The University of Minnesota Hospital and Clinic

Board of Governors

October 22, 1986

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** OTHER ATTACHMENTS **

"Business Up Since U Hospital's Move, Minnesota Daily, 10/1/86
"U Patient Tests New Drug Pump at Home", Minnesota Daily, 10/1/86
"U to Pioneer Hand Transplants", St. Paul Pioneer Press & Dispatch, 10/1/86
"U Gets Approval to Perform First Hand Transplant", Minnesota Daily, 10/2/86
"U Surgeon Plans Experimental Hand Transplant", Minneapolis Star & Tribune, 10/2/86

The University of Minnesota Hospital and Clinic
Board of Governors

October 22, 1986
1:30 P.M.
The Board Room, The University Hospital

AGENDA

I.	Approval of September 24, 1986 Minutes	Approval
II.	Chairman's Report - Ms. Barbara O'Grady	Information
III.	"Hospital Board Self-Evaluation: Commitment to Excellence" - Ms. Barbara O'Grady	Information
IV.	Hospital Director's Report - Mr. C. Edward Schwartz	Information
V.	Committee Reports	
	A. Planning and Development Committee Report - Mr. Robert Latz	
	1. Laboratory Computer Project	Approval
	2. Policy on Gifts and Gratuities	Approval
	B. Joint Conference Committee Report - Mr. George Heenan	
	1. Credentials Committee/Medical Staff-Hospital Council Report and Recommendations	Approval
	C. Finance Committee Report - Mr. Jerry Meilahn	
	1. August and September 1986 Financial Statements	Information

2.	Bad Debts	Approval
3.	Merit Pay Plan	Approval
4.	June 30, 1987 Financial Forecasts	Information

VI. Other Business

VII. Adjournment

MINUTES

Board of Governors

The University of Minnesota Hospital and Clinic

September 24, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the September 24, 1986 meeting of the Board of Governors to order at 1:40 P.M. in the Board Room of the University Hospital.

ATTENDANCE:

Present:	Leonard Bienias David Brown, M.D. Phyllis Ellis Al Hanser George Heenan Kris Johnson Jerry Meilahn James Moller, M.D. Robert Nickoloff Barbara O'Grady Nancy Raymond C. Edward Schwartz
Absent:	Shelley Chou, M.D. Robert Latz David Lilly Neal Vanselow, M.D.

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the July 23, 1986 meeting as written.

CHAIRMAN'S REPORT:

Chairman Barbara O'Grady introduced Ms. Dee Lutz from the Minnesota Daily and Ms. Helen Pitt, Associate Director of Nursing Services.

Chairman O'Grady noted that the Board of Governors Executive Committee would be meeting on October 9, 1986 to review the outcomes of the Board of Governors Retreat and to discuss a work plan for the Board of Governors for the coming year. A desire was expressed by several Board members to continue exploration of the relationship between the medical staff and the Hospital.

Chairman O'Grady reminded the members of the Board of the October 31, 1986 Metro Hospital Trustee Council conference entitled "The Quest For Quality: The Next Competitive Wave." Board members were encouraged to call the Board Office for registration information.

Lastly, Chairman O'Grady invited the members of the Board of Governors to view the 75th Anniversary slide show immediately following the business meeting and distributed information on the lecture series being sponsored by the Center for Biomedical Ethics and the Bakken Library.

HOSPITAL DIRECTOR'S REPORT:

Mr. C. Edward Schwartz outlined the details of the October 8, 1986 Minnesota National Leadership Homecoming and the annual dinner of the President's Club. The October 8, 1986 meeting of the Joint Conference Committee has been postponed until October 15, 1986 in light of this event.

Secondly, Mr. Schwartz announced that Mr. Robert Baker, formerly of The University of Minnesota Hospital and Clinic, and most recently the CEO of the University of Nebraska Hospital had accepted the position of the CEO of the University Hospital Consortium. The Consortium will be reformulating its strategic plan and accelerating purchasing efforts in the coming months.

The University Hospital Executive Committee, a subset of the Council of Teaching Hospitals, Mr. Schwartz reported, will be meeting at The University of Minnesota Hospital and Clinic on September 25 and 26, 1986. Several issues common to these teaching hospitals will be explored.

Mr. Schwartz also reported that the renovation options for the Jackson, Owre, Millard, and Lyon buildings, which house the basic sciences of the Medical School, are being evaluated. Mr. Schwartz and Dean Brown agreed to keep Board members up-to-date on the renovation plans. Both stressed the importance to the Hospital of the improving these basic science buildings.

Construction of the parking ramp tunnel, Mr. Schwartz reported, is proceeding just a few weeks behind schedule. Heavy rains caused some delay during the months of August and September. The tunnel is now scheduled for completion in late January, 1987.

Lastly, Mr. Schwartz reviewed the highlights of the September 17, 18, 19, 1986 Deans and Director's Retreat. The budget for the next biennium, the legal aspects of current employment practices, and foundation development strategies were discussed. The new Vice President for Academic Affairs, Dr. Roger Benjamin, attended the retreat and shared his ideas and plans with the Deans and Directors.

FINANCE COMMITTEE REPORT:

Mr. Robert Nickoloff and Mr. Cliff Fearing highlighted the Report of Operations for the period July 1, 1986 through June 30, 1986. The fiscal year was the third showing declines in admissions and length of stay. The declines in census levels did, however, turn around with the opening of the new

Hospital in April. In sum, at year end there were 17,694 admissions (1.3% under budget), 145,697 patient days (.6% over budget), and an average length of stay of 8.3 days (2.5% over budget). Outpatient clinic visits totalled 224,446 (6.4% over budget). Revenue over expense for the fiscal year after a loss on refinancing the long-term debt was $6,660,531.

Mr. Fearing also reviewed the Report of Operations for the period of July 1, 1986 through July 31, 1986. In general, the activity levels remained over budget at levels comparable to May and June. The Board of Governors did discuss the recent rise in the number of days in the accounts receivable. The number of days in accounts receivable has risen 8.4 days since June 30, 1985.

Mr. Greg Hart introduced three computer related projects that will be brought to the Board of Governors for approval in the near future. Two of those projects, the Laboratory computer replacement project, and a new computer for the Finance system were discussed in detail for informational purposes. The third project, an updgrade of the central mainframe hardware, will be presented in two or three months. Each of the three projects was anticipated in the Hospital's 1986-87 budget.

Mr. Al Dees traced the historical development of the labs data system, the status of the current system, the cost of the proposed replacement, and financing options for the acquisition. The total cost of replacing the lab computer is $1,500,000.

Mr. Nels Larson reviewed the rationale for purchasing a new financial system, a replacement which was recommended by Ernst and Whinney in 1984 and the Hospital's auditors, Peat, Marwick and Mitchell and Company in 1985. In evaluating the software packages that meet the identified requirements, it appears that only IBM Systems would meet the stated needs.

The Labs and Finance computer upgrade requests will be brought back to the Board for approval in October.

Mr. Greg Hart discussed the option of including a merit pay component in the employee compensation plan for 1987-88. Following several months of discussion, the management staff has concluded that this would be a positive step for several reasons, which Mr. Hart detailed. Five hundred two employees had been surveyed to solicit their impressions of this concept. Survey results clearly indicated an employee and management preference that at least part of the compensation system be merit based. Mr. Hart noted that it is not anticipated that the merit system would be extended to our unionized employees or to Nursing and Pharmacy staffs, who currently use seniority or step systems in their compensation plans.

The Board of Governors agreed, in concept, that it is appropriate for the Hospital to move toward a merit based compensation system. The importance of having a strong and consistent performance appraisal system was noted. The Board of Governors will be asked to take formal action on this issue at the October Board of Governors meeting.

JOINT CONFERENCE COMMITTEE REPORT:

Committee Chair Phyllis Ellis and Dr. James Moller presented the August and September reports of the Credentials Committee. The combined reports had been endorsed by the Joint Conference Committee on September 10, 1986. The Board of Governors seconded and passed a motion to approved the combined August and September Credentials Committee reports as submitted.

Secondly, Ms. Phyllis Ellis and Ms. Nancy Raymond presented the results of a questionnaire sent out to medical students to solicit their impressions of rotations at The University of Minnesota Hospital and Clinic. The results generally indicated that the rotations are of high quality. Some suggestions were offered for improvement. Of special interest was the finding that the decreased length of stay was not viewed by medical students as being an impediment. It was agreed that this data gathering provided valuable information and should be pursued further. It was also suggested that a similar process be undertaken with residents.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Mr. Mark Koenig presented the Quarterly Purchasing Report for the period of May through July, 1986. 8,715 purchase orders had been processed. The dollar value associated with these purchase orders was $11,401,274.17. Although the number of Unit J purchase orders tapered off during this period, Mr. Koenig noted, the increase in census levels kept the total purchasing volume at a level higher than expected. Mr. Koenig also reviewed set aside awards, awards to other than apparent low bidder, sole source awards, vendor appeals, and University Hospital Consortium purchases for the period. The Board of Governors seconded and passed a motion to accept the Purchasing Report as submitted.

Secondly, Mr. Koenig overviewed a series of recommended changes to the Purchasing Policies and Procedures. Following discussion on each of those changes, the Board of Governors discussed the policy on Gifts and Gratuities in detail. The Board questioned whether that policy should include a statement indicating that gifts of nominal value may be appropriate. Agreement was not reached on the appropriateness of this inclusion. The Board agreed to defer this one policy pending further discussion. With that one exclusion, the Board of Governors seconded and passed a motion to approve the revisions to the Purchasing Policies as submitted.

ADJOURNMENT:

There being no further business, the meeting of the Board of Governors was adjourned at 3:25 P.M.

Respectfully submitted,

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

MINUTES
Planning and Development Committee
October 8, 1986

CALL TO ORDER
Committee Chairman, Mr. Robert Latz, called the October 8, 1986 meeting of the Planning and Development Committee to order at 10:05 a.m. in Room 8-106 in the University Hospital.

Attendance:	Present	Robert Latz, Chair
		Leonard Bienias
		B. Kristine Johnson
		Geoff Kaufmann
		John LaBree, M.D.
		C. Edward Schwartz
		I. Dodd Wilson, M.D.
	Absent	Frank Cerra, M.D.
		Clint Hewitt
	Staff	Fred Bertschinger
		Al Dees
		Greg Hart
		Nancy Janda
		Mark Koenig
		Nels Larson
		Lisa McDonald
	Guests	Marjorie Carey
		Ed Nelson

APPROVAL OF MINUTES
The minutes of the September 10, 1986 meeting were approved as distributed.

REVISED PURCHASING POLICY
Mr. Koenig reviewed purchasing's revised policy on gift and gratuities which had been amended to allow for the acceptance of gifts with nominal value. It was agreed that the policy should not be adopted until the medical staff has reviewed it. Current wording was felt to be confusing as it related to gifts vs. fees for services rendered.

COMPUTER SYSTEMS PROPOSALS
Mr. Hart gave an overview of the University of Minnesota Hospital and Clinic's computer system and discussed two of the three computer-related projects which were budgeted in 1986/87.

The Laboratory computer system replacement project is being undertaken per Mr. Dees for the following reasons: the current system is at maximum capacity; response times during critical periods have increased beyond the two to five second acceptable level to 25-120 seconds; new labs cannot be added because of

capacity limitations; the hardware vendor will be ending product support by 12/31/86; existing software is obsolete and the vendor will be phasing out software support; increased downtimes due to software errors related to the hardware's age which was purchased in the early 70s; and service cutbacks in some laboratory areas in order to provide service for Unit J because of capacity limitations. I. Dodd Wilson, M.D. moved and Leonard Bienias seconded that $1,500,000 be approved for the Laboratory computer system replacement project. The motion carried.

Mr. Larson discussed the financial information system replacement project which would replace the general ledger system and other sub-systems. He recommended the purchase of an IBM 4381-12 in order to use software that is available which would provide finance the ability to make financial decisions on a more timely basis. The estimated cost of the project for both hardware and software is up to $1,125,000 depending on whether the equipment is leased or purchased. Various committee members requested that Mr. Larson quantify the benefits and see if there are any less costly hardware or software alternatives that could satisfy the department's needs.

UMCA UPDATE

Dr. Wilson updated the committee on UMCA's retreat and discussed their priorities for the next year which are in rank order: 1) Development of an adequate financial base for UMCA; 2) Act as an intermediary for outside provider groups.; 3) Define UMCA goals and role in relation to mission of medical school and hospital; 4) Proper role of UMCA in outpatient care; 5) (tie) Define "institutional" business we are in; 5) (tie) Develop internal mechanisms for billing, tracking, etc.

Dr. Wilson highlighted UMCA's accomplishments and mentioned that they are also looking at an Executive Health Program.

OUTREACH UPDATE

Dr. LaBree discussed UMHC's efforts in Hibbing, Fargo, Marshfield, and Sioux Falls. He also mentioned that several departments due to personnel shortages have been unable to respond to staffing requests and that this could limit outreach efforts in the near future. Dr. LaBree announced that the Physician Advisory Board will be meeting this weekend.

DEVELOPMENT OFFICE REPORT

Mr. Bertschinger reported that the U. M. Foundation Office estimates that the hospital exceeded its revenue goal of $1,000,000 by $18,000 in 1985/86 with 2,284 donors making 2,657 gifts. The goal for 1986/87 is $750,000 reflecting a decrease because of the extended vacancy in his position. In the last month the Development Office has concentrated their efforts on organizing the recognition luncheon for the Minneapolis Commodores Chorus on October 2 and the Minneapolis Campaign gala on October 8 which will recognize major donors. Mr. Bertschinger's efforts will focus on expanding the annual solicitation for the Patients Fund to all hospital employees from mid-November to mid-December. Other goals for the year are the expansion of the donor base, identification and cultivation of major gift prospects, improving working relationships, and increasing the understanding and support for the Development Office by UMHC employees.

NELSON INTERNATIONAL
Mr. Kaufmann introduced Mr. Nelson of Nelson International Medical Services Corporation who will assist UMHC in the next three years in expanding its international market. Initial efforts will concentrate on identifying clinical services and prioritizing geographical areas.

UNIVERSITY HOSPITAL EXECUTIVE COUNCIL
Mr. Schwartz reported on the annual meeting of the University Hospital Executive Council which he recently attended. The council is made up of representatives from University Hospitals in Indiana, Iowa, Northwestern, Wisconsin, Rochester, Chicago, Cleveland, and Michigan. Topics covered at the meeting centered around graduate medical education funding, marketing, joint ventures, brokers, referring physician programs and a status report of the participating institutions.

OAK STREET PROPERTY
Mr. Kaufmann informed the committee that UMHC is investigating a four-lot property that is for sale at Oak and Fulton for $700,000.

ADJOURNMENT
The Planning and Development Committee adjourned at 12:26 p.m.

Respectfully submitted,

Lisa G. McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

October 16, 1986

TO: Members, Board of Governors

FROM: C. Edward Schwartz C.E. Schwartz
Hospital Director

SUBJECT: Computer Projects

Last month the Finance Committee and the Board of Governors heard informational reports on two capital expenditure proposals, both computer related. The first project includes a $1,500,000 replacement and upgrade of our laboratory computer system. The second project is a $1,125,000 hardware/software proposal to support our financial systems.

Both of these projects were also reviewed by the Planning and Development Committee at their October meeting, per Board policy. The Planning and Development Committee endorsed the laboratory computer project. The Committee asked that further information regarding the benefits of the financial systems project be brought forward at the November meeting of the Committee, and thus did not act on the financial systems proposal.

Given the Planning and Development Committee's action, we are now recommending and requesting Finance Committee and Board of Governors approval of the laboratory computer project. Specifically, we are requesting approval for $1,500,000 expenditure authority for the project.

This project, as was noted last month, was included in this year's capital budget. Supporting material for the project, also reviewed last month, is attached. Mr. Hart and Mr. Dees from our staff will be available to respond to any remaining questions which the Committee members or Board members may have next week.

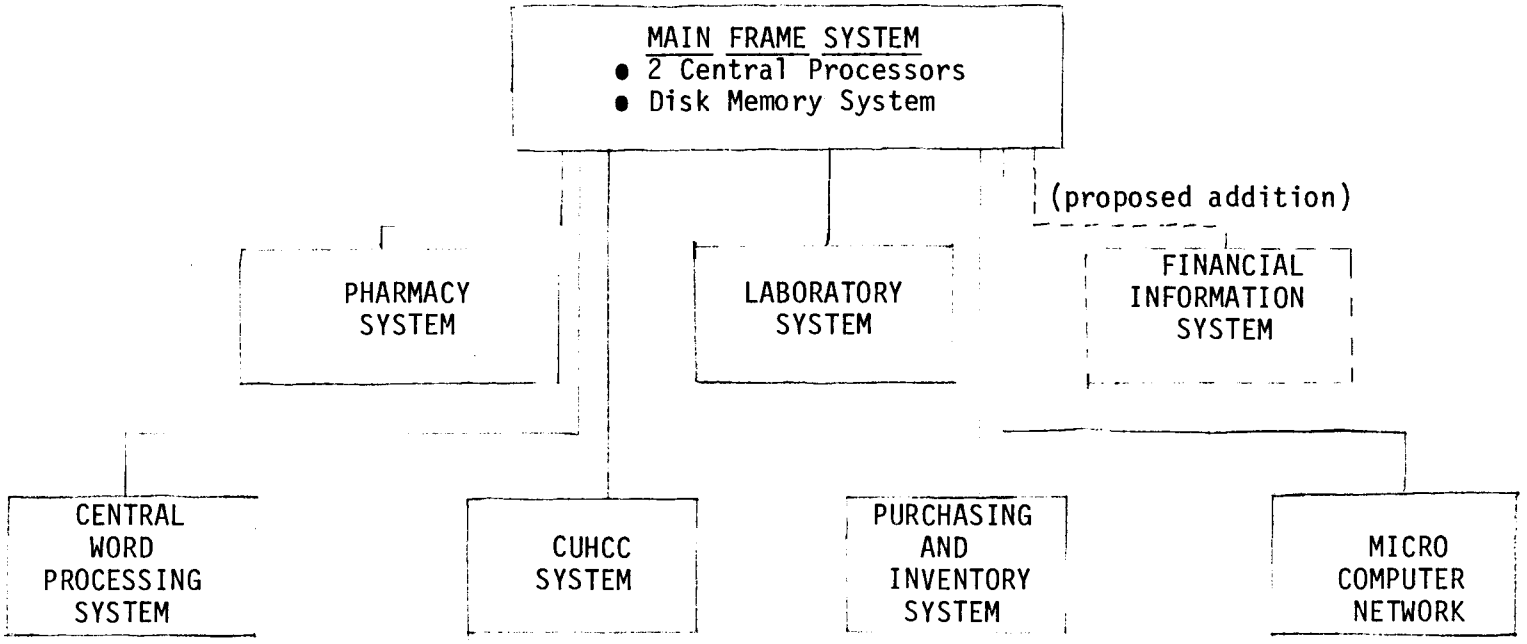
/kj

attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

COMPUTER SYSTEM DIAGRAM

September 1986



LABORATORY COMPUTER SYSTEM REPLACEMENT PROJECT

I. Introduction and Historical Development

The current Laboratory computer system was originally installed in April of 1975 to provide a more efficient and effective patient results reporting system. Previous to this time, results reporting was done manually. The Laboratory computer was then upgraded in June of 1981 to accommodate expanding workload and the need to add other laboratories such as Blood Bank, Microbiology and Immunology to the computer. The upgrade included new software and an additional central processing unit (CPU).

The Laboratory computer now supports these patient related functions:

- Order entry, logging and billing.
- Specimen receiving, labeling and preparation.
- Specimen processing and distribution.
- Automated and manual results entry.
- Patient results reporting including immediate, ward/clinic, and chart.
- Telephone inquiry reports.
- Quality Control.
- Laboratory Management.
- On-line communication of laboratory results to the Hospital's main computer system.

II. Current System Status

The current Laboratory computer system, whose hardware and software were developed in the early 1970s, is now exhibiting major deficiencies because of its obsolescence and age. The major problems involve:

- Computer system utilization is at maximum capacity.
- Response times during critical periods have increased beyond acceptable levels of two to five seconds. Response times that we are now experiencing are in the unacceptable range of 25-120 seconds (see Attachment A).
- Other Laboratories, such as Surgical Pathology, cannot be added to the current computer system because of its capacity limitations.
- System hardware cannot be expanded to relieve the capacity problem because of its age and obsolete technology.
- The hardware vendor has given formal notice that they will be ending product support by September 30, 1987. Informally, we have been told that this date may be advanced to December 31, 1986.
- The current software is obsolete and is no longer marketed by the vendor.

- The software vendor has announced that they will be phasing out support of the software over the next few years.
- Downtimes have increased due to software errors related to its age, and to hardware that is wearing out.
- Capacity limitations forced the cutback of service in some laboratory areas in order to provide service for Unit J.

III. Recommendation

After thorough evaluation of several alternatives, our recommendation is replacement of the existing computer system with a new system that will provide state of the art software and hardware.

The total cost of a new Laboratory computer system will be $1,500,000. This cost includes:

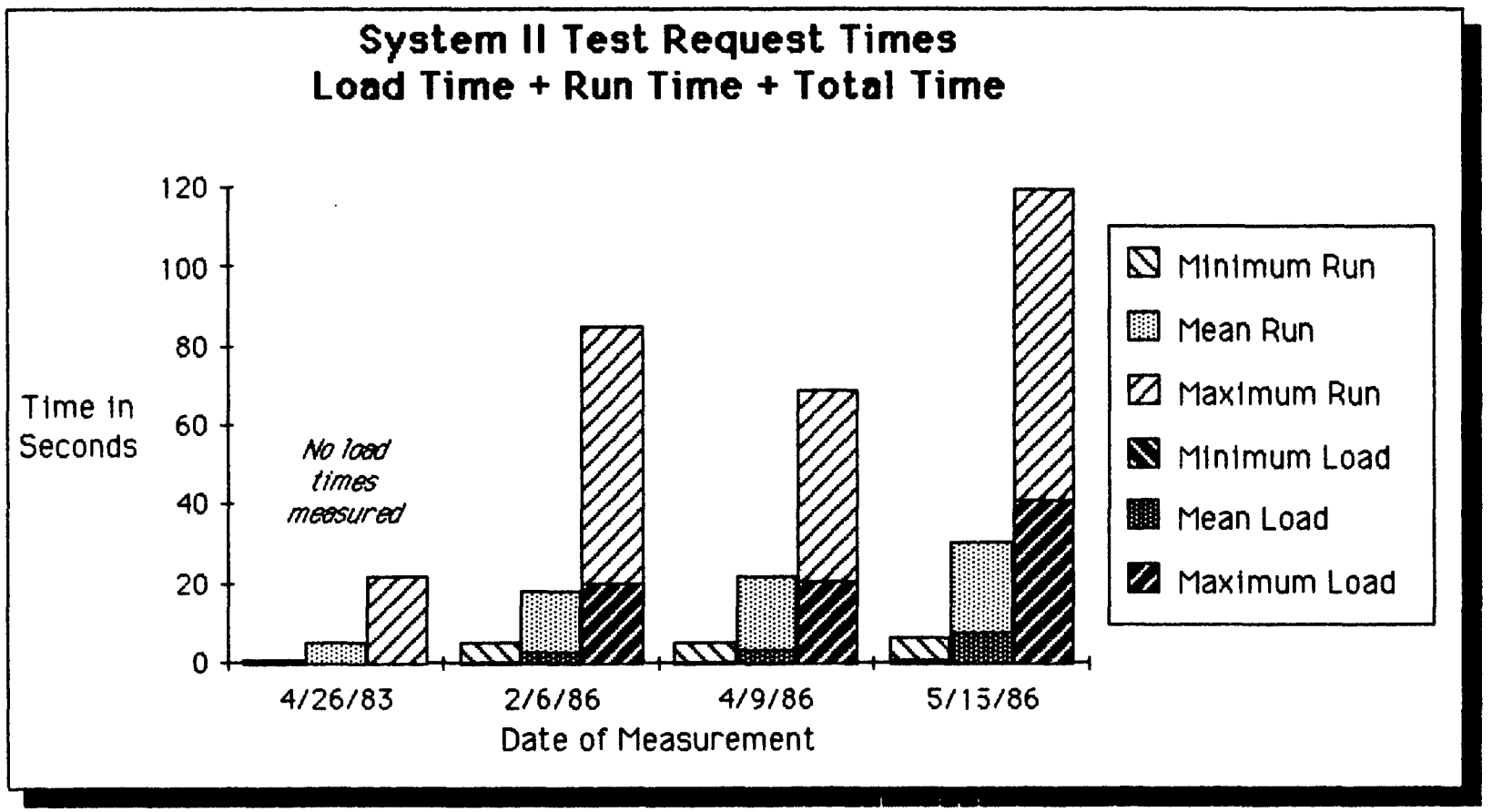
Hardware	1,139,200
Software	360,800
Total	$1,500,000

IV. Budget

When the analysis for this replacement project was begun during 1984-85, the original cost estimate and amount budgeted was $800,000. After formal proposals were received from vendors, however, it became clear that the cost of a system large enough to handle the current and foreseeable future load of UMHC's laboratories would be $1,500,000 or higher. Therefore, the Laboratory administrative staff has withheld purchase of $300,000 of computer related and other equipment during the past year and has included an additional $400,000 in their 1986-87 budget.

V. Financing

The present plan is to finance this purchase through the University's Equipment Loan Fund. The current interest rate is approximately 5%.


System II Test Request Times
Load Time + Run Time + Total Time
Time in Seconds
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100
80
60
40
20
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2/6/86
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5/13/86
Date of Measurement
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Mean Run
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UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 8, 1986

TO: Members of the Board of Governors

FROM: Mark Koenig
Assistant Director

SUBJECT: Policy on Gifts and Gratuities

Attached is a revised policy on acceptance of gifts and gratuities for your endorsement. The policy has been amended to allow for the acceptance of gifts with nominal value. This change was made as a result of discussion at the September Board meeting. The revision has been reviewed by Mr. Halverson and Mr. Vietti and is consistent with State statutes.

Also attached for comparison is a copy of the original policy.

Thank you for your consideration of this policy change.

MK/kj

attachments

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

POLICY AND PROCEDURES MANUAL

REVISION

SECTION	Page 1 of 1
VOL.	POLICY NUMBER
SUBJECT: GIFTS AND GRATUITIES	EFFECTIVE: 1/3/84
	REVISION: 10/7/86
SOURCE: MATERIALS SERVICES	REVIEWED: 12/31/85

Policy

Acceptance by an employee or a person affiliated with the University of Minnesota Hospital and Clinic of a rebate, gift, money, or anything of value, other than items of nominal value, from an individual or organization doing business with the University of Minnesota Hospital and Clinic is unacceptable.

Procedure

Any employee not complying with this policy is subjected to appropriate discliplinary action.

APPROVED: BOARD OF GOVERNORS	DATE
TITLE	

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

POLICY AND PROCEDURES MANUAL

SECTION	
Page 1 of 1	
VOL.	POLICY NUMBER

SUBJECT	EFFECTIVE
GIFTS AND GRATUITIES	1/3/84
	REVISION 1/2/86
SOURCE MATERIALS SERVICES	REVIEWED 12/31/85

Policy

Acceptance of gifts, personal loans, entertainment, or other special considerations by an employee from an individual or organization doing business with the University of Minnesota Hospital and Clinic is unacceptable.

Procedure

Any employee not complying with this policy is subjected to appropriate disciplinary action.

APPROVED	DATE
BOARD OF GOVERNORS	
TITLE	

MINUTES
Joint Conference Committee
Board of Governors
October 15, 1986

ATTENDANCE: Present: Phyllis Ellis, Chair
George Heenan
Dr. James Moller
Dr. Michael Popkin
C. Edward Schwartz

Absent: Dr. Jack Duvall
Dr. Seymour Levitt
Nancy Raymond

Staff: Jan Halverson
Greg Hart
Nancy Janda

Guests: Dr. David Hurd
Ron Werft

APPROVAL OF MINUTES

The minutes of the September 10, 1986 meeting of the Joint Conference Committee were approved as submitted.

AIDS TASK FORCE REPORT

Dr. David Hurd and Mr. Ronald Werft presented the report and recommendations of the AIDS Task Force. Dr. Hurd indicated that Dr. Moller and Mr. Schwartz had appointed this group several months ago to develop recommendations regarding our management of AIDS-related issues. Dr. Hurd then reviewed the Task Force recommendations.

It was noted that the Medical Staff-Hospital Council has received and approved the Task Force recommendations, and that the Council of Clinical Chiefs will be discussing the recommendations in several weeks. Dr. Moller will then report back to the Joint Conference Committee on the status of implementation of the report.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

The Joint Conference Committee received and endorsed the recommendations of the Credentials Committee.

Mr. Hart also reported that the Medical Staff-Hospital Council heard a summary from Jan Brockway on the local PRO contract recently awarded by the Federal Government to the Foundation for Health Care Evaluation. Mr. Hart reviewed the five objectives which the Foundation will be working on with the local hospitals this year. Those objectives include efforts on generic quality screens, adverse outcomes by certain physicians and hospitals, adverse outcomes by certain diagnostic related groups, unnecessary admissions or procedures by certain hospitals or physicians, and unnecessary admissions or procedures by certain diagnostic related groups. It was noted that for two of these objectives the Foundation will be looking in particular at a subset of the total State hospital population, and that it does not appear that UMHC will be part of that subset.

Mr. Hart also indicated that the Semiannual Medical Staff Meeting had been held on October 14, 1986, in conjunction with the University of Minnesota Clinical Associates. Reaction to the meeting content and format, which was primarily directed at the joint efforts of the Hospital and UMCA relative to HMO contracts, was received favorably.

CLINICAL CHIEFS REPORT

Mr. Hart indicated that the most recent Clinical Chiefs' meeting had been devoted to a discussion of the Hospital's new activity level and financial forecast, which will be shared with the Board of Governors' Finance Committee and full Board at the October meetings.

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

Respectfully submitted,

Greg Hart

GH/kjs

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

October 17, 1986

TO: Board of Governors

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Credentials Comittee/Medical Staff-Hospital Council
Report and Recommendations

The Medical Staff-Hospital Council acted on the attached Credentials Committee Report and Recommendations on October 14, 1986, and the Joint Conference Comittee endorsed these recommendations on October 15, 1986.

I am forwarding these recommendations to you for your approval on October 22, 1986.

Thank you.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 9, 1986

TO: Medical Staff-Hospital Council

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby recommend the approval of provisional status and clinical privileges to the following applicants to the medical staff of The University of Minnesota Hospital and Clinic.

Obstetrics and Gynecology	Category
Linda F. Carson	Attending
Otolaryngology	
Lawrence J. Marentette	Attending

HHB/cf

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

MEMBERS PRESENT:
Robert Nickoloff
Carol Campbell
Edward Ciriacy, M.D.
Clifford Fearing
William Krivit, M.D., Ph.D.
Jerry Meilahn
C. Edward Schwartz

MEMBERS ABSENT:
Al Hanser
Vic Vikmanis

STAFF:
Al Dees
Greg Hart
Nancy Janda
Nels Larson
Jane Morris
Helen Pitt
Dan Rode

CALL TO ORDER:
The meeting of the Finance Committee was chaired by Mr. Robert Nickoloff and was called to order at 9:50 a.m. in The Dale Shepherd Room of the Campus Club.

MINUTES APPROVED:
The minutes of the Finance Committee meeting held on 7/23/86 were approved.

7/31/86 FINANCIAL STATEMENTS (INFORMATION):
Mr. Fearing reviewed the Report of Operations for the period July 1, 1986 through July 31, 1986. He reported that inpatient and outpatient census levels continue to run well ahead of budget. Inpatient admissions for July of 1,611 were 3.0% above projections and patient days for the period totaling 13,391 were 590 above budget. Overall length of stay of 8.7 days was significantly above the projected level of 8.2 days. Outpatient clinic visits for the month of July totaled 21,141 or 12.3% above projected visits of 2,310.

Total revenues over expense for the period are $618,145, a favorable variance of $1,025,438. Patient care charges for the period totaled $19,764,490 (9.0% above budget). Routine revenue was 4.1% above budget, reflecting the favorable patient day variance and ancillary revenue was approximately $1,400,000 above budget. Operating expenditures for July were $18,576,222 or approximately $394,000 above budgeted levels.

The balance in patient accounts receivable as of July 31, 1986 totaled $60,294,828 representing 93.3 days of revenue outstanding. Mr. Fearing introduced Mr. Dan Rode who gave a detailed

explaination for the increase in accounts receivable days. Mr. Rode noted that the biggest problem is in the area of Medical Assistance and a meeting with Governor Perpich has been scheduled to discuss this problem. Delays in payments have also occurred with insurance companies, although the Hospital does offer discounts for payments made within 10 days. Blue Cross Blue Shield will soon be sending the Hospital an advance of $1.6 million to offset low periodic interim payments (PIP) made by BCBSM. Mr. Rode expected accounts receivable days to continue to rise until late in October when they would likely recede back to the 92 day level. Mr. Fearing added that the increase in receivables is also a direct result of the increase in volume and that the Hospital continues to be in a very good position financially.

Mr. Fearing noted that financial statements for August have not yet been completed, but will be presented at the October Finance Committee meeting.

1985-86 YEAR-END FINANCIAL STATEMENTS (INFORMATION):

Mr. Fearing reviewed the Report of Operations for the fiscal year 1985-86. He stated that inpatient admissions for the year totaled 17,694, a decline of 355 (2.0%) from the previous year. Patient days of 145,697 were down by 9,332, and the overall length of stay declined from 8.6 days last year to 8.3 days in the current year. Mr. Fearing noted that inpatient admissions dropped 4.6% during the first ten months of this year compared to last year and then increased 351 (12.3%) in the last two months of this year over last year. The major increases occurred in Medicine, Pediatrics, Surgery and Urology.

Outpatient clinic census showed a significant increase over the 1984-85 levels, going from 209,912 visits to 224,446 in the current year and representing a 6.4% increase over the 1985-86 budget. The increase occurred in nearly all clinic areas with the exception of Dentistry, Obstetrics/Gynecology and Otolaryngology.

Patient care revenue for 1985-86 totaled $198,970,537 and is an increase of 7.0% over the 1984-85 fiscal year. The increase in revenue of approximately $13,493,000 above budget is primarily due to higher than anticipated ancillary utilization. Operating expenses totaled $183,611,314 for the year, a variance over budget of 6.8%. Much of this variance was associated with the opening of the new hospital in April versus the original budget plan of July, 1986.

The expense associated with advanced refunding of the Series 1985A Fixed Rate Bonds is reflected in the 1985-86 financial statements. Mr. Ed Schwartz informed the Committee that a pay back schedule for the $8.8 million in short term notes will be presented to the Committee at the next meeting.

The balance in patient accounts receivable as of June 30, 1986 totaled $55,896,815 and represents 91.6 days of revenue outstanding, which is an increase of $11,033,257 and 6.7 days from June 30, 1985. Mr. Fearing stated major reasons for the increase relates to changes in payment regulations and delays for third party payors.

COMPUTER PROJECTS (INFORMATION):

Mr. Hart informed the Committee that three computer related projects are currently being considered, and two of these, a laboratory computer replacement and new financial systems computer hardware, are being brought to the Board of Governors for information in September. He introduced Mr. Al Dees to give information on the laboratory computer replacement project. Briefly, Mr. Dees noted that replacement of the labortory computers has been under evaluation for two years. He explained that capacity has been reached with the current system significantly affecting response times and efficiency of the lab. Also, Control Data has informed the Hospital that after 9/1/87, they will no longer be providing service or parts for our current laboratory computer system.

Mr. Hart next introduced Mr. Larson who summarized the need for additional financial systems computers. The system now in Financial Accounting has only data entry capability, and no ability for report writing, inquiry, etc. In the management letter for the 1984-85 audit, Peat, Marwick & Mitchell recommended an upgrade of the general ledger system. After thorough evaluation of application software alternatives, Mr. Larson stated that IBM based system is recommended.

Mr. Fearing added that when these projects are brought to the Committee for approval next month, a recommendation will also be made for their lease or purchase.

MERIT PAY PLAN (INFORMATION):

Mr. Hart outlined Hospital management's reasoning and position on the issue of re-instituiting a pay for performance system beginning in 1987-88. Employees and management staff have expressed that the Hospital's compensation system should be, at least in part, based on performance. Mr. Hart breifly went over a survey distributed to employees whose results confirmed this conclusion. He noted that unionized employees, and nursing and pharmacy staffs, would be excluded at this time because their compensation plans use seniority or "step" systems. To give employees advance notice of the change, Mr. Hart stated that an announcement would be made to the employees in November, pending the Board of Governors approval of this measure in October. Dr.s Ciriacy and Krivit both spoke in favor of initiating a merit pay system and agreed that it was long overdue.

ADJOURNMENT: There being no further business, the meeting of the Finance Committee was adjourned at 12:30 pm.

Respectfully submitted,

Jane E. Morris
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 22, 1986

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Report of Operations for the Period
July 1, 1986 through September 30, 1986.

The Hospital's operations through the month of September reflects both inpatient admissions and outpatient visit activity that are above budgeted levels. In addition, we continue to experience ancillary service utilization that is higher than anticipated. To highlight our position:

Inpatient Census: For the month of September, inpatient admissions totaled 1,591 or 228 above projected admissions of 1,363. Our overall average length of stay for the month was 8.3 days. Patient days for September totaled 12,245 and were 660 days above projections. The increase in admission levels is primarily in the areas of Medicine, Pediatrics, and Urology.

To recap our year-to-date inpatient census:

	1985-86 Actual	1986-87 Budget	1986-87 Actual	Variance	% Variance
Admissions	4,506	4,494	4,752	258	5.7
Avg. Lgth. of Stay	8.3	8.3	8.2	(0.1)	(1.2)
Patient Days	37,062	37,123	38,883	1,760	4.7
Percent Occupancy	67.2	67.3	70.4	3.1	4.6
Avg. Daily Census	402.8	403.5	422.6	19.1	4.7

Outpatient Census: Clinic visits for the month of September totaled 20,185 or 2,816 (16.2%) above projected visits of 17,369. The September year-to-date clinic census totals 61,888 visits and is 10.1% (5,660 visits) above budget and 10.6% (5,945 visits) above our September total of a year ago. The increase in activity has been experienced in nearly all clinic areas with the largest increases occurring in Dermatology, Medicine, Psychiatry, and Urology.

Financial Operations: The Hospital's Statement of Operations shows total revenues over expense of $1,883,298, a favorable variance of $3,094,036.

Patient care charges through September totaled $57,921,203 and is 10.2% above budget. Routine revenue is 3.7% above budget and reflects our favorable patient day variance. Ancillary revenue is approximately $4,786,000 (13.1%) above budget and reflects (1) the favorable variance in both admissions and clinic visits, and (2) the utilization of ancillary services per patient being higher than anticipated. Inpatient ancillary revenue has averaged $6,521 per admission compared to the budgeted average of $6,199 per admission. Outpatient revenue per clinic visit is averaging $166 compared to the budgeted average of $153.

Operating expenditures through September totaled $54,459,762 and are approximately $1,605,000 (3.0%) above budgeted levels. The overall unfavorable variance continues to relate to the increased personnel costs (salaries and fringe benefits) associated with the increased census levels.

Accounts Receivable: The balance in patients accounts receivable as of September 30, 1986 totaled $63,036,030 and represents 95.9 Days of Revenue outstanding. Our overall patient receivables declined by 1.4 days in September due to improved payment levels from Blue Cross and Medicare. We continue, however, to see the level of Medical Assistance receivables increase.

Conclusion: The Hospital's overall operating position continues to be positive and above budgeted levels. Both inpatient and outpatient census levels remain above budget. While our inpatient census levels declined slightly during the latter part of August and the first two weeks of September, our census has since increased to levels experienced throughout the months of May, June and July. We continue to monitor our demand for service closely and make those operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO SEPTEMBER 30, 1986

Annual Budget		Budgeted	Actual	Variance Over/-Under Budget	Variance %
	Patient Care Charges				
$60,169,700	Routine	$16,061,438	$16,652,427	$590,989	3.7%
139,094,000	Ancillary	36,482,845	41,268,776	4,785,931	13.1
$199,263,700	Gross Charges	$52,544,283	$57,921,203	$5,376,920	10.2%
	Deductions from Charges				
$16,821,600	Third Party Contractual Adjustments	$4,435,725	$5,166,668	$730,943	16.5%
8,124,800	Billing Adjustments & Employee Benefits	2,142,446	1,968,258	-174,188	-8.1
420,000	Charitable Care	110,750	161,545	50,795	45.9
3,026,700	Other Contractual Adjustments	798,118	878,402	80,284	10.1
2,644,100	Provisions for Uncollectables	697,228	768,345	71,117	10.2
$31,037,200	Total Deductions	$8,184,267	$8,943,218	$758,951	9.3%
	Other Operating Revenue				
$1,165,100	Food Services	$293,670	$334,352	$40,682	13.9%
452,400	Parking Services	44,792	0	-44,792	-100.0
99,900	Department Non-Patient	25,181	68,001	42,820	170.0
1,023,100	CUHCC Grants	257,876	264,454	6,578	2.6
1,486,100	Reference Lab Income	374,579	414,372	39,793	10.6
1,119,800	Pro Fees - Net Revenue	295,282	330,078	34,796	11.8
0	Donations to Operations from Restricted Funds	0	3,886	3,886	
$5,346,400	Total Other Revenue	$1,291,380	$1,415,143	$123,763	9.6%
$173,572,900	Total Revenue from Operations	$45,651,396	$50,393,128	$4,741,732	10.4%
	Expenditures				
$87,879,400	Salaries	$22,311,313	$23,758,647	$1,447,334	6.5%
17,115,800	Fringe Benefits	4,306,243	4,609,408	303,165	7.0
1,875,700	Academic Contracts	467,041	467,041	0	0.0
4,685,500	Resident Contracts	1,171,374	1,171,374	0	0.0
2,208,200	Physician Compensation	552,051	567,501	15,450	2.8
$113,764,600	Total Salary, F.B. & Fees	$28,808,022	$30,573,971	$1,765,949	6.1%
2,079,600	Laundry & Linen	547,242	510,632	-36,610	-6.7%
1,392,200	Raw Food	350,911	385,610	34,699	9.9
13,975,900	Drugs	3,677,725	3,705,904	28,179	0.8
4,880,400	Blood & Blood Derivatives	1,284,266	1,261,340	-22,926	-1.8
11,136,100	Medical Supplies	2,930,438	2,911,609	-18,829	-0.6
3,055,900	Utilities	815,366	1,126,715	311,349	38.2
2,832,400	Insurance	456,447	434,514	-21,933	-4.8
2,335,200	Rental	583,800	450,031	-133,769	-22.9
3,349,300	Maintenance & Repair	844,207	736,251	-107,956	-12.8
1,312,800	Communications	330,897	329,229	-1,668	-0.5
6,222,500	Campus Administration Expense	1,568,411	1,568,411	0	
14,103,400	Depreciation and Amortization	3,554,830	3,942,426	387,596	10.9
14,001,200	Interest	3,529,070	3,305,607	-223,463	-6.3
14,177,500	General Supplies & Expense	3,573,506	3,217,512	-355,994	-10.0
$208,619,000	Total Expenditures	$52,855,138	$54,459,762	$1,604,624	3.0%
$ -35,046,100	Net Revenue from Operations	$ -7,203,742	$ -4,066,634	$3,137,108	
	Non-Operating Revenue and Expenses				
$13,638,900	Appropriations & Support	$3,437,749	$3,493,480	$ 55,731	1.6%
511,500	Accrued Interest on Appropriation	128,925	131,068	2,143	1.7
7,187,600	Interest Income on Reserves	1,811,670	1,787,068	-24,602	-1.4
364,300	Shared Services	91,824	80,826	-10,998	-12.0
2,074,300	Investment Income Held by Trustee	522,836	457,490	-65,346	-12.5
$23,776,600	Total Non-Operating Revenue and Expenses	$5,993,004	$5,949,932	$ -43,072	-0.7%
$ -11,269,500	Revenue Over/-Under Expense	$ -1,210,738	$1,883,298	$3,094,036	(1)

(1) Variance equals 6.0% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO SEPTEMBER 30, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$52,544,283	$57,921,203	$5,376,920	10.2%
Deductions from Charges	8,184,267	8,943,218	758,951	9.3%
Other Operating Revenue	1,291,380	1,415,143	123,763	9.6%
Total Revenue from Operations	$45,651,396	$50,393,128	$4,741,732	10.4%
Expenditures				
Salaries	$22,311,313	$23,758,647	$1,447,334	6.5%
Fringe Benefits	4,306,243	4,609,408	303,165	7.0
Contract Compensation	2,190,466	2,205,916	15,450	0.7
Medical Supplies, Drugs, Blood	7,892,429	7,878,853	-13,576	-0.2
Campus Administration Expense	1,568,411	1,568,411	0	
Depreciation and Amortization	3,554,830	3,942,426	387,596	10.9
General Supplies & Expense	11,031,446	10,496,101	-535,345	-4.9
Total Expenditures	$52,855,138	$54,459,762	$1,604,624	3.0%
Net Revenue from Operations	$-7,203,742	$-4,066,634	$3,137,108	
Non-Operating Revenues and Expenses				
Appropriations	$3,566,674	$3,624,548	$ 57,874	1.6%
Interest Income on Reserves	1,811,670	1,787,068	-24,602	-1.4%
Shared Services	91,824	80,826	-10,998	-12.0%
Investment Income on Trustee Held Assets	522,836	457,490	-65,346	-12.5
Total Non-Operating Revenues and Expenses	$5,993,004	$5,949,932	$-43,072	-0.7%
Revenue Over / -Under Expenses	$-1,210,738	$1,883,298	$3,094,036	(1)

(1) Variance equals 6.0% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1986 TO SEPTEMBER 30, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$52,544,283	$57,921,203	$5,376,920	10.2%
Deductions from Charges	-8,184,267	-8,943,218	-758,951	-9.3%
Other Operating Revenue	1,291,380	1,415,143	123,763	9.6%
Total Operating Revenue	45,651,396	50,393,128	4,741,732	10.4%
Total Expenditures	-52,855,138	-54,459,762	-1,604,624	-3.0%
Net Operating Revenue	-7,203,742	-4,066,634	3,137,108	0.0%
Non-Operating Revenue and Expenses	5,993,004	5,949,932	-43,072	-0.7%
Revenue Over Expense	$ -1,210,738	$1,883,298	$3,094,036	(1)

(1) Variance equals 6.0 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	4,494	4,752	258	5.7%
Patient Days	37,123	38,883	1,760	4.7%
Average Daily Census	403.5	422.6	19.1	4.7%
Average Length of Stay	8.3	8.1	-0.2	-2.4%
Percentage Occupancy	67.3%	70.4%	3.1%	4.6%
Outpatient Clinic Visits	56,228	61,888	5,660	10.1%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 15, 1986

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Bad Debts -- July 1, 1986 through September 31, 1986

The total amount recommended for bad debt of Hospital and Clinic accounts receivable during the first quarter of 1986-86 is $378,933.69, represented by 1451 accounts. Bad debt recoveries during the period amounted to $19,801.07, leaving a net charge off of $359,132.62.

A statistical summary follows on this report with detailed description of losses over $2000 and recoveries over $200 for each of the months in the first quarter. We have also included two additional reports with a break down of bad depts by residence and by admitting clinical service.

CPF/dfr

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1986 THROUGH SEPTEMBER 1986

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	48,549.33	126	92,684.38	12	141,233.71	138
Total	48,549.33	126	92,684.38	12	141,233.71	138
Recoveries	(3,135.95)	16	(6,765.64)	2	(9,901.59)	18
Net Total	$ 45,413.38	126*	$ 85,918.74	12*	$ 131,332.12	138*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 5,189.04	13	$ 93,074.39	4	$ 98,263.43	17
Bad Debt (701) Write-Offs	106,073.70	1282	30,547.48	5	136,621.18	1287
Total	111,262.74	1295	123,621.87	9	234,884.61	1304
Recoveries	(6,028.18)	85	(3,871.30)	1	(9,899.48)	86
Net Total	$ 105,234.56	1295*	$ 119,750.57	9*	$ 224,985.13	1304*
INPATIENT AND OUTPATIENT TOTAL	$ 150,647.94	1421*	$ 205,669.31	21*	$ 356,317.25	1442*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 2,492.00	6	$ --	--	$ 2,492.00	6
Outpatient (710)	323.37	3	--	--	323.37	3
Total	2,815.37	9	--	--	2,815.37	9
Recoveries	(000.00)	0	--	--	(000.00)	0
Net Total	$ 2,815.37	9*	$ --	--	$ 2,815.37	9*
TOTAL NET BAD DEBT	$ 153,463.31	1430*	$ 205,669.31	21*	$ 359,132.62	1451*

NOTE: More than $2,000 amount includes legal settlements totaling $11,013.54

DOLLARS BUDGETED **$ 697,228.00**

*Net total of accounts do not include recoveries.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BAD DEBT STATISTICS

JULY 1986 THROUGH SEPTEMBER 1986

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$1,743.88	48	$27,250.21	66	$1,955.24	12	$35,914.74	8	$56,769.64	4	$141,233.71	138
Total	$1,743.88	48	$27,250.21	66	$1,955.24	12	$35,914.74	8	$56,769.64	4	$141,233.71	138
Recoveries	($145.60)	10	($2,990.35)	6	$0.00	0	($6,765.64)	2	$0.00	0	($9,901.59)	18
Net Total	$1,598.28	48 *	$24,259.86	66 *	$1,955.24	12 *	$29,149.10	8 *	$56,769.64	4 *	$131,332.12	138 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$174.50	4	$1,795.83	7	$3,219.51	2	$12,678.40	2	$80,395.99	2	$98,263.43	17
BAD DEBT (701) WRITE-OFFS	$31,112.23	987	$67,320.99	290	$7,640.48	5	$19,533.94	4	$11,013.54	1	$136,621.18	1287
Total	$31,286.73	991	$69,116.82	297	$10,859.99	7	$32,212.34	6	$91,409.53	3	$234,884.61	1304
Recoveries	($1,901.52)	66	($4,126.66)	19	$0.00	0	($3,871.30)	1	$0.00	0	($9,899.48)	86
Net Total	$29,385.21	991 *	$64,989.36	297 *	$10,859.99	7 *	$28,341.04	6 *	$91,409.53	3 *	$224,985.13	1304 *
INPATIENT AND OUTPATIENT TOTAL	$30,983.49	1039 *	$89,249.22	363 *	$12,815.23	19 *	$57,490.14	14 *	$148,179.17	7 *	$356,317.25	1442 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$2,492.00	6	$0.00	0	$0.00	0	$0.00	0	$2,492.00	6
Outpatient (710)	$69.50	2	$253.87	1	$0.00	0	$0.00	0	$0.00	0	$323.37	3
Total	$69.50	2	$2,745.87	7	$0.00	0	$0.00	0	$0.00	0	$2,815.37	9
Recoveries	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Net Total	$69.50	2 *	$2,745.87	7 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$2,815.37	9 *
TOTAL NET BAD DEBT	$31,052.99	1041 *	$91,995.09	370 *	$12,815.23	19 *	$57,490.14	14 *	$148,179.17	7 *	$359,132.62	1451 *
DOLLARS BUDGETED											$697,228.00	

* Net total of accounts do no include recoveries.

NOTE: More than $2000 amount includes legal settlements totaling $11,013.54

FIRST QUARTER FISCAL YEAR 1987
BAD DEBTS BY STATE

STATE	NUMBER	AMOUNT[1]
Alabama	7	$ 399.92
Alaska	1	29.08
Arizona	3	488.52
Arkansas	1	193.45
California	10	669.46
Colorado	2	60.82
Florida	7	11,514.84
Georgia	3	476.43
Illinois	13	851.94
Indiana	4	192.86
Iowa	8	1,022.84
Kansas	3	739.00
Massachusetts	4	189.97
Michigan	2	218.80
Minnesota	1,213[2]	246,9323.96[2]
Missouri	1	294.58
Montana	1	384.10
Nebraska	1	12.96
Nevada	1	22.22
New Mexico	1	123.20
New York	15	1,436.69
North Carolina	1	98.00
North Dakota	31	23,876.20
Ohio	1	169.72
South Carolina	1	282.46
South Dakota	21	39,678.64
Tennessee	3	95.50
Texas	5	10,610.62
Utah	1	120.38
Washington	1	27.38
Wisconsin	57	17,504.93
Unidentified	28	20,215.22
TOTALS	1,451	$378,933.69

[1]These figures do not include recoveries to bad debt.
[2]The Minnesota figures include not only Minnesota Bad, but also includes some group bad debts including Medicare and Legal categories.

FIRST QUARTER FISCAL YEAR 1987
BAD DEBTS BY ADMITTING SERVICE

ADMITTING SERVICE	NUMBER	AMOUNT
Dentistry	1	$ 9.93
GYN	4	2,292.71
GYN - Oncology	13	8,013.22
Medicine - Blue	1	3,480.22
Medicine - Green	4	2,504.22
Medicine - Masonic (Oncology)	5	2,377.00
Medicine - Purple	1	2,213.99
Medicine - Red A	2	534.30
Medicine - Rose A	2	105.25
Medicine - White A	4	2,809.68
Medicine - White B	2	955.31
Neurology	4	568.02
Neurosurgery	7	2,484.90
Newborn General	2	736.92
OB General	3	358.15
Ophthalmology	4	909.24
Orthopedics	14	8,902.94
Otolaryngology	6	3,337.28
Pediatrics General	9	19,794.84
Pediatrics Neurology	2	265.66
Pediatrics Orthopedics	1	1,091.68
Pediatrics Surgery - Green	1	20.00
Pediatrics Surgery - Orange	1	773.45
Physicial Medicine and Rehabilitation	1	23.12
Psychiatry - Child	1	1,734.05
Psychiatry - Adult	6	4,912.18
Surgery - Blue	4	8,018.48
Surgery - Orange	2	675.20
Surgery - Purple	2	1,077.17
Surgery - Red	2	2,736.62
Surgery - White	2	2,464.26
Urology	4	706.93
Unknown	26	56,838.75
Subtotal	144	$143,725.71
Outpatient	1,307	235,207.98
TOTAL	1,451	$378,933.69

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

October 16, 1986

TO: Members, Board of Governors

FROM: C. Edward Schwartz
Hospital Director

SUBJECT: Merit Pay

The Finance Committee and Board of Governors discussed the subject of merit pay last month. At that time we indicated that we wish to incorporate merit pay as a component in our 1987-88 pay plans, and, if we are to do so, would like to indicate that intent to our employees in November. Before communicating that intent with our employees, we would request Board endorsement of those actions at a conceptual level. The precise structure and dollar amounts related to a merit pay plan would then be presented next spring as part of our budget and annual compensation plan.

As was noted last month, we believe merit pay will be an important management tool in helping to accomplish hospital objectives, through the availability of a system to reward superior performance. This is particularly true in the context of our "Patients First" program, as was expressed frequently in our employee survey for "Patients First." There is also a high level of employee support for at least a partial merit pay plan, as is indicated by the results of the attached employee survey on merit pay.

We do not anticipate extending the merit pay plan to our unionized employees or our nursing and pharmacy staffs, all of whom currently use seniority or "step" systems in their compensation plans.

At last month's meeting there appeared to be a general expression of support for the concept of merit pay. Employee communication and supervisory training were items noted as being particularly important to successful implementation. Both of these topics have been or will shortly be addressed by hospital management.

We would ask, at this month's meeting of the Finance Committee and Board of Governors, for approval to (a) proceed with design of a merit pay plan for 1987-88, and (b) announce to our employees that merit will become a consideration in next year's pay plans. We would plan on a follow-up report with the Board as part of next year's specific compensation plan recommendations.

We will be happy to answer any questions which you may have next week.

attachments

SUMMARY OF RESULTS

The attached questionnaire was sent to 502 employees as follows:

346 randomly selected non-supervisory employees
108 randomly selected supervisors
all 48 department heads and administrators

Total population consisted of 1,616 employees who are not students, not in an organized bargaining unit, and not in a group that is covered by a step-increase compensation plan. The population included all supervisors, department heads and administrators, and employees in data processing, clerical, finance, personnel, medical technology, social work, respiratory therapy, dietetics, radiology, and related occupations in both Hospital- and University-dominated classes.

247 questionnaires (49%) were returned. Of these, 148 were from non-supervisory employees, 65 from supervisors, and 34 from department heads and administrators. The selected group consisted of 69% employees, 21% supervisors, and 10% department heads and administrators. The group of respondents matched the selected group fairly well with 60% employees, 26% supervisors, and 14% department heads and administrators.

Choices were ranked number one (most preferred) in the following order:

	NUMBER OF TIMES SELECTED AS NO. 1
1. B - Partial merit	96
2. D - 100% merit	90
3. A - Across-the-board	39
4. C - Lump sum	20

Supervisors and non-supervisory employees followed this same pattern. The group of department heads and administrators deviated from this ranking in that more (20) chose D as number one than B (6).

Choices were ranked number four (least preferred) in the following order:

	NUMBER OF TIMES SELECTED AS NO. 4
1. B - Partial merit	7
2. D - 100% merit	33
3. C - Lump sum	41
4. A - Across-the-board	109

The groups were almost completely in agreement on this.

Supervisors and managers were also asked if they would like the employees they supervise to be paid in the same way as themselves. 87 out of 99 said yes. Six did not answer the question. Six chose a different option for their employees. Three of these chose one of the merit pay choices for themselves (B, C, or D) and an across-the-board increase for their employees. Two chose a partial merit (B) for themselves and 100% merit (D) for their employees. One wanted an across-the-board increase (A) for himself and a 100% merit for his employees. This is interesting, but hardly significant because of the small numbers. It is important that 88% of the supervisors and managers said they would choose the same options for their employees as for themselves.

Comments were not solicited but were volunteered by 19 individuals. These are attached. They represent 8% of the respondents, and generally expand on why these employees did or did not choose certain options. Most of them express concerns about a merit-based pay system. These also should not be considered as representative of the group as a whole because of the relatively small numbers and because most of this group chose Option A in contrast to the larger group.

CONCLUSION: A partial merit increase as described in the questionnaire is most often the first choice of the group of 247 respondents taken as a whole and also of the non-supervisors as a separate group and supervisors as a separate group. Department Heads and Administrators prefer a full merit plan. A partial merit increase was their second choice.

A 100% merit plan is the second most frequent No. 1 choice of the group as a whole, and of the non-supervisory and supervisory groups individually. Department Heads and Administrators, as noted above, ranked this option as number one most frequently.

The across-the-board increase, Option A, received the third highest number of number one rankings by the group as a whole. It also had the largest number of number four rankings.

Comparative rankings:

	Frequency of No. 1 Rank				Frequency of No. 4 Rank			
	E	S	D&A	TOTAL	E	S	D&A	TOTAL
1	B 62	B 29	D 20	B 96	B 4	B 0	D 1	B 7
2	D 50	D 21	B 6	D 90	D 24	D 8	B 3	D 33
3	A 27	C 8	A 5	A 39	C 29	C 9	C 3	C 41
4	C 9	A 7	C 3	C 20	A 58	A 35	A 16	A 109

Option C, an across-the-board increase with a lump sum for outstanding performers, is the fourth choice of the group as a whole, of the non-supervisory employees as a group and of the department heads and administrators. However, supervisors ranked it as third choice.

The clearest conclusion to be drawn from this survey is that these employees prefer the combination of a small across-the-board increase with a larger pay for performance increase or a total merit plan to the other two options.

The difference between the preference for the D or B option and the preference for A or C is quite noticeable. 39% of the respondents chose Option B as number one and 36% chose Option D as number one, as contrasted to 16% for A and 8% for C. On the other end of the scale, of those responding, only 4% ranked Option B as number four and 18% ranked Option D as number four, as contrasted to 22% for Option C and a surprising 58% for Option A.

To combine, 75% of the employees listed the two merit pay options as their first or only choice, and 80% of those responding listed the two across-the-board options as last choices. A weighted ranking of all the responses repeats the conclusions:

Option B - Partial Merit	1.9
Option D - Full Merit	2.2
Option C - ATB plus Lump Sum	2.8
Option A - Across-the-board	3.2

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

October 16, 1986

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director and Director of Finance

SUBJECT: October 1986 Year End Financial Projections

The attached materials are a summary of our forecasts for our financial position as of June 30, 1987. These forecasts have been based on September year to date data and have been adjusted for seasonal variations and other changes in our financial operations since you approved the budget in May 1986.

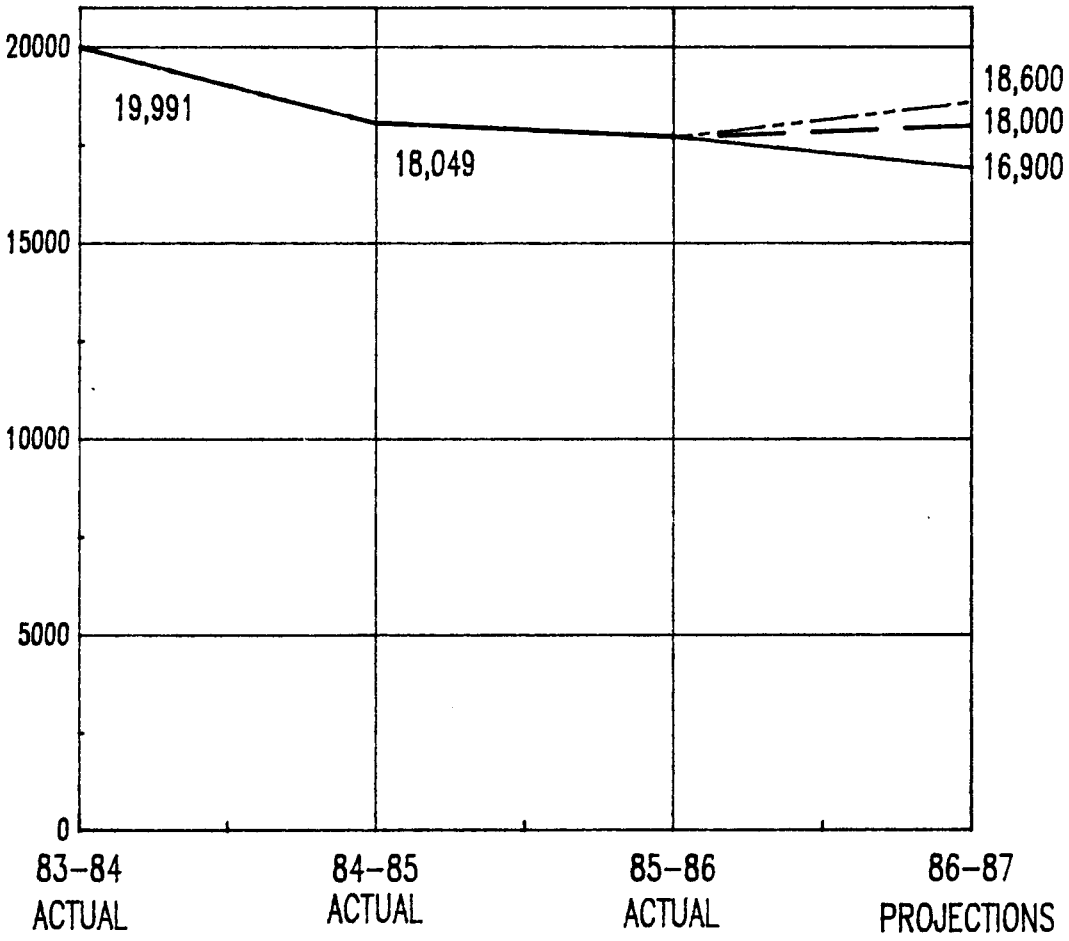
In addition to the projected financial statement we have provided graphs depicting our forecasts of admissions, average daily census, Clinic visits, FTE's and we have provided certain selective measurement comparisons on activity for your review.

We will be prepared to address your concerns on October 22, 1986.

Enclosure

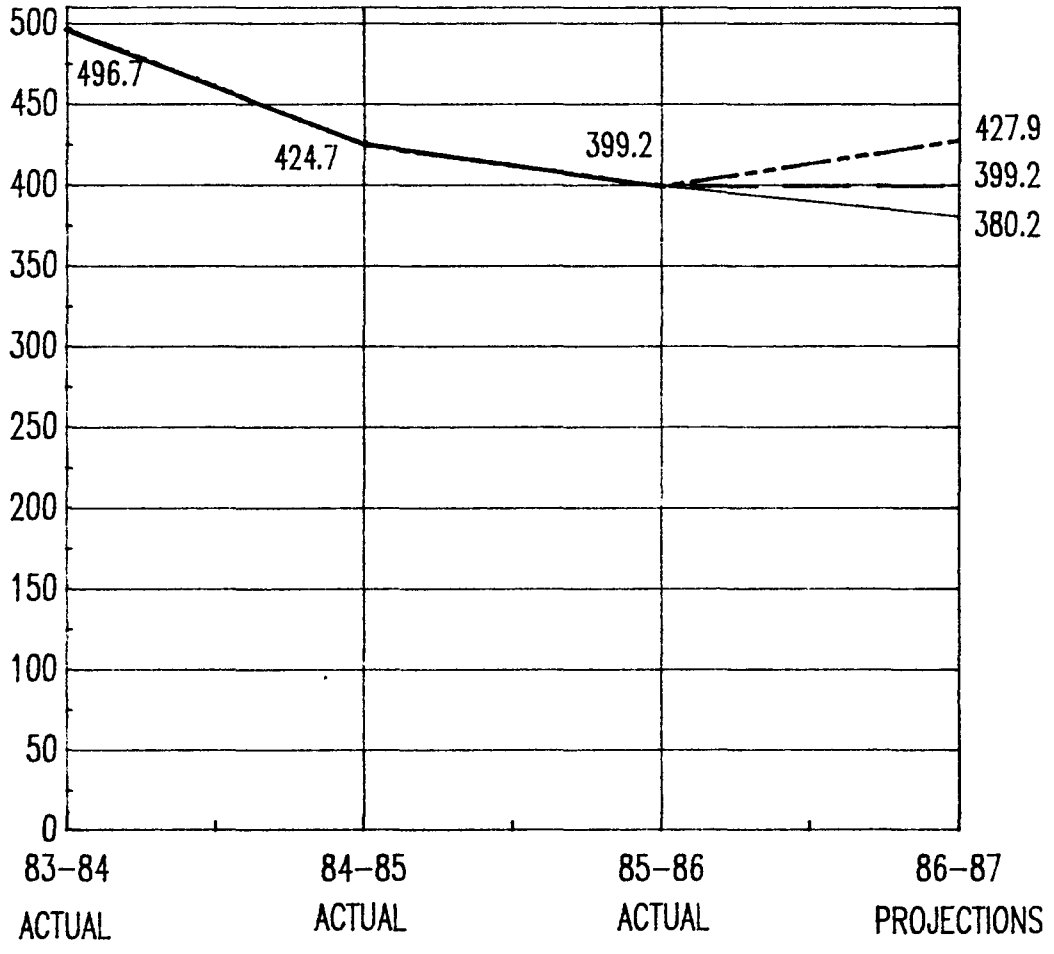
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMISSIONS



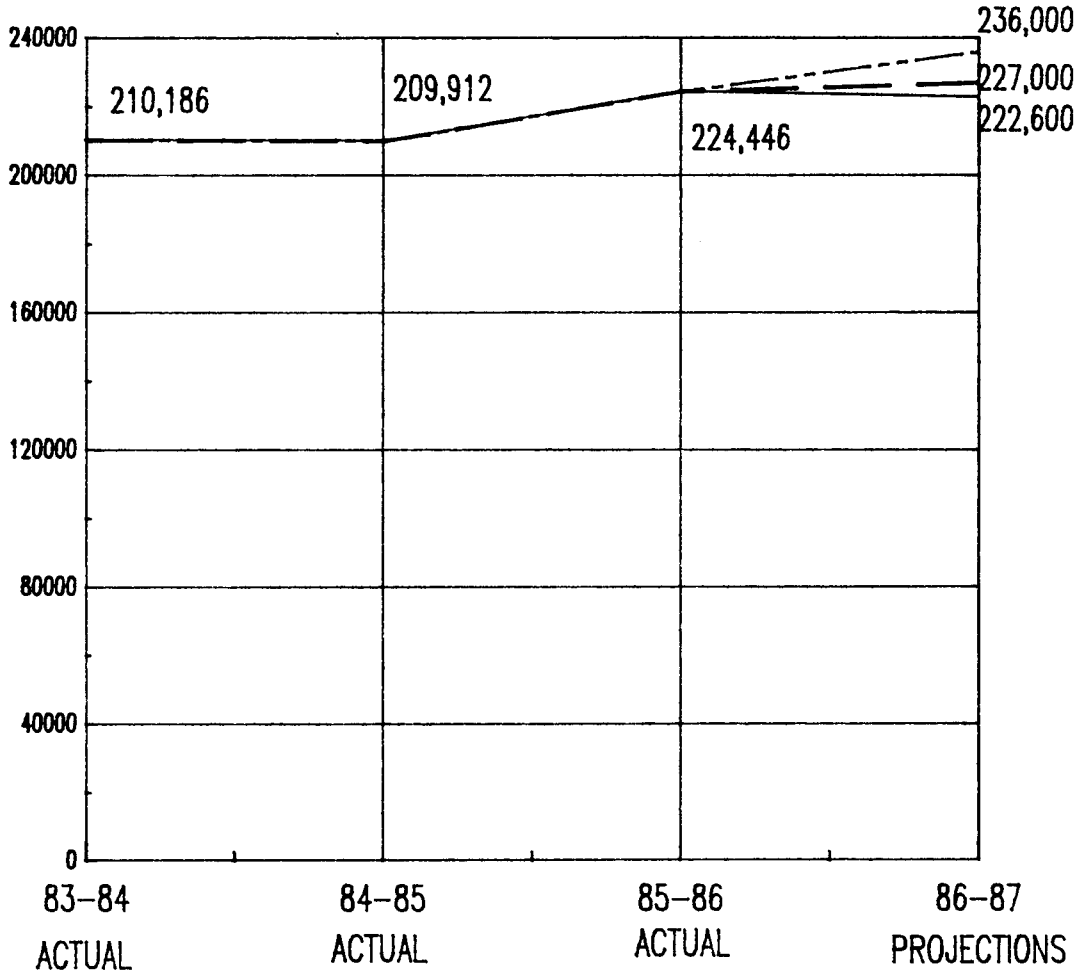
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

AVERAGE DAILY CENSUS



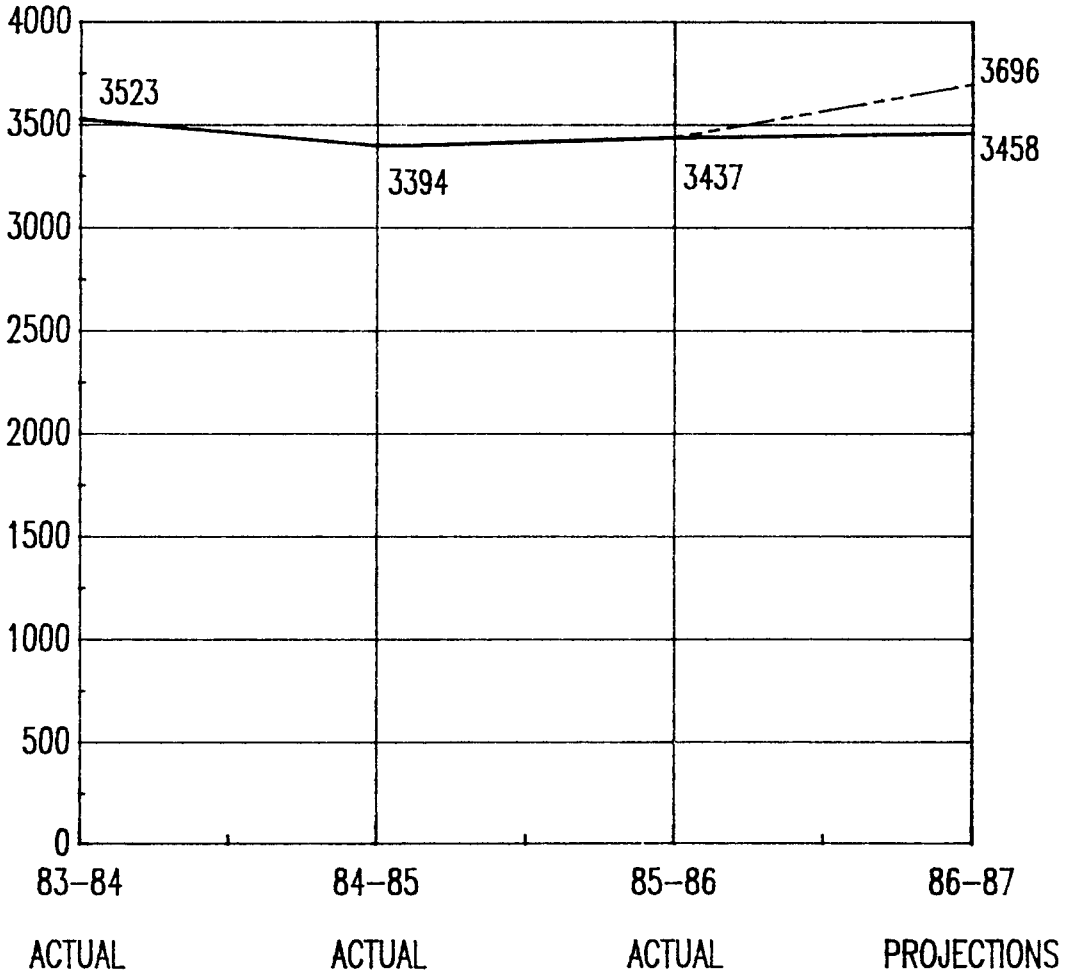
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

CLINIC VISITS



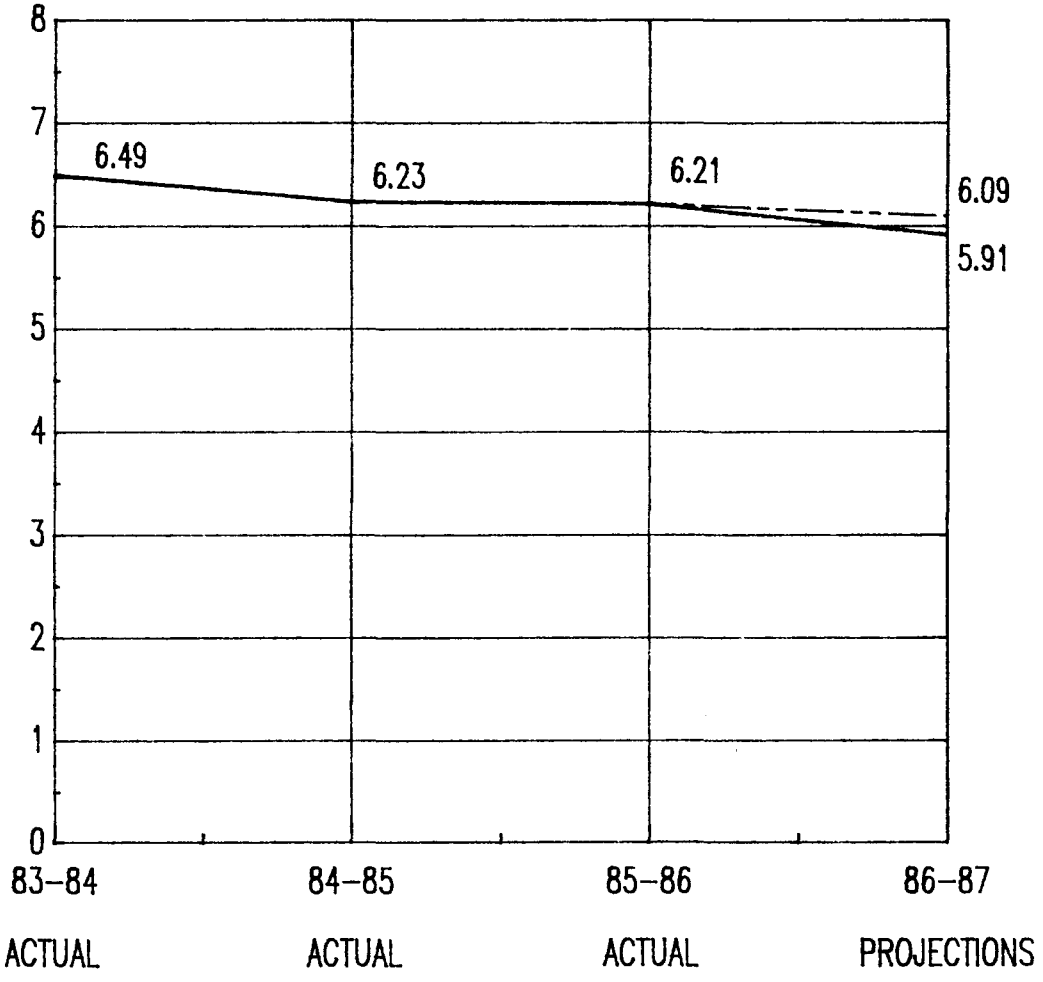
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

FTE'S



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADJUSTED ADMISSIONS/FTE



Medicare Case Mix Index

1983-84	1.28	
1984-85	1.35	5.5%
1985-86	1.45	7.4%
1986-87	1.51 (YTD)	4.1%

NUMIS
Nursing Hours Required Per Patient Day

1983-84	10.73
1984-85	11.46
1985-86	12.61
1986-87	13.57 (estimated)

ANCILLARY INTENSITY

RESPIRATORY CARE

Year	Units	Units/Adjusted Admission	% Change
1983-84	416,894	18.24	
1986-87	742,368	32.98	81%

PATIENT MONITORING

Year	Units	Units/Adjusted Admission	% Change
1983-84	178,034	7.79	
1986-87	225,304	10.01	28%

LABS

Year	Units	Units/Adjusted Admission	% Change
1983-84	1,493,403	65.4	
1986-87	1,625,142	72.2	10%

RADIOLOGY

Year	Units	Units/Adjusted Admission	% Change
1983-84	113,321	4.96	
1986-87	119,069	5.29	7%

University of Minnesota Hospital & Clinic
Summary Statement of Operations and Operating Cash Flow
For Fiscal Year 1986-87

	1985-86 Actual	Original 1986-87 Board of Gov. Budget	October 1986-87 Fiscal Year End Projection
Gross Patient Charges	$ 198,970,537	$ 199,263,700	$ 223,694,000
Deductions from Charges	26,617,386	31,037,200	33,628,900
Other Operating Revenue	4,785,454	5,346,400	5,464,000
Total Revenue from Operations	$ 177,138,605	$ 173,572,900	$ 195,529,100
Expenditures			
Salaries	$ 83,621,300	$ 87,879,400	$ 92,626,900
Fringe Benefits	15,386,480	17,115,800	17,999,200
Contract Compensation	8,494,711	8,769,400	8,826,800
Medical Supplies, Drugs, Blood	28,940,160	29,992,400	35,073,700
Campus Administration Expense	5,926,200	6,222,500	6,222,500
Depreciation	9,966,366	14,103,400	14,147,300
Interest	2,798,996	14,001,200	12,520,000
General Supplies & Expense	28,477,101	30,534,900	33,588,400
Total Expenditures	$ 183,611,314	$ 208,619,000	$ 221,004,800
Net Revenue from Operations	$ -6,472,709	$ -35,046,100	$ -25,475,700
Total Non-Operating Revenue	$ 23,060,131	$ 23,776,600	$ 22,629,200
Revenue Over Expenses	$ 16,587,422	$ -11,269,500	$ -2,846,500
Loss on Refinancing of Long Term Debt	-9,926,891		
Revenue Over/(Under) Expenses	$ 6,660,531	-11,269,500	-2,846,500
Add Non-Cash Outlays:			
Depreciation	$ 9,966,366	$ 14,103,400	$ 14,147,300
Campus Administration Expense	5,926,200	6,122,500	6,122,500
K.E. Utilities	135,299	136,300	136,300
Increase in Accrued Interest	1,947,943	2,039,200	2,656,200
Increase in Accrued Expense	1,522,646	1,196,000	1,032,800
Increase in 3rd Party Payable	0	227,700	249,400
Miscellaneous Sources	794,690		
Loss on Refinancing of Long Term Debt	9,926,891		
Decrease in Accrued Revenue	-823,554	142,600	378,500
Total Funds Provided	$ 36,057,012	$ 12,698,200	$ 21,876,500
Funds Applied:			
Increase in Accounts Receivable	$ 8,662,940	$ 435,900	$ 5,738,000
Increase in Prepaid Expense	-135,336	285,500	475,900
Increase in Inventories	957,199	308,500	608,900
Increase in Deferred 3rd Party	63,119		
Transfer to Reserves - 3rd Party	126,787	227,700	249,400
Investment Income Held by Trustees	1,829,961		
Capital Obligations:			
Principal Payment on Fixed-Rate Bonds	1,315,000	2,550,000	2,550,000
Direct Purchased Capital Equipment and Remodeling	7,865,643	4,108,500	5,108,500
Parking Ramp Sinking Fund	0	60,300	76,200
Debt Service Reserve	7,000,000		
Reserve for Accrued Interest	2,932,262	4,721,800	4,263,100
Total Funds Applied	$ 30,617,575	$ 12,698,200	$ 19,070,000
Total Cash Available from Operations	$ 5,439,437	$ 0	$ 2,806,500
Census:			
Admissions	17,694	16,950	18,600
Average Length of Stay	8.3	8.2	8.4
Patient Days	145,697	138,790	156,200
Average Daily Census	399.2	380.2	427.9
Clinic Visits	224,446	222,600	227,000
Full-time Equivalents (FTE)	3,437	3,458	3,696

Wednesday, October 1, 1986
Minnesota Daily

U patient tests new drug pump at home

By **Delores Lutz**
Staff Writer

Patrick O'Brien is receiving his chemotherapy from a new machine at his Anoka home this week, instead of coming to University Hospital like other cancer patients.

University home health services nurses hooked him up to a computerized pump Tuesday morning. The device will release four potent drugs into his body, following a precise schedule that takes into account his body rhythms.

The arrangement suits O'Brien just fine. "I don't like hospitals," he said.

The 41-year-old former railroad switchman is the first patient to test the pump at home. The device will help revolutionize cancer treatment, according to Dr. William Hrushesky, a University medical oncologist who is studying the pump's effectiveness.

"This is going to be a very important step in administering future generations of cancer therapy," Hrushesky said.

The drugs used to kill cancer cells are very toxic, and it is possible for the drugs to harm the patient's healthy cells. It is important to administer the drugs at the times of the day when they will be most

Pump to 12

Pump from 5

effective and do the least damage, he explained.

The most effective chemotherapy schedule takes account of the patient's circadian rhythms — the normal fluctuations in sleepiness, hunger, wakefulness and so on. The rhythms influence how the body absorbs chemicals, metabolizes food, activates drugs and excretes wastes.

Hrushesky has been researching chronobiology, or the body's rhythms, for 10 years.

The pump can be programmed to perform 1,440 steps per day for each of its four channels, and it can deliver the drugs for up to 31 days, he said.

Besides making chemotherapy safer and more effective, the $5,000 pump also will lower health care costs, according to Hrushesky.

Instead of staying in the hospital, where expenses may reach $300 a day, patients could receive their treatment at home for a fraction of the cost, he said.

A nurse will check on O'Brien at home on Wednesday and Thursday and will disconnect the pump from a catheter in his chest on Friday.

So far, O'Brien said officials at his insurance company have not decided whether to pay for his home treatment because they consider it experimental. However, his insurance does cover his hospital bills, he said.

O'Brien, who had surgery last spring, already has had one round of chemotherapy using the pump, but that regimen was done at University Hospital. He has a rare form of cancer, but asked that the type not be disclosed.

The battery-operated, four-channel pump — which is about the size of a child's shoe box — is not much of a nuisance, O'Brien said. But he must stay in a bed or chair because he also is connected to an intravenous bag.

"I'm confined, more or less," he said. "If it weren't for the I.V. bag, I could hook (the pump) over my shoulder and go."

The next generation of pump will be much smaller, about the size of a paperback copy of *War and Peace*, said Todd Langevin, associate director of medical chronobiology at the University.

The pump is manufactured by Intelligent Medicine, a Colorado firm.

Wednesday, October 1, 1986
Minnesota Daily

Business up since U Hospital's move

By **Delores Lutz**
Staff Writer

University Hospital has attracted more patients than expected since the new building opened in April, turning around a three-year drop in the hospital's patient census.

Having more patients than expected has forced hospital administrators to recruit more staff, particularly nurses. Over the summer, the hospital hired 222 additional full-time and part-time employees, according to Elisabeth White, University Hospital's director of human resources.

The increase in patients has also escalated drug and supply costs $3 million over budget and personnel costs $1 million over budget, according to the hospital's report for the fiscal year that ended June 30.

During the 10 months before the hospital moved to its new location, admissions were down by almost 5 percent compared to the previous fiscal year. But in May and June, admissions jumped by more than 12 percent over last year, according to the report, released last week.

In the University's outpatient clinics, the census was up almost 7 percent over the last fiscal year.

Census to 16

Few on the hospital staff are complaining, however. "It's been stressful to a lot of people, but they're happy about it," said Clifford Fearing, University Hospital senior associate director.

Most of the increases in University Hospital admissions have occurred in transplant surgery, adolescent psychiatry and urology.

Coming in the midst of a health care revolution that has cut hospital use across the country, the shift in the hospital's fortunes has University officials baffled but openly pleased. "We don't know why the census has increased," Fearing said.

The new $125 million building may have helped slightly, but more important factors probably are the University's growing emphasis on transplant surgery, physician outreach programs, new contracts with health maintenance organizations, new technology and a marketing campaign, he said.

"A number of efforts started a number of years ago are just starting to come to fruition," Fearing said.

The building itself is a factor, he said, only because "physicians probably are less reluctant to send patients to this facility. The facility is not bringing patients, but it no longer is a deterrent to patients."

Surgery admissions were up 9 percent over the previous year, psychiatry admissions were up 14 percent and the urology figures jumped by 33 percent. Fearing said the urology increase is a result of the arrival last December of the lithotripter, a machine that destroys kidney stones without painful surgery.

Clinics with the biggest gains are ambulatory surgery, emergency services, medicine, orthopedics, psychiatry, surgery and urology.

Some hospital departments have continued their admissions declines, including the medicine, obstetrics, and physical medicine and rehabilitation departments. Clinic censuses dropped in dentistry, otolaryngology, and obstetrics and gynecology.

Wednesday, October 1, 1986
St. Paul Pioneer Press & Dispatch

U to pioneer hand transplants

By John Camp
Staff Writer

Surgeons at the University of Minnesota are prepared to transplant a hand to a living recipient immediately upon the brain death of a donor. It only awaits a proper candidate.

The operation, when performed, would be a medical first.

The recipient of the hand transplant should be able to grip, turn his hand, flex it, and would develop some level of sensation — perhaps 50 percent of the normal level, doctors said.

The actual joint would be just above the wrist, in an area mostly of tendons below most of the recipient's arm muscle. The transplant would retain the donor's wrist joint.

"It would offer a substantial improvement in function over any available prosthesis," said Dr. Bruce Cunningham, who is expected to perform the first operation. Cunningham, a micro-surgeon and a plastic surgeon, is director of the university's department of plastic and reconstructive surgery.

Regents' Professor Dr. John Najarian, chairman of the department of surgery, confirmed Tuesday that the department had gained approval to perform the operation on a person who is already being treated for another transplant. The approval was granted by the University's Committee for the Use of Human Subjects in Research.

"We've been developing the techniques in the lab, but I have no idea exactly when we'll do it. We're ready if a suitable recipient shows up," Najarian said.

Please see Transplant/4A

The procedure is experimental, he said. "We don't want people to get their hopes up."

Cunningham said that approval for the first transplant is being limited to a person who is already receiving drugs to suppress rejection of other transplanted organs such as kidneys.

The human body normally rejects foreign tissue — tissue from other bodies — Cunningham explained. Drugs, called immuno-suppressants, are available to fight that reaction.

The drugs may have undesirable side-effects, however, so "there is a certain reluctance to begin giving them to people who don't need them as a life-saving measure," he said. "If you're having a kidney or liver transplant, it's a matter of life and death. If you're having a hand transplant, it's not a matter of life and death, though it certainly is a matter of quality of life."

Other possible side-effects involve the toxicity of the drugs, and the possibility that the patient may be increasingly subject to infection because of a suppressed immune system.

Cunningham said studies by Dr. Gabriela Guzman, a research fellow in the University Hospital's plastic and reconstructive surgery laboratory, suggest that transplants might be done with new drugs and lower-level drug dosages that are not as troublesome as older drugs which are given in larger amounts.

Cunningham noted that surgeons conducting re-implant operations are obtaining greater success with retaining limb function and sensation, although neither is as good as it is in an undamaged limb.

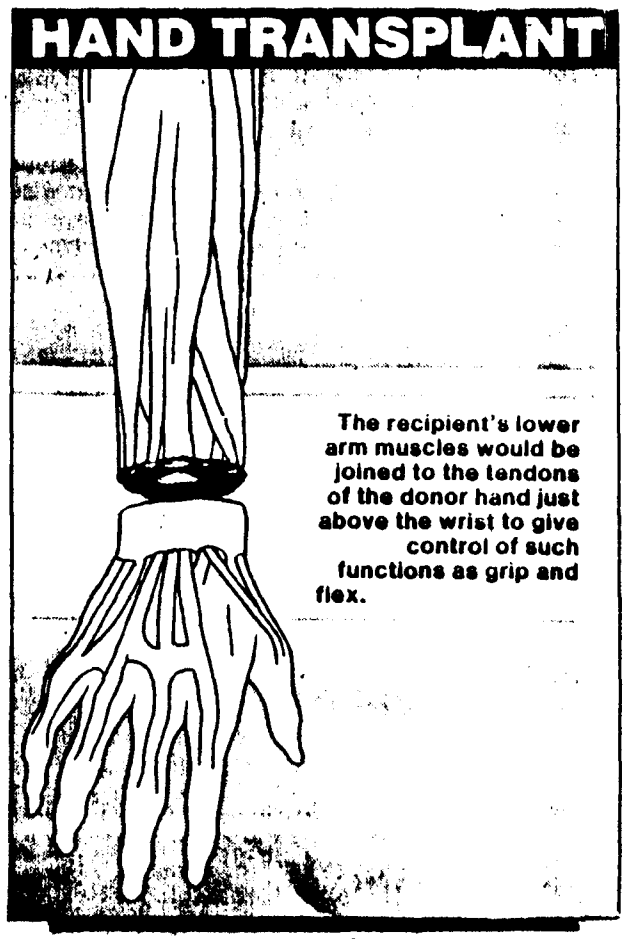
"Aside from the (rejection problem), we think we could have better success with transplants than we do with re-implants because transplants don't involve traumatic injury to the tissue," Cunningham said. "We can put everything back together very carefully. With re-implants, we have to work with what we have left after the accident."

Cunningham said the transplant attempt would almost certainly be limited to a hand, because "lower limb prostheses are generally much more successful than upper limb prostheses. You can get around quite well on a lower limb prosthesis, but an upper limb prosthesis lacks qualities of sensation and the ability to manipulate, which we would hope to retain in a transplant."

He said there are drawbacks to doing the surgery on many people who are already immuno-suppressed, "because they have other serious medical problems which might make complete success of the transplant less likely."

For example, severe diabetics often develop kidney and vascular diseases, and lose their kidneys and limbs, he said. Because these patients are immuno-suppressed, they would be eligible for the hand transplants, Cunningham said. Unfortunately, the vascular disease might cause the transplant to fail, he said.

"The reason we're willing to go ahead with that kind of subject is because we want to see, experimentally, if we can do this thing and how successful it will be," Cunningham said. "Even if a patient has vascular disease and the disease eventually causes the transplant to die, they're no worse off than when they had no hand at all. With a transplant, they have a decent chance for a functional hand, and we learn a lot about the technique and the possibilities."



Chuck Logan / Staff Artist

Thursday, October 2, 1986
Minnesota Daily

U gets approval to perform first hand transplant

Surgeons confident of success for complex set of surgical procedures

By Liz Holm
Staff Writer

Surgeons at the University Hospital confirmed Tuesday that they have received permission to perform the first human hand transplant on a living recipient.

Hands for transplant will be taken from brain-dead donors.

Approval for the transplant, granted by the University's Committee for the Use of Human Subjects in Research, is limited to a person who is already taking drugs to prevent tissue rejection of other transplanted organs.

The six- to eight-hour surgery will be performed by Dr. Bruce Cunningham, director of the University Department of Plastic and Reconstructive Surgery.

"This first transplant will be the beginning step along a road that might open a new horizon," he said Wednesday. He cautioned, however, that people shouldn't get their hopes up, because the surgery is still very experimental.

Cunningham said he thinks transplant surgery may be more successful than re-implant surgery (the re-attachment of a limb that has been severed in an accident) because transplants don't involve traumatic injury to the tissue.

"When a limb has been brutally torn in an injury, the surgery consists of taking what's left of the limb and attaching it the best we can. With a transplant, we have better control over everything," he said.

The major risk with the procedure is not from the surgery itself — which is fairly routine — but from tissue rejection and toxic side-effects caused by the drugs given to prevent this, Cunningham said.

Because the body normally rejects foreign tissue, a transplant recipient must take drugs that suppress the immune system, leaving it unable to identify the foreign tissue and thus reject it. Patients often take these drugs for the rest of their lives. One side-effect of immunosuppressant drugs is that patients taking them may become increasingly susceptible to infection.

As a result, the only people who will be considered as candidates for the surgery will be those who have received transplanted organs and are already taking drugs to suppress rejection.

Cunningham said the University is now aware of several patients who may need hand transplants. After a candidate is chosen, a suitable brain-dead donor will be sought. Because hand size of donor and recipient must be closely matched, they will probably be of the same sex, he added.

A hand transplant patient should be able to turn his hand and grip with it and should develop some level of sensation. Cunningham said the function of the transplanted hand will be compared to the functional level achieved by a person wearing a prosthesis or artificial limb.

"It's our hope that a transplanted hand will have better grip and flexibility than a prosthesis provides," he said.

Research for transplant surgery first began at the University five years ago, Cunningham said. The procedure has been performed on rats at the University and on monkeys in Montreal.

Thursday, October 2, 1986
Minneapolis Star & Tribune

'U' surgeon plans experimental hand transplant

By Gordon Slovut
Staff Writer

A University of Minnesota Hospital surgeon said Wednesday that he hopes to sew the hand of a cadaver onto the wrist of a transplant patient whose own hand has been severely damaged by disease.

Dr. Bruce Cunningham, the microsurgeon who would do the operation, said it would be the world's first human hand transplant.

If a transplanted hand doesn't work, he said, perhaps the emphasis should be on developing better artificial hands.

Cunningham said that he knows of several "possible potential prospects" but that he doesn't know when the first operation will be done.

The hospital's Committee for the Use of Human Subjects in Research approved Cunningham's proposal last September.

The committee restricted the trial to patients who already are receiving antirejection drugs and said Cunningham could do the operation on up to five patients.

Dr. John Najarian, chief of surgery at the hospital, said the first patients almost certainly will be people who have received a kidney, liver or heart.

He said there are significant risks associated with antirejection drugs, including infection, some types of cancer and kidney damage.

It would be improper, at this experimental stage, to subject otherwise healthy people to the risks of those drugs, Najarian said.

Cunningham said the most likely candidates for the transplant are people with severe diabetes who have received kidney transplants and have lost the use of a hand because of impaired blood circula-

Transplant continued on page 8B

tion.

Najarian said that only one or two of the approximately 800 diabetic university kidney transplant patients have lost a hand so far and that other complications, such as inadequate circulation or skin cancer, have disqualified them as candidates for the program.

Dr. Lawrence Lockman, a pediatric neurologist who headed the committee that cleared Cunningham's experiment, said the committee will meet with Cunningham in the next week or two to review the status of his experiment.

Cunningham said it isn't clear whether nerve regeneration will occur to provide sensation in the transplanted hand to, for example, protect it against damage from heat or cold.

He said people with severe diabetes frequently have suffered from damage to the nerves and the blood vessels that serve their wrists and hands.

Najarian stressed that the experiment, at this point, is not for people who were born with deformed hands or who lost their hands in accidents.

INTRODUCTION OF BOARD SELF-EVALUATION TAPE
October 22, 1986

- We would like to further refine our self-evaluation process

- Today's goal: get ourselves thinking about self-evaluation

- Tape produced by Michigan Hospital Association

  interviewees on tape:

  Richard Umbdenstock
  Barry Bater
  } both have done extensive consulting on trustee effectiveness

- Tape discusses:
  - definition of self-evaluation
  - traits of an excellent Board
  - reasons to evaluate
  - the process of evaluation
  - individual Board member assessment

- The tape is 48 minutes long so we will view highlights only
  - reasons to evaluate
  - recommended components of evaluation process

October 15, 1986

Metro Hospital Trustee Council
7150 CAHILL ROAD ◆ SUITE 314
EDINA, MINNESOTA 55435
612-941-3908

METRO HOSPITAL TRUSTEE COUNCIL

OCTOBER NEWS SUMMARY

- Council deliberates its future.

In September, the Trustee Council met at the new University Hospitals to tour the facilities and to consider focus and priorities for the Council's future.

There was a strong consensus that the Council's role and purpose are equally or even more important today than in 1978 when it was organized. Themes from the discussion included:

1. The unique role of the hospital trustee in representing the community interest.

2. The challanging demands for leadership that hospital trustees face during these years of change and consolidation.

3. The importance of proactive leadership from the Hospital Trustee Council on significant policy issues.

- Conference XIII held on Quality in Health Care.

Minnesota Hospital Trustee Conference XIII, "The Quest For Quality: The Next Competitive Wave", will be held on Friday, October 31st at the Holiday Inn International. This theme raises an issue central to trustee interests and responsibilities. Medical directors, as well as hospital CEO's, have been invited to participate in the conference to chair the round table discussion.

These conferences are planned by hospital trustees for hospital trustees with a strong emphasis on community and public policy issues that have a major impact on the hospitals. They provide an exceptional local opportunity to participate in a quality educational event.

- Position Statement on Quality and Community Values.

A task force of the Trustee Council is issuing its Position Statement on Quality and Community Values, as it has recently been approved by the full Council.

This statement evaluates the impact of changing market focuses on the quality of health care and suggests a beginning community agenda for addressing quality issues. Hospital Trustees are seen as central to these community deliberations, as well as in leadership roles for quality assurance in their individual hospital organizations. Copies of this

(Over)

report will be circulated at the October 31st conference. They can also be obtained from: Metro Hospital Trustee Council
7150 Cahill Road, Suite 314
Edina, MN 55435

941-3908

- Recent Appointments

Vern Hoium, trustee, Unity--

Recently elected as Chair elect to the National Congress of Governing Board of American Hospital Association.

Vern Hoium--

Also appointed to represent the Trustee Council on the University of Minnesota Health Sciences Advisory Committee that deals with graduate medical education.

Barbara O'Grady, Chair of the Board, University of Minnesota Hospitals--

Has recently been appointed as Vice Chair of the Twin City Community Program which will be implementing the Community Buyer System. She is also a newly appointed member to the Board of the Minnesota Coalition on Health.

LuVerne M. Molberg
Staff Consultant

Revised 10/13/86

Metro Hospital Trustee Council

7150 CAHILL ROAD ◆ SUITE 314
EDINA, MINNESOTA 55435
612-941-3908

ROSTER OF MEMBERS

ABBOTT NORTHWESTERN

Chuck Moos
1560 Dain Tower
Mpls., MN 55402
333-1871

BAPTIST HOSPITAL FUND

Harry Atwood
90 West Point Ave.
Tonka Bay, MN 55331
474-9130

BETHESDA LUTHERAN

Don Doyon
1397 Birmingham
St. Paul, MN 55101
774-8153

Dean Wahlberg (Alternate)
DCA, Inc.
400 DCA Center
13100 Wayzata Blvd.
Minnetonka, MN 55343
541-7518

CARONDELET COMMUNITY

Sister Ann Elise Tschida
DH - 204
2004 Randolph Ave.
St. Paul, MN 55105
690-6858

DISTRICT MEMORIAL

Jeanette Houle
8110 20th Avenue N.
Hugo, MN 55038
429-2466

FAIRVIEW RIVERSIDE

Bill Thiele
Administrative Services - 3M
220 3M Center
St. Paul, MN 55144-1000
733-1686

FAIRVIEW COMMUNITY

Gerald Simonson
5813 Jeff Place
Mpls., MN 55436
831-3350

FAIRVIEW SOUTHDALE/RIDGES

Ruth K. Hustad
Hustad Real Estate
7460 Market Place Drive
Eden Prairie, MN 55344
941-4383

Marianne Curry (Alternate)
State Representative
326 State Office Bldg.
St. Paul, MN 55155
296-5366

GILLETTE CHILDREN'S HOSPITAL

Florence Gray
2710 University Ave. S.E.
Suite #106
Mpls., MN 55414
331-4477

Janet Brodahl (Alternate)
Health Resource Director
Minnesota Dept. of Health
717 Delaware St. S.W.
Mpls., MN 55440
623-5440

HEALTH CENTRAL SYSTEMS

Lee Canning (Past Pres.)
Suburban Newspapers
7401 Bush Lake Road
Edina, MN 55435
831-1200

HEALTHONE CORPORATION

J. Stanley Hill
70 Spruce Street
Mahtomedi, MN 55116
426-2508

HENNEPIN COUNTY MED CTR

Samuel Sivanich
A-2400 Government Center
Mpls., MN 55487
348-3082

Pj Doyle (Alternate)
A-2400 Government Center
Mpls., MN 55487

LIFESPAN, INC.

Frances Naftalin
39 Greenway Gables
Mpls., MN 55403
339-4952

MERCY MEDICAL CENTER

Naomi Johnson
647 School Street
Anoka, MN 55303
421-8742

METHODIST HOSPITAL

Robert Galloway
Photo Control Corporation
[illegible]0 Quebec Ave. North
Mpls., MN 55428
537-3601

METROPOLITAN MEDICAL CENTER

Barbara Klemme
9263 St. Croix Trail N.
Stillwater, MN 55082
623-9704

Marion Etzwiler (Alternate)
Minneapolis Foundation
Foshay Tower
Mpls., MN 55402
339-7343

MPLS. CHILDREN'S MEDICAL CTR

Beth Bennett
3680 Northome Road
Wayzata, MN 55391
[illegible]-3122

MOUNT SINAI HOSPITAL

Stephen Davis, Attorney
4114 IDS Center
Mpls., MN 55402
341-0300

Framajane Wolfson (Alternate)
14601 Rocksborough Road
Minnetonka, MN 55343
935-6400

NORTH MEMORIAL

William Woyda, M.D.
Oakdale Medical Center
Suite #200
Robinsdale, MN 55422
588-0734

QUEEN OF PEACE

Howard Winholtz
Charter House
211 Second Street N.W.
Suite #606
Rochester, MN 55902
(507) 286-7890

REGINA MEMORIAL

Tabitha Van Deursen
Regina Memorial Hospital
Hastings, MN 55033
437-3121

SAMARITAN HOSPITAL

William Watson, M.D.
2660 Borden Court
Inver Grove Heights, MN 55075
455-4233

ST. PAUL CHILDREN'S

Eleanor Bourquin
3673 Big Fox Road
Glen Lake, MN 55110
429-1260

ST. PAUL RAMSEY MEDICAL CTR

Marlene Marschall
670 Lovell
Roseville, MN 55113
221-2184

Steven Schmidt (Alternate)
880 Lumber Exchange Bldg.
Mpls., MN 55402
333-3343

SHRINERS HOSPITAL

Don Hoglund
40 Bay Street
Tonka Bay, MN 55331
474-5612

UNITED HOSPITAL

William Podas
1119 Davern
St. Paul, MN 55116
699-1089

UNITY MEDICAL CENTER

Vernon Hoium
925 Dain Tower
Mpls., MN 55402
339-9341

UNIVERSITY HOSPITALS

Barbara O'Grady (President)
5130 Emerson Ave. South
Mpls., MN 55419
298-4549

WACONIA RIDGEVIEW

Bob Lind
19 Alfred Boulevard
Waconia, MN 55387
1-442-4431

EX-OFFICIO'S

Marvin Borman
1800 Midwest Plaza
Mpls., MN 55402
339-8015

Bob Christenson
4920 Newton Ave. South
Mpls., MN 55409
922-2324

John Harris
Fagre and Benson
2300 Multifoods Bldg.
Mpls., MN 55402
371-5323

Allen Housh
Cargill, Inc.
PO Box 9400
Mpls., MN 55440
475-6149

David LaVine
505 East Grant
Mpls., MN 55404
333-4455

Carlos Luis
2045 Summit Avenue
St. Paul, MN 55105
642-4548

Joan Nickells
6360 Red Fox Lane
Edina, MN 55436
920-7505

William Randall
1500 First Nat'l Bank Bldg.
St. Paul, MN 55101
291-9333

Joseph O'Neill
800 Norwest Center
55 E. 5th Street
St. Paul, MN 55101
227-9505

Frank Bremer
1650 Woodside Court
Mpls., MN 55432
571-8247