P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
40. 86-680	B-D/ Disp. Needles and Syringes	$ 374,685.03	$ 337,983.57	Materials
	James Phillips/B-D Disp. Needles and Syringes	$ 374,685.03	$ 313,783.95	Materials
	Medix/B-D Disp. Needles and Syringes	$ 374,685.03	$ 308,916.98	Materials
	Transhealth/ B-D Disp. Needle and Syringes	$ 374,685.03	$ 320,746.41	Mateirals
	Whittaker/ B-D Disp. Needles and Syringes	$ 374,685.03	$ 315,338.67	Materials

REASON: The Needle Sheaths are not uniform in thickness and the packaging is difficult to open while maintaining sterility.
The Syringe sizes do not conform to the dosage capacities and established Nursing procedures. The Syringes have a smaller Reserve capacity for maintaining the Plunger within the Barrel while drawing Over-Fills.

ATTACHMENT D

VI. VENDOR APPEAL

1. Vendor Name: Roger Meill, Inc.
   Nature of Purchase: Microscope
   Amount of Award: $ 11,284.00
   Reason for Appeal: The Vendor was of the opinion that the product was comparable to the item specified. UMHC explained the award rationale to both parties satisfaction.

2. Vendor Name: Simmons
   Nature of Purchase: Hospital Beds
   Amount of Award: $ 86,875.95
   Reason for Appeal: Simmons appeal was based upon their opinion that they indeed met UMHC's specifications. UMHC requested a bed for testing and evaluation, however, Simmons did not comply. UMHC subsequently awarded the bid to Hill-Rom.

3. Vendor Name: Joerns Healthcare
   Nature of Purchase: Hospital Beds
   Amount of Award: $ 86,875.95
   Reason for Appeal: Joern's appeal was based upon their opinion that they indeed met UMHC's specifications. UMHC requested a bed for testing and evaluation, however, Joern's did not comply. UMHC subsequently awarded the bid to Hill-Rom.

4. Vendor Name: Medtronic/Andover Medical
   Nature of Purchase: Adult Electrodes
   Amount of Award: $ 13,350.00
   Reason for Appeal: The Vendor contends that the product bid allows the skin to breathe and incompatable Lead Wires may have caused snaps to disengage during the initial evaluation. The product is currently being re-evaluated.

5. Vendor Name: Scanlan International
   Nature of Purchase: Aortic Punches
   Amount of Award: $ 20,157.12
   Reason for Appeal: Scanlan disagreed with rationale for Non-Award due to their product having an Open Shaft, Spring Tension and Ring Handles. UMHC re-evaluated with similar results and awarded product to Johnson and Johnson, upon responding to Scanlan's request.

ATTACHMENT E

VII. University Hospital Consortium Activity

1.	Nature of Purchase:	Parts
	Consortium Vendor Name:	Castle/Sybron
	Purchase Order #:	H 060395
	Value of Purchase:	$ 2,079.89
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 103.99
2.	Nature of Purchase:	Parts
	Consortium Vendor Name:	Castle/Sybron
	Purchase Order #:	H 314859
	Value of Purchase:	$ 3,531.56
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 176.58
3.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 317279
	Value of Purchase:	$ 2,310.00
	Value of Next Lowest Bidder:	$ 2,388.00
	Savings:	$ 78.00
4.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 317280
	Value of Purchase:	$ 2,538.00
	Value of Next Lowest Bidder:	$ 2,940.00
	Savings:	$ 402.00
5.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 318534
	Value of Purchase	$ 1,326.00
	Value of Next Lowest Bidder:	$ 1,508.00
	Savings:	$ 182.00
6.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 319131
	Value of Purchase::	$ 3,195.00
	Value of Next Lowest Bidder:	$ 3,550.00
	Savings:	$ 355.00
7.	Nature of Purchase:	Hospital Beds
	Consortium Vendor Name:	Hill-Rom
	Purchase Order #:	H 062146
	Value of Purchase:	$ 86,875.95
	Value of Next Lowest Bidder:	$ 93,415.00 (Hill-Rom Bid)
	Savings:	$ 6,539.05

ATTACHMENT E

VII. University Hospital Consortium Activity

8.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Paper
	Purchase Order #:	H 319935
	Value of Purchase:	$ 2,670.00
	Value of Next Lowest Bidder:	$ 2,697.00
	Savings:	$ 27.00
9.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 320600
	Value of Purchase:	$ 1,468.00
	Value of Next Lowest Bidder:	$ 1,630.00
	Savings:	$ 162.00
10.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 320601
	Value of Purchase:	$ 3,300.00
	Value of Next Lowest Bidder:	$ 3,665.00
	Savings:	$ 365.00
11.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 321633
	Value of Purchase:	$ 360.40
	Value of Next Lowest Bidder:	$ 400.00
	Savings:	$ 40.00
12.	Nature of Purchase	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	H 321633
	Value of Purchase:	$ 2,773.00
	Value of Next Lowest Bidder:	$ 3,256.50
	Savings:	$ 483.50

MINUTES
Joint Conference Committee
Board of Governors
November 12, 1986

ATTENDANCE: Present: Phyllis Ellis, Chair
George Heenan
Dr. James Moller
Dr. Michael Popkin
Nancy Raymond

Absent: Dr. Jack Duvall
Dr. Seymour Levitt
C. Edward Schwartz

Staff: Greg Hart
Geoff Kaufmann
Nancy Janda
Barbara Tebbitt

Guests: Nancy Green

APPROVAL OF MINUTES

The minutes of the October 15, 1986 meeting of the Joint Conference Committee were approved as submitted.

AIDS TASK FORCE UPDATE

Dr. Moller indicated that the Clinical Chiefs reviewed and endorsed the recommendations and report of the AIDS Task Force. The Medical Staff-Hospital Council had previously approved this report at its October meeting. Dr. Moller indicated that he will now be initiating the necessary actions to implement the recommendations contained in the report, including the appointment of an ongoing committee and the reallocation of beds relative to the AIDS patient population. Ms. Tebbitt indicated that the Bed Allocation Committee will be starting a review of bed allocation in Unit J on November 17.

PATIENTS FIRST UPDATE

Nancy Green reviewed progress on the Patients First program with the Committee. She indicated that employee training sessions are well underway, and that over 3,000 employees will have participated in those sessions by early December. The employees are generally responding well to the training sessions; also coming out of the sessions are employee observations and recommendations on priority systems problems which need the attention of Hospital management. Ms. Green then reviewed some of the materials used in the employee sessions.

It was also noted that the Patients First program will become more visible with the medical staff in December and January, and that Dr. Frank Cerra is leading a group of medical staff who are designing a Patients First program to be used with the physicians.

The most recent data from the patient surveys was also reviewed and discussed. A continuing positive response from patients is evident in the survey. Ms. Green also discussed future information gathering plans which her department will be initiating, including a visit with each patient shortly after admission by a member of the Patient Relations Department.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

There were no action items requiring the Committee's endorsement from the most recent Medical Staff-Hospital Council meeting. Dr. Moller indicated that the meeting was largely used as a planning session for future agenda topics of interest. Assessment of quality, patient severity, and cost were items which the Council expressed particular interest in pursuing further in future months.

CLINICAL CHIEFS REPORT

Mr. Hart indicated that most recent Clinical Chiefs meetings have included presentation of the AIDS Task Force report, and presentation of a plan for operation of the new patient and visitor parking ramp. Clinical Chiefs meetings in the next several weeks will include discussion of graduate medical education, a visit from Senator Durenburger's new health aide, and a visit from Dr. Arthur Kaplan, new director of the Center for Biomedical Ethics.

OTHER

Mr. Hart reported that the Council of Community Hospitals price disclosure project will likely be reported on by the media in the next few days. The COCH price data indicates that University Hospital is at a level approximately 20% higher than the community norm for the case mix groups studied.

The COCH price data led into a discussion about the importance of attempting to quantify differences in types of patients seen at University Hospital compared to those seen at other hospitals. The concept of severity measurement was also a major topic at a recent Metro Trustees Conference; Mr. Hart and Mr. Heenan discussed the MEDISGRPS system which was presented at that conference. Mr. Hart indicated that Mr. Al Dees will be making a presentation to the Joint Conference Committee at its December meeting on severity measurement systems. The Committee agreed that this will be an important agenda topic in the future, and that the Committee's work plan should incorporate this subject as a priority item.

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

Respectfully submitted,

Greg Hart

GH/kj

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 14, 1986

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: "Patients First"

At next week's meeting of the Board we will provide an update on the "Patients First" program. The program has moved into a high visibility phase with our employees, as we are now several weeks into training sessions, which will continue for approximately two months. All employees in the Hospital are expected to attend these sessions. We will distribute some examples of the materials used for employee training at the Board of Governors meeting.

Also, attached for your information is the most recent three month summary of the returns received from the patient survey.

We look forward to next week's discussion.

GH/kff

Attachment

PATIENT RELATIONS

"Your Opinion Counts"

TEN MONTH UPDATE

"Your Opinion Counts" surveys are mailed to all patients discharged from UMHC with the exception of those previously hospitalized within the past seven months and those who have died. Return rate is based on those returned from that months mailing.

NOVEMBER -	1,100 mailed	
	249 returned	- 23%
DECEMBER	931 mailed	
	308 returned	- 33%
JANUARY	1,005 mailed	
	366 returned	- 36%
FEBRUARY	872 mailed	
	308 returned	- 35%
MARCH	1,009 mailed	
	367 returned	- 36%
APRIL	844 mailed	
	342 returned	- 41%
MAY	985 mailed	
	313 returned	- 32%
JUNE	959 mailed	
	358 returned	- 37%
JULY	878 mailed	
	362 returned	- 41%
AUGUST	977 mailed	
	464 returned	- 47%

Approximately 1/3 of those returned request follow-up which involves various degrees of problem solving. Thank you letters are sent to those who provide us with complimentary feedback. Overall, patients and visitors are pleased with an opportunity to provide feedback and impressed with the follow-up.

"YOUR OPINION COUNTS"
SIX MONTH COMPARISON

	OLD			NEW		
	MAR.	APR.	MAY	JUNE	JULY	AUG.
I. General Information	%	%	%	%	%	%
A. Reasons of choosing UMHC						
Physician's referral	49	48	49	47	48	56
Physician is here	24	26	12	28	24	21
University reputation	14	21	19	18	23	26
B. Gender						
Female	45	52	52	49	53	51
Male	55	48	40	50	43	48
II. Directions/Registration						
A. Parking difficulty	26	24	22	21	21	31
B. Directions difficulty	17	14	13	10	7	15
C. Reasonable admission time	89	92	88	92	91	92
D. Staff friendliness	97	99	98	98	97	98
III. Accomodations						
A. Room ready and clean	93	93	96	95	98	96
B. Room clean during stay	86	89	90	90	89	89
C. Disturbed by noise	39	36	32	28	32	32
IV. Food Service						
A. Proper temperature	72	75	78	84	81	77
B. Quality of food	76	74	82	83	84	78
C. Food choice satisfactory	80	79	85	83	88	80
D. Received food ordered	79	77	82	80	75	84
V. Physicians						
A. Medical staff introduction	93	96	94	97	94	89
B. Aware of teaching role	91	90	92	91	89	87
C. Positive effect of role	81	80	78	83	85	74
D. Care coordinated	90	90	91	92	88	92
E. Physicians courteous	95	99	97	98	96	99
VI. Diagnostic Procedures						
A. Diagnostic & lab explained	92	94	94	96	98	96
B. Results received	77	78	79	78	86	71
C. Delays in therapy	11	6	11	3	12	10
D. Delays in tests/xrays	18	17	23	12	19	18
E. Delays in surgery	21	21	21	24	20	20
VII. Nursing Staff						
A. Respond promptly	91	92	95	95	92	95
B. Courteous and caring	96	98	99	95	97	99
C. Questions answered	96	97	97	97	98	99
VIII. Hospital Staff						
A. General staff courteous	99	99	99	99	98	98

	-------OLD-------			-------NEW-------		
	Mar. %	Apr. %	May %	June %	July %	Aug. %
IX. Discharge						
A. Received assistance	94	95	93	98	93	96
B. Received meds timely	89	90	85	81	87	89
C. D/c questions answered	95	96	94	94	93	95
X. Overall Impressions						
A. Treated in caring manner	95	98	97	98	97	98
B. Privacy respected	96	95	97	98	99	98
C. Would you choose UMHC again	93	95	96	98	95	98

Minutes
Meeting of the
Board of Governors Finance Committee
The University of Minnesota Hospital and Clinic
October 22, 1986

MEMBERS PRESENT:	Edward Ciriacy, M.D. Clifford Fearing William Krivit, M.D., Ph.D. Jerry Meilahn C. Edward Schwartz Vic Vikmanis
MEMBERS ABSENT:	Carol Campbell Al Hanser Robert Nickoloff
STAFF:	Al Dees Kay Fuecker Greg Hart Nels Larson Dan Rode Barbara Tebbitt

CALL TO ORDER: The meeting of the Finance Committee was chaired by Mr. Jerry Meilahn 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 9/26/86 were approved.

9/30/86 FINANCIAL STATEMENTS: Mr. Fearing reviewed the Report of Operations for the period July 1, 1986 through September 30, 1986. He reported that the inpatient and outpatient census continues at a high level. We experienced a slight drop in September, but have since leveled off to the 430-433 average daily census level. For the first three months of the fiscal year admissions are 258 above budget (5.7% variance), patient days are 1,760 above budget (4.7% variance), and our average daily census (including the downtrend) was 422.6. We had budgeted 403.5. The three areas of continued inpatient increase are Urology, Pediatrics and Medicine. Mr. Fearing noted that the Lithotripter at Health One is now operational and we may see a change in usage of our Lithotripter as a result. Outpatient visits for the month of September totaled 20,185 or 2,816 (16.2%) over budget. The September year-to-date clinic census totals 61,888 visits which is 5,660 over budget. Most of the clinics, with the exception of Audiology, have continued to increase their census levels. The drop in Audiology is due to the loss of a faculty member.

Total revenues over expense for the period are $1,883,298, a favorable variance of $3,094,036. The increase in favorable variance is due to the increase in census and our continuing trend of higher and higher acuity in patients, which tends to generate more dollars. 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.

Mr. Fearing noted that, on the other hand, we are experiencing operating expenditures that are $1,650,000 above budget with $54,459,762 in expenditures through September. A major concern is the amount in Accounts Receivable, which is running approximately 96 days at September 30, 1986. The total accounts receivable increase through the end of September is approximately $5,500,000, resulting in much of our operating income being tied up in accounts receivable.

The Committee discussed the Health One lithotripter now on line at Metropolitan Medical Center and its possible effect on the Hospital's case load. The MMC lithtripter is a newer model than the Hospital's, but is technologically the same. The MMC one is a "mobile" unit, but is probably less mobile than expected.

PROJECTED JUNE 30, 1987 FINANCIAL STATEMENTS:

Mr. Greg Hart reported that when the 1986-87 budget forecasts were drawn up the Hospital expected to continue the decline in admissions to the 16,900 level. The revised volume forecast are: 18,600 admissions for 1986-87 (up from the 16,900 originally projected); 427.9 projected average daily census (up from the 380.2 originally projectioned); 236,000 clinic visits (up from the projected 222,600 level); and 3,696 FTE's (up from the original 3,458 projections). The substantial increase in FTE's is primarily due to the patient volumes and their acuity level, and 85% of this increase is in the direct patient care type of departm ents (nursing or ancillary departments).

Mr. Fearing reviewed the Summary Statement of Operations and Operating Cash Flow for Fiscal Year 1986-87. The three primary things that have impacted this situation are volume, FTE/s and the increase in accounts receivable. Last spring''s objective was a

zero cash flow budget for 1986-87. Currently we are projecting a fiscal year end cash flow of $2,806,500. The current 96 day delay in accounts receivable is adversely affecting our cash flow. It is hoped we will be able to reduce this to 90 days in the next couple of months. The committee discussed the proposed Blue Cross/Blue Shield contract and the Indian Health contract and their affects on our cash flow problem. Mr. Fearing reported that accounting will be completing their calculations and will bring recommendations to the Committee next month. Dr. Krivit expressed the hope that the medical staff would assist in presenting the Hospital's case to the Washington, D.C. Indian Health individuals and our other political contacts.

BOARD DESIGNATED FUND UTILIZATION: In June the question of graduate medical education reimbursements and funding sources, was discussed by the Committee as part of the broader Board Designated fund discussions. A survey of sister institutions to gather more information on funding sources is being finalized and will be discussed in the near future after review and recommendation by the Education Committee.

NOTE REPAYMENT: Mr. Fearing reported a communication from Vice President Lilly's Office regarding the proposed repayment of the Hospital's $8.8 Million Note associated with the planning fees for the original Unit J plans. The Hospital has been paying the interest, now the Hospital will begin paying the principal in 1987 and complete repayment in 1990.

COMPUTER PROJECTS: The only computer project being brought forward for approval is the laboratory computer project. The Planning and Development Committee endorsed this project at their October meeting. The Committee has asked for more information on the financial accounting system so it will be brought to this committee at a later date. A motion was made and seconded to accept the recommendation of the purchase of the laboratory computer project as forwarded.

MERIT PAY PLAN: Mr. Greg Hart briefly noted that the Board's approval is being sought to communicate to the employees the Hospital's intent to make merit pay a component of next year's pay plan so Administration can proceed with the details setting the plan in motion. A motion was made and passed to approve the merit pay plan concept.

BAD DEBTS: First quarter bad debts amount to $378,933.69, representing 1451 accounts. After recoveries of $19,801.07, the net charge off is $359,132.62. The Committee has been provided with a statistical break down for each month as well as by state. A motion was made and seconded to recommend that the Regents authorize the write off of the bad debt charges of $378,933.69.

ADJOURNMENT: There being no further business, the meeting was adjourned at 11:55 A.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 19, 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 October 31, 1986

The Hospital's operations through the month of October continues to reflect 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 October, inpatient admissions totaled 1,596 or 153 above projected admissions of 1,443. Our overall average length of stay for the month was 8.5 days. Patient days for October totaled 13,401 and were 1,334 days above projections. The increase in admission levels is primarily in the areas of Medicine, Pediatrics, Surgery, and Urology.

To recap our year-to-date inpatient census:

	1985-86 Actual	1986-87 Budget	1986-87 Actual	Variance	% Variance
Admissions	6,047	5,937	6,348	411	6.9
Avg. Lnth. of Stay	8.3	8.3	8.3	--	--
Patient Days	49,634	49,190	52,284	3,094	6.3
Percent Occupancy	67.7	66.7	71.0	4.3	6.4
Avg. Daily Census	403.5	399.9	425.1	25.2	6.3

Outpatient Census: Clinic visits for the month of October totaled 22,684 or 2,779 (14.0%) above projected visits of 19,905. The October year-to-date clinic census totals 84,572 visits and is 11.1% (8,439 visits) above budget and 11.2% (8,536 visits) above our October total of a year ago. The increase in activity has been experienced in nearly all clinic areas with the largest increases occurring in Medicine, Psychiatry, and Urology.

Financial Operations: The Hospital's Statement of Operations shows total revenues over expense of $2,160,797, a favorable variance of $3,579,591.

Patient care charges through October totaled $78,410,683 and is 12.4% above budget. Routine revenue is 5.4% above budget and reflects our favorable patient day variance. Ancillary revenue is approximately $7,515,000 (15.5%) 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 $6,593 per admission compared to the budgeted average of $6,199 per admission. Outpatient revenue per clinic visit is averaging $167 compared to the budgeted average of $153.

Operating expenditures through October totaled $72,420,039 and are approximately $2,117,000 (3.0%) above budgeted levels. The overall unfavorable variance continues to relate to the increase in demand for patient services and is seen primarily in increased personnel costs (salaries and fringe benefits) and patient care supplies (drugs, blood, medical supplies).

Accounts Receivable: The balance in patients accounts receivable as of October 31, 1986 totaled $66,854,456 and represents 100.5 days of revenue outstanding. The overall increase in our patient receivables in October of 4.6 days occurred primarily in the Medicare, Medical Assistance, Blue Cross, and HMO categories.

Conclusion: The Hospital's overall operating position continues to be positive and above budgeted levels. Both inpatient and outpatient census levels remain above budget. We continue to monitor our demand for service closely and make those operating changes that are that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1986 TO OCTOBER 31, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$69,754,611	$78,410,683	$8,656,072	12.4%
Deductions from Charges	-10,798,489	-13,811,179	-3,012,690	-27.9%
Other Operating Revenue	1,754,932	1,887,208	132,276	7.5%
Total Operating Revenue	60,711,054	66,486,712	5,775,658	9.5%
Total Expenditures	-70,302,695	-72,420,039	-2,117,344	-3.0%
Net Operating Revenue	-9,591,641	-5,933,327	3,658,314	0.0%
Non-Operating Revenue and Expenses	8,172,847	8,094,124	-78,723	-1.0%
Revenue Over Expense	$-1,418,794	$2,160,797	$3,579,591	(1)

(1) Variance equals 5.2 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	5,937	6,348	411	6.9%
Patient Days	49,190	52,284	3,094	6.3%
Average Daily Census	399.9	425.1	25.2	6.3%
Average Length of Stay	8.3	8.3	0	0.0%
Percentage Occupancy	66.7%	71.0%	4.3%	6.4%
Outpatient Clinic Visits	76,133	84,572	8,439	11.1%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO OCTOBER 31, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$69,754,611	$78,410,683	$8,656,072	12.4%
Deductions from Charges	10,798,489	13,811,179	3,012,690	27.9
Other Operating Revenue	1,754,932	1,887,208	132,276	7.5
Total Revenue from Operations	$60,711,054	$66,486,712	$5,775,658	9.5%
Expenditures				
Salaries	$29,634,508	$31,615,353	$1,980,845	6.7%
Fringe Benefits	5,737,481	6,094,678	357,197	6.2
Contract Compensation	2,923,132	2,938,161	15,029	0.5
Medical Supplies, Drugs, Blood	10,459,632	11,250,485	790,853	7.6
Campus Administration Expense	2,096,897	2,096,897	0	
Depreciation and Amortization	4,752,653	5,265,554	512,901	10.8
General Supplies & Expense	14,698,392	13,158,911	-1,539,481	-10.5
Total Expenditures	$70,302,695	$72,420,039	$2,117,344	3.0%
Net Revenue from Operations	$-9,591,641	$-5,933,327	$3,658,314	
Non-Operating Revenues and Expenses				
Appropriations	$4,882,773	$4,992,882	$110,109	2.3%
Interest Income on Reserves	2,468,300	2,332,029	-136,271	-5.5%
Shared Services	122,765	150,158	27,393	22.3%
Investment Income on Trustee Held Assets	699,009	619,055	-79,954	-11.4
Total Non-Operating Revenues and Expenses	$8,172,847	$8,094,124	$-78,723	-1.0%
Revenue Over / -Under Expenses	$-1,418,794	$2,160,797	$3,579,591	(1)

(1) Variance equals 5.2% of total budgeted revenue.

Minnesota Daily
October 22, 1986

Patient at U Hospital tests new AIDS drug

By Delores Lutz
Staff Writer

Patrick Dillree swallowed two purple-and-white capsules Tuesday afternoon, becoming the first University Hospital and Clinic patient to be treated with the experimental AIDS drug called AZT.

"I don't know if it will give me extra time," Dillree, 26, said at a campus news conference. "But if I gain weight, I can build energy. If I have extra energy, that will be a boost."

So far, the drug — azidothymidine — is the only known effective treatment for acquired immune deficiency syndrome, said Dr. Frank Rhame, Dillree's physician and the University Hospital's director of infection control.

The drug is not a cure for AIDS, but Rhame said he hopes it will keep patients alive until a better treatment is developed.

AZT prevents the AIDS virus from multiplying, and it allows the patient's immune system T-cells to increase. "It handcuffs the virus and allows him to reconstitute his immune system," Rhame said.

In an earlier trial of the drug, the patients receiving it had such a dramatically lower death rate that researchers halted the study early, Rhame said. Of 190 patients taking

AZT not a cure, but may slow syndrome

AZT from 1

the drug, only one died, while 16 of the 190 patients receiving a placebo died.

Dillree, whose acquired immune deficiency was diagnosed last November, will take AZT pills every four hours. He is one of two University patients who met the testing criteria set by the national treatment center supervising the experiments, Rhame said. Three other University AIDS patients didn't meet the criteria.

Dillree has had *Pneumocystis carinii* pneumonia, and his blood, kidneys and liver passed five required laboratory tests. The rejected patients did not qualify because their liver function tests did not fall within the established parameters, he added.

"One of the patients was just a fraction out of range," Rhame said, and he urged the experts at the treatment center to explain the scientific basis for the criteria.

The national treatment center was created by the Burroughs Wellcome pharmaceutical company, the drug's manufacturer, with assistance from the National Institutes of Health. Doctors who want to treat patients with the experimental drug must submit an application for each patient, Rhame explained.

So far, only patients who have had the rare form of pneumonia qualify for the drug, but Rhame said that AZT might benefit all patients who have AIDS or AIDS-related complex, a less severe form of the disease.

AZT, which belongs to a group of antiviral drugs called nucleoside analogs, is a derivative of thymidine, one of the building blocks of DNA. When the drug enters a cell infected by the AIDS virus, the AZT floods the cell with false building blocks so that it cannot copy itself, according to researchers at the National Cancer Institute.

Dillree swallowed his first dose of pills for the television cameras, then joked, "I don't feel any better."

"It'll take three weeks before you feel any better," Rhame told him. The main side effect of AZT is anemia, a shortage of red blood cells. The condition is readily treated with blood transfusions, Rhame said. The drug can also reduce the patient's platelets, the cells that help the blood to clot.

If the drug affects the liver and kidneys, patients on AZT must have those organs' functions carefully monitored. Effects on the kidneys and liver can be reversed by reducing the dosage of AZT, Rhame said.

Dillree said that he has lost about 28 pounds since he developed AIDS, and he has to sleep about 10 to 12 hours each night.

"I feel bad for the people who can't have (AZT)," Dillree said. "I know what it has done for me knowing that I can have it."

Photo/Jay [illegible]

Patrick Dillree was hugged by his mother Lois Tuesday after he was selected as one of two patients from the University Hospital and Clinic to participate in a test of an experimental AIDS drug.

October 28, 1986
Minnesota Daily

Cochlear implant program revived at U

By **Liz Holm**
Staff Writer

James Butzer can hear again.

After 25 years of wearing a hearing aid and four years of acute deafness, Butzer was selected as the first "bionic ear" implant recipient of the newly revived University Cochlear Implant Program.

The implant was performed last month at University Hospital. Last week Butzer was fitted with the external portion of the implant device enabling him to hear sounds for the first time in four years.

"A good summary of my thoughts and feelings is that I consider it a miracle. I still think I'm dreaming and am going to wake up," Butzer said.

Butzer, 51, a principal systems analyst at Sperry Corp., and an Eagan resident, has gradually suffered sensory hearing loss since he was a college senior.

Deafness caused by sensory loss occurs when hearing nerves are intact but damaged hair cells inside the inner ear, or cochlea, cannot produce the electrical currents needed to stimulate the nerves for hearing. This type of hearing loss can be helped by a cochlear implant.

The implant is actually a two-part system. A speech processor is usually worn on the patient's belt and codes sound into electrical signals. A receiver implanted into the inner ear picks up the signals and carries them to the auditory nerves via the electrodes in the implant.

'Bionic ear' recipient calls implant 'miracle'

Hearing from 1

"I still have to read lips; people still have to get my attention before they start rattling off," he said. "Before (the operation) I had to strain to understand, but with this (implant) I can relax and listen."

Ear implants won't restore normal hearing, but they do enable users to hear better and understand sounds, said Liz Crump, an audiologist with the cochlear implant program.

Most implant users can hear environmental sounds such as a knock on the door, a telephone ringing, car horns or approaching footsteps. This helps them to feel less isolated and more secure, Crump said.

Butler said it is difficult to hear his 3-year-old grandson, and the whistling of the teapot sounds like static. But he said his dog's bark "really sounded like a dog.

"So far, I've been concentrating mainly on voices. The important thing is not so much that I can hear those other sounds, but that I can hear my wife and co-workers. I just want to hear people," Butzer said.

Crump said the implant also improves the patient's ability to speak, especially if he or she has been deaf for several years.

"The longer a person goes without feedback from their own voice, the more they lose their ability to monitor loudness and modulate the tone of their voice," she said. The implant may also help a deaf person understand speech without having to rely solely on lip-reading, Crump said. Speech features, such as voice rhythm, intensity and pitch are accentuated with the implant.

She said, so far, the first multichannel ear implant appears to be "very, very successful." She cautioned, however, that not all implant users would receive the dramatic benefits from the device that Butzer did.

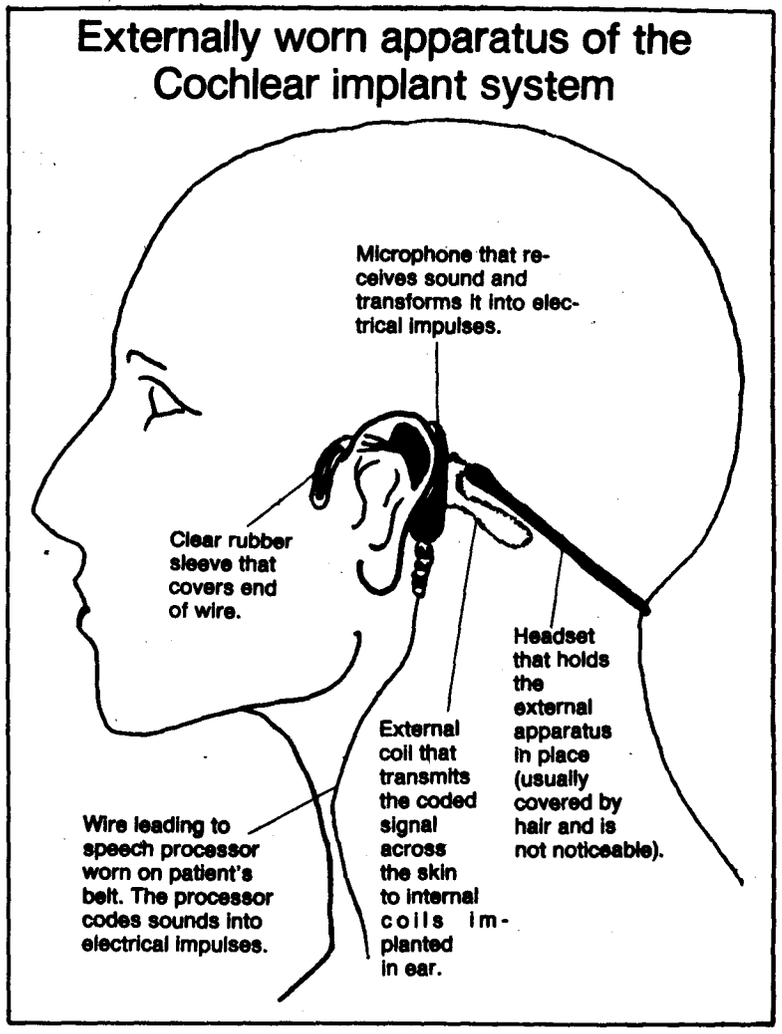
"We try to keep the patient's expectations on the low side," she said.

The University had performed a half dozen cochlear implants five years ago, but the program was discontinued when the chief implant surgeon left the University.

Cochlear implants have been approved by the U.S. Food and Drug Administration and the American Medical Association and have become more widely accepted as a therapeutic technique. The University Hospital's Department of Otolaryngology decided it "behooved them to get involved in it again," Crump said.

The total cost for the implant device, diagnosis, evaluation, surgery, hospitalization and rehabilitation is between $18,000 and $25,000. Crump said after the FDA approved the use of multichannel implants, more insurance companies were willing to cover all or part of the cost.

The next implant surgery at the University hasn't been scheduled, but about five candidates are currently being evaluated, Crump said.



Mary Lou Butzer said neither she nor her husband have had any regrets about their decision to go ahead with the implant surgery.

"It's been an ordeal, but things are looking up," she said. "The people at the implant program are wonderful; they've just been terrific. I just hope that if any other person has this problem (hearing loss), they won't be afraid to go ahead and have the surgery."

Transplant gives woman lease on life

By Delores Lutz
Staff Writer

Delores Sellden, born 33 years ago with a hole in her heart, had looked blue all of her life.

A heart-lung transplant Saturday, however, has given her normal circulation. Now she is pink all over, according to Dr. Stuart Jamieson, one of the University surgeons who performed the five-hour operation.

"She can't get over the fact that she's got pink fingernails," Jamieson said at a news conference Monday. Sellden is in critical but stable condition in an intensive care unit at the University Hospital. Doctors anticipate some complications over the next four weeks, said Jamieson, University Hospital's head of cardiothoacic surgery. Both rejection and infection are risks.

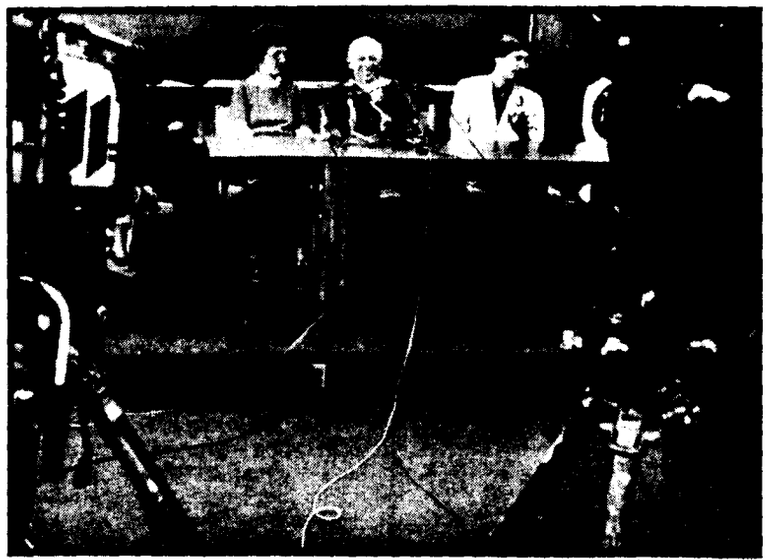
"We expect that there will be difficulties, problems. That really is the name of the game," Jamieson said. Sellden will be encouraged to cough to prevent secretions from building up in her lungs. The lungs will be X-rayed to detect any fluids, a sign of rejection.

Because her disease was limited to her heart and lungs, her health is expected to be normal if the transplant proves successful, he said.

Sellden suffered from Eisenmenger's syndrome, a congenital defect that gave her only one heart ventricle instead of two. The defect caused her lungs to be exposed to damaging high blood pressure, Jamieson explained.

An Internal Revenue Service employee from Moorhead, Minn.,

Transplant to 8



Photo/Geoff Hansen

Dr. Stuart Jamieson, right, spoke at a news conference Monday explaining the heart-lung transplant he performed on Delores Sellden over the weekend. Sellden's parents, Darlene and Gilbert, listened.

Transplant from 1

Sellden had been tired all of her life and unable even to ride a bicycle for the past 15 years, according to her parents, Gilbert and Darlene Sellden.

She was so happy about the transplant that she celebrated with a special meal Friday night, a pineapple pizza, said Dr. Steve Ring, an assistant professor of surgery who heads the University's heart transplant program.

When Sellden was born, the surgical techniques to correct her problem were undeveloped. "Thirty-four years ago, to have open heart surgery of this magnitude was just out of the question," Jamieson said. As she grew older, the damage to her lungs made surgery impossible.

Eisenmenger's syndrome victims usually die in their 20s, according to Jamieson. The transplant was her only hope for a longer life. "It's very unusual to live into their 30s, and it's almost unheard-of to live much longer than that, so she had pretty much come to the end of the road," he said.

Jamieson, who performed heart-lung transplants at Stanford University before coming to the University of Minnesota last March, said 70 percent of heart-lung transplant patients survive at least one year after the operation.

Sellden is the second patient to undergo the double organ transplant at the University Hospital. Ken Jones, a 37-year-old St. Paul man, had a heart-lung transplant last May because he suffered from primary pulmonary hypertension, a disorder of unknown cause.

University surgeons had not performed a heart-lung transplant for six months because of a shortage of suitable donors, Jamieson said. Six potential recipients — one from each blood group — are kept on a University waiting list.

University staff members have declined to discuss the donor for Sellden's operation, but the Associated Press reported that she was a 21-year-old cheerleader from North Dakota State University who was declared brain dead Friday following a fall earlier in the week.

Tuesday, November 4, 1986
Minnesota Daily

Tuesday, November 4, 1986
Minnesota Daily

New ethics chief says doctors can't mix economics, good patient care

By Delores Lutz
Staff Writer

Physicians who must worry about holding down health care costs have a conflict of interest, according to the newly appointed head of the University's Biomedical Ethics Center.

"You cannot, in my opinion, have good medical ethics if the doctor at the bedside is worrying about the gross national product of Brazil and the international monetary fund balance, in addition to maximizing quality care for the person he's trying to care for," said Arthur Caplan, who will take over as the center's director next June.

The cost-containment push and the associated changes in Medicare and insurance payments are stimulating interest in the ethical issues of health care financing, he said.

"That's a driving force these days in terms of why physicians, hospital administrators and trustees of hospitals are keenly interested in ethics at the policy level," Caplan said in a recent interview.

But Caplan, who is an associate director at the Hastings Center, a prestigious ethics think tank in New York state, says questions about cost containment should be asked.

"There's a lot of rhetoric about it and a lot of yelling from Washington," he said, and the federal government is interested in controlling its deficits. "But, of course, if it spent less on Star Wars, it might not have to worry so hard about cost containment of health care, so that's a political matter."

If cost containment is necessary, people interested in medical ethics then have to ask whether Medicare and Medicaid are the places to start, Caplan said.

"Those programs cover the old and the poor," he said. "I have a hunch that they might not be the best groups to start with . . . to divide up the burden of cost containment."

Medical ethicists also must wrestle with questions about how many hospitals and organ transplant programs are necessary, Caplan said.

Caplan was attracted to Minnesota, he said, because it is a leader in health care change. "Minnesota

Ethics to 3

Ethics from 1

happens to be a hotbed of experimentation in delivery of health care, and in that sense it's a model for the nation," he said. "The ethical questions that come up also are models to be looked at."

He wants the Biomedical Ethics Center to be interdisciplinary and eclectic, he said, a place where people can "talk freely and openly without worrying about the political consequences."

Caplan, who has four philosophy degrees from Columbia University, said his favorite issues in medical ethics focus on high technology and the "problems of success" associated with artificial organs, transplants, neonatal care and surrogate mothers.

Although modern medicine's machines can extend life and improve its quality, he said, they can be "depersonalizing, intimidating" and raise questions patients have never confronted before.

High technology also forces physicians to re-examine the issue of informed consent, according to Caplan. "What does it mean to get informed consent from someone dying of heart failure and you say, 'I need your permission to put this artificial heart in you. If you take it, maybe you'll live. If you don't, you'll die. Is it okay?' I'm not sure that's the most elegant informed consent set-up I've heard," Caplan said.

Allowing patients their autonomy — including the right to refuse extraordinary measures — may be the best way to show respect for them, he said. "If you are sick and dying," Caplan said, "one of the few things that is left is to control what is done to you."

Photo/Rick Verner

Arthur Caplan discussed some of the issues he expects will generate debate when he takes over next June as director of the University Biomedical Ethics Center.

2 busiest Twin Cities hospitals to affiliate

Minneapolis Star & Tribune
November 7, 1986

By Gordon Slovut
Staff Writer

The Twin Cities area's two busiest hospitals, Abbott Northwestern and Methodist, plan to affiliate before the end of the year, officials of both said Thursday.

Richard Kramer, executive vice president of Lifespan, Abbott Northwestern's parent corporation, said the affiliation "technically is not a merger because the two hospitals will retain their own assets."

The affiliation would make it possible for the hospitals, both of which have been able to fight the trend toward lower hospital use, to compete better for patients, he said.

With Abbott Northwestern and Methodist under its wing, Kramer said, Lifespan could offer area employers and insurers complete health care

Hospitals continued on page 9A

1 page 1A

program, had 7.9 percent of the area's hospital admissions, the largest share of any hospital. Methodist was second in market share, with 6.5 percent. Their combined 40,840 admissions constituted almost 15 percent of the patients who entered Twin Cities hospitals during the year.

Robert Galloway, president and chief executive officer of Methodist Health Care of Minnesota, Methodist's new nonprofit parent corporation, said he expects to conclude the talks soon.

"They've been going on long enough," he said at a press conference called to announce a corporate reorganization of Methodist in which the hospital becomes one of four subsidiaries of the new parent corporation headed by Galloway. The reorganization creates a corporate structure similar to Abbott Northwestern and its Lifespan. Kramer said Methodist's reorganization makes the affiliation easier to do because of the parallel structures.

Many of the doctors on Abbott Northwestern's staff also are on the staff of Methodist, but there are differences between the two hospitals.

Abbott Northwestern is primarily a specialty care hospital, competing with University of Minnesota Hospital, for example, for patients who need heart surgery. Abbott Northwestern has moved into heart transplantation and is the only hospital in the state with an artificial heart program.

Methodist has some specialty areas, such as cancer treatment and an artificial-kidney program, but is a more general hospital, with one of the region's more active emergency departments and the state's busiest obstetrical department.

Galloway said the corporate restructuring won't affect patients.

Methodist and Abbott Northwestern already participate in SelectCare, the preferred provider organization marketed by Lifespan in competition with health maintenance organizations (HMOs). Both hospitals have contracts with most of the area's health maintenance organizations.

Kramer said that some "duplicated services" probably would be eliminated, but that no one has discussed how those changes would be made.

"At a minimum we would want to coordinate the home health care programs of the two hospitals to avoid duplications there," he said. He said that overall the change could mean more job opportunities because "As we add nonhospital services, more job opportunities become available."

Galloway, the head of Methodist's new parent corporation, said that under the corporate reorganization, which is independent of the proposed affiliation with Abbott Northwestern, Terry Finzen will remain as president and chief executive officer of the hospital.

Eric Bundgaard, senior vice president of Methodist, will be chief administrative representative of Methodist Health Care Service, a nonprofit subsidiary designed to promote the growth of hospital-based services to businesses. Steve Martin, hospital vice president of finance, will be chief administrative representative of Methodist Health Care Associates, a for-profit subsidiary to develop profit-making ventures. John Herman, hospital vice president, will be administrative representative of Methodist Health Care Partners, a for-profit subsidiary to develop joint ventures with physicians, and Ken Merwin will continue as executive director of Methodist Hospital Foundation.

Carl Pohlad, president of Marquette Bank Minneapolis and owner of the Minnesota Twins, is chairman of the board of governors of Methodist's new corporation.

Monday, November 10, 1986
Minnesota Daily

Photo/Rick Verner

Chaplain Judi Klepperich visited with hospice patient Ed Buckingham recently at the University Hospital.

Hospital chaplains add healing spirit to U's high-tech health-care team

By Liz Holm
Staff Writer

Judi Klepperich sees 15 to 20 patients daily. Sometimes, she's on call 24 hours a day and more than once has had to hurry to the bedside of a seriously ill patient. The work is emotionally demanding, and at times, Klepperich said, depressing.

Klepperich is not a doctor or a nurse. She is one of four University Hospital chaplains.

Chaplaincy is "an extension of home for people who are not at home," she said.

"The hospital is a real technical place. And scary," Klepperich said. "Because of us, people feel a sense of advocacy, they feel like they know someone. We're not here just for spiritual people. Everybody has a spiritual side, whether they're religious or not. We try to tap into that."

Sister Eileen Schiltz, another University Hospital chaplain, said the services they provide are an important part of holistic health care. Pastoral care can help overcome the depersonalization and overly mechanized aspect of modern hospitals.

"We've come a long way in meeting the physical and psychological needs of the patient, but the spiritual needs need to be met too," Schiltz said. "Pastoral care is especially important (at University Hospital) because so many pa-

Chaplain to 5

Chaplain from 1

tients come long distances and don't have friends or family close by."

Unlike what some people assume, chaplains don't spend all their time praying with patients or giving theological advice, Schiltz said.

"Chaplains don't have all the answers. We can't take away the pain. We can't take away the outcome. But we can be by their side during it," she said, quoting the 23rd Psalm: "Though I walk through the valley of the shadow of death, I fear no evil, for Thou art with me."

Ed Buckingham, who is in the hospital for chemotherapy, has visited with Klepperich several times.

"You build up a relationship," Buckingham said. "Judi has helped me develop the coping skills you need to get you through a situation like this. She offers me communion in my room, and sometimes we pray together. But the important thing is just having a person to talk to."

While satisfying and rewarding, chaplaincy work can be difficult, Klepperich said.

"We walk with one foot in depression, the other in joy. We see the tremendous amount of courage of the human spirit," she said.

The chaplains make contacts with patients in several ways. Chaplain request cards are given to each patient by church workers who volunteer their time in the hospital.

Often nurses will make referrals suggesting the chaplains see a patient they feel would benefit from a visit. Sometimes the chaplains receive a phone call from a patient's hometown pastor, or the chaplains themselves make the first contact by visiting the patient's room.