Governors to order at 1:35 P.M. in Room 555 Diehl Hall.

ATTENDANCE:

Present: Leonard Bienias
Shelley Chou, M.D.
Al Hanser
George Heenan
Kris Johnson
Robert Latz
Jerry Meilahn
James Moller, M.D.
Barbara O'Grady
Nancy Raymond
C. Edward Schwartz

Absent: Phyllis Ellis
David Lilly
Robert Nickoloff
Neal A. Vanselow, M.D.

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of February 26, 1986 meeting of the Board of Governors as written.

CHAIRMAN'S REPORT:

Chairman Barbara O'Grady distributed a work plan for the Board of Governors for 1986, encouraging Board Members to review and comment on the plan.

Secondly, Chairman O'Grady reminded the Board of Governors that the April 23, 1986 Board Meeting would be held in the Board Room on the 8th floor of the new University Hospital.

Thirdly, Chairman O'Grady shared a letter authored by the Chairman of the Board of Regents, Charles McGuiggan, expressing appreciation for the March 7, 1986 Unit J Opening Event. Each of the Board Members signed a letter expressing their gratitude to Mrs. Jolene Chou, Mrs. Mignette Najarian, Mrs. Mary Vanselow, and Mrs. Hallie Wannamaker for their efforts in organizing the event.

Lastly, Ms. O'Grady reminded the Board of the May 6, 1986 Trustee Conference being held at the Amfac Hotel.

HOSPITAL DIRECTOR'S REPORT:

Mr. C. Edward Schwartz distributed the newspaper insert that will appear in the Sunday version of the Minneapolis Star and Tribune and St. Paul Pioneer Press on the weekend of the move into the new Hospital.

Secondly, Mr. Schwartz updated the members of the Board on medical staff recruitment. Candidates for the Chairmanship in Neurology and the Director of Adult Cardiology are currently being interviewed. The search processes for Chairmen in OB/Gyn (Dr. Bruce Work), Radiology (Dr. William Thompson) and Dermatology (Dr. Peter Lynch) are now concluded.

The recruitment of the new Director of Development for the Hospital and a new Dean in the School of Dentistry are also underway.

Thirdly, Mr. Schwartz noted that the construction of the new parking ramp has begun. The design for the connecting tunnel is now being finalized.

The Primary Care Network, Mr. Schwartz reported, is currently enrolling members in its first target community with a great deal of success.

Lastly, Mr. Schwartz shared a copy of the written submittal to the Subcommittee on Health of the Committee on Finance of the United States Senate. Mr. Schwartz compared the financial implications to The University of Minnesota Hospital and Clinic of each of the proposals; Senator Durenberger's proposal is slightly less severe than that being proposed by the Administration. The Board of Governors discussed the need to continue communicating these ideas to Senator Durenberger.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Committee Chairman Robert Latz and Mr. Geoff Kaufmann briefly reviewed comments submitted in response to the draft Metropolitan Health Board Health Plan. Many of the comments, particularly from the Council of Community Hospitals, challenged the congruence of including specific quantified goals and guidelines in a document that also endorses the benefits of competitive marketplace forces.

Secondly, Mr. R. Edward Howell described The University of Minnesota Hospital and Clinic participation in the Set Aside Program. The Set Aside Program was

mandated by State law and Regent's resolution. The program is designed to provide opportunities for growth of small businesses and for small businesses owned and operated by socially or economically disadvantaged people.

Lastly, Mr. Greg Hart overviewed plans for moving into the new hospital. The departments will begin moving several days before the actual patient move, which is scheduled for April 18 and April 19, 1986. Mr. Hart noted that there are several aspects of building completion and certification that are under tight time frames for completion and are being closely monitored.

JOINT CONFERENCE COMMITTEE REPORT:

In the absence of Committee Chair, Phyllis Ellis, Mr. George Hennan reported on the proceedings of the March 12, 1986 Joint Conference Committee meeting. At that session, the Committee members spent a considerable period of time discussing the credentialing process for new medical staff members. Mr. Heenan noted that a great deal of verification of information presented in the Medical Staff Application takes place.

The Committee had also discussed their work plan for 1986. Priorities included the new Guest Relations Program, Quality Assurance Program, and an evaluation of the effect of changing health care patterns on the educational opportunities available to students in our Hospital.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing presented a summary of the first eight months of financial activity. Admissions are running 2.5% under budget year to date and the average length of stay is running 2.5% above budget. This results in an overall patient day total of 1.9% below budgeted levels. The Outpatient Clinic census for the first eight months of the 1985-86 fiscal year totaled 145,034 visits, 5.2% above budgeted levels.

The Hospitals Statement of Operations shows total revenues over expenses of \$12,344,884; a favorable variance of \$6,488,781. This overall variance reflects both a favorable variance in net revenues from operations and a favorable variance in non-operating revenue.

Mr. Cliff Fearing briefly overviewed the Peat, Marwick, Mitchell and Co. management letter of recommendations. The primary recommendation noted in the year end audit encouraged the Hospital and the University to work together to investigate alternatives to the current Hospitals' general ledger system.

Following a brief analysis of the financial implications of refinancing the fixed portion of the 1985 Series A Bonds, the Board of Governors seconded and passed the following resolution:

Whereas, the Board of Governors of the University of Minnesota Hospital and Clinic (UMHC) support the principal of providing the highest quality of health care at the lowest reasonable cost, and

Whereas, the present financial markets provide an opportunity to reduce the interest expense on UMHC's long term debt,

Therefore be it resolved, that the Board of Governors endorse UMHC's plan to refinance UMHC's long term debt and reduce its interest expense, and instructs Hospital management to continue working with the appropriate University officials to accomplish these objectives.

Mr. Greg Hart summarized the comparable worth plan originally endorsed by the Board of Governors in April of 1985. That plan is as follows:

1. The male market line, established as part of University Hospitals' job evaluation and comparable worth study, shall be the pay line which shall be targeted for purposes of the Hospitals' compensation practices.
2. The use of the targeted pay line shall be applied to female dominated, male dominated and balanced job classifications.
3. The initial phase of implementation shall be structured such that the affected job classifications which are more than 5% away from the targeted pay line shall be brought to within 5% of the targeted pay line.
4. The initial phase of implementation shall be four years in length.
5. During the four year initial implementation period, and at the end of the four year implementation period, continued comparable worth analyses will be conducted. Additional adjustments may be necessary after the initial four year period if there continues to be a differential between the target payline and the female internal payline.

The Board of Regents approved the pay equity plan for the University at their March meeting. With that information, the Board of Governors seconded and passed a motion to approve the actual payment of comparable worth increases per the above principles. The cost of implementation of that plan is \$450,000.

HELICOPTER UPDATE:

Mr. Ron Werft outlined the chronological history of the development of the helicopter program. In July of 1985 the Bell 222 UT helicopter arrived and service began. Mr. Werft reported the number of patient transports per month. They ranged from a low of 20 during the first month of implementation to a high of 38 in August of 1985. During the first seven months of operation 64 flights came to The University of Minnesota Hospital and Clinic. This number represents 43% of the Consortium flights and 32% of the total flights. Patients in three diagnostic categories; pulmonary, cardiac and trauma,

comprise a majority of flights. When the revenues generated by patients flown in by the helicopter are taken into consideration, the program is operating at an approximate \$10,000 loss. Mr. Werft also summarized a series of current issues and responded to questions about the program.

ADJOURNMENT:

There being no further business, the meeting of the March 26, 1986 Board of Governors was adjourned at 3:45 P.M.

Respectfully submitted,

Nancy C. Janda /kj

Nancy C. Janda
Assistant Director and
Secretary to the Board of Governors

MINUTES
Planning and Development Committee
April 9, 1986

CALL TO ORDER

In the absence of Committee Chairman, Mr. Robert Latz, Mr. Leonard Bienias called the April 9, 1986 meeting of the Planning and Development Committee to order at 10:11 a.m. in Hospital Dining Room III.

Attendance: Present Leonard Bienias, Chair
Frank Cerra, M.D.
Clint Hewitt
Geoff Kaufmann
John LaBree, M.D.
I. Dodd Wilson, M.D.

Absent B. Kristine Johnson
Robert Latz
C. Edward Schwartz

Staff Cliff Fearing
Greg Hart
Nancy Janda
Mark Koenig
Merle McGrath

APPROVAL OF MINUTES

The minutes of the March 12, 1986 meeting were approved as mailed.

CAPITAL BUDGET

Mr. Greg Hart presented the 1986-87 Capital Budget for informational purposes. He went over the budget line-by-line and explained each item. He said that each item that amounts to \$600,000 or more would be reported on separately. Those items include cardio-respiratory and the ISD computer upgrade. He reported that the budget is lower than past years and the reason for this is that there were many new items of equipment purchased for the move into Unit J. He also said that the Heart Cath Lab may be spending more on equipment when the new director is on the job. After going to the Finance Committee, the budget will come back to the Planning and Development Committee for approval.

UMCA UPDATE

Dr. Wilson stated that UMCA is getting busier although there have been no new contracts. These are some of the projects that UMCA is working on at the present time: HCA regarding UMHC being a regional provider as a Center of Excellence; Aetna Insurance regarding workman's comp and second opinion; Fireman's Fund; PHP; GHI; Share; and PCN where they are marketing in smaller communities. PCN has done a survey and the results are very favorable. UMCA is close to signing some contracts and they are working on a physician-to-physician hotline where, initially, committee members would carry beepers. The next priority will be communications.

FACILITY AND PARKING TUNNEL UPDATE

Mr. Koenig reported that bids will go out for the basic tunnel with additional bids for work above ground -- skylights, site work, etc. in front of Masonic. If the tunnel comes in under what's allocated, extra items will be researched further. Construction should start approximately June 1 and be completed in late December. A question of security was raised and Mr. Koenig said that the security cameras in Unit J will provide security in the tunnel. The Planning and Development Committee unanimously endorsed the bidding and construction of the parking tunnel ramp.

METROPOLITAN HEALTH PLANNING BOARD HEALTH PLAN

Mr. Kaufmann reported on the summary of major comments made by area hospitals to the Metropolitan Health Planning Board's 1986 Draft Health Plan and their responses. The Health Board says that their goal is to provide information for buyers and that they have no power to make changes in the system, but the buyers can.

UNIT J MOVE UPDATE

Ms. Janda reported that Pharmacy moved into Unit J on April 8 and that everything went smoothly. Two more departments, radiology and central supply, will move this week. The move schedule for next week is on Wednesday and Thursday the departments, Friday the ICU, and Saturday the remaining patients will be moved to their new locations. She said that there were still minor problems cropping up but that nothing major has occurred. The changes in the building occur almost hourly. On the days of the move there will be volunteers riding the shuttlebus and there will be signs in the nursing stations to notify visitors of new locations. There will also be volunteers in the main lobby to take families and visitors to the new locations.

ADJOURNMENT

The Planning and Development Committee adjourned at 11:20 a.m.

Respectfully submitted,



Ann S. Frohrip
Senior Secretary
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

April 4, 1986

TO: Board of Governors

FROM: Clifford Fearing
Senior Associate Director



SUBJECT: Approval of Parking Ramp Tunnel Construction

In February of 1985 the Board of Governors approved development of the Hospital Parking Ramp. In conjunction with the ramp we have discussed on many occasions the need for an enclosed and heated walkway connecting the ramp to Unit J and the clinic buildings.

In January of 1986 the Board approved funds for the design of this link. Design work is now complete.

Today I am requesting approval for bidding and construction of the underground link including the related elevator and walkway which connects Unit J and the Masonic Hospital to the new Parking Ramp Facility.

Estimate of the cost of this construction remains at \$1.5 million. Estimated tunnel construction time is six months beginning June 1, 1986.

CF/kf

**MINUTES
JOINT CONFERENCE COMMITTEE
APRIL 8, 1986**

ATTENDANCE: PRESENT:

Phyllis Ellis, Chair
Jack Duvall, M.D.
George Heenan
Nancy Raymond

STAFF: Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt

GUEST: Ann Russell

I. Call to Order

The meeting was called to order at approximately 4:45 p.m.

II. Approval of Minutes

The minutes of the March 12, 1986 meeting of the Joint Conference Committee were approved as submitted.

III. Medical Staff Hospital Council Report

Mr. Hart reported on the most recent meeting of the Medical Staff Hospital Council, noting that the Council approved the nominations for the upcoming Medical Staff elections and the appointment of several medical directors related to Dialysis programs. Ms. Janda also provided the Joint Conference Committee with an update on plans for occupancy of Unit J.

IV. End Stage Renal Disease Program Policies

Ms. Barbara Tebbitt presented the recommended policy revisions for the End Stage Renal Disease Program. She noted that the ESRD program requires that all new or revised policies be approved each year by the governing board.

Ms. Tebbitt noted that the major changes addressed the creation of a pediatric dialysis unit in Unit J and in the centralization of nursing education. Policies on chronic ambulatory peritoneal dialysis were also added.

The Committee moved to endorse the policy changes and additions, and to recommend their approval to the full board.

V. Malpractice Insurance Update

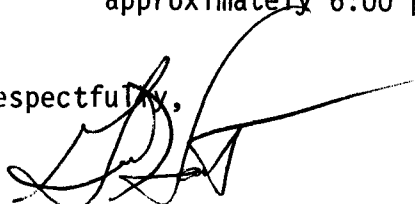
Mr. Jan Halverson presented this item. He began by describing the history of the University's captive insurance company, Ruminco Ltd., and the evolution of the Hospitals malpractice insurance program. He noted that when Ruminco Ltd. was created the medical staff chose not to place their insurance through this company, but rather continue to purchase malpractice insurance through other corporations. The board bylaws relative to medical staff insurance requirements were then reviewed.

Mr. Halverson then discussed the recent difficulties the University and others are having in placing malpractice coverage. These difficulties are related to the changing nature of the insurance market place. Mr. Halverson noted that in part because of the projected cost increases in purchasing malpractice insurance, Dr. Vanselow has appointed a task force which will be making recommendations relative to insurance for residents and fellows.

Mr. Halverson and the Committee also discussed the potential for tort reform and the discussions occurring at national and state levels. Mr. Halverson indicated that he would provide the Committee with further updates in the coming months.

There being no further business, the meeting was adjourned at approximately 6:00 p.m.

Respectfully,



Gregory Hart
Senior Associate Director
Director of Operations



UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

April 18, 1986

TO: Board of Governors

FROM: Barbara Volk Tebbitt, Senior Associate Director and Chief Executive
Officer for UMHC's End Stage Renal Disease Program

Barbara Tebbitt

One of the End Stage Renal Disease Program's Standards states all new or revised policies are to be approved by the governing body annually.

Attachment I identifies a number of policies changed throughout the past year. The rationale for these changes have been noted and relate almost entirely to the move of four pediatric beds to Unit J and retention of eight adult beds in the Mayo complex thereby, necessitating two hemodialysis units instead of one. The second major change was in centralizing nursing education. We eliminated an instructor (SI) on all patient care units and combined management and education responsibilities in the role of the Assistant Head Nurse (AHN). Other minor changes reflect additions or changes in practice endorsed by nursing department policy and procedure over the past year and relate to charting, IV medication administration and reverse osmosis water maintenance. I have not included copies in their entirety since the basic content has been approved previously.

Two new policies have been added on mobile pediatric dialysis, a service added within the past year and an AIDS protocol for the dialysis unit.

In addition to Hemodialysis a component of End Stage Renal Disease is Chronic Ambulatory Peritoneal Dialysis (CAPD). This program has been in the elementary stages of development for the past few years and had previously been housed in the hemodialysis unit. Due to program expansion, relocation was necessary. When a separate cost center was established we also were required to develop policies and procedures for that area.

A basic overview of CAPD is included in Attachment II followed by the policies and procedures for this program.

All new and revised policies have been reviewed and endorsed by the Joint Conference Committee. They are now being submitted to you for consideration and approval.

Thank you for your attention to this matter. I will be happy to answer any questions at our April meeting.

BVT/phl
bvt.1.38186

<u>POLICY NUMBER</u>	<u>REASON FOR CHANGE</u>
1	Language change to reflect 2 Units
2	Language change to include Peds
3	Addition of CAPD
4	Language change to separate Peds
5	Language change to reflect 2 Units
6	Language change to reflect 2 Units
7	New Chart Order for clarity
8	Language change to reflect 2 Units
9	Guardian added
* 10	Board hasn't reviewed- Established Guidelines for Mobile Peds Dialysis
11	Language change to reflect 2 Units and 2 directors
12	Language change to reflect 2 Units
13	Language change to reflect 2 Units and identification of Medical Directors
14	Language change to separate Peds
15	Language change to indicate 2 Medical Directors and 2 AHN's
16	Language change to reflect AHN replacements of SI's functions
17	Addition of Valium as an approved med for administration by R.N.'s
18	Reflects change in Unit - Peds
19	Reflects charting change from SOAP notes to DAP notes
20	Removal of reference to Station 22
21	Reflects changes in leadership staff and deletion of SI's
22	Change in language to account for AHN role change
23	Reflects addition of an AHN
24	Changed to reflect changes to Dept. of Nursing Policy
25	Changed to reflect station changes in new hospital
New Job Descriptions for Head Nurse and Assistant Head Nurses	
26	Changed to reflect current guidelines from the CDC
* 27	New policy reflecting CDC's guidelines for AIDS control in dialysis units
28	Additions of Peds patients
29	Bladder irrigation deleted-not done anymore
30	Addition of the AIDS patient
31	Indication of 2 Units and addition of nursing decision
32	Addition of AIDS patient
33	Addition of <u>each</u> to indicate 2 Units
34	Language change to indicate 2 Units
35	Removal of reference to SI's
36	Language change to reflect services in 2 Units
37	Change to indicate 2 Units
38	Reflects new practise in R/O maintenance
39	Reflects service in new Unit
40	Reflects Peds Unit
* NEW POLICY	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	MOBILE PEDIATRIC DIALYSIS
SOURCE:	Head Nurse, K.D., Chief Exec. Officer, K.D., Assoc. Med Dir., Peds

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: August 1, 1985	
REVISION:	
REVIEWED: 1/86	

MOBILE PEDIATRIC DIALYSIS

University of Minnesota Hospitals has contracted with St. Paul Children's Hospital to provide off-site pediatric dialysis services on an as-needed basis. Services shall include hemoperfusion, hemodialysis and hemodialysis related care. Hemodialysis related care is defined as all activities necessary to the safe and efficacious delivery of dialytic therapy, such as, but not limited to, blood pressure regulation, body weight regulation, blood access maintenance, the monitoring of equipment and vital signs and adjustments in dialysis medications.

STAFFING

A registered nurse, dialysis technician and pediatric nephrologist from the University of Minnesota Hospitals and Clinics will provide dialysis care for each treatment. During normal hours of Kidney Dialysis operation, a nurse and technician will be pulled from that shift to go to St. Paul Children's Hospital. During on-call hours, the on-call nurse and technician will respond to requests for services.

The nurse and technician assigned to the mobile treatment will be expected to complete the treatment unless a significant portion (i.e. one hour or greater) of the treatment falls into the next shift or the 16 hour rule intervenes.

An attending Pediatric Nephrologist from the University of Minnesota Hospitals and Clinics will be present for all off-site mobile dialysis treatments. When the physician feels that the patient is stable, he/she may elect to leave with the nurse's agreement and will be available by beeper.

APPROVED:	<i>Michael M. [Signature]</i>
TITLE:	CEO Medical Director

DATE: 3/11/86

SECTION:	
VOL:	POLICY NUMBER:
SUBJECT: MOBILE PEDIATRIC DIALYSIS	

TRANSPORTATION

Employees providing care at off-site facilities will use their own vehicles for transportation. Mileage will be reimbursed between the University of Minnesota Hospitals and Clinics and the off-site facility and back at the rate of 20.5¢ per mile. When requesting reimbursement, complete the form titled Mobile Pediatric Hemodialysis Program Mileage Reimbursement Record and forward it to the Assistant Administrator for Kidney Dialysis. A subsequent form will be sent for your signature and return. Reimbursement will be made within 2 to 4 weeks.

PARKING (See Maps)

Two parking spots reserved for dialysis personnel will be available at off-site facilities. Maps, describing the fastest routes to the off-site facility and the location of parking spots will be available.

When parking at St. Paul Children's Hospital, the parking ticket is to be taken to the staff in Peds ICU. They will validate it so that staff are not charged. The validated ticket must be turned in to the parking attendant when leaving the ramp.

DRESS CODE

Employees are expected to follow University of Minnesota Hospital Nursing Department Dress Code when performing off-site dialysis.

SUPPLIES AND EQUIPMENT

Supplies for treatment will be carried by the nurse and technician responsible for care. There will be two supply cases equipped with all necessary supplies except for the following:

- appropriate dialyzer
- appropriate blood lines
- appropriate bath and additives (i.e., CaCl,
KCl, Bicarb, PO₄)
- emergency access
- arteriosounde (if appropriate)

SECTION:

VOL.:

POLICY NUMBER:

SUBJECT:

MOBILE PEDIATRIC DIALYSIS

When called to a remote facility bring two of the prescribed dialyzers and two sets of blood lines. Check with the attending physician regarding access and bath.

An AK10 and a 200 liter tank will be on the mobile site at all times. The AK10 will be locked in a storage area in the Peds ICU. The tank will be in the store room in the Peds ICU. All equipment on site will be checked and maintained on a monthly basis whether used or not.

The nurse or technician going on a remote run must take the key to the locked storage area. The key is located in the Narcotics Cabinet in the Dialysis Unit.

Upon return to UMHC, the nurse will restock the supply cases.

WATER TREATMENT AND EQUIPMENT MAINTENANCE

Water treatment equipment at St. Paul Children's Hospital will be maintained and disinfected by the staff of St. Paul Children's Hospital. Cultures will be obtained on a bi-monthly basis. Water samples to determine dissolved solute content and levels will be obtained twice a year. It is recommended they be obtained pre and post treatment in May/June and in October. Disinfection is recommended on a bi-monthly basis.

AUXILLARY EQUIPMENT

Sigma pumps for Mannitol and Heparin delivery will be hand carried to the remote site by the nurse and technician. If Sigmas are left for future use, it should be written on the note for that run. An arterio-sonde with transducer, cuff and paste should be taken when deemed appropriate.

FORMS

The Hemodialysis Record will look identical to the University of Minnesota Hospitals and Clinic's record except that it will be labeled with St. Paul Children's logo. When the treatment is complete, leave the original (white) in the patient's chart and bring the carbon (yellow) copy back.

SECTION:	
VOL:	POLICY NUMBER:
SUBJECT:	
MOBILE PEDIATRIC DIALYSIS	

FORMS (continued)

The Kidney Dialysis Charges/Credits slip is to be completed at the remote site by the nurse. Leave the white sheet at the remote facility and bring the yellow and pink copies back. The yellow copy should be stapled to the yellow copy of the Hemodialysis Record. The pink copy should be sent to Medicare Supervisor, Patient Accounting, Box 602, Mayo.

LEGAL ASPECTS

As agents of the University of Minnesota Hospitals and Clinics, the University of Minnesota Hospitals and Clinics assumes full responsibility for the performance of all personnel involved in the delivery of remote care. Nurses and technicians are responsible for adherence to the policies, procedures and standards of care that govern the remote facility and the ICU.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



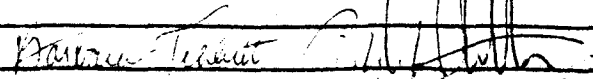
SUBJECT:	AIDS PROTOCOL - DIALYSIS
SOURCE:	DR. THOMAS HOSTETTER, MEDICAL DIRECTOR

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 3/86	
REVISION:	
REVIEWED:	

AIDS PROTOCOL - DIALYSIS

For purposes of infection control in the Dialysis Unit, all persons infected by the AIDS virus will be considered infectious for the AIDS virus. These persons include persons with diagnosed AIDS and others defined as AIDS virus infectious in Hospital Policy 33.12, Isolation Policy.

1. New chronic patients shall be screened for anti-HTLV-III at their first or second dialysis and thereafter every six months (in January and July).
2. Patients with AIDS or a positive Western Blot will be dialyzed in isolation with separate equipment that shall be labeled HTLV-III USE ONLY. The nurse assigned to dialyze that patient will not care for other patients during that shift unless it is another AIDS patient.
3. Bag out all laundry and equipment used in the usual manner.
4. All machines, furniture and equipment are to be cleaned with Osoyl, followed by bleach.
5. Restrict the use of nondisposable supplies (i.e., B/P cuffs) to individual AIDS patients unless sterilized between uses.
6. All blood request slips and all labels MUST be stamped with the red "BLOOD PRECAUTIONS" warning. The blood specimens are then individually bagged out and sent to the appropriate labs. Clean off any blood spillage from the tubes with bleach.
7. Nurses and technicians should always wear gown and gloves (a mask is optional) whenever working with the patient's blood access.
8. Post a Blood Isolation sign at the patient's room entry.
9. Food trays are handled in the same way as all non-infectious patients.

APPROVED: 
TITLE: CEO Medical Director

DATE: 3/13/86

Background Information on Peritoneal Dialysis

Peritoneal Dialysis works inside the body, using the body's own peritoneal membrane as the dialyzer. Waste products and water pass from the blood stream, through the peritoneal membrane, and into the dialysis solution. Used solution is periodically drained from the abdominal cavity and replaced with fresh solution.

Continuous Ambulatory Peritoneal Dialysis CAPD, offers continuous self-care dialysis 24 hours a day, 7 days a week. CAPD patients perform 3-5 daily exchanges. In peritoneal dialysis an exchange procedure involves draining used dialysis solution and instilling fresh dialysis solution into the abdominal cavity. Aseptic technique is required. The total procedure takes about 30-40 minutes. It can be done anywhere that provides privacy and a clean, well lighted environment.

Continuous Cycling Peritoneal Dialysis CCPD, offers daytime freedom from dialysis as the exchange process is done by a machine (cyclor) at night. After the last nightly exchange, fresh dialysate is left in the peritoneal cavity and continues to cleanse the blood all day. CCPD is appealing to patients with busy lifestyles who want to free up their daytime hours. Patients who need the help of a partner may also prefer CCPD. Some patients use a combined program of CCPD and CAPD.

Choosing a Treatment The choice of self-care dialysis is based on the patient's health situation, motivation, and other needs. Most often, it is a decision shared by the patient, family, physician, nurse, and social worker. Together they discuss issues like the patients life style, distance from a dialysis center, home environment, availability of a partner to help; and emotional and physical capabilities.

Training Time CAPD/CCPD training is provided on an outpatient basis. Training sessions are 5 to 6 hours long and continue until mastery is achieved, the average being 7 sessions. Medicare allows for up to 18 training sessions.

Patient Census The number of patients followed on a monthly basis at UMHC varies (range 12-31). Variation is accounted for by transplantation, death, transfer to hemodialysis or transfer to another program.

Cost CAPD is generally considered the least costly dialysis option. Disposable supply costs range from \$10,000 - \$11,000 per year. Intraperitoneal insulin and custom dialysate formulas would further increase cost.

CCPD costs range from \$12,500 - \$13,500. Again intraperitoneal medication and custom dialysate formulas would further increase supply costs.

sks
041686

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Amino Acid Dialysate Protocol (AAD)

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/86

The primary nutritional concern for the patient undergoing CAPD and CCPD is to maintain an adequate nutritional status, while taking into account dietary concerns related to weight changes and blood chemistries.

Of major concern is dietary protein intake. The recommendation is a normal protein intake plus protein to replace losses found in the dialysate.

A serum albumin of less than 3.3 indicates that dietary intake of protein is too low.

Many factors promote nutritional wasting in the PD patient. Psychosocial problems and depression influence the amount of food that the patient is able to eat. Illness such as peritonitis affects appetite and increases the amount of protein lost in the dialysate.

For those patients unable to take adequate amounts of protein, amino acid dialysate will be used for one to two of the daily exchanges. These amino acid dialysate exchanges are to be done before or after lunch and dinner, for example:

8 am 1.5% Dextrose
12 pm Amino Acid dialysate
5 pm Amino Acid Dialysate
10 pm 1.5% Dextrose

CCPD patients will cycle with 1 to 2 bags of amino acid dialysate and three bags of standard solution.

In addition to using the AAD at or near meal times, the dietician will work closely with these patients to tailor individual nutritional needs.

Amino acid dialysate will be delivered to the patient every two weeks because amino acids are stable for a shorter period of time than standard dialysate. The usual mechanism will be employed for deliveries.

As the patient's nutritional status improves, the number of amino acid dialysate exchanges may be decreased as determined by the physician.

sks
041686

Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar

Barbara Tebbitt

DATE: 3/13/86

21.

TITLE: Medical Director Director of Nursing

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Protocol for Monthly Antileukocyte Antibody Screening
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
REVISION:	
REVIEWED:	2/14/86

1. On the first of every month, have 20 cc of blood drawn into red top vacutainer tubes. It is preferable, but not mandatory, that this blood be centrifuged and only the serum mailed.
2. Label the tubes with your full name, birthdate, the date and time the specimen was drawn and your University Hospital Number.
3. Bring one of the Immunology Request Slips to your doctor's office when having your blood drawn. On the slip, fill in your full name, birthdate, the date and time the specimen was drawn, and your University Hospital Number.
4. Mail the specimen and the slips to the following address using the postage paid mailers which are enclosed.

OUTREACH PROGRAM
University of Minnesota Hospitals
Box 198, Room C-290 Mayo Bldg.
420 Delaware Street S.E.
Minneapolis, MN 55455

The specimen needs to be to the University within 2-3 days of being drawn, therefore DO NOT send by parcel post.

5. When the last mailer is sent, include a note requesting more mailers.

*****THIS BLOOD MUST BE SENT EVERY MONTH IF YOU ARE TO RECEIVE A TRANSPLANT*****
ANYTIME IN THE FUTURE.

If you have any questions concerning these instructions, please contact the Outreach Program at the numbers below:

Local, 376-3570

Outside the metro area, within Minnesota, call toll-free, 1-800-462-5301, ask for ext. 65370.

Out-of-state, call toll-free,
1-800-328-5517, ask for ext. 63570.

NAME: _____

UNIVERSITY HOSPITAL NUMBER: _____

*****PHYSICIANS PLEASE NOTE: To have the above mentioned supplies mailed*****
to your patient(s), call the numbers above.

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Silvia Azar *Barbara Tebbitt*

APPROVED:	Silvia Azar	Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Mini Transfusions
Azathioprine/Transfusion Protocol

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/14/86

Prior to transfusions, give:

1 mg/kg body weight Azathioprine daily after assessment of White Blood Count and 3-7 days before transfusion scheduled.

If WBC less than 5000, give 0.5 mg/kg

Transfuse with:

10 mini units of blood from 10 random donors.
(A "mini" unit is usually 75 cc of packed red blood cells, sometimes known as a pediatric blood unit)

If patients' cardiovascular status can tolerate 750cc of blood products, this may all be given in one sitting. It may be divided up into two different blood administrations with 5 "mini" units (325cc) at each sitting, or whatever the patient can tolerate.

Maintain dose of Azathioprine at 1 mg/kg body weight for one week after transfusions, then decrease dose to 0.5 mg/kg body weight for three weeks after transfusion, then discontinue.

IMPORTANT:

WBC should be initially monitored on a daily basis to prevent Azathioprine toxicity.

WBC should then be monitored at least 2 X week for one week then decreased to weekly.

Liver functions should be obtained prior to Azathioprine therapy and at the discontinuance of the drug.

Blood samples for ALA screening should be obtained at two weeks, four weeks, and monthly after transfusion.

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Silvia Azar *Barbara Tebbitt*

APPROVED: Silvia Azar Barbara Tebbitt

TITLE: Medical Director Director of Nursing

DATE: 3/13/86

23.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Diet and Dietary Supplementation Protocol

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: March 1985

REVISION:

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1. All patients will be placed on 1.5 mg/kg IBW protein diet. No other restrictions are necessary unless a need is identified (eg., diabetic or chronically hyperkalemic patients.0
2. If albumin is less than 3.0:
Propac with instructions and recipes
Citrotein with instructions and recipes
Meritene with instructions and recipes
Ensure with instructions and recipes
3. If there is medical indication of poor absorption or striking hypoalbuminemia for two successive measurements of albumin, the patient may be placed on Amino Acid Dialysate Protocol, where applicable

sks
041686

Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar

Barbara Tebbitt

TITLE: Medical Director

Director of Nursing

DATE: 3/13/86

24.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 1 March 1985	
REVISION:	
REVIEWED: 2/14/86	



SUBJECT: Discontinuation of Dialysis Therapy
SOURCE: CAPD/CCPD

If a patient or the patient's guardian wishes to discontinue dialysis treatment, a team conference will be held. The consequences of discontinuing dialysis will be explained to the patient and family members. If the patient wishes to discontinue dialysis treatment and appears to fully understand the consequences, psychiatric evaluation will be sought to determine the patient's competency to make this decision. If all relevant personnel and the patient agree to discontinue dialysis, this will be done.

S. Azar Barbara Tebbitt

APPROVED: Silvia Azar Barbara Tebbitt	DATE: 3/13/86	25.
TITLE: Medical Director Director of Nursing		

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Documentation of Care
SOURCE: CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: March, 1985	
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Each patient will have a chart in the Peritoneal Dialysis Office.
This chart will include, but is not limited to, documentation of:

- a) training for self-care or care-provider,
- b) health professional progress notes,
- c) transplantation status,
- d) dialysis care plan,
- e) nursing care plan,
- f) clinic visits nursing evaluation,
- g) multidisciplinary team conferences,
- h) recent laboratory data,
- i) dialysis run records, and
- j) physicians orders.

The peritoneal dialysis team will meet weekly to discuss, evaluate, and document patient care.

S. Azar *Barbara Tebbitt*

APPROVED	Silvia Azar	Barbara Tebbitt	DATE: 3/13/86	26.
TITLE:	Medical Director	Director of Nursing		

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Evaluation of Self Care
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 1 March 1985	
REVISION:	
REVIEWED: 2/14/86	

Care will be evaluated by the peritoneal dialysis team in the following ways:

1. The patient will send and nurses will review, weekly CAPD or CCPD flow sheets which document:
 - a. Daily (or pre and post-CCPD) postural blood pressures
 - b. Weights
 - c. Temperatures
 - d. Pulse rates
 - e. Dextrose concentration of dialysates used
 - f. Medications added to dialysate
 - g. Number of exchanges during each day.
2. Patients will be evaluated by the Medical Director or designated physician in the Medicine Clinic once per month for three consecutive months following completion of training or discharge from the hospital. When the patient has been discharged for a period of three months, the interval between clinic appointments may be extended to a maximum of three months.
3. Peritoneal Dialysis Nurses will maintain regular telephone contact with patients.
4. Home patients are expected to notify the peritoneal dialysis Team by telephone should any change in their condition occur or should questions arise.
5. If a patient fails to participate in this process, he will be considered non-compliant.

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Silvia Azar

Barbara Tebbitt

APPROVED:	Silvia Azar	Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Patients Failure to Comply with Terms of the Program
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	March, 1985
REVISION:	
REVIEWED:	2/14/86

The following are responsibilities of any patient in home peritoneal dialysis. These responsibilities are explained to the patient during his/her training period:

1. The patient must send weekly flowsheets to the hospital for routine follow-up.
2. The patient must attend renal clinic.
3. The patient must notify dialysis personnel of visits to local physicians.
4. The patient must adhere to the program designed for him/her by the dialysis team.

It is also explained to the patient, that if at any time he/she does not wish to remain on Peritoneal Dialysis and comply with the program, that every effort will be made to provide for satisfactory alternative therapy.

In the event that a patient fails to comply with the above responsibilities, the following actions will be taken:

1. The Peritoneal Dialysis nurse will place a call to the patient.
2. The Peritoneal Dialysis nurse will send a letter restating patient responsibilities to the patient.
3. The Medical Director will send a similar letter to the patient via registered mail.

If the above actions do not improve patient compliance, a team conference will be held, and the patient encouraged to participate.

The team conference may result in any of the following actions:

1. Notification to the manufacturers of the patient's dialysis supplies that he/she is no longer compliant, that the home training unit can no longer authorize delivery of supplies until the patient can be evaluated in renal clinic.
2. Contact of local community health agencies to arrange for home visits and assessment of the patient until the patient can be evaluated in renal clinic.
3. Arrange for the patient to be transferred to in-center dialysis where ongoing medical evaluation is possible.

S. Azar *Barbara Tebbitt*

APPROVED:	Silvia Azar	Barbara Tebbitt	DATE: 3/13/86	28.
TITLE:	Medical Director	Director of Nursing		

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Infection Control

SOURCE: CAPD/CCPD

SECTION:

VOL.: POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

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1. All procedures will be done under sterile or aseptic technique.
2. All suspected infections will be cultured. Positive cultures will be set up for sensitivities.
3. There will be ongoing record keeping to include:
 - a. Date of onset of any case of peritonitis
 - b. Identification of the organisms involved.
 - c. Sensitivities and MIC in; drugs used in treatment.
 - d. Peritonitis rates expressed in number of cases per patient month.
4. Any patient who experiences peritonitis more than twice in a 16-week period will be reviewed in the weekly team conference. Repeated peritonitis may result in admission to the U of M Hospital for aggressive antibiotic treatment and/or catheter removal and replacement.
5. Any patient who suffers more than three episodes of peritonitis in a period of six months will be reviewed in the weekly team conference. If there is no demonstrable medical explanation for the recurring infections, the patient will be conferenced by the team. In this conference, the risks of frequent peritonitis will be reviewed with the patient, and the option of hemodialysis discussed. If, in the opinion of the medical director, the patient is no longer a home peritoneal dialysis candidate, other therapeutic options will be presented during that conference.
6. Infection control policies 33.6 and 33.12 will be implemented in the Home Training Unit.

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Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar Barbara Tebbitt

TITLE: Medical Director Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Infection Protocols

SOURCE: CAPD/CCPD

SECTION:

VOL.:

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EFFECTIVE: 1 March 1985

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Suspected Exit Site Infection

1. Remove suture if 7 days post placement.
2. Culture drainage and set up sensitivities if growth is found.
3. Velosef 500mg p.o. qid times one day then 250 mg p.o qid times ten days.
4. Vitamins BID while on antibiotic.

Suspected Peritonitis

1. Peritonitis is indicated by the presence of any three of the following symptoms:
 - a) Cloudy effluent
 - b) Fever
 - c) Abdominal pain/cramping
 - d) Bloody effluent
 - e) Nausea and vomiting
 - f) Peritoneal fluid WBC count greater than 100

Upon noting these symptoms, the patient will call the CAPD/CCPD office or dialysis fellow on-call, do three rapid exchanges, the first bag of effluent should be saved and refrigerated until brought to laboratory for culture.

2. Fourth exchange to contain:

Kefzol 1 gram
Tobramycin 1.7 mg/kg IBW
Heparin 500u/liter dialysate
This exchange to dwell times six hours.
3. Subsequent exchanges to contain 500 mg Kefzol for ten days unless otherwise instructed by the peritoneal dialysis team.
4. First effluent to laboratory for culture and sensitivities, fluid cell count and gram stain.
5. When sensitivities are available, nurse may order:
 - a) Kefzol 500 mg IP each exchange OR
 - b) Tobramycin 8 mg/liter IP each exchange OR
 - c) Vancomycin 1 gram IP to dwell six hours followed by repeat dose in 10 days.

Most efficacious drug on screen to be used. Nurse should consult physician within 8 hours of instituting these orders. If most efficacious drug is not one of the above, nurse must notify physician immediately.

APPROVED: *Silvia Azar* Silvia Azar

Barbara Tebbitt Barbara Tebbitt

TITLE: Medical Director

Director of Nursing

DATE: 3/13/86

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SECTION: Page 2	
VOL:	POLICY NUMBER:
SUBJECT: Infection Protocols	

Gross Contamination of Peritoneal Fluid Pathway

1. Drain abdomen completely.
2. Instill Vancomycin 1 gram IP to dwell times six hours.
3. Transfer set should be changed within 7 to 10 days.

Prophylactic Antibiotics During Dental Work

Penicillin G 2 grams P.O. 30-60 minutes before the procedure then 500 mg P.O. qid times eight doses.

If patient is allergic to penicillin, the patient should be given Vancomycin 1 gram IP to dwell six hours, or Erythromycin 1 gram P.O. 90-120 minutes before the procedure followed by Erythromycin 500 mg P.O. every 6 hours times eight doses.

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POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Protocol for Intraperitoneal Insulin

SOURCE: CAPD/CCPD

SECTION:

VOL.: POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/86

The peritoneal dialysis team and patient will make the decision whether a patient is appropriate for intraperitoneal insulin administration. CCPD patients will continue with subcutaneous insulin during the daytime.

Training Day # 1: Patient should administer subcutaneous insulin as usual. The nurse will obtain every 2 hour glucose measurements using the equipment that the patient will use for home glucose monitoring.

Training Day # 2: Patient should come to the training unit with a fasting blood sugar measurement and hold his own morning subcutaneous insulin dose.

The first exchange of the day will include insulin according to the following formula

Total number of units of insulin patient normally uses in a 24 hour period } divided by 4 plus { 0 units for 1.5% Dextrose
2 units for 2.5% Dextrose
4 units for 4.25 Dextrose

If fasting blood sugar is greater than 250, add 2 additional units regular insulin.

Blood glucose monitoring will continue every 2 hours during training.

The Nurse may give subcutaneous regular insulin for blood sugars over 250 according to sliding scale:

250 - 350 5 units regular
450 + 10 units regular

Check urine ketones for blood sugar greater than 250 times 24 hours.

Continue with intraperitoneal insulin per the schedule above.

Training Day # 3: Continues with intraperitoneal insulin per basic formula. If subcutaneous insulin was required on Day # 2, that amount of insulin will be calculated into the basic formula.

The nurse may also titrate by increments of 1-2 units to establish control evidenced by random blood sugars less than 200.

If the patient is not able to dialyze at home independently, cover evening blood glucoses per sliding scale.

Training Day # 4: As for Day # 3. Patient may begin to titrate own insulin at the discretion of the dialysis nurse.

Only those patients who have been trained to use intraperitoneal insulin should receive insulin by this route.

Silvia Azar *Barbara Tebbitt*

sks
041686

APPROVED: Silvia Azar Barbara Tebbitt

TITLE: Medical Director Director of Nursing

DATE: 3/13/86

32.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Masks in Dialysis
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	March 1, 1979
REVISION:	March, 1986
REVIEWED:	

MASKS IN DIALYSIS

Masks will be worn when:

- A. Setting up sterile trays.
- B. Performing sterile procedures.
- C. Working over an exposed shunt or wound.
- D. Staff member has an upper respiratory infection.

sks
041686

APPROVED:	<i>Silvia Azar</i> Silvia Azar	<i>Barbara Tebbitt</i> Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Medical Records Retention
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 1 March 1985	
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REVIEWED: 2/14/86	

All records held by the Peritoneal Dialysis Home Training Unit will be maintained on the premises for a period of 5 years, or that period mandated by state statute, which ever is longer.

These records will be limited to the contents of the patient's dialysis chart i.e., physician orders, training records, progress notes, Dialysis Flow Sheets, Laboratory data sheets, and hospital discharge summaries.

sks
041686

<i>Silvia Azar</i>	<i>Barbara Tebbitt</i>	DATE: 3/13/86	34.
APPROVED: Silvia Azar	Barbara Tebbitt		
TITLE: Medical Director	Director of Nursing		

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: MEDICATION PROTOCOL
SOURCE: CAPD/CCPD

SECTION:	Page 1
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
REVISION:	
REVIEWED:	2/14/86

Routine Medications

Alternagel 15-30 cc po tid or qid OR
Alucaps 1-6 p.o. with meals and at HS OR
Basalgel 1-6 caps p.o. with meals and at HS
Amphogel 15-30 cc p.o. with meals and at HS
Tums 1-2 tablets with meals and at HS
Amphogel tabs (10 grain) as directed by cookie receipt
Calcium carbonate 15 cc or one tab with meals and at HS
Berocca vitamin 1 p.o. qd, except while on antibiotics
(If patient is on antibiotics, Berocca 1 tab p.o. bid)

For Constipation

For constipation: Colace 100 mg p.o. qd or BID
OR
Lactulose 15-30 cc p.o. qd BID or TID
Should be titrated by nurse and patient.

For Urine Output

Lasix should be given to patients with urine output. Nurse may titrate dose to 240 mg p.o. BID. 24 hour urine volumes should be documented both on and off Lasix. If no significant response to Lasix, the medication should be discontinued.

Antihypertensives

Nurse may instruct patients to hold antihypertensive medications for blood pressure less than 100/60. The physician must be consulted if titration or discontinuation of antihypertensive medications is desired.

Heparin

Heparin 500u/liter dialysate IP prn notation of fibrin in effluent. The nurse should instruct the patient in the addition of medications to dialysate and send Heparin and supplies with the patient at the time of discharge from training.

S. Azar *Barbara Tebbitt*

APPROVED:	Silvia Azar	Barbara Tebbitt	DATE: 3/13/86	35.
TITLE:	Medical Director	Director of Nursing		

SECTION: Page 2	
VOL.:	POLICY NUMBER:
SUBJECT: MEDICATION PROTOCOL	

Other

All other medications should be reviewed with the patient and continued. The physician should be consulted if there is a question about continuing any outpatient medications.

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POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	MINIMUM REQUIREMENTS FOR HOME CARE DIALYSIS
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
REVISION:	
REVIEWED: 2/14/86	

Patients who have been discharged from training will be considered safe to perform self dialysis if the following items can be documented:

1. Repeated return demonstrations of vital signs measurement.
2. Repeated return demonstrations of the exchange procedure without error.
3. One demonstration of the ability to use the toll-free number to summon peritoneal dialysis nurses.
4. Demonstration of an ability to maintain and mail the dialysis flow sheets.

These criteria will be met by the patient or a resident of the same home.

If there is reason to question the patient's ability to learn, performance of exit site care will be used to determine the patient's appropriateness for home care. At least two attempts will be made over a two week period to teach proper exit site care. The patient will demonstrate site care at least four times. If at the end of the two week period, the patient cannot correctly demonstrate exit site care, he/she will be deemed inappropriate for home care training at that time. This will not preclude future home care training.

If the patient cannot meet the minimum criteria for home care within 15 training days, the medical director will be informed. If it appears that the patient can meet the criteria within three additional training days, application will be made to Medicare for the three additional days, and training will continue. If it does not appear that the patient will be able to meet minimum requirements, a conference will be held to explore other options for care with the patient and/or family. This will not preclude the patient from further training attempts.

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S. Azar *Barbara Tebbitt*

APPROVED:	Silvia Azar	Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

37.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Notifying the Physician of
Patient Problems and Emergencies

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: March, 1985

REVISION:

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There will be a physician rotation and on call schedule posted in the training unit. This schedule will indicate the attending physician in charge plus the daily fellow coverage in the unit for that month.

The responsible physician in charge will be called any time nursing judgement indicates that a changing patient condition cannot be solved. Things which can be done to resolve problems in relation to the patient are covered by the standing orders.

In the case of emergency, the nurse will immediately notify the physician in charge of the renal unit via the triple page procedure and/or initiate the appropriate emergency response. Cardio-pulmonary resuscitation will be initiated immediately by qualified nurses.

If the nurse receives an order from a physician that is questionable, he/she may call the attending physician or the Medical Director of the Peritoneal Dialysis Unit.

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041686

Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar

Barbara Tebbitt

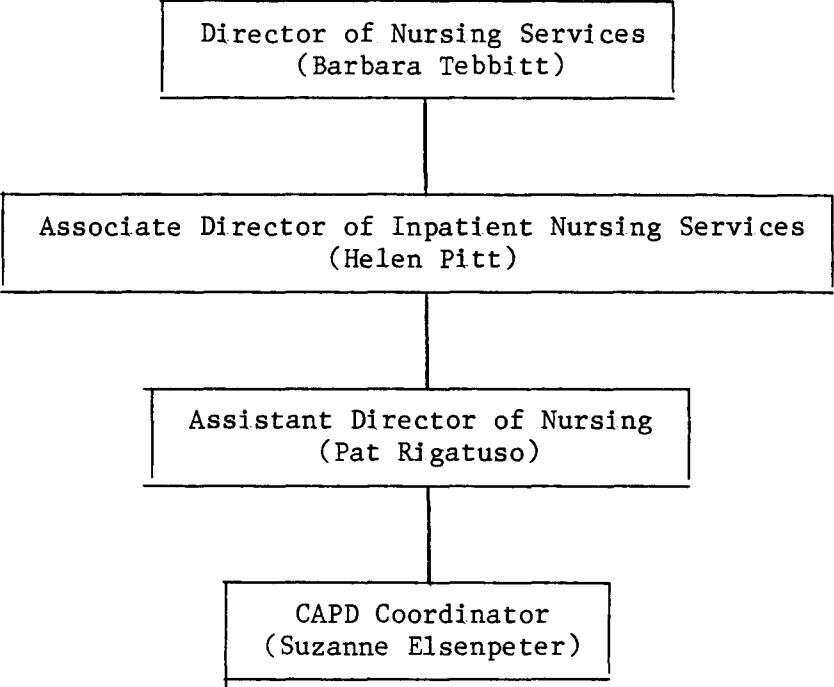
TITLE: Medical Director

Director of Nursing

DATE: 3/13/86

38.

ORGANIZATIONAL STRUCTURE
FOR
PATIENT CARE AREA CAPD



LEGEND:

_____ indicates direct responsibility and authority

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: PATIENT EDUCATION/INFORMATION
SOURCE: CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
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1. Patients receive basic information about dialysis from nurses, social workers and/or physicians. This information includes the types of dialysis available (i.e., hemodialysis or peritoneal dialysis), the advantages and disadvantages to either method, and the feasibility of transplantation; patient expectations are also reviewed.
2. If medically feasible, patients will attend pre-dialysis classes before training is begun.
3. Patients may review the contents of their medical record in accordance with hospital policy, i.e., in the presence of a physician who can explain the contents of the record.
4. All patients are encouraged to attend and participate in any team conference which includes discussion of his/her condition and plan of care.

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S. Azar *Barbara Tebbitt*

APPROVED: Silvia Azar	Barbara Tebbitt	DATE: 3/13/86	40.
TITLE: Medical Director	Director of Nursing		

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	PATIENT SELECTION CRITERIA
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
REVISION:	
REVIEWED:	2/14/86

The philosophy of the Dialysis Programs is to accept anyone who is in need of treatment for Acute or Chronic Renal Failure.

We believe that there are no criteria for predicting a patient's ability to learn self-care or for predicting his or her eventual adaptation to such a program. Furthermore, it is impossible to adequately define a patient's rehabilitative potential. Therefore, any patient deemed by the medical director fit for home training will be admitted to the training unit, with the following exceptions:

1. In accordance with Medicare regulations, no residents of a Nursing Home can be admitted to or maintained by the program. If a patient is admitted to the Nursing Home after he/she has been dialyzing at home, the team will consult with the patient and/or family to provide other dialysis options and care until such time as the patient is able to return home.
2. Patients unable to be adequately dialyzed at home, or who appear to need acute peritoneal dialysis will be admitted to the hospital until the medical director has deemed them stable for home care.

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APPROVED:	Barbara Tebbitt	Silvia Azar	DATE:	3/13/86	41.
TITLE:	Director of Nursing	Medical Director			

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Physician Orders
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
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REVIEWED:	2/14/86

1. The training nurse will institute dialysis orders using the peritoneal dialysis physician standing orders and protocols. The medical director or designated physician will be informed of the patient's condition within 8 hours of instituting any protocol or standing orders.
2. Orders will be initiated on the first training day and updated as appropriate.
3. The medical director or designated physician will sign off all orders within one working day.

sks
041686

Silvia Azar

Barbara Tebbitt

APPROVED:	Silvia Azar	Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Priority for Dialysis
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 4 September 1985	
REVISION:	
REVIEWED: 2/14/86	

Under some circumstances, there will be more patients needing dialysis training than the facility is able to accommodate. On these occasions, the physician in charge will review all patients ready for training to determine the options available. Some patients may be able to undergo hemodialysis, other may be able to delay dialysis until a later date. In making this decision, the patients proximity to other resources, the patient's urea, creatinine, potassium, and fluid status, and relevant social factors will be considered.

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041686

<i>Silvia Azar</i>	<i>Barbara Tebbitt</i>
APPROVED: Silvia Azar	Barbara Tebbitt
TITLE: Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	Statement of Purpose of the Peritoneal Dialysis Unit
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE: 4 September 1984	
REVISION:	
REVIEWED: 2/14/86	

The purpose of the Peritoneal Dialysis Unit at the University of Minnesota includes, but is not limited to:

1. Provision of training for self-care peritoneal dialysis to any patients with end-stage renal disease.
2. Provision of on-going education and management of those patients on self-care peritoneal dialysis.
3. Provision of education and consultative support services to patient care areas at the University of Minnesota which house peritoneal dialysis patients.

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041686

Silvia Azar

Barbara Tebbitt

APPROVED:	Silvia Azar	Barbara Tebbitt
TITLE:	Medical Director	Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT:	SUPPORT SERVICES
SOURCE:	CAPD/CCPD

SECTION:	
VOL.:	POLICY NUMBER:
EFFECTIVE:	1 March 1985
REVISION:	
REVIEWED:	2/14/86

1. The Home Training Unit makes available under agreement, the ordering of supplies and the installation and maintenance of patient equipment.

During training, the dialysis team determines the appropriate method of peritoneal dialysis based on patient need and ability. A prescription is completed and submitted to the appropriate manufacturer who then assumes responsibility for the ordering of supplies and the installation and maintenance of the patient's equipment.

If at any time the patient requests to use an alternate system of peritoneal dialysis, this request will be accommodated if in the assessment of the dialysis team, the alternate method is appropriate to patient need and ability.

2. The Home Training Unit also provides:
 - a) a direct record keeping system
 - b) direct Social Service consultation
 - c) direct dietician consultation
 - d) direct or by arrangement the services of local social workers, nurses and/or dieticians.
 - e) emergency and resource phone numbers.

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S. Azar *Barbara Tebbitt*

APPROVED:	Silvia Azar	Barbara Tebbitt	DATE:	3/13/86	45.
TITLE:	Medical Director	Director of Nursing			

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Support Services Provided to Home Patients

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: September, 1984

REVISION: 2/14/86

REVIEWED:

1. A Peritoneal Dialysis Nurse will provide on-call coverage to self care patients during regular office hours. M-F, 8:00 - 4:30 pm. Evening, weekend and holiday coverage will be provided by the dialysis fellow.
The training program will address the mechanisms by which emergency assistance can be obtained.
2. In the event that the patient or peritoneal dialysis nurse on-call feel that hospital admission is indicated or specific medical management is required, the nurse will notify the dialysis fellow on-call or the Medical Director.
3. In the absence of the Medical Director, the dialysis fellow and dialysis attending physician will provide medical coverage to the peritoneal dialysis unit.

sks
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Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar

Barbara Tebbitt

TITLE: Medical Director

Director of Nursing

DATE: 3/13/86

46.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Training Hours and Days

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/14/86

1. In accordance with Medicare Regulations, all patients will be discharged from the hospital at least one calendar day prior to the first training day.
2. Training will commence only on Mondays or Tuesdays because it is the experience of the Home Training Unit that at least four training days are required before a patient is ready for independent dialysis. No training will occur on Saturdays or Sundays.
3. Training days will be a minimum of 5 hours in length.
4. Training will continue until the patient can meet the optimum standards (see Training Log) or 18 training days have been used.

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Silvia Azar

Barbara Tebbitt

APPROVED: Silvia Azar

Barbara Tebbitt

TITLE: Medical Director

Director of Nursing

DATE: 3/13/86

47.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Transfer of Medical Information

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/14/86

1. When a patient is transferred to another facility for dialysis, the peritoneal dialysis nurse will complete a Home Health Referral and send a copy to the receiving facility within 24 hours of the transfer. If applicable, a letter will also be sent, along with a copy of the most recent hospital discharge summary to the receiving unit. The letter may contain, but is not limited to routine therapeutic needs of the patient and special approaches. A copy of this communication will be included in the patient's U of M medical record.

sks
041686

Silvia Azar *Barbara Tebbitt*
APPROVED: Silvia Azar Barbara Tebbitt
TITLE: Medical Director Director of Nursing

DATE: 3/13/86

48.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Transfer Set Changes

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 1 March 1985

REVISION:

REVIEWED: 2/14/86

1. All CAPD patients will have timely transfer set changes.
2. If the patient is expected to change his/her own transfer set, return demonstration of this skill will be documented.
3. Patients using urethane lines will have the lines changed every 6 months or more often, as indicated.
4. Transfer sets will be changed within 10 days of the onset of any episode of peritonitis.

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041686

Silvia Azar
APPROVED: Silvia Azar

Barbara Tebbitt
Barbara Tebbitt

TITLE: Medical Director Director of Nursing

DATE: 3/13/86

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services

SECTION: Page 1	
VOL:	POLICY NUMBER:
EFFECTIVE: 1 March 1985	
REVISION: 14 February 1986	
REVIEWED:	



SUBJECT: TRAINING PROTOCOLS
SOURCE: CAPD/CCPD

1. Peritoneal dialysis nurses will utilize any of the following the nurse's assessment of the patient's need:
 - Abbott Inpersol LM Dialysate in 1.5%, 2.5%, or 4.25% dextrose concentration.
 - Travenol PD II Dialysate in 1.5%, 2.5%, 3.5%, or 4.25% dextrose concentration.
 - McGaw Dialysate in plastic jugs (Nal31) in 1.5% or 4.25% dextrose concentration.
 - Abbott System Three connectology.
 - Abbott System One connectology.
 - Travenol conventional connectology.
 - Travenol UVXD connectology.
 - Delflex Safe-Lock connectology.
 - Delmed cycler tubing with Unispikes prongs, or Safe-Lock connectology
 - Abbott Patient Assist Device
 - Travenol UVXD Germicidal Chamber
 - Travenol Pnc X Cyclor
 - Travenol Cyclor Tubing
 - Delflex LM Dialysate 1.5%, 2.5%, 4.25%
2. Exchanges will be of 750cc, 1000cc, 1500cc, 2000cc, 2500cc, or 3000cc volumes to achieve maximum clearances without respiratory distress or excessive patient discomfort. Clearance studies and laboratory determination of serum chemistries will indicate appropriate clearance.
3. Cyclor patients will use volumes, fill and dwell times and drain time as recommended based on laboratory determination of appropriate clearance.
4. The goal of dialytic therapy is to maintain ideal body weight, with serum potassium less than 5.5, BUN less than 110, and creatinine less than 12.0, and establish nitrogen balance as close to normal as possible.
5. CAPD patients will do 3-5 exchanges daily to maintain adequate dialysis as defined in item 4 above.
6. The peritoneal dialysis nurse may irrigate the P.D. catheter with 1000u Heparin per liter of dialysate prn failure of the catheter to drain.
7. Laboratory studies will be drawn on the first or second training day at discharge and on each clinic visit. These studies will include:
 - a. GNEC, calcium, phosphorous, magnesium
 - b. Albumin and alkaline phosphatase
 - c. CBC with differential
 - d. SGOT (if not documented within 1 month)
 - e. Hepatitis profile (once yearly)
 - f. Mg once yearly
 - g. AST once every 3 months

S. Azar *Barbara Tebbitt*

APPROVED: Sylvia Azar	Barbara Tebbitt	DATE: 3/13/86	50.
TITLE: Medical Director	Director of Nursing		

SECTION: Page 2	
VOL.:	POLICY NUMBER:
SUBJECT: TRAINING PROTOCOLS	

8. Exit site care with peroxide and Betadine solution will be done once daily unless exit site infection is suspected. If infection is suspected or present, care will be done twice daily.
9. Social service and Dietary evaluations will be completed during training.
10. All diabetic patients will be trained in the use of home glucose monitoring equipment, blood pressure instrumentation, talking scales and other equipment specifically designed for use by the visually impaired.
11. All patients considered medically eligible for transplantation will attend the Pre-Transplant Class.
12. The peritoneal dialysis nurse will assist all transplant candidates in completing the transplant work-up by making the necessary referrals and asking that the patient be presented in Transplant Conference when work-up is complete.
13. A family member may be trained to assist with or perform dialysis therapy. Nurses or other care assistants will not be trained for this purpose.
14. Referral to the patient's local PHN and or social service is made if deemed appropriate by the dialysis team.
15. The first return to clinic appointment will be made by the training nurse. The interval between discharge from training will be not less than 4 weeks and determined by the nurse based on patient's stability and need for follow up.
16. The peritoneal dialysis nurse will place the initial supply order with the appropriate manufacturer and monitor the patient's management of his home supplies.

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POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

Department of Nursing Services



SUBJECT: Self-Care Training

SOURCE: CAPD/CCPD

SECTION:

VOL.:

POLICY NUMBER:

EFFECTIVE: 4 September 1986

REVISION:

REVIEWED: 2/14/86

1. Training to prepare a patient for performing self-care peritoneal dialysis will include, but not be limited to:
 - a. education and understanding of their disease,
 - b. ability to perform the complete procedure which includes sterile techniques,
 - c. understanding their diet, blood pressure, body weight and how each affects the other,
 - d. ability to recognize adverse symptoms of their disease or complications of the dialysis,
 - e. recognition of peritonitis symptoms, knowledge of, and ability to perform the necessary emergency treatment procedures,
 - f. understanding their medications and their effects,
 - g. ability to properly care for the site of the peritoneal dialysis catheter, and
 - h. knowing who to contact at the University Hospitals when the need arises.

2. A patient will be deemed ready for discharge to his/her home for self-care when these minimum standards can be documented:
 - a. the home training log is completed,
 - b. the ability to reliably measure and report vital signs and body weights has been demonstrated by the patient and or the dialysis assistant,
 - c. the patient's medical condition has been evaluated and pronounced to be stable by the attending physician,
 - d. the patient has demonstrated the ability to call for help during off-hours,
 - e. the social worker and dietician have evaluated the patient, and
 - f. the patient has demonstrated rudimentary understanding of emergency procedures.

3. In the event that minimum standards cannot be met in the 15 training days, a team conference will be held to explore options for provision of dialysis care.

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Silvia Azar Barbara Tebbitt

APPROVED: Silvia Azar Barbara Tebbitt

TITLE: Medical Director Director of Nursing

DATE: 3/13/86

**Minutes
Meeting of the
Board of Governors Finance Committee
University of Minnesota Hospitals & Clinics
March 26, 1986**

**MEMBERS
PRESENT:** Edward Ciriacy, M.D.
Clifford Fearing
William Krivit, M.D., Ph.D.
Jerry Meilahn
Anton Potami
C. Edward Schwartz
Vic Vikmanis

**MEMBERS
ABSENT:** Al Hanser
Robert Nickoloff

STAFF: Greg Hart
Nels Larson
Jane Morris
Helen Pitt

GUESTS: Jerry Collingham

**CALL TO
ORDER:** The meeting of the Finance Committee was chaired by
Mr. Jerry Meilahn and was called to order at 10:00 a.m.
in Room 626 of the Campus Club.

**MINUTES
APPROVED:** The minutes of the Finance Committee meetings held on 2/26/86
and 1/22/86 were approved.

**FEBRUARY YTD
FINANCIAL
STATEMENTS
(INFORMATION):** Mr. Fearing reviewed the Report of Operations for the period
July 1, 1985 through February 28, 1986. He reported that
admissions through February of 11,555 were 2.5% below projections
and patient days for the period totaling 95,222 were 1,829 below
budget. Overall length of stay of 8.3 days was slightly above the
projected level of 8.1 days. Outpatient clinic visits for the
period were 145,034 or 7,121 (5.2%) above projected visits.

Total revenues over expense through February 28, 1986 are
\$12,344,884, a favorable variance of \$6,488,781 reflecting both a
favorable variance in net operating and non-operating revenues.
Patient care charges through February totaled \$128,518,101 (4.6%
above budget). Ancillary revenue is approximately \$5,375,000
(6.3%) above budget. Operating expenditures for the period were
\$115,758,077, or approximately \$1,700,000 above budgeted levels.

The balance in patient accounts receivable as of February 28, 1986 totaled \$52,096,901 representing 94.3 days of revenue outstanding. Total receivables increased during the month of February primarily within the commercial insurance and Minnesota Medical Assistance category.

Mr. Fearing gave an itemized review of the January financial statements. In regard to the cash flow, he stated that total operating cash available of \$1,843,176 plus transfers to plant of \$5,426,714 plus transfer to sinking fund of \$5,078,333 equals cash generated from operations of \$12,348,223. Also, \$7,597,713 in Medicare recoupments earned in fiscal year ending 6/30/85 was received in the current year and transferred to reserves. Mr. Fearing concluded that the Hospital continues to be in a very good position financially.

**1986-87
PRELIMINARY
BUDGET REVIEW
(INFORMATION):**

Mr. Fearing provided the Committee with a packet of materials describing the 1986-87 Operating Budget for UMHC. Review of the budget packet is being initiated in the Finance Committee only this month, with presentation to the full Board of Governors scheduled for April, and final approval scheduled to occur in May. Mr. Fearing explained that there needs to be some fine tuning made to the figures presented here. Mr. Fearing also noted that this budget has been projected from a macro planning perspective rather than from departmental detail. After the move into Unit J however, departments will complete their budgets consistent with the parameters identified in the budget schedules. Major assumptions used in building this budget are: 1) changes in the Medicare payment system, Medical Assistance (Medicaid) and General Assistance Medical Care (GAMC), 2) the 1985-86 budget base, and 3) fiscal year 1986-87 price and revenue increases.

Mr. Fearing reviewed the accompanying budget schedules projecting inpatient and outpatient admissions, patient days, expense and revenues summaries, Statement of Operations and Cash Flow. In regard to inpatient admissions, he stated that comparisons are being prepared to show the affect of significant changes in the projected admission figure which will be brought to the Committee in April. There was discussion by committee members regarding methods to improve admissions and on initiating outside contracts as a preferred hospital.

A schedule regarding full-time equivalents was reviewed by Mr. Hart. Budgeted FTEs for 1986-87 are 3,458.35, with the greatest increases relating to Bone Marrow Transplant and Unit J changes.

**REFINANCING
UPDATE
(ENDORSEMENT):**

Mr. Fearing distributed a schedule outlining net debt service for 1987 and a proposed resolution for Hospital debt refinancing. He explained that a refinancing now would save \$575,000 on an annual basis of the \$75,000,000 in long term bonds, with an aggregate savings of \$14 - \$15 million. The proposed refinancing resolution reads as follows:

Whereas, the Board of Governors of the University of Minnesota Hospital and Clinic (UMHC) support the principal of providing the highest quality of health care at the lowest reasonable cost, and

Whereas, the present financial markets provide an opportunity to reduce the interest expense on UMHC's long term debt,

Therefore be it resolved, that the Board of Governors endorse UMHC's plan to refinance UMHC's long term debt and reduce its interest expense, and instructs Hospital management to continue working with the appropriate University officials to accomplish these objectives.

A motion was made and approved by the Committee to endorse the proposed resolution and recommend it for approval to the full Board of Governors.

**COMPARABLE
WORTH
(ENDORSEMENT):**

Mr. Hart informed the Committee that the Board of Regents approved a pay equity plan at their March 7th meeting. In April, 1985, the Board of Governors approved a comparable worth implementation plan, but with the understanding that action on this would take place in concert with the Board of Regents action. Given the Regent's action, Mr. Hart requested that the Finance Committee give authorization to actually pay the comparable worth increases endorsed earlier. Mr. Hart added that the Hospital is in the process of developing recommendations for all UMHC employees, including those classified as University-dominated, to be under Hospital autonomy.

A motion was made and approved by the Committee to endorse taking action on the comparable worth implementation plan and to recommend this action for approval to the full Board of Governors.

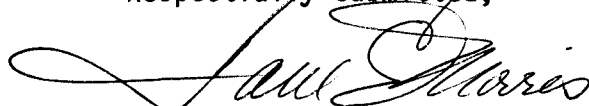
**AUDITORS MANAGEMENT
LETTER OF
RECOMMENDATIONS
(INFORMATION):**

Mr. Fearing presented the management letter of recommendations from the Hospital's auditors, Peat, Marwick, Mitchell & Co. Only one recommendation is being brought to the attention of the Committee at this time as a Board-related item. The recommendation suggests that the Hospital develop an alternative

to the current general ledger system. Mr. Fearing introduced Mr. Jerry Collingham who explained the problem of the University and the Hospital using different accounting systems. Because of this, an inordinate amount of time is spent transferring Hospital transactions to the University system. Software packages are now being evaluated to change the Hospital's current general ledger system with an anticipated implementation date of July, 1987. When the appropriate package is decided upon, it will be brought to this Committee for its review and approval.

ADJOURNMENT: There being no further business, the meeting of the Finance Committee was adjourned at 11:45 am.

Respectfully submitted,



Jane E. Morris
Recording Secretary

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS
EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY
FOR THE PERIOD JULY 1, 1985 TO MARCH 31, 1986

	<u>Budgeted</u>	<u>Actual</u>	<u>Variance Over/-Under Budget</u>	<u>Variance %</u>
Patient Care Charges	\$138,587,724	\$145,695,059	\$7,107,335	5.1%
Deductions from Charges	-21,992,039	-22,179,108	-187,069	-0.9%
Other Operating Revenue	3,159,144	3,653,797	494,653	15.7%
Total Operating Revenue	<u>119,754,829</u>	<u>127,169,748</u>	<u>7,414,919</u>	<u>6.2%</u>
Total Expenditures	-128,718,039	-130,984,874	-2,266,835	-1.8%
Net Operating Revenue	-8,963,210	-3,815,126	5,148,084	0.0%
Non-Operating Revenue	<u>15,496,256</u>	<u>17,527,759</u>	<u>2,031,503</u>	<u>13.1%</u>
Revenue Over Expense	<u>\$6,533,046</u>	<u>\$13,712,633</u>	<u>\$7,179,587</u>	<u>(1)</u>

(1) Variance equals 5.3 % of total budgeted revenue.

	<u>Budgeted</u>	<u>Actual</u>	<u>Variance Over/-Under Budget</u>	<u>Variance %</u>
Admissions	13,388	13,000	-388	-2.9%
Patient Days	109,237	107,721	-1,516	-1.4%
Average Daily Census	398.7	393.1	-5.6	-1.4%
Average Length of Stay	8.2	8.3	0.1	1.2%
Percentage Occupancy	66.7%	66.6%	-0.1%	-0.2%
Outpatient Clinic Visits	155,047	163,361	8,314	5.4%



April 23, 1986

TO: Board of Governors
FROM: Clifford P. Fearing
Senior Associate Director
SUBJECT: Report of Operations for the Period
July 1, 1985 through March 31, 1986.

The Hospital's operations for March reflects inpatient admission levels that are below budget and an outpatient census that continues to be above budgeted levels. Ancillary service utilization continues at levels higher than anticipated with regard to both inpatient and outpatient populations. To highlight our position:

Inpatient Census: For the month of March, inpatient admissions totaled 1,445 or 97 below projected admissions of 1,542. Our overall average length of stay for the month was 8.5 days. Patient days for March totaled 12,499 and were 313 days above projections.

Most service areas experienced admission levels below budget this month. However, Ophthalmology, Psychiatry, Surgery and Urology experienced admission levels above budget during March. The year-to-date decrease in admission levels remains primarily in the areas of Medicine, Newborn/Obstetrics, and Otolaryngology.

To recap our year-to-date inpatient census:

	1984-85 Actual	1985-86 Budget	1985-86 Actual	% Variance	% Variance
Admissions	13,706	13,388	13,000	<388>	<2.9>
Avg. Lgth. of Stay	8.6	8.1	8.4	0.3	3.7
Patient Days	118,622	109,237	107,721	<1,516>	<1.4>
Percent Occupancy	65.0	66.7	65.7	<1.0>	<1.5>
Avg. Daily Census	432.9	398.7	393.1	<5.6>	<1.4>

Outpatient Census: Clinic visits for the month of March totaled 18,327 or 1,193 (7.0%) above projected visits of 17,134. The March year-to-date clinic census totaled 163,361 visits and is 5.4% (8,314 visits) above budget and 6.4% (9,765 visits) above our March total of a year ago.

Financial Operations: The Hospitals Statement of Operations shows total revenues over expenses of \$13,712,633 a favorable variance of \$7,179,591. This overall variance reflects both a favorable variance in net revenues from operations of \$5,148,000 and a favorable variance in non-operating revenue of \$2,021,000 due primarily to our investment income being higher than anticipated.

Patient care charges through March totaled \$145,695,059 and is 5.1% above budget. Routine revenue is 1.3% above budget and differs from our patient day variance which is 1.4% below budget. This difference continues to be due to a change in the mix of our bed utilization whereby we have experienced a slightly higher proportion of patient days in our higher priced beds (Intensive Care Units and Psychiatry). Ancillary revenue is approximately \$6,537,000 (6.8%) above budget and relates to the fact that (1) outpatient clinic visits are above projections, and (2) the utilization of ancillary services per patient are higher than anticipated. Inpatient ancillary revenue has averaged \$5,945 per admission compared to the budgeted average of \$5,570 per admission. Outpatient revenue per clinic visit is averaging \$149 compared to the budgeted average of \$136.

Operating expenditures through March totaled \$130,984,874 and are approximately \$2,267,000 (1.8%) above budgeted levels. The overall unfavorable variance is primarily related to personnel costs (salaries and fringe benefits), drugs, and medical supplies. The increased expenditure levels in these categories continues to reflect an increase in the average acuity of the inpatient population and the increase in our outpatient census levels. The increase in the overall acuity level of our inpatient population is evidenced by both the increase in the utilization of intensive care beds and the increased level of ancillary service utilization.

Accounts Receivable: The balance in patient accounts receivable as of March 31, 1986 totaled \$54,951,247 and represents 96.0 days of revenue outstanding. While our receivables increased in a number of areas this month, the largest increases occurred within the Medicare and Minnesota Medical Assistance categories. It should be noted that Medicare is not paying any claims submitted after March 15 pending HCFA direction on how to handle the reduction in payment levels authorized under the Gramm-Rudmann-Hollings Act.

Conclusion: The Hospital's overall operating position through March remains positive and above budgeted levels. While our inpatient census levels continue to be lower than anticipated, the impact is being offset by increased intensity of care and by outpatient demand in excess of budgeted levels.

/jem

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1985 TO MARCH 31, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	\$138,587,724	\$145,695,059	\$7,107,335	5.1%
Deductions from Charges	21,992,039	22,179,108	187,069	0.9%
Other Operating Revenue	3,159,144	3,653,797	494,653	15.7%
Total Revenue from Operations	\$119,754,829	\$127,169,748	\$7,414,919	6.2%
Expenditures				
Salaries	\$60,562,303	\$61,951,439	\$1,389,136	2.3%
Fringe Benefits	10,790,137	11,603,976	813,839	7.5
Contract Compensation	6,595,920	6,395,222	-200,698	-3.0
Medical Supplies, Drugs, Blood	19,431,882	20,483,634	1,051,752	5.4
Campus Administration Expense	4,448,664	4,448,664	0	
Depreciation	5,571,879	5,816,317	244,438	4.4
General Supplies & Expense	21,317,254	20,285,622	-1,031,632	-4.8
Total Expenditures	\$128,718,039	\$130,984,874	\$2,266,835	1.8%
Net Revenue from Operations	\$-8,963,210	\$-3,815,126	\$5,148,084	
Non-Operating Revenue				
Appropriations	\$10,619,616	\$10,619,616	0	
Interest Income on Reserves	3,221,750	5,182,501	\$1,960,751	
Shared Services	299,997	338,665	38,668	12.9%
Investment Income on Trustee Held Assets	1,354,893	1,386,977	32,084	2.4
Total Non-Operating Revenue	\$15,496,256	\$17,527,759	\$2,031,503	13.1%
Revenue Over / -Under Expenses	\$6,533,046	\$13,712,633	\$7,179,587	(1)

(1) Variance equals 5.3% of total budgeted revenue.



UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

April 23, 1986

TO: Members, Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Bad Debts -- July 1, 1985 through March 31, 1986.

The total amount recommended for bad debt of Hospital accounts receivable during the third quarter of 1985-86 is \$487,173.89, represented by 1,266 accounts. Bad debt recoveries during the period amounted to \$8,038.00, leaving a net charge off of \$479,135.89.

Total bad debts for the first three quarters of 1985-86 amount to \$1,595,687.44 which is 1.1% of gross charges. This compares to a budgeted level of bad debts of 1.33%.

A statistical summary follows on this report with detailed description of losses over \$2,000 and recoveries over \$200.

CPF/jem

enc.



UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

April 23, 1986

TO: Members, Board of Governors
FROM: Greg Hart
Senior Associate Director
SUBJECT: Capital Budget.

Attached is a proposed Capital Budget Summary for 1986-87, along with a major capital expenditure projection for the next five years. We will review this item for informational purposes with the Board in April, seeking your approval in May.

We will be happy to answer any questions you may have on Wednesday.

GH/jem

CAPITAL BUDGET SUMMARY

I. 1986-87 Recurring Capital Items (Funded from current year capital)

Cardio-Respiratory	\$ 600,000
Operating Rooms	400,000
Heart Cath Lab	350,000
Clinical Laboratories	450,000
Labs Computer	400,000*
Radiology	500,000
ISD Computer Upgrade	700,000**
Miscellaneous Equipment/Remodeling	700,000
	<u>\$4,100,000</u>

* Total Purchase \$1,200,000; \$800,000 budgeted last year not yet spent.

** Total Purchase estimated at \$2,100,000; payments to be spread over approximately three years.

II. Major Capital Expenditures (Funded from prior year reserves)

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Clinic Space Completion	\$539,000				
Mayo Remodeling-General		\$1,000,000	\$1,000,000	\$1,000,000	
Mayo Remodeling-OB	\$1,000,000	\$1,000,000			
Mayo Remodeling-Equipment	\$250,000	\$250,000			
Epilepsy Remodeling	\$550,000	\$600,000			
CRC Remodeling	\$125,000				
MRI (Second Unit)		\$2,000,000	\$2,000,000		
Human Genetics	\$150,000				
	<u>\$2,614,000</u>	<u>\$4,850,000</u>	<u>\$3,000,000</u>	<u>\$1,000,000</u>	

III. Other Major Projects (Funded by borrowing)

Parking Ramp/Tunnel	\$ 5,900,000
Psychiatry	4,200,000
cystoscopy	400,000
Other Mayo	1,300,000
	<u>\$11,800,000</u>