UNIVERSITY OF MINNESOTA
TWIN CITIES

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

CANCELLATION NOTICE

The September, 1987 Board of Governors meeting was cancelled due to the Board of Governors Retreat in September.

Nancy C. Janda
Secretary
Board of Governors

The University of Minnesota Hospital and Clinic

Board of Governors

October 28, 1987

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***** OTHER ATTACHMENTS *****

The University of Minnesota Hospital and Clinic
Board of Governors
October 28, 1987
2:30 P.M.
555 Diehl Hall

AGENDA

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II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Committee Reports	
	A. Planning and Development Committee - Ms. Kris Johnson	
	1. Magnetic Resonance Imaging Unit II	Information
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	1. Medical Staff-Hospital Council Credentials Committee Recommendations	Approval
	2. Bylaws Committee Recommendations	Approval
	3. Quality Assurance/Utilization Review Plan	Approval
	C. Finance Committee - Mr. Robert Nickoloff	
	1. June 30, 1987 Year-End Financial Statements	Information
	2. September 30, 1987 Year-to-Date Financial Statements	Information
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Minutes

Board of Governors

The University of Minnesota Hospital and Clinic

August 26, 1987

CALL TO ORDER:

Chairman Robert Latz called the August 26, 1987 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	David Brown, M.D.
	Shelley Chou, M.D.
	Phyllis Ellis
	Donald Gilmore
	Greg Hart
	Robert Latz
	Jerry Meilahn
	James Moller, M.D.
	Robert Nickoloff
	Barbara O'Grady
Absent:	Leonard Bienias
	Al Hanser
	George Heenan
	Kris Johnson
	David Lilly
	Neal Vanselow, M.D.

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approved the minutes of the July 22, 1987 minutes as written.

CHAIRMAN'S REPORT:

Chairman Latz noted that the Board of Governors Retreat agenda is in the final stages of development. Primary topics include: 1) multi-institutional affiliations; 2) local and outstate physician viewpoints of UMHC; 3) the effects of regulation and competition on our missions of teaching and research; and 4) biomedical ethics.

Chairman Latz reminded the Board that the September 23, 1987 Board of Governors meeting is cancelled.

HOSPITAL DIRECTOR'S REPORT:

Mr. Greg Hart reported recent progress in the search for a chairman in the Department of Neurology. A short list of recommended candidates will be forwarded to Dean David Brown shortly.

Mr. Hart also highlighted a series of issues related to the care of patients infected with the human immunodeficiency virus which causes AIDS. An AIDS Coordinating Committee, chaired by Dr. Paul Quie, serves as an advisory group to medical staff, nursing staff and hospital management in matters pertaining to care of the AIDS population.

BIOMEDICAL ETHICS PRESENTATION:

Dr. Arthur Caplan, Director, Center for Biomedical Ethics and Professor of Philosophy and Surgery, reviewed the current and planned activities of the Biomedical Ethics Center. The Center staff intends to be available as a resource throughout the University and the state. The staff is teaching in the Medical School, frequently speaks to hospital, university and community groups and is engaged in research.

Dr. Caplan briefly discussed several complex issues facing hospitals including the ethics of governance, cost containment, professional liability, genetic engineering and access to health care.

Dr. Caplan discussed the issue of informed consent more extensively. A paternalistic approach to informed consent, although once broadly acccepted, has become less acceptable as patients have become more knowledgeable about their health care and more participative in decision-making about their care. Dr. Caplan suggested "The Silent World of Doctor-Patient" by Jay Katz for those interested in reading more about this subject.

PLANNING AND DEVELOPMENT REPORT:

Mr. Greg Hart reviewed the Purchasing Report for May and June of 1987. $11,964,940 in purchasing activity for the two month period is significantly above previous periods. This variance is due almost exclusively to a $3,736,748 computer acquisition.

The Board seconded and passed a motion to approve the Purchasing Report as submitted. Beginning in July, 1987, the Purchasing cycles will again be three months in duration but will now correspond to the quarters of our fiscal year.

Mr. Hart also reviewed the results of a community-wide hospital image study. Overall, UMHC has the strongest reputation among Twin Cities hospitals. The public apparently knows us as having highly specialized care, modern technology and highly qualified physicians. The public also perceives us as leaders in several clinical areas including oncology, cardiology, intensive care and comprehensive eye care.

The Community University Health Care Center, Mr. Hart reported, is exploring a facilty replacement. In evaluating options for a replacement facility the CUHCC staff is also reexamining its mission in the community, the hospitals role in caring for the indigent, CUHCC's financial status and future directions for the Center. The Board, the Planning and Development Committee and the Finance Committee will each be asked to review the proposal for replacing the CUHCC facility in October and November, 1987.

FINANCE COMMITTEE REPORT:

Mr. Dan Rode reviewed the 4th Quarter Bad Debt report. Bad debts for the quarter totalled $806,128.34, representing 1667 accounts. Recoveries during the period amounted to $14,232.70, leaving a net charge-off of $791,895.64. This represents 1.3% of gross charges and is compared to a budgeted bad debt level of 1.33%. The fiscal year bad debt was $2,600,851.38 or 1.1% of gross charges and represents no significant change from previous years.

The Board of Governors seconded and passed a motion to approve the bad debt charge-off of $791,895.64 for the fourth quarter, 1986-87 as presented.

Mr. Greg Hart reviewed the 1987-88 Compensation Plan for The University of Minnesota Hospital and Clinic. The Board of Governors approved the first half of the 1987-88 pay plan in June. Additionally, Mr. Hart recommended in-range adjustments be provided on a merit basis to non-union, Hospital dominated classes in an amount equivalent to 1.8% of the applicable salaries, resulting in a 3.8% weighted average salary increase for this group. The pay plan for non-union, University dominated classes recommends an additional 1.5% merit-based progression increase and a lump sum merit increase to highly rated employees totaling $80,000. This would result in a weighted average increase of 3.3%. Both of these recommendations would be retroactive to July 1, 1987. Mr. Hart noted that the Hospital's budget allows for an average increase of 4.5%.

The Board of Governors seconded and passed a motion to approve the 1987-88 compensation plan as presented.

ADJOURNMENT:

There being no further business, the August 26, 1987 meeting of the Board of Governors was adjourned at 4:15 p.m.

Respectively submitted,

Kay F. Fuecker
Secretary
Board of Governors Office

MINUTES
Planning and Development Committee
October 13, 1987

CALL TO ORDER
In the absence of Committee Chairman, Ms. B. Kristine Johnson, Leonard Bienias called the October 13, 1987 meeting of the Planning and Development Committee to order at 10:08 a.m. in Room 8-106 in the University Hospital.

Attendance: Present
Leonard Bienias
Robert Dickler
S. Albert Hanser
Clint Hewitt
William Jacott, M.D.
Geoff Kaufmann
Peter Lynch, M.D.
Ted Thompson, M.D.

Absent — B. Kristine Johnson, Chair

Staff — Al Dees
Cliff Fearing
Greg Hart
Lisa McDonald

Guests — Sally Howard
William Thompson, M.D.

APPROVAL OF MINUTES
The minutes of the August 12, 1987 meeting were approved as distributed.

MAGNETIC RESONANCE IMAGING PROPOSAL
Dr. Thompson reviewed current MRI usage at UMHC. Given the current excess demand for the MRI and emerging applications Dr. Thompson feels that the volume is sufficient to support an additional MRI. He recommended purchasing a computerized MRI unit with a 2.0 Tesla (20 Kilogous) magnet.

Mr. Dees reviewed the financial and facilities considerations associated with the MRI purchase. The cost of purchasing and installing the MRI is $3,600,000. Based on volume projections the payback period is 2.99 years. Sufficient funds were budgeted in the hospital's plan. The proposed location is adjacent to the current MRI suite on the first floor of the University Hospital.

Given the size of the investment the proposal will be reviewed by the Finance Committee and brought back again next month for approval from the planning and development committee as well as the Board of Governors.

COMMUNITY UNIVERSITY HEALTH CARE CENTER UPDATE
Mr. Hart updated the group on the CUHCC replacement facility search. A portion of the Mt. Sinai Hospital facility is currently being investigated. This alternative would offer several advantages including an excellent location, a flexible physical plant, an existing facility, and a lower up-front capital investment. It also carries with it the possibility of some sort of collaborative relationship with Mt. Sinai and/or Health One.

Dr. Lynch expressed UMCA's concern about the lack of reimbursement and Mr. Hart responded that the hospital is considering alternatives that would limit the debt that is being written off by the hospital due to partial reimbursement. A status report on the CUHCC facility search will be given at the next planning and development meeting.

HEALTH SCIENCES PUBLIC RELATIONS UPDATE
Ms. Sally Howard, Director of Health Sciences Public Relations, discussed her department's public relations activities. The department's goal is to respond to all media requests in order to be known as the source for "health care" in the Twin Cities. Monthly T.V. and newspaper contact reports summarize the media activity. UMHC gets the most medical coverage in the Twin Cities on a variety of topics. Some of the services that have been offered are the development of service and recruitment brochures, coordination of a medical talk show, a quarterly magazine "Health Sciences," and Health Sciences News (a bi-weekly newsletter for faculty and staff). The Department also works extensively with Planning and Marketing, Community Services, and Community Relations at the hospital. The department's funding comes from Health Sciences and the hospital.

UMCA UPDATE
Dr. Lynch told the committee that the University of Minnesota Clinical Associates (UMCA) have agreed to increase their budget to hire a chief operating officer. UMCA has agreed in principal to finance their organization on a direct assessment and a pay by project basis through the departments.

RETREAT FOLLOW-UP
Mr. Dickler informed the committee that the hospital is currently sorting out the issues and opportunities emanating from the Board Retreat. A summary of the retreat has been sent to the participants. Mr. Dickler commented that the next step is to determine the role of the Strategic Planning Coordinating Committee and how to make it a faster and more effective for planning input.

OTHER
Mr. Hanser expressed a concern that the physicians were being burdened by practice subsidization. Dr. Lynch will address the issue at the next meeting.

ADJOURNMENT
The Planning and Development Committee adjourned at 11:45 a.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 22, 1987

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Magnetic Resonance Imaging (MRI) Project

Earlier this year Dr. William Thompson, Clinical Chief of Radiology, provided the Board of Governors with an overview of the status of MRI technology and its application at University Hospital. We indicated at that time that our current MRI capability is saturated, and that a proposal for an additional MRI unit would be presented later in the year.

In the intervening months our staff has gone through the process of technology assessment, financial analysis, site evaluation, and the like, and we are now prepared to recommend the proposal described in the attached document. Mr. Al Dees presented this proposal at the October meetings of the Planning and Development and Finance Committees. The October presentations will be for information; we will ask for your approval to proceed with this project at the November meetings.

We look forward to presentation and discussion of this important project with you.

GH/kj

attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Radiology
Medical School
Box 292 UMHC
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

PROPOSAL FOR A SECOND MRI FACILITY
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Department of Radiology
University of Minnesota Hospital and Clinic
October 1987

PROPOSAL FOR A SECOND MRI FACILITY
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

CURRENT MRI PROGRAM AT UMHC

During the past six months, the Magnetic Resonance Imaging volume has averaged 206 cases per month, or approximately 10 cases each day. Since the average case requires between 60-90 minutes to complete, our current volume requires a 12-14 hour workday. This volume has been obtained without specifically advertising or promoting MR throughout the Hospital. Currently, 6-8 patients each day, or 80%, require imaging of the brain or spine. This has transpired without a strong neurology program. After a new Neurology department chairman is appointed, we anticipate even greater demand for this aspect of MR imaging.

In addition, we have not optimally utilized MR for imaging the abdomen. We anticipate using a major portion of the second MR system's time on the large number of patients with malignancies and cardiovascular diseases presently treated at the University of Minnesota. MR has been shown to be the most effective method for evaluating the liver in patients with suspected malignancies, and currently it has become a very important modality in staging patients with cancers of the kidneys, bladder, prostate and female endocrine system. MR may prove to be the most sensitive modality for evaluating the skeletal system in patients with suspected metastatic disease and it is already the best modality for evaluating tumors of the musculoskeletal system. Many of these studies have not been pursued at this hospital simply due to a lack of capacity on our present system.

The current strength of the magnet (1.0 Tesla) limits types of state-of-the-art procedures which can be performed. By adding a machine with a higher field strength (2.0 Tesla), we will be able to do patients more quickly, improve our imaging of the brain and spinal cord, and begin to develop spectroscopy which cannot be performed on the current unit. By providing these services, we will place the University of Minnesota at the cutting edge of this technology which should improve our image and increase our referrals to the University of Minnesota Hospital.

PROPOSAL

Purchase a computerized MRI Unit with a 2.0 Tesla (20 kilogaus) magnet.

Expand the current MRI suite on the first floor of Unit J by finishing 1,000 square feet of shelled space immediately adjacent.

The estimated cost of this proposal is:

Equipment	$2,473,867
Construction	1,126,133
	$3,600,000

BUDGET IMPACT

Staffing Requirements

Acquisition of an additional MRI unit will require an additional 3.0 FTE radiologic technologists and 1.0 FTE secretary to cover one and one-half shifts. Annual salary and fringe benefits for this additional staff are anticipated at $107,950.

Annual Operating Expenses

Annual marginal operating expenses are projected at $694,310 and include marginal salaries and fringe benefits ($107,950), film ($24,000), cryogens ($37,000), magnetic tape ($22,500), service expenses ($210,000), general supplies ($15,000), utilities ($50,000), interest expense ($198,696) and funded depreciation shortfall ($29,164).

Projected Procedure Volumes/Charges

Growth in patient load is anticipated for several reasons. First, increased utilization of MR for non-neurologic disease is now a reality, especially in patients with cardiovascular, hepatic, musculoskeletal and malignant disorders. Second, development of spectroscopy as a non-invasive method of evaluating response of tumors to therapy is extremely applicable in this institution. Finally, ability to accomodate patients on a second system which are now being referred to other MR centers represents a real need.

Accordingly, marginal volume increase resulting from acquisition of a second MRI system is projected at 75% for established MRI procedures and 25% for new spectroscopy procedures. This increase is the result of two marginal sources: (1) additional exam volumes due to increased scheduling of machine time availability; and (2) emergence of new spectroscopy-related exam volumes.

Additional exam volume for established MRI procedures due to new machine time availability will approximate a 75% growth rate in the following areas:

MRI Exam Area	1st Unit 1987-88 Volumes	2nd Unit Annual Volumes	Revised Annual Volumes
Brain	1,622	1,217	2,839
Spinal Cord	539	404	943
Extremities	187	140	327
Myocardium	135	101	236
Pelvis/Hips	123	92	215
Abdomen	91	68	159
Head	43	32	75
Chest	33	25	58
	2,773	2,079	4,852

This represents a marginal volume increase of 2,079 exams, or $1,351,350 ($650 per exam) in additional billable revenues.

To complement this increase in established exam volumes, the availability of spectroscopy and chemical shift analysis procedures are projected to result in the following new exam volumes:

Exam Type	2nd Unit Annual Volumes
Brain Spectroscopy	374
Myocardial Spectroscopy	33
Hepatic Spectroscopy	33
Muskulo/Skeletal Spectroscopy	126
Gall Bladder Spectroscopy	33
Renal Spectroscopy	95

This represents a marginal volume increase of 694 exams, or $902,200 ($1,300 per exam) in additional billable revenues.

MRI-II FINANCIAL ANALYSIS

Summary

Purchase Price	$2,473,867
Expected Life	5 years
Annual Depreciation	$494,773
Construction Costs	$1,126,133
Expected Life	10 years
Annual Depreciation	$112,613
Projected Incremental Annual Revenue	$2,091,794
Projected Incremental Annual Operating Expense	$1,301,696
Payback Period	2.58 years

I. Incremental Annual Volume

MRI	2,079
Spectroscopy	694

II. Incremental Annual Revenue

A. Total Charges:

MRI	$1,351,350
Spectroscopy	$902,200

B. Net Revenue:

Payer	% Mix	Charges	Reimburse. %	Revenue
Agency	9.6	$217,980	86.9	$189,337
BC/AWARE	11.7	$264,932	88.8	$235,259
HMOs	3.2	$ 73,492	85.0	$ 62,468
Commercial	15.6	$354,075	100.0	$354,075
Medicare	15.2	$344,775	90.2	$310,987
MA/GAMC	8.5	$192,575	75.1	$144,663
Self-Pay	27.5	$609,517	98.7	$601,411
Other	8.7	$196,204	98.7	$193,594
			Total Annual Revenue	$2,091,794

III. Incremental Annual Operating Expense

Salaries/Fringe Benefits	$107,950
Maintenance	$210,000
Depreciation	$607,386
Supplies	$148,500
Funded Depr. Shortfall	$ 29,164
Interest	$198,696
Total	$1,301,696

IV. Net Payback Period

Purchase Price/(Incremental Revenue - Incremental Expense + Depreciation Expense) = 2.58 years

ADDENDUM 1

PROPOSAL FOR A SECOND MRI FACILITY
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

INTRODUCTION

CLINICAL BACKGROUND AND HISTORY

In 1984, the University of Minnesota Hospital and Clinic joined over one hundred other health care institutions in providing a new and exciting non-invasive imaging technology to its patients and referring medical staff. Published research continues to indicate that Magnetic Resonance Imaging (MRI) is recognized as a clinically accepted diagnostic tool for certain specialty applications and anatomical images. Developments to date indicate that MRI is the preferred method of imaging the brain, brainstem and spinal cord. MRI images are unobstructed by bone, allowing for viewing of the posterior fossa of the brainstem and improved imaging of the pituitary, plus MRI can image along the sagittal plane providing a clear image of the spinal cord for assessing spinal cord tumors, injury or disease. MRI imaging of the spinal cord makes it the preferred diagnostic tool for back injury or myelopathy including nerve root compression associated with disc disease.

MRI visualization of the pelvis, urinary/bladder, and prostate have also been established as clinically proven diagnostic options. To a smaller extent, MRI has become a successful diagnostic tool in the non-invasive imaging of the abdomen (liver, kidney, spleen, pancreas and adrenal), pelvis/hips, extremities and myocardium. Present distribution of MRI examinations at the University Hospital can be summarized as follows: brain (57.0%); spinal cord (21.4%); extremities (6.4%); myocardium (4.7%); pelvis/hips (4.2%); abdomen (3.7%); head (1.5%); chest (1.1%).

MRI imaging continues to add to the diagnostic capabilities of the University Hospital. Although MRI technology has been applied to some cases previously studied with computerized tomography (CT) scanning, the addition of this technology has not significantly eroded CT volume. This is largely because MRI's imaging capabilities, although superior to CT for many applications, are secondary to its biochemistry measurement capabilities. MRI is a significant imaging modality for the head and spine and its potential for assessing biochemistry are clear.

Since the first MRI unit was installed at UMHC in 1984, CT volume has continued to grow significantly. During 1985-86, CT volume increased from 7,836 to 8,783 annual procedures, or 12.1%, despite the emergence of 1,425 MRI exams during this same period. For the first six months of 1986-87, CT volumes continue to climb an additional 5.1% while MRI volumes are concurrently growing at an annualized rate of 9.6%.

SIGNIFICANT EMERGING APPLICATIONS

MRI technology is rapidly becoming the diagnostic option of choice for bone and soft tissue tumors. MRI is showing increasing applications for bone marrow studies, liver exams, and heart images. Bone marrow studies to examine metastasis and blood supply are emerging as significant.

Cardiac imaging is improved with MRI over the CT methods. MRI does not necessarily compete with angiography, but is able to view the heart wall in motion providing information on cardiac output.

MRI is also used to identify early chemical changes in a tumor responding to therapy and in organ transplant rejection. These capabilities are extremely important to the oncology and transplant patient population at the University Hospital. Further expected developments include a non-invasive biopsy tool which differentiates malignant from non-malignant tissue.

FUTURE DIRECTIONS

The University of Minnesota Hospital and Clinic, one of the ten finest institutions in the United States, must remain at the forefront of new technology. Our present MRI unit provides excellent clinical images but does not have the necessary field strength required to perform many special techniques involving spectroscropy. It is imperative that a magnetic resonance spectroscopy program be established at the University of Minnesota as quickly as possible so that this institution can remain at the forefront of medical imaging, particularly with respect to non-invasive methods in biomedical research and diagnosis.

The Department of Radiology, with the support of the Department of Biochemistry, is in the process of capitalizing on current magnetic resonance spectroscopy strengths presently at the University of Minnesota. During these past four years, Dr. Kamil Ugurbil of the Gray Freshwater Biological Institute has developed a very successful in vivo magnetic resonance spectroscopy research group in collaboration with faculty from the departments of Biochemistry, Cardiology, and Surgery. This effort has been extensively funded by the National Institute of Health (NIH) to the amount of $5,000,000 over five years, and has made Dr. Ugurbil and his group a national leader in this research arena. Our objective is to draw from this tremendous research confedera-

tion in order to develop a Nuclear Magnetic Resonance Institute or Center at the University of Minnesota which can be supported at the interdepartmental and interdisciplinary level. This Institute would pursue ongoing input and support from both the basic and clinical science departments within the Medical School as well as other pertaining collegiate units.

Dr. Ugurbil's research group has begun to develop significant clinical protocols, particularly in the area of cardiac disease and transplantation. In order to take advantage of this effort, we must move quickly to concurrently develop a strong clinical site located within the University of Minnesota Hospital, as well as develop a major research institute dedicated toward in vivo imaging and spectroscopy. Accordingly, this new magnetic resonance technology combined with the focus of Dr. Ugurbil's work can promote a unique opportunity for the University of Minnesota to develop and establish a nationally-reknowned interdisciplinary magnetic resonance center of excellence. In addition, this center will be complementary to the expansions that are desirable in high resolution magnetic resonance and chemistry, biochemistry, and clinical service (including radiology). This type of program is currently in place at such major institutions as Yale, Duke, Stanford, and the universities of Pennsylvania, Alabama, New Mexico and California-San Francisco. For such a program to exist at the University of Minnesota, our major advantage over other current sites is a much stronger basic science group specializing in spectroscopy. Our challenge, however, is to develop an outstanding clinical and research group which will allow us to compete with the established centers as well as stay in the forefront of this exciting and important medical break-through.

The Department of Radiology has already begun collaborating with Dr. Ugurbil's basic science research team this year by virtue of our financial support of Dr. Michael Garwood at the Gray Freshwater Biological Institute. Dr. Garwood has recently joined our department faculty to serve as the main interface between our clinical and basic science research groups. Our objective will be to develop imaging protocols and spectroscopic analyses in the research laboratory and bring these into the clinical environment for development and application. This objective and program is in concurrence with President Keller's Commitment to Focus. This program will be an interdisciplinary effort requiring the input from many aspects of the University of Minnesota. The University's Central Administration has already expressed a strong interest at the highest levels in supporting the development of this program.

NEW CLINICAL APPLICATIONS

MRI spectroscopy of high field strength magnets (15 kilogauss) has been under a great deal of investigation since 1982. This capability allows for the physiologic evaluation of tissues in this area. The focus of this program proposal stems from the belief that sound clinical applications now exist for MR spectro-

scopy and chemical shift analysis. The proposed MR unit would be acquired at 2.0 Tesla (kilogaus) and would run at 1.5 Tesla. This magnet would be dedicated to supporting our current clinical activities which are stressing our current 1.0 Tesla system to the point where it is not capable of keeping up with present clinical demand. This has happened in spite of the fact that MRI applications in the body have not been optimized here at the University of Minnesota. In addition, there exist major clinical applications which we have not been able to develop because of our limited magnet time and personnel.

The second magnet would increase the availability of this technology in rapidly developing non-neuro applications. We would anticipate expanding our current imaging program to include imaging evaluation of the heart, liver, genitourinary system (including the pelvis), female reproductive system, bone marrow, and musculoskeletal system. MR's multiplaner images allow for more accurate evaluation of diseases in these sites than ever before. In addition to these expanded imaging capabilities, there is a real need to begin a major spectroscopy program here at the University of Minnesota. Under the direction of the Department of Radiology and Dr. Ugurbil's Magnetic Resonance Spectroscopy Laboratory, we would anticipate evaluating the following problems using magnetic resonance spectroscopy:

Malignancies. Spectroscopy would be used to characterize and evaluate therapy in patients with tumors of the brain, breast, liver, kidney and musculoskeletal systems, specifically using phosphorus 31 and hydrogren spectroscopy.

Transplantation. Spectroscopy would be employed to evaluate patients with kidney, liver, heart and bone marrow transplants in an attempt to characterize the rejection phenomenon and its successful or unsuccessful treatment.

Cardiovascular. Spectroscopy would be employed to evaluate the patho-physiology and treatment of patients with heart failure and those with diseases which cause significant myocardial hypertrophy.

Musculoskeletal System. Spectroscopy can be employed to diagnose and evaluate the treatment of patients with specific enzyme deficiencies such as McArdle's Disease.

PATIENTS SERVED

The current MRI facility has served the University Hospital patient population since December 1984. The ratio of outpatient to inpatient examinations has approximated 3:2; 62% of the MRI examinations have been conducted on an outpatient basis. In 1983, it was predicted that the outpatient population would approximate 60% at this institution.

MINUTES
Joint Conference Committee
Board of Governors
September 9, 1987

ATTENDANCE:

Present: Phyllis Ellis
Donald Gilmore
Gregory Hart
James Moller, M.D.
Michael Popkin, M.D.

Absent: George Heenan
Patricia Ferrieri, M.D.
Bruce Work, M.D.

Staff: Jan Halverson
Nancy Janda
Barbara Tebbitt

Guests: Michelle Johnson
Ted Yank

I. APPROVAL OF MINUTES

The minutes of the July 8, 1987 meeting were approved as submitted.

II. MEDICAL STAFF-HOSPITAL COUNCIL REPORT

Dr. James Moller presented the Credentials Committee/Medical-Staff Hospital Council's July 10 and September 3, 1987 recommendations of candidates for provisional status and clinical privileges for UMHC. Donald Gilmore questioned the deletion of spinal puncture privileges of Dr. James Moriarty, a neurologist. Dr. Moller noted that this had been an insurance question and Dr. Moriarty had recinded his request for the deletion.

Donald Gilmore, acting as chairman, moved that the recommendations be approved, without the deletion of Dr. Moriarty's privileges. The motion was seconded and the committee unanimously endorsed the candidates.

III. JCAH REVIEW PREPARATION

Nancy Janda conveyed to the committee that UMHC was scheduled to be surveyed by the JCAH on November 11, 12 and 13, 1987. Ms. Janda gave a brief history of the JCAH organization and its structure. She also briefly discussed the structure of the 3 day survey and noted that during our last survey in November of 1984 we were given 17 contingencies.

Ms Janda noted that JCAH is emphasizing quality assurance and that by 1990 JCAH may well be including some type of overall clinical outcome measure when evaluating hospitals. It was conveyed that JCAH will probably examine the medical records department very closely this year. Dr. Moller noted that there had been significant improvement in medical record completion rates, but there was still a lot of work to be done.

IV. BIOMEDICAL ETHICS

Jan Halverson asked for the committee's ideas on how to best conduct a session on biomedical ethics for the upcoming board retreat. Discussion ensued concerning various topics in biomedical ethics and how to best structure the discussion at the retreat. It was suggested by Dr. Moller that some type of case study methodology could be used as a springboard to the retreat discussion.

V. ADJOURNMENT

There being no further business, the meeting was adjourned at approximately 5:30 P.M.

Respectfully submitted,

Ted Yank/kff

Ted Yank
Administrative Fellow

TY/kff

MINUTES
Joint Conference Committee
Board of Governors
October 14, 1987

ATTENDANCE:

Present: Robert Dickler
Patricia Ferrieri, M.D.
Donald Gilmore
George Heenan
James Moller, M.D.
Michael Popkin, M.D.

Absent: Phyllis Ellis
Bruce Work

Staff: Jan Halverson
Nancy Janda
Helen Pitt
Ted Yank

Guest: Jan Brockway

I. APPROVAL OF MINUTES

The minutes of the September 9, 1987 meeting were approved as submitted.

II. MEDICAL STAFF-HOSPITAL COUNCIL REPORT

Dr. James Moller proposed revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff. The amended sections were from:

Bylaws of the Medical Staff

Article II, Part A: Qualifications for Appointment
Article III, Part C: Procedure for Initial Clinical Privilege
Article IV, Part A: Procedure for Reappraisal and Reappointment
Part D: Summary Suspension of Clinical Privilege
Part E: Procedure for leaves of absence

Rules & Regulations of Medical & Dental Staff

Section V: Conduct of Patient Care
Section E: Medical Record Completion

Section VII. Medical/Legal
D. Pediatric Holds
I. Brain Death
K. Reporting Requirements

A discussion ensued. George Heenan moved that the recommendations be approved. The motion was seconded and the Committee unanimously approved the changes.

III. QUALITY ASSURANCE/UTILIZATION REVIEW PLAN

Dr. James Moller, Chairman of the Quality Assurance Steering Committee, presented the Quality Assurance Program, Organizational Plan. Dr. Moller assented that there are two reasons for the development of the plan. First, it supports our own need to enhance our patient care. Secondly, it meets the needs for JCAH requirements.

He described the quarterly reports that each clinical department receives which contain the appropriate complication indicators for each department. These reports are then used in departmental patient care meetings to identify alarming trends. The department then recommends actions to improve the situation and will be able to monitor the impact of the proposed interventions through the quarterly report. The departments are required to document these meetings with minutes.

Dr. Moller concluded that he is happy with the progress that has been made through the efforts of the Quality Assurance Department. He noted that most clinical departments are receptive to the plan, though much work is still needed to develop and document the system.

George Heenan inquired about to know how we were progressing in preparing for the JCAH survey. Jan Brockway, Director of Quality Assurance, answered that every department should be having scheduled meetings that are documented with minutes. She noted that we may get a contingency for lack of proper documentation in some clinical areas. She also explained implementation monitoring to the committee.

Discussion ensued concerning problems in specific departments and the role the Board should play in making departments more accountable for their documentation. The discussion concluded with Chairman Heenan requesting that Dr. Moller get a group of interested committee members together to discuss the Quality Assurance Program. Dr. Moller agreed.

Chairman Heenan moved to endorse the plan. The motion was seconded and the plan was unanimously endorsed.

IV. JCAH VISIT PREPARATION

Nancy Janda described the previous day's Mock Survey in preparation for the actual survey. She stressed that the emphasis in this year's

survey will be quality. Specifically, she suggested, that translates into thee medical staff quality assurance areas. Nancy announced the dates of the actual survey: November 11, 12 and 13. She noted that this committee was responsible for monitoring JCAH activities and that members will be inviittted to attend either the Governing Body Conference or the Medical Staff Conference on the afternoon of the 13th and the Summary Conference later that afternoon.

Chairman Heenan noted that he would be gone that afternoon, but would like to participate in those conferences via some type of teleconferencing arrangement.

V. ADJOURNMENT

There being no further business, the meeting was adjourned at 5:45 P.M.

Respectfully submitted,

Ted Yank

Ted Yank
Administrative Fellow

TY/kff

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

September 10, 1987

TO: Members of the Board of Governors

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

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

The Medical Staff-Hospital Council and the Joint Conference Committee have endorsed the attached Credentials Committee Report and Recommendations.

I am forwarding this report to you for your review and approval on October 28. If you should have any questions, please feel free to call on me.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 10, 1987

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.

FAMILY PRACTICE AND COMMUNITY HEALTH	**CATEGORY**
Patricia Conboy Fontaine	Attending Staff
MEDICINE	
Mark L. Gilberstadt	Attending Staff - ER
Linda S. Snyder	Attending Staff
Anthony C. Woolley	Attending Staff - ER
PHYSICAL MEDICINE AND REHABILITATION	
Elizabeth A. Davis	Clinical Staff
ORTHOPEDICS	
Ensor E. Transfeldt	Attending Staff
OTOLARYNGOLOGY	
Edward H. Szachowicz	Clinical Staff
UROLOGY	
Gerald D. McEllistrem	Clinical Staff

The following physicians have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges and change in staff category. The Committee has reviewed and considered their requests and hereby recommend approval.

MEDICINE	CATEGORY	PRIVILEGES REQUESTED
Jeffrey M. Rank	Attending Staff	**Add:** Gastroenterology **Delete:** ER Privileges

The Committee recommends acceptance of the resignations of medical staff appointments from the following physicians.

MEDICINE	CATEGORY
Joseph M. Cardamone	Clinical Staff
Linda Hedemark	Attending Staff
Fran E. Kaiser	Clinical Staff
Raymond L. Marecek	Clinical Staff
William F. Schoenwetter	Clinical Staff
Thomas R. Smith	Clinical Staff

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

September 3, 1987

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.

Department of Hospital Dentistry

Mark C. Herzberg	Attending Staff

Department of Medicine

Barbara S. Daniels	Attending Staff
John A. Hitt	Attending Staff-ER
Kathleen M. Ogle	Attending Staff
Reinhard von Roemeling	Attending Staff

Department of Ophthalmology

Edward J. Holland	Attending Staff

Department of Orthopedics

Oheneba Boachie-Adjei	Attending Staff

Applications for Provisional Appointment to the Medical Staff and Requests for Clinic Privileges Continued:

Department of Pediatrics

Kimberly A. Krabill	Attending Staff
Laurie C. Miller	Attending Staff
Joseph P. Neglia	Attending Staff

Department of Physical Medicine and Rehabilitation

John Speed	Attending Staff

Department of Radiology

Joseph H. Tashjian	Attending Staff
Lee Beville	Attending Staff

The following physicians have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges and change in staff category. The Committee has reviewed and considered their requests and hereby recommend approval.

Addition and Deletion of Clinical Privileges

Department of Medicine	**Category**	**Privileges Requested**
Larry P. Bell	Attending Staff	**Add:** Attending patients in the Heart Disease Prevention Clinic and clinical consults in the hospital **Delete:** ER privileges

Change in Staff Category

Department of Urology	**Present Category**	**Requested Categroy**
Cesar J.J. Ercole	Clinical Staff	Attending Staff
Abraham A. Sidi	Clinical Staff	Attending Staff

The following physicians are completing their provisional status and are eligible for regular appointments as members of the medical staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed recommendations concerning their appointment and hereby recommend approval.

Department of Anesthesiology	**Category**	**Date Eligible**
Ellen L. Finch	Attending Staff	June 17, 1987
Department of Dermatology		
Mitchell E. Bender	Clinical Staff	June 17, 1987
Department of Medicine		
Katherine E. Dusenbery	Attending Staff-ER	June 17, 1987
Connie L. Manske	Attending Staff	June 17, 1987
Roderick P. Robertson	Attending Staff	June 17, 1987
Robert F. Wilson	Attending Staff	June 17, 1987
Department of Radiology		
Christopher Kuni	Attending Staff	June 17, 1987
Robert McGeachie	Attending Staff	June 17, 1987
William Wilcox	Clinical Staff	June 17, 1987

The Committee recommends acceptance of the resignations of medical staff appointments from the following physicians.

Department of Medicine	**Category**
Munir Abid	Attending Staff
Peter M. Anderson	Attending Staff
Robert L. Colbert	Attending Staff
Jeffrey Schwartz	Attending Staff
Department of Radiology	
Andrew Cragg	Attending Staff
Jeffrey Crass	Attending Staff
Michael Darcy	Attending Staff
Timothy Larson	Attending Staff
Richard Patterson	Attending Staff
Tony Smith	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

October 15, 1987

TO: Members of the Board of Governors

FROM: James H. Moller, M.D.
Chief of Staff

SUBJECT: Proposed Revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff

Enclosed are proposed revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff forwarded to you for your review and approval. The revisions have been endorsed by the Medical Staff-Hospital Council, Council of Chiefs of Clinical Services, and the Joint Conference Committee.

Most of the revisions are not substantive and are proposed to simply update what is current practice. Several of the revisions to the Rules and Regulations of the Medical and Dental Staff reflect revisions to Hospital policies recently approved by the Medical Staff-Hospital Council which correspond with a particular Rule or Regulation. One exception is Section V. Number 11 of the Rules and Regulations.

The following is an explanation of each revision:

BYLAWS OF THE MEDICAL AND DENTAL STAFF

ARTICLE II

PART A: QUALIFICATIONS FOR APPOINTMENT

The language currently in place allows the Credentials Committee to exempt the licensure requirement. This situation has never occurred and is felt to be inappropriate.

ARTICLE III

PART C: PROCEDURE FOR INITIAL CLINICAL PRIVILEGES

This addition to the Bylaws is a statement currently included with the application for clinical privileges and has been approved by the Credentials Committee, Medical Staff-Hospital Council, and the Board of Governors. Documentation of the requirement in the Bylaws is in keeping with JCAH (Joint Commission on Accreditation of Hospitals) standards.

ARTICLE IV

PART A: PROCEDURE FOR REAPPRAISAL AND REAPPOINTMENT

Section 1. Schedule for Reappraisal and Reappointment
This revision establishes a process for handling reappraisal and reappointment when a member of the medical staff is on a leave of absence. This situation surfaced last year with several members of the Medical Staff

PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

(a), (b). Reflects the changes in committees previously approved in Article VI, Committees of the Medical Staff.

PART E: PROCEDURE FOR LEAVE OF ABSENCE

References the reappraisal and reappointment process proposed in Article A:, Section 1 above.

RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

Section V. Conduct of Patient Care

E. Medical Record Completion Requirements

Number 11

Revisions to Hospital Policy 14.1, Medical Record Completion, is being brought to the Medical Staff-Hospital Council for approval on October 13. Included is the deletion of number 11.

Number 14 (to be changed to number 13) Orders - Requirements

b. Verbal:

Reflects revisions to Hospital Policy 4.3, Physicians Orders for Treatment, recently approved by the Medical Staff-Hospital Council.

Section VII. Medical/Legal

D. Pediatric Holds

Reflects revisions to Hospital Policy 6.11, 72 Hour Police and Health and Welfare Hold Orders-Child, recently approved by the Medical Staff-Hospital Council.

I. Brain Death

Reflects revisions to Hospital Policy 4.5, Time of Brain Death, previously approved by the Medical Staff-Hospital Council. The policy number was also changed from 4.9 to 4.5.

K. Reporting Requirements

Reflects the deletion of Policy 29.7, Confirmed Cases of Battered Women. Minnesota Statute Section 611A.36 no longer requires hospitals to collect and report this information.

JHM/cf

BYLAWS OF THE MEDICAL AND DENTAL STAFF

ARTICLE II

PART A: QUALIFICATIONS FOR APPOINTMENT

2. Only physicians and dentists who have been appointed to faculty rank in the University of Minnesota, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession and their good reputation with sufficient adequacy to assure the medical staff and the Board that any patient treated by them in the hospital will receive a high quality of medical care, shall be qualified for membership on the medical staff. Applicants must be licensed in the State of Minnesota. ~~or be specifically exempted from licensure by the Credentials Committee.~~

ARTICLE III

PART C: PROCEDURE FOR INITIAL CLINICAL PRIVILEGES

(b) Every initial application for staff appointment must contain, as part thereof, a request for the specific clinical privileges desired by the applicant. The clinical privileges requested should be only those necessary to fulfill the applicants responsibilities at The University of Minnesota Hospital and Clinic. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competency and judgment, references and other relevant information, including an appraisal by the clinical service in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications for and competence to exercise the clinical privileges he or she requests. Recommendations

of the chief of the clinical service in which clinical privileges are sought shall be forwarded to the Credentials Committee through the Chief of Staff and thereafter processed as part of the initial application for staff membership.

Article IV

PART A: PROCEDURE FOR REAPPRAISAL AND REAPPOINTMENT

Section 1. Schedule for Reappraisal and Reappointment:

Members of the medical staff shall be reappraised and considered for reappointment to the medical staff biennially~~.~~ unless the staff member is on leave of absence. If a member of the Medical Staff is on an approved leave of absence at the time that members of his or her department are considered for reappointment, his or her application shall not be acted upon until the term of the leave of absence has expired. At the expiration of the leave of absence, the application for reappointment shall be submitted at that time through his or her Chief of Service to the Chief of Staff in accordance with the usual process for reappointment. The reappraisal and reappointment of medical staff shall be conducted on a rotation basis of the medical staff in a clinical service department of one of two designated units. The units of clinical services and the schedule for processing are as follows:

ARTICLE IV

PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 3. Other Grounds for Suspension:

(a) A summary suspension in the form of withdrawal of an individual's elective admitting privileges may be imposed by the Board, upon recommendation of the chairman of the ~~Utilization Management Committee~~ Medical Record and Patient Care Information Committee, with concurrence of the Medical Staff-Hospital Council, after written warning to the individual and the Chief of his or her service of delinquency for failure to complete medical records within 30 days of a patient's discharge. Such suspension shall remain in effect until the records which caused the suspension have been satisfactorily completed.

(b) A summary suspension in the form of withdrawal of an individual's elective admitting privileges may be imposed by the Board upon recommendation of the Chairman of the ~~Utilization Medical Records Committee~~ Quality Assurance Steering Committee with concurrence of the Medical Staff-Hospital Council after written warning of the suspension to the Chief of Service for repeated delinquency in hospital utilization. Such suspension shall remain in effect until the matter has been resolved in conference with the Medical Staff Hospital Council.

PART E: PROCEDURE FOR LEAVE OF ABSENCE

Members of the medical staff may for good cause be granted leaves of absence for a definitely stated period of time by the Board. Requests for leaves of absence shall be made to the clinical chief of the service in which the staff member is applying for leave has his or her primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The clinical chief shall transmit the request together with his or her recommendation to the Medical Staff-Hospital Council which shall submit its recommendation to the Board for action: Provisions for reappraisal and reappointment of staff on leaves of absence are included in Part A, Section 1 of this article.

Section V. Conduct of Patient Care

E. Medical Record Completion Requirements

~~11. Utilization Review: Documentation. In the event that an admission appears unnecessary or a patient's stay appears to be continuing beyond that needed, a Utilization Review Notice will be placed in the medical record. A justification note must be written by the attending physician or a Medical Fellow or Medical Fellow Specialist to whom the function is delegated within 24 hours after the notice is placed in the medical record.~~

~~12.~~ 11. Facsimile Signatures.

~~13.~~ 12. Termination of Staff Membership: Completion of Record.

~~14.~~ 13. Orders - General Requirements

b. Verbal: Orders may be taken verbally and transcribed by an RN, ~~or secretary~~ registered pharmacist, or Cardiorespiratory Services clinical personnel at the direction of an authorized practitioner only when circumstances prevent the practitioner from writing the order. These orders must be cosigned by the practitioner within 24 hours.

~~15.~~ 14. Abbreviations Allowed.

~~16.~~ 15. Minimum documentation Requirements for Procedures Performed on the Station

~~17.~~ 16. Psychiatric Special Treatment Procedures. Documentation Requirements.

Section VII, Medical/Legal

D. Pediatric Holds

~~In certain suspected child abuse or neglect cases, parent(s), guardian(s), custodian(s), or other person(s) responsible for a child or children's care may demand or attempt to remove a child or children from the Hospital before all examinations, evaluations and treatments are completed. When, in the judgement of the physician, removal from the Hospital will be threatening or injurious to the child or children, the physician shall contact the University Police Department, the Minneapolis Police Department or the Hennepin County Sheriff's Department to put into effect the "72 Hour Police Health and Welfare Hold Order" (Juvenile Court Act of Minnesota, Minn. Stat. Section 260.165 Subdivision 1(c)(2)), (see Policy and Procedures Number 6.11.~~

When medical judgment indicates that a child's health and welfare would be endangered if she/he is discharged to the person to whose lawful custody the child would ordinarily be released, a physician may implement a 72-hour police health and welfare hold. Minnesota

Statute Section 260.165, subd. 1(c)(2). To implement this hold the responsible staff physician should contact the University of Minnesota Police Department and proceed in accord with policy 6.11. The police officer will take legal custody of the child and transfer the physical custody of the child to the physician. If a non-University of Minnesota peace officer comes to the hospital to place a hold on a pediatric patient the officer should be directed to the Hospital Protection Services Department.

I. Brain Death

The attending physician or other staff physician, using accepted medical criteria, should declare the patient dead when ~~the second testing~~ a second clinical examination or appropriate laboratory examination confirms brain death. When death occurs, all appropriate documentation should be made in the medical records, (see Policy and Procedure Number ~~4.8~~ 4.5).

K. Reporting Requirements

Members of the Medical Staff shall comply with State of Minnesota Statutes and regulations for the reporting of gunshot wounds, contagious diseases; births, coroners cases (see Policy and Procedures Number 15.8), deaths, suspected abuse or neglect or children (see Policies and Procedures Numbers 6.11, 29.3), suspected abuse or neglect of vulnerable adults (see Policy and Procedures Numbers 29.5, 29.6, 29A.6)~~, or confirmed cases of battered women (see Policy and Procedures 29.7).~~

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 22, 1987

TO: Members, Board of Governors

FROM: James H. Moller, M.D.
Chief of Staff

SUBJECT: Quality Assurance and Utilization Review Plan

Attached please find our Hospital-wide Quality Assurance Organizational Plan and Utilization Review Plan. Both documents have been approved by the medical staff's Quality Assurance Steering Committee, the Medical Staff-Hospital Council, and the Joint Conference Committee. The Board of Governors has historically delegated approval authority for these documents to the Joint Conference Committee, with brief informational reports to the Board of Governors. We presume that the Board would wish to follow that same pattern, but because of the growing emphasis being placed on Quality Assurance, both internally and externally, we thought it important that the Board receive more information on this subject than it has in the past. We will thus discuss the attached plans with the Board on October 28.

We have not included the appendices to the Quality Assurance and Utilization Review plans, for reasons of brevity, and because the appendices are somewhat technical in nature.

We look forward to discussing this subject with the Board at your upcoming meeting.

/kj

attachment

QUALITY ASSURANCE PROGRAM

ORGANIZATIONAL PLAN

The University of Minnesota Hospital and Clinic

QUALITY ASSURANCE PROGRAM
ORGANIZATIONAL PLAN
TABLE OF CONTENTS

QUALITY ASSURANCE PROGRAM

ORGANIZATIONAL PLAN

INTRODUCTION:

As reflected in The University of Minnesota Hospital and Clinic's Statement of Mission and Goals, the Hospital and Clinic has many different responsibilities and goals requiring that its mission be uniquely broad. In pursuit of patient care, education, and research goals, the Hospital and Clinic strives to provide leadership through the development of model programs.

As a teaching hospital of national stature, the Hospital and Clinic has many activities that are intended to assure high quality patient care at the lowest possible costs. Participation of students, residents, and staff physicians in rounds and clinical conferences, particularly death and complications conferences, provides a protocol for constant evaluation of clinical judgement. Multidisciplinary committees of the organized medical staff also serve important quality assurance functions. All Hospital and Clinic's clinical services and hospital clinical support departments have ongoing quality and appropriateness of care monitoring and evaluation activities. The Hospital and Clinic's Quality Assurance Program is designed to enhance patient care and assure appropriate allocation of health care resources through ongoing objective assessment of important aspects of patient care and the correction of identified problems.

PURPOSE OF THE HOSPITAL AND CLINIC'S QUALITY ASSURANCE PROGRAM:

The purpose of the Hospital and Clinic's Quality Assurance Program is to provide for coordination and to enhance, where necessary, the many quality and appropriateness of care monitoring and evaluation activities. Along with this coordination, the intent of the Quality Assurance Program is to improve the process of focusing these quality and appropriateness of care monitoring and evaluation activities on the most important aspects of patient care and to aid in the correction of identified problems. The Hospital and Clinic believes best results will be achieved by sharing information and integrating studies where a synergistic outcome can be predicted.

AUTHORITY:

The overall responsibility and authority for quality assurance lies with the Governing Board which delegates authority to the organized medical staff and to Hospital and Clinic's management. The organized medical staff, through the Medical Staff-Hospital Council, in turn, delegates authority to committees or task forces of the medical staff. Likewise, Hospital and Clinic's management delegates authority to individual departments. The Quality Assurance Steering Committee, an advisory committee to the Medical Staff-Hospital Council and Hospital and Clinic's management, is charged with the responsibility for coordinating all quality assurance activities and providing program direction.

COORDINATION;

Quality Assurance Steering Committee:

The Quality Assurance Steering Committee facilitates coordination of these committee and department activities and provides program direction. This Committee, chaired by the Chief of Staff, is composed of the chairmen of the, the Credentials Committee, the Outpatient Committee, and the Tissue and Procedure Review Committee; Two clinical chiefs, one of whom shall be the chairman of the Council of Chiefs of Clinical Services; Three other representatives of the Medical Staff; Director of Nursing, or designee, General Director, or designee; Director of Medical Staff Services; Director of Quality Assurance Services; and Director of Patient Relations.

The Committee meets as often as is necessary to advise the Medical Staff-Hospital Council as to directions that should be taken to improve the hospital and clinic's quality assurance and utilization review systems. The advice will be based on the committee's evaluation of patient care concerns and of the effectiveness of the continuous monitoring and other quality assurance and utilization review activities carried out by hospital departments, clinical departments, and medical staff committees.

(a) Evaluate the continuous monitoring systems and other quality assurance and utilization review activities of each department and of Medical Staff-Hospital Council committees at least annually.

(b) Identify problems with the quality of patient care and utilization of services, and recommend assignment of assessment, resolution, and follow-up activities for these problems.

(c) Develop an annual work plan for the quality assurance and utilization review activities. The work plan will be submitted for approval to the Medical Staff-Hospital Council, and the Board of Governors.

(d) Serve as an advisory group to Quality Assurance Services.

(e) Coordinate and monitor compliance with JCAH, PRO, and other external quality assurance and utilization review requirements.

(f) Recommend organizational changes in the hospital and clinic's quality assurance and utilization review systems, as needed.

Quality Assurance Services:

The Quality Assurance Services department of evaluation specialists will facilitate the Quality Assurance Program process by providing quality assurance staff support throughout. The responsibilities of the department are to:

1. provide quality assurance activity staff support to the Board of Governors, the Medical Staff-Hospital Council, the Quality Assurance Steering Committee, the standing committees of the Medical Staff-Hospital Council, and hospital and clinical departments as determined by the Quality Assurance Steering Committee
2. serve as a central quality assurance information monitoring resource
3. provide a central resource for following up on actions recommended through the quality assurance system
4. coordinate and monitor compliance with JCAH, PRO, and other external quality assurance and utilization review requirements, recommending modification or improved coordination as necessary
5. document Hospital and Clinic's program activity and actions taken

QUALITY ASSURANCE PROGRAM COMPONENTS:

Committees of the Medical Staff

Each of the following committees of the Medical Staff-Hospital Council is involved in ongoing monitoring and evaluation activities. In addition to these routine activities, if an area of concern or problem falls within the scope of one of the committees, the committee will be responsible for the assessment, resolution, and follow-up activities. (See Section A of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

Each of the committees reports and makes recommendations to the Medical Staff-Hospital Council. The Committees are:

Biomedical Ethics Committee
Cardio-Respiratory Advisory Committee
Credentials Committee
Emergency Room Committee
Hospital Infection Committee
Medical Record and Patient Care Information Committee
Operating Room Committee
Outpatient Committee
Pharmacy & Therapeutics Committee
Product Evaluation and Standardization
Tissue and Procedure Review Committee
Transfusion Therapeutics Committee

Clinical Departments:

Individual clinical departments are routinely involved in quality and appropriateness of care monitoring and evaluation activities. Each clinical service will have a defined quality assurance process. The clinical service will submit a copy of the process to the Quality Assurance Steering Committee for approval. Each Clinical Service will incorporate the following, at minimum, into its quality assurance review process:

1. Monthly meetings at which clinical performance and patient care are discussed with the staff of the service. During the course of a year the minutes of these meetings should include evidence of consideration of the following:
   - o comprehensive mortality and morbidity review which should be conducted at-least once a month
   - o data from the Clinical Service Quality Assurance Monitoring System
   - o problems or issues identified through hospital-wide monitoring systems such as tissue and procedure review, drug usage review, medical record review, blood usage review, utilization review, infection control, patient monitoring usage review, and respiratory therapy usage review

- o occasional instructive case reports or presentations of a topic relevant to patient care

2. A written response to the Clinical Service Quality Assurance Monitoring System data at least once a quarter. The response will include conclusions and recommendations or actions taken as a result of reviewing the monitoring data and any additional data judged by the clinical service to appropriately monitor quality and appropriateness of patient care. The response will be forwarded to Quality Assurance Services for review and for consideration by the Quality Assurance Steering Committee, as appropriate.

   In lieu of a separate written response to the Quality Assurance Monitoring data a clinical service can choose to forward copies of its minutes provided the minutes include conclusions and recommendations or actions taken as a result of reviewing the data.

In addition to these routine activities, if an area of concern or problem does not fall within the scope of one of the committees of the Medical Staff-Hospital Council but relates to one department, responsibility for the assessment, resolution, and follow-up activities may be assigned to the department chairperson. (See Section B of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

Hospital Clinical Support Departments:

Hospital clinical support departments are routinely carrying out quality and appropriateness of care monitoring and evaluation activities. Each hospital clinical support department will have in writing a defined quality assurance process. The department will submit a copy of this document to the Quality Assurance Steering Committee for approval.

Each hospital clinical support department will incorporate the following, at minimum, into their quality assurance review process:

1. A systematic process for monitoring and evaluating the quality (e.g., outcomes, timeliness, effectiveness) and appropriateness of the care or services provided by the department. Such monitoring and evaluation will be accomplished through the following:

   - o Identification of critical indicators reflecting important aspects of care or services provided by the department.

   - o Routine collection of data related to the critical indicators.

   - o Periodic assessment of the collected information in order to identify important problems and opportunities to improve care. Criteria will be used, as needed, in the evaluation process.

2. A written response to the monitoring system data at least once a quarter. The response will include conclusions and recommendations or actions taken as a result of reviewing the data and any additional data judged by the department to appropriately monitor quality and appropriateness of the care and services prepared by the department. The response will be forwarded to Quality Assurance Services for review and for consideration by the Quality Assurance Steering Committee, as appropriate.

The Quality Assurance Program Review and Evaluation Reporting Form, minutes of staff meetings, or other formats can be used for this response provided they include conclusions and recommendations or actions taken as a result of reviewing the data.

In addition, if an area of concern or problem does not fall within the scope of one of the committees of the Medical Staff-Hospital Council but relates to one department, responsibility for the assessment, resolution, and follow-up activities may be assigned to the department head. (See Section B of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

DATA SOURCES:

The Quality Assurance Program will use a variety of data sources to identify potential areas for review, evaluation, and resolution and to properly monitor the quality and appropriateness of patient care provided at The University of Minnesota Hospital and Clinic. These may include but are not limited to:

1. Committee findings
2. Hospital and Clinic's department findings
3. Clinical service findings
4. Medical staff concerns
5. Hospital and Clinic's staff concerns
6. Profiles (external and internal)
7. Studies
8. Incident reports
9. Patient surveys
10. Complaints and compliments
11. Financial reports
12. Outside agency reports
13. Claims data
14. Malpractice claims data
15. Medical examiner cases

CONFIDENTIALITY:

All data and information acquired and prepared for Quality Assurance Program or Credentialing activities are strictly confidential and are not considered discoverable or admissable in a court of law (protected under Minnesota State Statute 145.64). These data will be used, disseminated or published only to the extent required to effectively perform activities associated with the carry out Quality Assurance or Credentialing activities.

No person shall disclose to any individual, organization, or association, any Quality Assurance or Credentialing Information that was discussed at any meeting or other review proceeding, except to the extent required to effectively perform those evaluation activities as set forth in Minnesota State Statute 145.61, Subdivision 5. Obviously, information, documents, or records otherwise available from original sources do not become confidential merely because they were utiliz-

ed in connection with a Quality Assurance or Credentialing activity (See Appendix D, Confidentiality Policy for Quality Assurance/Credentialing Information).

EVALUATION OF THE QUALITY ASSURANCE PROGRAM:

The quality assurance process of each hospital and clinical department and Medical Staff-Hospital Council committee shall be evaluated at least annually to assure that they meet the quality assurance needs of the Hospital and Clinic. As often as this ongoing evaluation process indicates, the organizational plan shall be reviewed and revised, if necessary, by the Quality Assurance Steering Committee with input and assistance from other committees, clinical departments, Hospital and Clinic's departments, and the Director of Quality Assurance Services. The Medical Staff-Hospital Council, hospital management, and the Governing Board, through the Joint Conference Committee, shall approve revisions and changes.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
UTILIZATION REVIEW PLAN

Introduction:

The University of Minnesota Hospital and Clinic participates in or conducts utilization review processes for a variety of programs including the review programs for Medicare and Medicaid recipients, the Blue Cross Cost Containment Program, and the review programs of health maintenance organizations and private review agencies. Participation of nursing, social service, physicians, and other health care professionals in discharge planning activities provides a protocol for constant evaluation of patients' hospitalization needs. Multi-disciplinary committees and Hospital and Clinic's departments also are involved in assuring allocation of the hospital's resources.

Purpose:

The purpose of the Hospital and Clinic's Quality Assurance Program, which integrates quality assurance and utilization review activities, is to provide for coordination and to enhance, where necessary, the many quality and appropriateness of care monitoring and evaluation activities. Along with this coordination, the intent of the Quality Assurance Program is to aid in the correction of identified problems in overutilization, underutilization, and inefficient scheduling of resources.

Authority:

The Quality Assurance Steering Committee, an interdisciplinary committee of the Medical Staff-Hospital Council, is charged with the responsibility of advising the Medical Staff-Hospital Council as to directions that should be taken to improve the hospital and clinic's utilization review systems.

Functions:

The functions of the Quality Assurance Steering Committee relative to utilization of services shall be:

a. To evaluate the continuous monitoring systems and other utilization review activities of each department and of Medical Staff-Hospital Council committees at least annually.

b. To identify problems with the utilization of services and recommend assignment of assessment, resolution, and follow-up activities for these problems.

c. To develop an annual work plan for utilization review activities. The work plan will be submitted for approval to the Medical Staff-Hospital Council and the Board of Governors.

d. To serve as an advisory group to Quality Assurance Services which provides utilization review and evaluation staff support.

e. To coordinate and monitor compliance with JCAH, PRO, and other external utilization review requirements.

f. To recommend organizational changes in the hospital and clinic's utilization review systems, as needed.

Meetings:

The Quality Assurance Steering Committee shall meet as often as necessary, shall maintain a permanent record of its findings, and shall make reports thereof to the Medical Staff-Hospital Council, the Council of Chiefs of Clinical Services, and the General Director.

Confidentiality:

All data and information acquired and prepared for utilization review program activities are strictly confidential and are not considered discoverable or admissable in a court of law (protected under Minnesota State Statute 145.64). These data will be used, disseminated or published only to the extent required to effectively carry out activities associated with the Utilization Review Program and will not be disclosed to anyone except to authorized individuals.

Conflict of Interest:

No member of the Committee will have a direct financial interest in any hospital. In general, no person may participate in the review of any case in which he has had significant professional involvement.

Composition of the Committee:

The Committee is chaired by the Chief of Staff and consists of the chairmen of the Credentials Committee, the Outpatient Committee, and the Tissue and Procedure Review Committee; two clinical chiefs, one of whom shall be the chairman of the Council of Chiefs of Clinical Services; three other representatives of the medical staff; the General Director, or designee; the Director of Nursing Services, or designee; Director of Medical Staff Services; Director of Quality Assurance Services; and Director of Patient Relations.

Methods of Review:

Review and evaluation activities are conducted using a variety of mechanisms and data sources. These mechanisms provide the Hospital with various types of data essential to appropriate and efficient evaluation of utilization patterns and practices. The mechanisms include retrospective analysis of data and/or concurrent review of known or suspected problem areas and analysis of data to identify utilization problems and to monitor the hospital's utilization of resources.

A. Concurrent Review:

Concurrent review is focused on diagnoses, procedures and/or physicians with identified or suspected utilization-related problems. In addition, it is carried out at the request of specific third party payors. The process is outlined in Appendix A.

Concurrent review is performed under the direction of the Quality Assurance Steering Committee utilizing non-physician evaluators and physician reviewers from the medical staff. All decisions made by the Committee and its representatives will be based on the Criteria for Inpatient Treatment included in Appendix B.

As required, the norms utilized in assigning review points are specific to diagnoses or procedures and are contained in the most current edition of Length of Stay in PAS Hospitals, by Diagnosis, United States North Central Region, and Length of Stay in PAS Hospitals, by Operation, United States, North Central Region.

B. Problem Focused Studies:

When the Quality Assurance Steering Committee identifies areas that are associated with unusually high costs, excessive services including categories of admission wherein patterns of care are found to be questionable, such areas undergo closer professional assessment using comprehensive objective criteria and standards which are approved by the Quality Assurance Steering Committee, or other committees of the medical staff, as appropriate. Such activities include review of the appropriateness of ancillary services as well as the need for an acute level of care.

C. Problem Identification and Monitoring:

To identify utilization problems and to monitor the hospital's utilization of resources, the Committee or its representative examines the findings of related activities including PRO-generated profiles, study results, and hospital-specific third party utilization reports.

Responsibilities of Hospital and Clinics Management:

Quality Assurance Services provides utilization review and evaluation staff support to the Quality Assurance Steering Committee. Quality Assurance Services serves as the liaison with Hospital and Clinic's departments as appropriate. Hospital and Clinic management is responsible for considering and acting upon decisions and recommendations made by the Committee with respect to policy, procedures, and staffing.

Evaluation of the Quality Assurance Program:

The program shall be evaluated on an ongoing basis to assure that it meets the utilization review needs of the Hospital and Clinic. At least annually, the plan and work program shall be reviewed and revised, if necessary, by the Quality Assurance Steering Committee. Appropriate findings and revisions shall be reported to the Medical Staff-Hospital Council, hospital management and the Governing Board, through the Joint Conference Committee.

Appendices:

Appendix A: Concurrent Utilization Review and Denial Process

Appendix B: Criteria for Hospital Level of Care

Appendix C: Discharge Planning Policy and Mechanisms

Appendix D: Utilization Review Plan Modifications Specific to Minnesota Medicaid Requirements

Approved by:

James H Hoover MD

Chairman, Quality Assurance Steering Committee

James H Hoover MD

Chief of Staff

Chief Executive Officer

Pending October, 1987 Board of Governors Review

Chairman, Board of Governors

Minutes
Meeting of the
Board of Governors Finance Committee
The University of Minnesota Hospital and Clinic
August 26, 1987

MEMBERS PRESENT:	Carol Campbell Clifford Fearing Gregory Hart J.E. Meilahn Robert Nickoloff Barbara O'Grady Vic Vikmanis
MEMBERS ABSENT:	Edward Ciriacy William Krivit, M.D.
STAFF:	Amos Deinard, M.D. Kay Fuecker Steve Grygar Nancy Janda Nels Larson Helen Pitt Dan Rode Susan Weber Mary Ellen Wells Ted Yank

CALL TO ORDER: The meeting of the Finance Committee was called to order by Mr. Jerry Meilahn at 12:13 P.M. in the Board Room (8-106 University Hospital). Mr. Robert Nickoloff commenced as Chairman at 12:20 P.M.

MINUTES: A motion was seconded and passed to approve the minutes of the June 24, 1987 meeting of the Finance Committee as written.

1986-87 CENSUS: Mr. Nels Larson reported that both inpatient admissions and outpatient visit activity for June and July continued to be above budgeted levels. June admissions were 18% above budgeted levels. The average length of stay was 8.1 days. Patient days in June were 13% above budgeted levels. The June outpatient visits totaled 22,211 or 11.8% above budgeted levels. Increased activity was experienced in nearly all clinic areas, with the largest increases occurring in Medicine, Surgery, and Urology.

The July admissions were 63 above budgeted admissions of 1,650. The average length of stay was 7.9 days. Patient days totaled 13,496 and were -310 days under budget. The increase in admissions was primarily in Medicine and Opthalmology. Outpatient visits in July totaled 22,426 or 720 (3.3%) above budgeted levels. The largest increases occurred in Radiation Therapy, Emergency Room, and Opthalmology.

The June Accounts Receivables totaled $72,249,631, representing 101.4 days outstanding (down from 103 days). This decrease occurred primarily in the organ transplants, receivables and older BCBSM accounts.

The July Accounts Receivables totaled $73,343,543, representing 103.4 days outstanding. The overall increase was the result of an increase in revenue due to our price change effective July 1st. In addition, increases were seen in Special Contractuals, Medicare and older accounts.

4th QUARTER 1987 BAD DEBTS:

Mr. Dan Rode reported that bad debts for the quarter totalled $806,128.34, representing 1667 accounts. Recoveries during the period amounted to $14,232.70, leaving a net charge-off of $791,895.64. This represents 1.3% of gross charges and is compared to a budgeted bad debt level of 1.33%.

For the fiscal year bad debts totaled $2,600,851.38 (1.1% of gross charges), representing 5,607 accounts. Recoveries during the fiscal year amounted to $49,147.96, leaving a net charge-off of $2,551,703.42.

A motion to endorse the 4th Quarter, 1987 Bad Debt write-off as submitted was seconded and passed by the Finance Committee.

COMMUNITY UNIVERSITY HEALTH CARE CENTER:

Dr. Amos Deinard and Ms. Mary Ellen Wells reviewed the current CUHCC facility. CUHCC provides primary medical, medical, dental and mental health services to a low income population in South Minneapolis. CUHCC scheduled approximately 48,000 patient visits in 1986-87 and is currently engaged in 12 research projects. CUHCC's annual operating budget is approximately $2,000,000. Dr. Deinard noted that 60% more space is needed to o appropriately

treat the current patient population. Dr. Deinard indicated that $850,000 - $1.5 million is needed to secure a replacement facility. A space program analysis was completed by Hans Tronnes Associates. A decision must be made whether to stay on Franklin Avenue or to move to Lake Street before the cost of replacement can be identified.

Greg Hart reported that the CUHCC replacement issue will be brought back to both the Finance and Planning and Development Committees for discussion and endorsement in October, with Board approval sought in October.

COMPENSATION PLAN: Mr. Greg Hart reported recommendations for in-range adjustments be provided on a merit basis to non-union, Hospital dominated classes in an amount equivalent to 1.8% of the applicable salaries, resulting in a 3.8% weighted average salary increase for this group (a 2% across the board salary increase was provided to these employees 7/1/87). The pay plan for non-union, University dominated classes recommends a 1.5% merit-based progression increase in addition to a 1% July 1, 1987 across the board increase, and provides a one time lump sum merit increase to highly rated employees. This would result in a weighted average increase of 3.3%. Both of these recommendations would be retroactive to July 1, 1987. Mr. Hart noted that the Hospital budget allows for an average increase of 3.8% and 3.3% respectively.

A motion to endorse the 1987-88 Compensation Plan as submitted was seconded and passed by the Finance Committee.

INTERNAL AUDIT: Mr. Nels Larson reported that the Internal Audit Department reviewed Nutrition, Parking, and Accounts Payable for the first time. The areas cited for procedural changes were Purchasing, Personnel, Emergency Room, and Pharmacy. The majority of the proposed changes have already been implemented.

ADJOURNMENT: There being no further business, the Finance Committee adjourned at 1:15 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 28, 1987

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Report of Operations for the Period
July 1, 1986 through June 30, 1987

The 1986-87 fiscal year for University of Minnesota Hospital and Clinic has shown an increase in inpatient admissions and outpatient clinic visits over the prior two years. Our levels of staffing and operating expenses gradually increased during the year to meet the increased demand for service. Below is a brief summary of major factors which have contributed to our 1986-87 financial position.

Inpatient Census: Admissions for the 1986-87 fiscal year totaled 19,169 compared to 17,694 for the previous year, an increase of 1,475 (8.3%). Patient days for the year totaled 154,282, up by 8,585 (5.9%) from 145,697 days in 1985-86. The hospital overall average length of stay declined from 8.3 days last year to 8.1 days in the current year.

We budgeted for a decline in our inpatient census levels in 1986-87 which was consistent with industry trends. However, we experienced much higher than anticipated inpatient admissions and patient days. Areas in which admissions increased from the prior year are Medicine, Pediatrics, Surgery, Clinical Research, and Urology. Contributing to this increase were factors such as additions to medical staff, increased efforts in the area of planning and marketing, new technology such as the lithotripter and the MRI, and operating in the new hospital building for an entire year. Of the services with major increases, the most noteworthy are in the area of transplants and in the area of oncology. Average length-of-stay continued to

decline as a result of our efforts at better discharge planning and scheduling of same-day admissions. The decline was experienced in almost all clinical areas, with major decreases in Ophthalmology, Clinical Research, Neurology, Child Psychology, and Urology.

To recap our inpatient census for the 1986-87 fiscal year:

	1985-86 Actual	1986-87 Budget	1986-87 Actual	Variance	% Variance
Admissions	17,694	16,950	19,169	2,219	13.1
Avg. Lgth. of Stay	8.3	8.3	8.1	-.2	-2.4
Patient Days	145,697	138,790	154,282	15,492	11.2
Percent Occupancy	67.3	63.4	72.2	8.8	13.9
Avg. Daily Census	399.2	380.2	422.7	42.5	11.2

Outpatient Census: The Hospital's outpatient clinic census showed a significant increase over the 1985-86 levels, going from 224,446 visits in the prior year to 248,137 in the current year. This represents a 10.6% increase over the prior year levels and an 11.5% increase (25,537) over the budgeted 1986-87 total of 222,600.

The increase in clinic census occurred in nearly all clinic areas. The most significant increases occurred within Surgery, Medicine, Dermatology, Urology, and the Emergency Room. Areas that experienced a decline in clinic census included Neurology and Audiology. The decline in Neurology was due to the epilepsy program withdrawing from the hospital while Audiology visits declined in conjunction with a loss in medical staff.

To recap our outpatient census for the 1986-87 fiscal year:

	1985-86 Actual	1986-87 Budget	1986-87 Actual	Variance	% Variance
Clinic Visits	224,446	222,600	248,137	25,537	11.5
CUHCC Visits	42,526	37,600	47,202	9,602	25.5
HHA Visits	9,421	14,881	9,011	-5,870	-39.4

Operations - Revenue: Patient care revenue for the 1986-87 fiscal year totaled $238,045,424 and is an increase of $39,074,887 (19.6%) over the 1985-86 fiscal year. The increase in revenue is approximately $38,781,700 above budget and results in an overall favorable variance of 19.5%. This overall variance is due to higher than anticipated patient days and higher than anticipated ancillary utilization for both inpatient and outpatient populations.

Routine revenue totaled $67,354,752, and represents a favorable

variance of approximately $7,185,000. Ancillary service revenue totaled $170,690,672, and was approximately $31,596,700 (22.7%) above budget. The overall ancillary variance reflects a utilization level per patient that was higher than anticipated. Inpatient ancillary revenue per admission averaged $6,705 compared to the budgeted average of $6,199. Outpatient revenue per clinic visit averaged $170 compared to the budgeted average of over $152. Nearly all ancillary areas experienced revenues above budget, with the greatest increases occurring in the operating room, pharmacy, clinical labs, cardio-respiratory areas, patient monitoring and radiology.

Deductions from Charges: Deductions from charges totaled $37,846,568 for the fiscal year and represent an overall unfavorable variance of $6,809,368. This overall variance reflects both the increase in patient census levels and the increase in average charges per case over budget. The overall increase in deductions from charges closely parallels the increase in patient charges. This relationship indicates that overall reimbursement levels were close to budget.

Operations - Expenditures: Operating expenses for the 1986-87 fiscal year totaled $227,941,205 and was an increase of $44,524,799 (24.3%) over the 1985-86 fiscal year. The increase in expense was approximately $19,322,200 over budget and resulted in an overall unfavorable variance of 9.3%. Much of this variance was associated with the increase in demand for patient services.

Personnel costs (salaries and fringe benefits) were over budget by nearly $8,944,000. The increased salary costs were the result of higher staffing levels. During the 1986-87 fiscal year we averaged 3,793 full-time equivalents (FTE's), which was an increase of 335 over the budgeted total of 3,458. The increase in staffing levels is largely attributed to the increased census levels experienced throughout the year. The unfavorable variance in fringe benefit expenses relates to the higher salary costs.

Supplies and expense directly related to patient care activities were more than $8,861,100 over budget in aggregate. These costs would include such things as drugs, blood and blood derivatives, laboratory and medical supplies, laundry and food services, services related to kidney and bone marrow acquisitions, rental of patient care equipment, and patient care contracted services.

Expenses related to buildings, building services, and equipment were more than $4,303,100 over budget. These costs include utilities, maintenance and repair, communications, building rental, and depreciation. Depreciation expense accounted for $2,314,000 of the total unfavorable variance. The higher depreciation expense results from breaking down the total building costs for Unit J into all its

various building components. Doing this has the effect of accelerating our depreciation expense and provides for a more rapid recovery of capital costs by Medicare. The majority of the utility expense variance was the result of underestimating utilization in Unit J.

Insurance expense for 1986-87 totaled $2,115,636 and was nearly $717,000 below budget. This variance is the result of reduced premium levels for our calendar year 1987 general comprehensive liability and professional malpractice insurance. The reduction in premium cost brought with it, however, a reduction in coverage from $10,000,000 down to $5,000,000.

Interest expense for the 1986-87 fiscal year was $4,025,676 under budget. This favorable variance was the result of (1) the refinancing which took place in June 1986, and (2) the offsetting of interest income earned on bond proceeds still held by the trustee.

Finally, we experienced a net unfavorable variance in other supply and expense categories totaling $1,491,965. Major variances occurred in other services such as physician recruitment, printing costs, advertising, postage and travel.

Non-Operating Revenue: Non-operating revenues totaled $21,972,361 in 1986-87 and represent an unfavorable variance from budget of $1,804,239. The overall variance is primarily the result of two factors. First, we are recognizing the loss in our equity position of Primary Care Network (PCN) together with our share of outstanding liabilities in the form of loan guarantees. The net loss being recognized by UMHC is $1,134,760. The second factor relates to lower than anticipated interest earnings on our reserve funds. This was primarily the result of declining interest rates throughout the 1986-87 fiscal year.

Accounts Receivable: The balance in patient accounts receivable as of June 30, 1987 totaled $72,366,775 and represents 101.4 days of revenue outstanding; this is an increase of $16,469,960 and 9.8 days from June 30, 1986. Factors contributing to this increase include the overall increase in patient volume coupled with the higher charge levels per patient, and continuing changes in third party billing requirements. In addition, the increase in HMO activity has contributed to the rise in receivables because of difficulties in establishing payment protocols with these new contracts.

Capital Expenditures: During the 1986-87 fiscal year, UMHC expended $11,874,700 from hospital funds for current year capital expenditures. The primary components of our capital spending were: (1) $8,792,300 for recurring equipment and remodeling, (2) $1,871,700

related to the new tunnel, and (3) $1,210,700 in principal payments for computer hardware and the lithotripter.

Conclusion: The 1986-87 fiscal year was one of notable changes for University of Minnesota Hospital and Clinic. For the first time since 1982-83 we experienced significant increases in our admission levels and our patient days. These increases reflected our first full year of operation in the new hospital, our increased marketing efforts, and the expansion of several programs and services. While our admissions and patient days went up, we saw a slight drop in the average length of stay. This can be attributed to our continuing efforts at cost reductions through greater use of same day surgery and improved discharge planning.

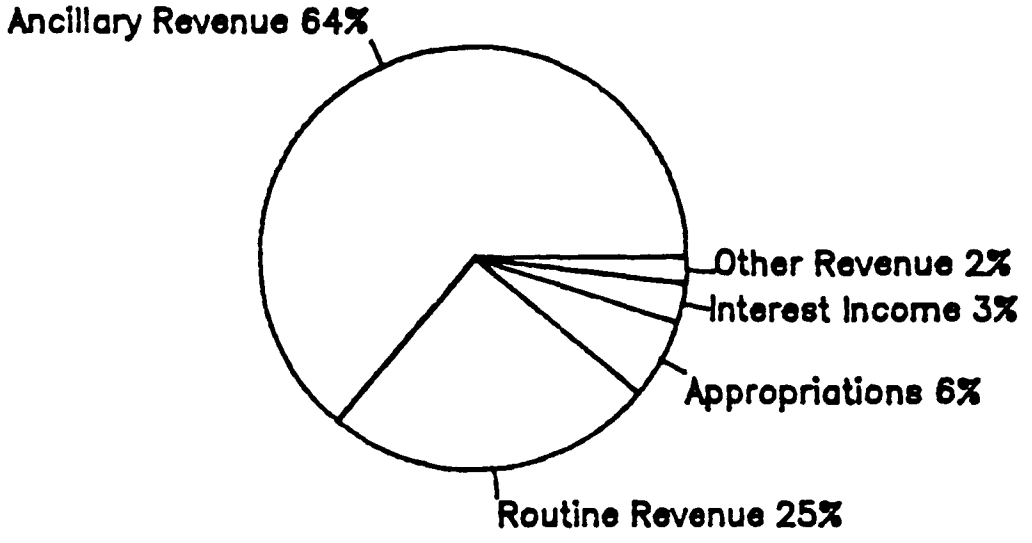
UMHC continued to experience increasing pressure from third party payors as HMO's, insurance companies, and self-insured companies moved to contract for specific services, and as more governmental agencies moved towards prospective payment systems. These activities are continuing to force UMHC, as well as other providers, away from fee-for-service medicine and toward negotiated fixed fee pricing. UMHC must keep working with numerous HMO's, PPO's, and other insurers to develop pricing strategies which will enhance our competitive position while enabling us to meet our financial goals and objectives.

The competitive and cost conscious environment we are in will continue, and will challenge us to find new sources of revenue and ways to reduce costs. Market penetration, program diversification and expansion, program affiliation, and possible program divestiture, where appropriate, may be required for UMHC to sustain its mission of patient service, education, and research.

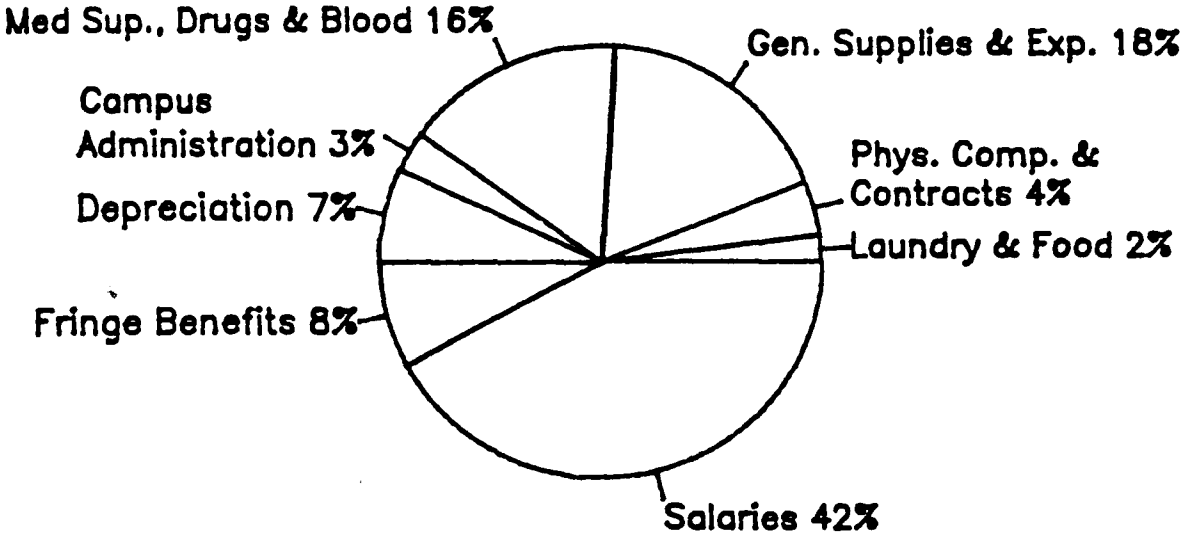
University of Minnesota Hospital and Clinic

Year Ending June 30, 1987

Revenue Summary

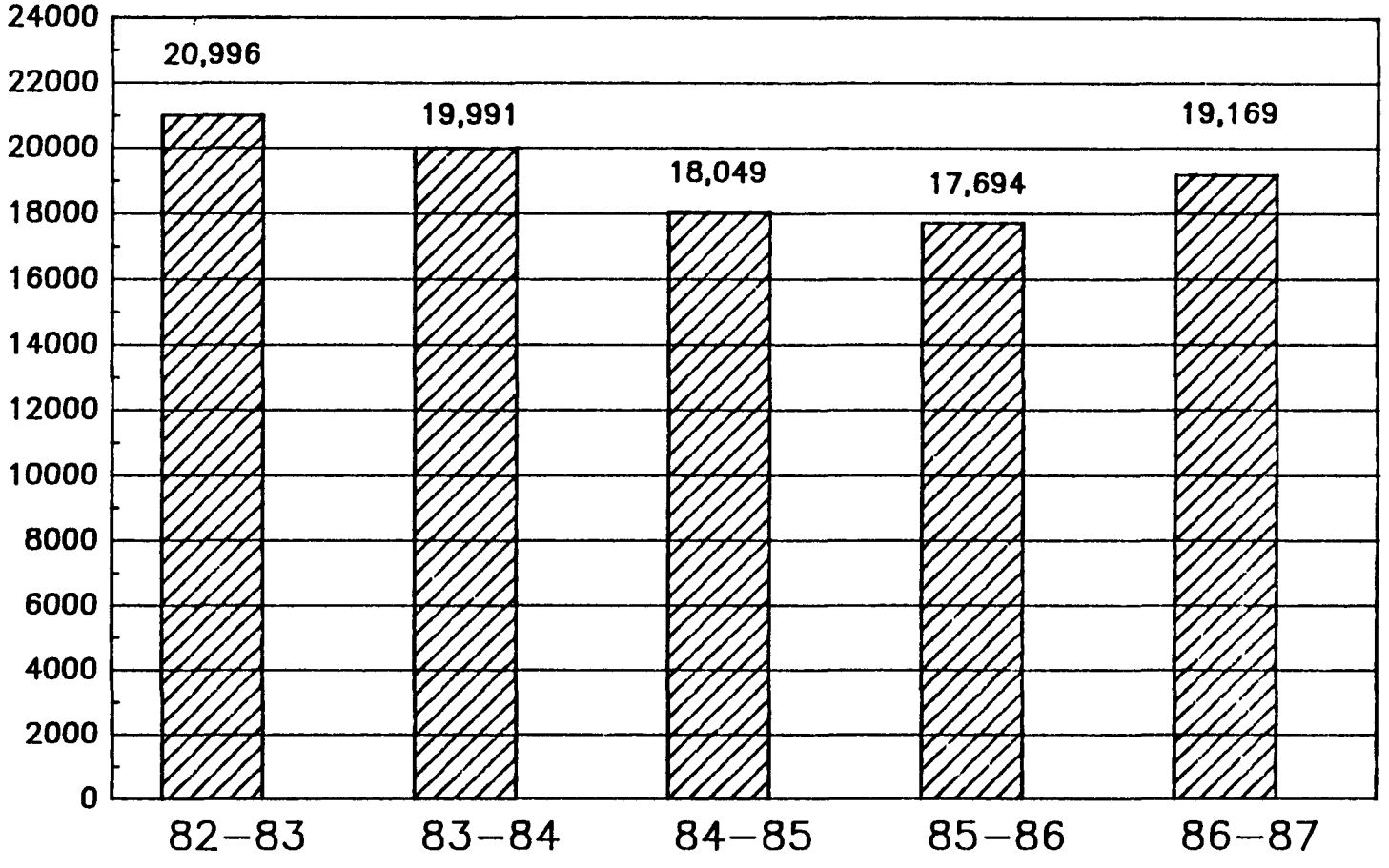


Expense Summary



University of Minnesota Hospital and Clinic Admissions

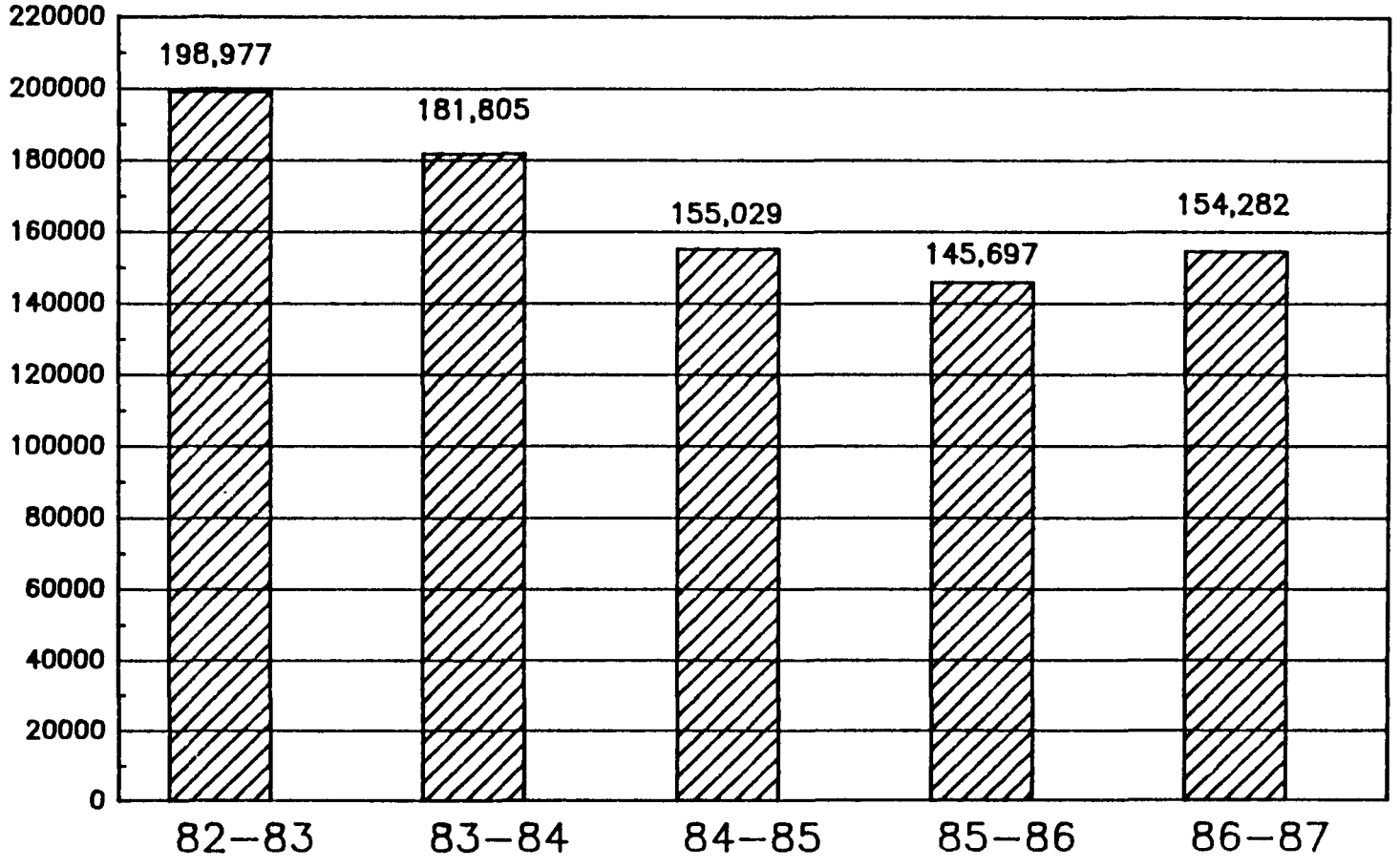
1982–83 through 1986–87



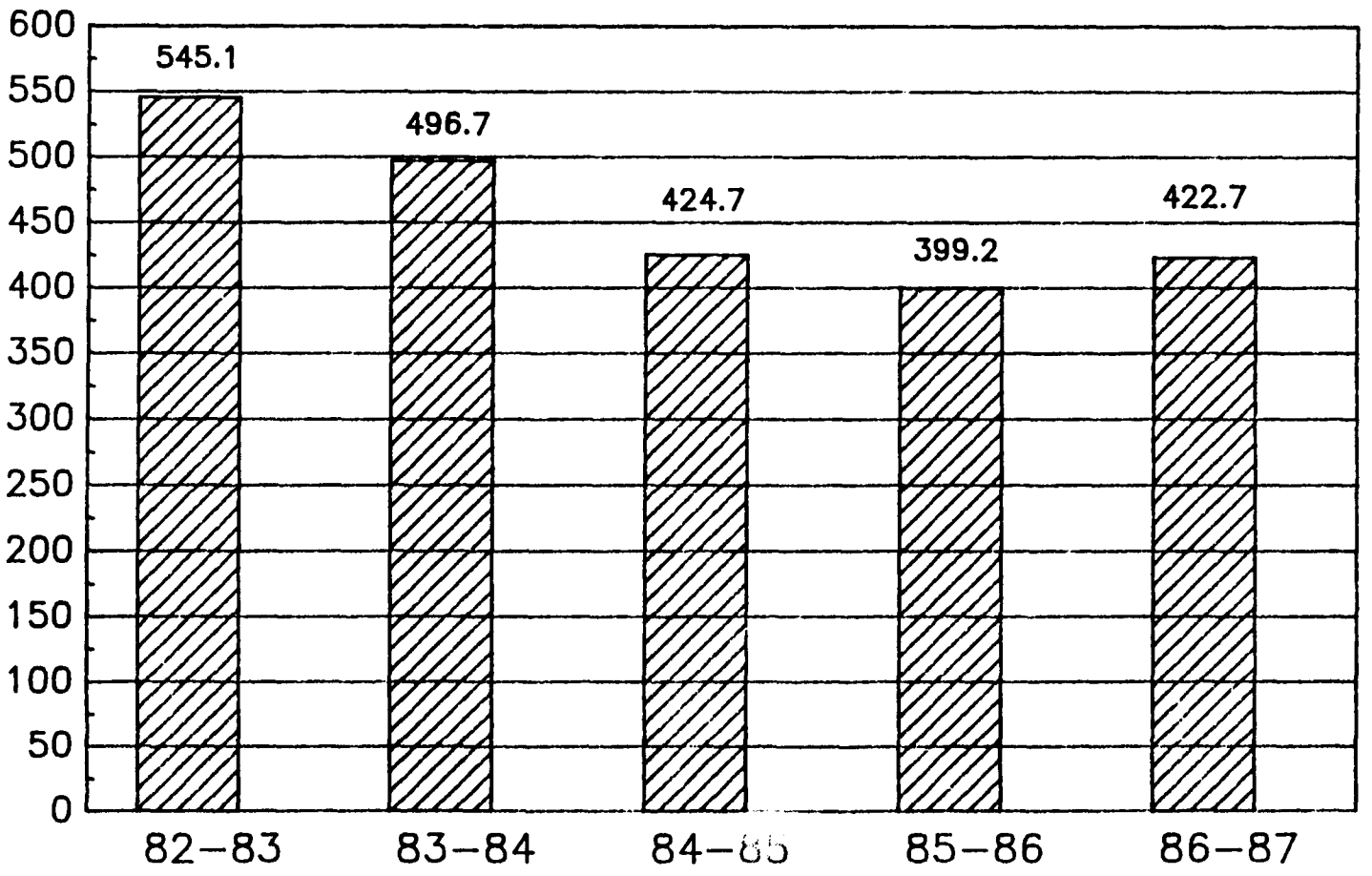
University of Minnesota Hospital and Clinic
Inpatient Admissions by Clinical Service
For FY 1982-83 through 1986-87

Admissions	1982-83	1983-84	1984-85	1985-86	1986-87
Anesthesiology	1	1	1	1	0
Clinical Research	405	409	370	359	482
Dentistry	211	165	97	74	70
Dermatology	122	105	52	30	23
Family Practice	47	57	49	33	27
Gynecology	1,578	1,368	1,390	1,325	1,476
Medicine	3,888	3,597	3,473	3,297	3,981
Neurology	845	772	627	634	431
Neurosurgery	1,016	1,068	996	919	878
Newborn	820	787	453	318	346
Nuclear Medicine	2	5	7	2	3
Obstetrics	1,096	1,083	654	508	594
Opthalmology	919	876	1,015	994	990
Orthopaedics	986	1,017	1,057	979	1,020
Otolaryngology	955	941	569	502	459
Pediatrics	3,403	3,423	3,075	3,097	3,322
PM & R	289	246	300	197	163
Psychiatry - Adult	483	615	619	728	783
Psychiatry - Child	129	85	91	83	90
Radiation Therapy	7	1	1	3	1
Surgery	2,964	2,594	2,456	2,678	2,931
Urology	830	776	697	933	1,099
Total	20,996	19,991	18,049	17,694	19,169

University of Minnesota Hospital and Clinic
Patient Days
1982–83 through 1986–87

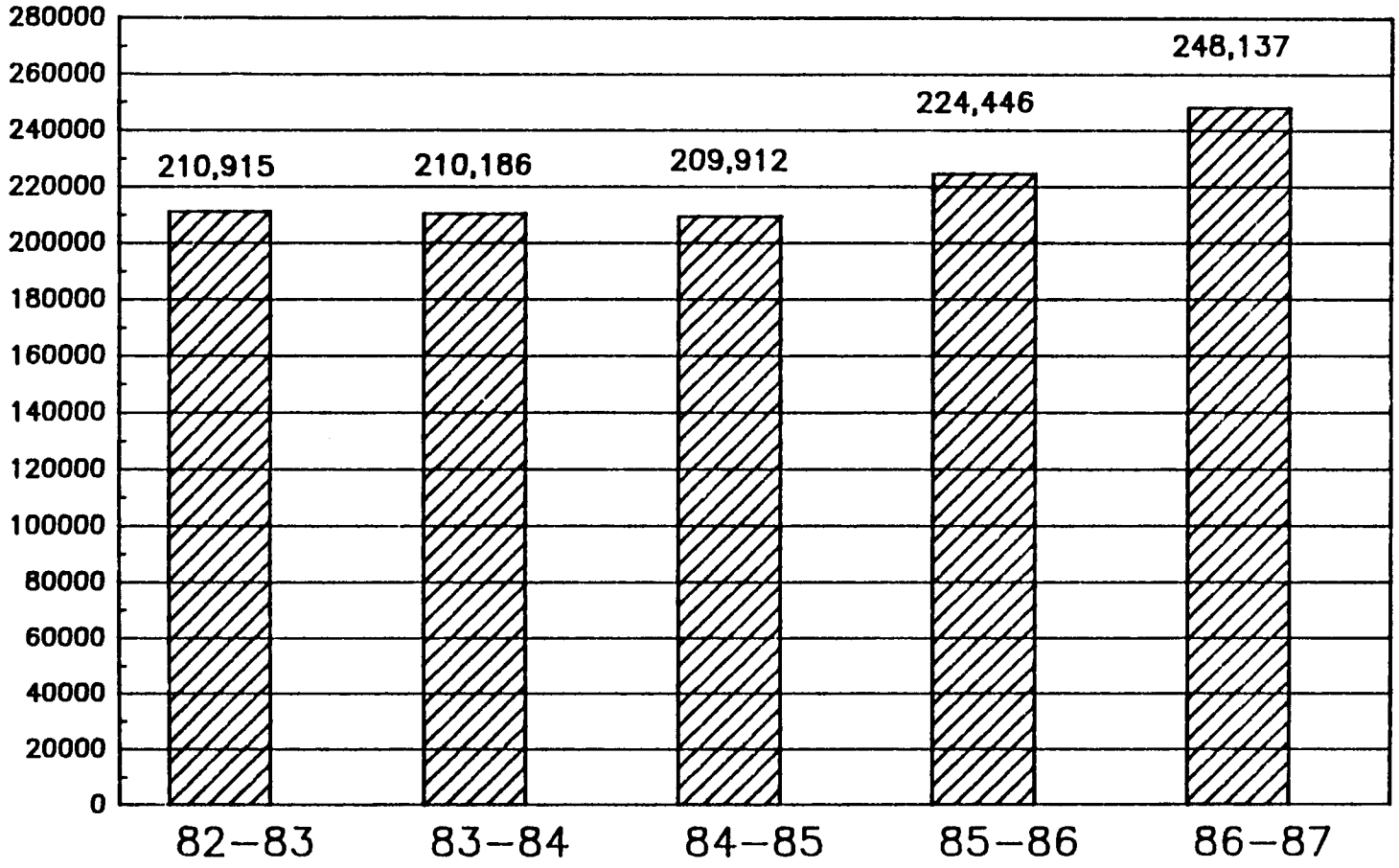


University of Minnesota Hospital and Clinic
Average Daily Census
1982–83 through 1986–87

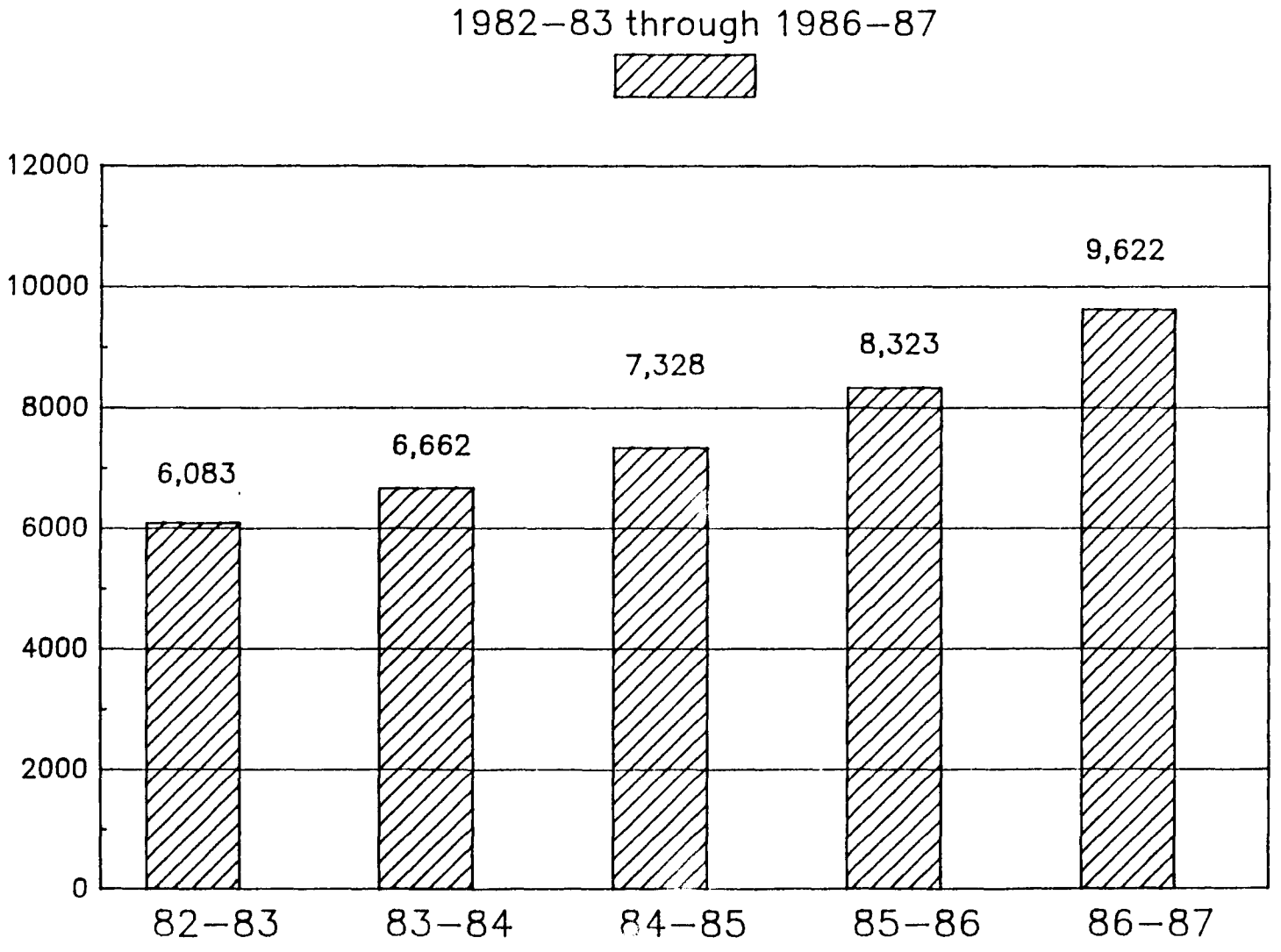


University of Minnesota Hospital and Clinic
Outpatient Clinic Visits

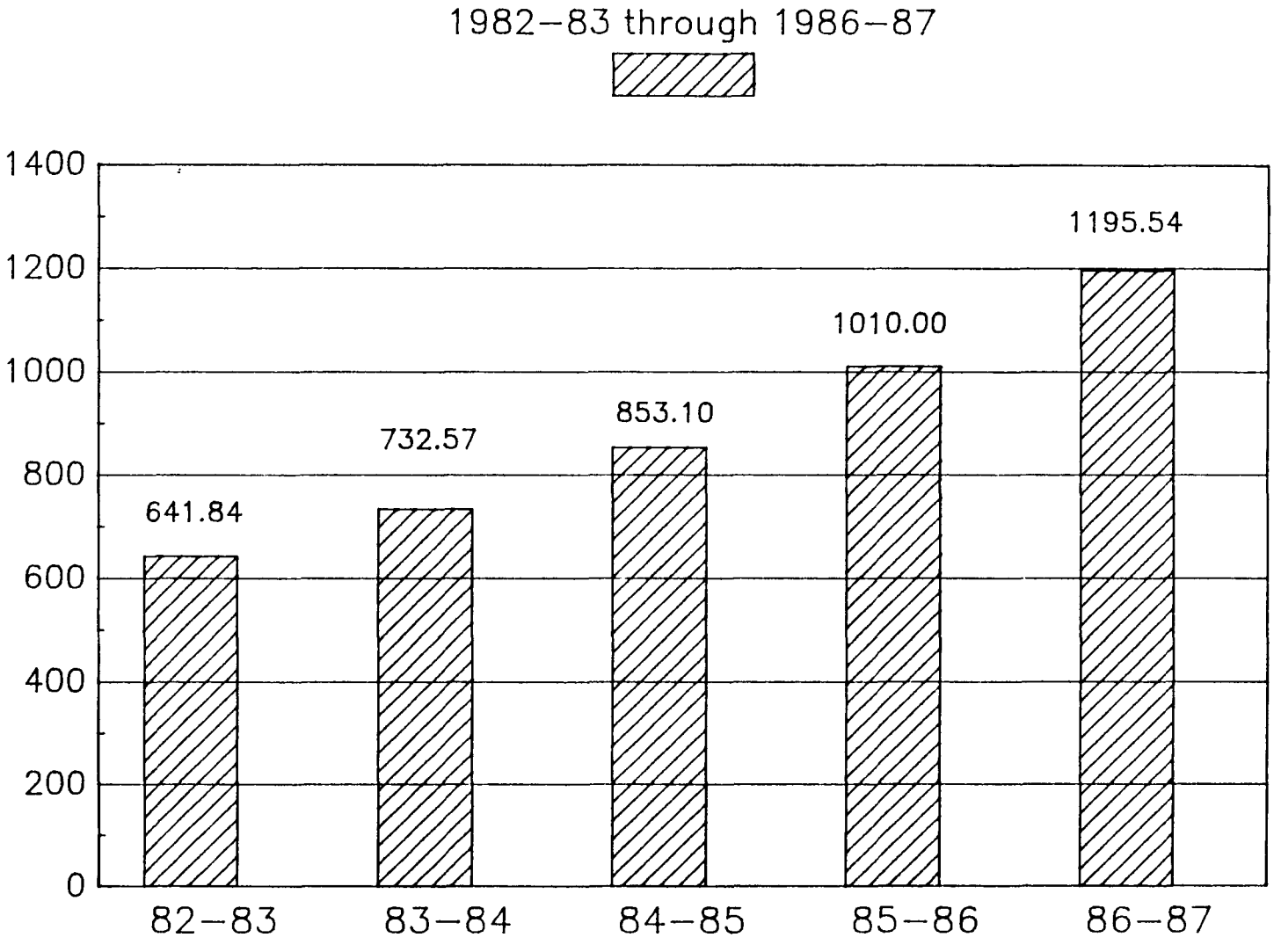
1982–83 through 1986–87



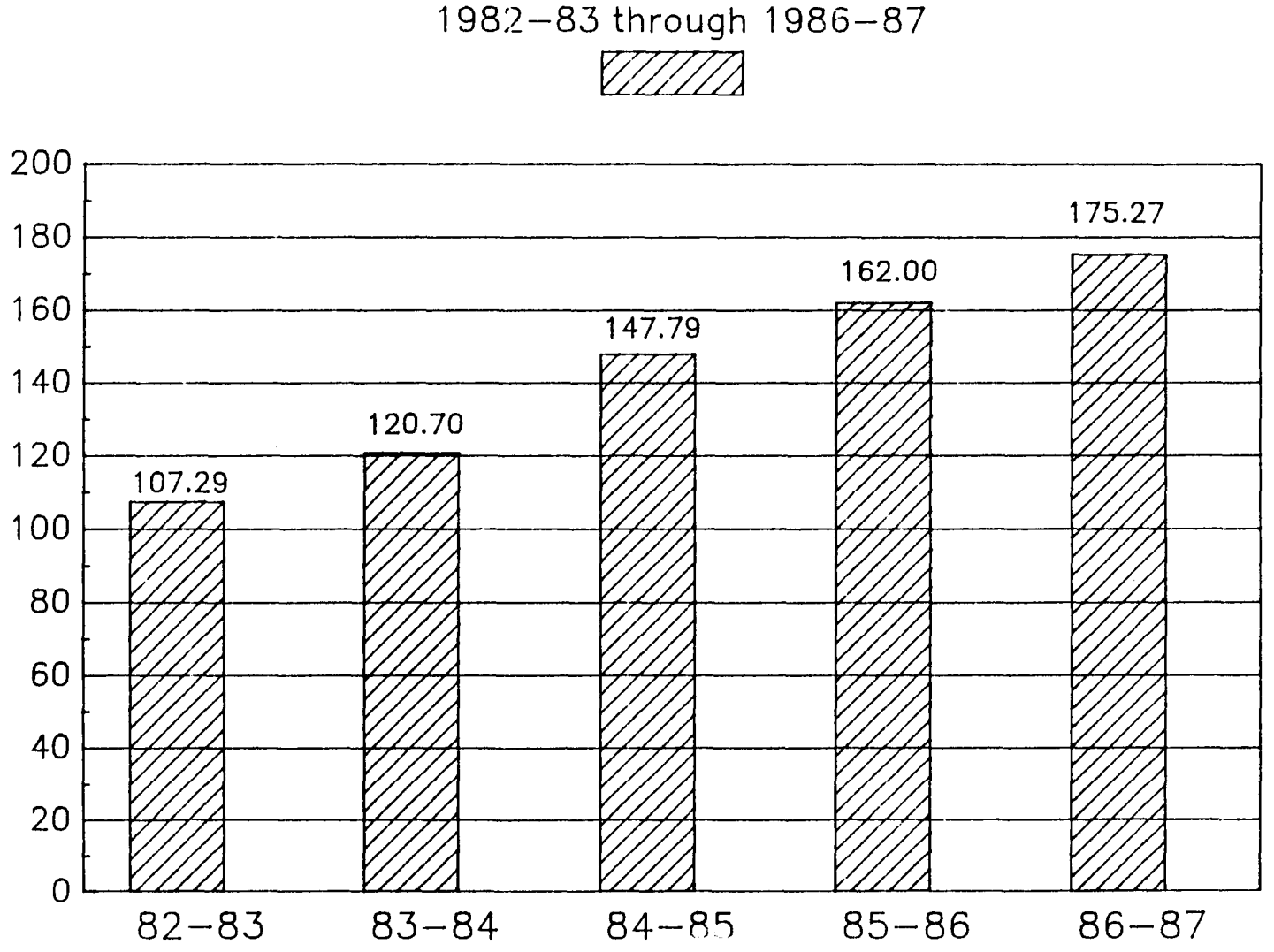
University of Minnesota Hospital and Clinic
Inpatient Cost Per Admission



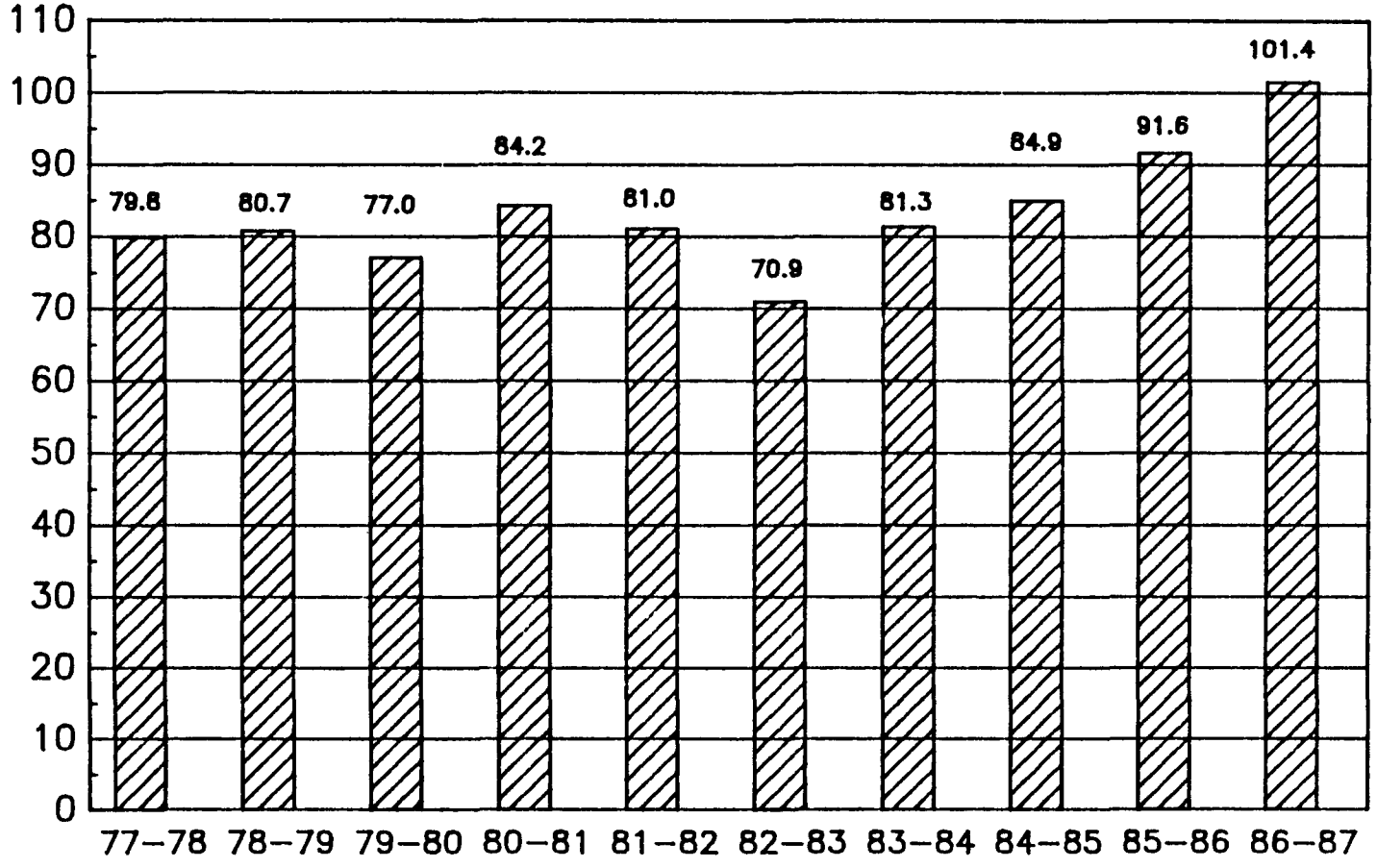
University of Minnesota Hospital and Clinic
Inpatient Cost Per Patient Day



University of Minnesota Hospital and Clinic
Outpatient Cost Per Visit



University of Minnesota Hospital and Clinic
Revenue Days in Accounts Receivable
1977–78 through 1986–87



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
SOURCE OF RECEIPTS
1983 TO 1987

	1983		1984		1985		1986		1987	
	AMT. IN 1,000'S	% OF TOTAL	AMT. IN 1,000'S	% OF TOTAL	AMT. IN 1,000'S	% OF TOTAL	AMT. IN 1,000'S	% OF TOTAL	AMT. IN 1,000'S	% OF TOTAL
MEDICARE	$37,470	21.4	$36,437	19.8	$39,556	20.7	$39,984	20.5	$44,949	19.7
MEDICAL ASSISTANCE & FEDERAL CRIPPLED CHILDREN	19,503	11.2	15,227	8.3	12,983	6.8	12,181	6.2	19,526	8.6
BLUE CROSS	21,362	12.2	19,281	10.5	20,203	10.6	18,185	9.3	28,578	12.5
OTHER COMMERCIAL INSURANCE	60,743	34.7	70,545	38.4	71,879	37.5	78,602	40.2	89,312	39.2
PATIENT LIABILITY	8,942	5.1	8,897	4.8	9,567	5.0	9,288	4.8	9,817	4.3
MISC. AGENCY ACCOUNTS	8,450	4.8	10,435	5.7	12,383	6.5	10,144	5.2	9,182	4.0
COUNTY	2,555	1.5	1,647	0.9	994	0.5	1,318	0.7	825	0.4
STUDENT HEALTH SERVICE	172	0.1	118	0.1	36	0.0	12	0.0	N/A	
COLLECTION AGENCIES	467	0.3	557	0.3	687	0.4	729	0.4	811	0.4
OTHER	852	0.5	1,303	0.7	1,040	0.5	261	0.1	810	0.4
REFUNDS	-4,416	-2.5	-4,531	-2.5	-3,948	-2.1	-3,340	-1.7	-4,860	-2.1
SUBTOTAL: PATIENT CARE RECEIPTS	$156,100	89.3	$159,916	87.0	$165,380	86.4	$167,364	85.6	$198,950	87.4
APPROPRIATIONS/SUPPORT	11,557	6.6	12,421	6.8	12,939	6.8	13,106	6.7	13,860	6.1
INVESTMENT INCOME	3,587	2.1	7,600	4.1	8,580	4.5	9,756	5.0	8,771	3.8
OTHER INCOME	3,581	2.0	3,830	2.1	[illegible]49	2.[illegible]	5,201	2.7	6,145	2.7
TOTAL	$174,825	100.0	$183,767	100.0	$191.[illegible]	[illegible]	$195,427	100 0	$227,726	100.0

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1986 TO JUNE 30,1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$199,263,700	$238,045,424	$38,781,724	19.5%
Deductions from Charges	-31,037,200	-37,846,568	-6,809,368	-21.9%
Other Operating Revenue	5,346,400	5,668,918	322,518	6.0%
Total Operating Revenue	173,572,900	205,867,774	32,294,874	18.6%
Total Expenditures	-208,618,997	-227,941,205	-19,322,208	-9.3%
Net Operating Revenue	-35,046,097	-22,073,431	12,972,666	0.0%
Non-Operating Revenue and Expenses	23,776,600	21,972,361	-1,804,239	-7.6%
Revenue Over Expense	$ -11,269,497	$ -101,070	$11,168,427	(1)

(1) Variance equals 5.7 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	16,950	19,169	2,219	13.1%
Patient Days	138,790	154,282	15,492	11.2%
Average Daily Census	380.2	422.7	43	11.2%
Average Length of Stay	8.3	8.1	-0.2	-2.4%
Percentage Occupancy	63.4%	72.2%	8.8	13.9%
Outpatient Clinic Visits	222,600	248,137	25,537	11.5%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO JUNE 30, 1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$199,263,700	$238,045,424	$38,781,724	19.5%
Deductions from Charges	31,037,200	37,846,568	6,809,368	21.9%
Other Operating Revenue	5,346,400	5,668,918	322,518	6.0%
Total Revenue from Operations	$173,572,900	$205,867,774	$32,294,874	18.6%
Expenditures				
Salaries	$87,879,400	$95,950,578	$8,071,178	9.2%
Fringe Benefits	17,115,800	17,987,902	872,102	5.1
Contract Compensation	8,769,400	9,059,159	289,759	3.3
Medical Supplies, Drugs, Blood	29,992,400	36,956,213	6,963,813	23.2
Campus Administration Expense	6,222,497	6,222,497	0	
Depreciation and Amortization	14,103,400	16,417,549	2,314,149	16.4
General Supplies & Expense	44,536,100	45,347,307	811,207	1.8
Total Expenditures	$208,618,997	$227,941,205	$19,322,208	9.3%
Net Revenue from Operations	-35,046,097	-22,073,431	$12,972,666	
Non-Operating Revenues and Expenses				
Appropriations	$14,150,400	$14,618,231	$467,831	3.3%
Interest Income on Reserves	7,187,600	6,167,728	-828,059	-12.5
Shared Services	364,300	475,990	91,642	27.4
Investment Income on Trustee Held Assets	2,074,300	1,845,172	-229,128	-11.0
Loss on Writeoff of Other Assets	0	-1,134,760	-1,134,760	
Total Non-Operating Revenues and Expenses	$23,776,600	$21,972,361	$ -1,804,239	-7.6%
Revenue Over / -Under Expenses	$ -11,269,497	$ -101,070	$ 11,168,427	

(1) Variance equals 5.7% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO JUNE 30, 1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges				
Routine	$60,169,700	$67,354,752	$7,185,052	11.9%
Ancillary	139,094,000	170,690,672	31,596,672	22.7
Gross Charges	$199,263,700	$238,045,424	$38,781,724	19.5%
Deductions from Charges				
Third Party Contractual Adjustments	$16,821,600	$18,897,212	$2,075,612	12.3%
Billing Adjustments & Employee Benefits	8,124,800	9,644,292	1,519,492	18.7
Charitable Care	420,000	713,871	293,871	70.0
Other Contractual Adjustments	3,026,700	5,170,041	2,143,341	70.8
Provisions for Uncollectables	2,644,100	3,421,152	777,052	29.4
Total Deductions	$31,037,200	$37,846,568	6,809,368	21.9%
Other Operating Revenue				
Food Services	$1,165,100	$1,396,893	$231,793	19.9%
Parking Services	452,400	223,973	-228,427	-50.5%
Department Non-Patient	99,900	181,910	82,010	82.1
CUHCC Grants	1,023,100	1,160,856	137,756	13.5
Reference Lab Income	1,486,100	1,358,564	-127,536	-8.6
Pro Fees - Net Revenue	1,119,800	1,311,613	191,813	17.1
Donations to Operations from Restricted Funds	0	35,109	35,109	
Total Other Revenue	$5,346,400	$5,668,918	322,518	6.0%
Total Revenue from Operations	$173,572,900	$205,867,774	$32,294,874	18.6%
Expenditures				
Salaries	$87,879,400	$95,950,578	$8,071,178	9.2%
Fringe Benefits	17,115,800	17,987,902	872,102	5.1
Academic Contracts	1,875,700	1,868,150	-7,550	-0.4
Resident Contracts	4,685,500	4,644,141	-41,359	-0.9
Physician Compensation	2,208,200	2,546,868	338,668	15.3
Total Salary, F.B. & Fees	$113,764,600	$122,997,639	$9,233,039	8.1%
Laundry & Linen	2,079,600	2,080,423	823	0.0%
Raw Food	1,392,200	1,621,696	229,496	16.5
Drugs	13,975,900	17,185,579	3,209,679	23.0
Blood & Blood Derivatives	4,880,400	5,748,524	868,124	17.8
Medical Supplies	11,136,100	14,022,110	2,886,010	25.9
Utilities	3,055,900	3,947,316	891,416	29.2
Insurance	2,832,400	2,115,636	-716,764	-25.3
Rental	2,335,200	2,640,762	305,562	13.1
Maintenance & Repair	3,349,300	4,242,258	892,958	26.7
Communications	1,312,800	1,493,963	181,163	13.8
Net Loss on Disposal of Assets	0	161,408	161,408	
Campus Administration Expense	6,222,497	6,222,497	0	
Depreciation and Amortization	14,103,400	16,417,549	2,314,149	16.4
Interest	14,001,200	9,975,524	-4,025,676	-28.8
General Supplies & Expense	14,177,500	17,068,321	2,890,821	20.4
Total Expenditures	$208,618,997	$227,941,205	$19,322,208	9.3%
Net Revenue from Operations	-35,046,097	-22,073,431	$12,972,666	
Non-Operating Revenue and Expenses				
Appropriations & Support	$13,638,900	$13,860,000	$221,100	1.6%
Accrued Interest on Appropriation	511,500	758,231	246,731	48.2
Interest Income on Reserves	7,187,600	6,167,728	-1,019,872	-14.2
Shared Services	364,300	475,990	111,690	30.7
Investment Income Held by Trustee	2,074,300	1,845,172	-229,128	-11.0
Loss on Writeoff of Other Assets		-1,134,760	-1,134,760	
Total Non-Operating Revenue and Expenses	$23,776,600	$21,972,361	-1,804,239	-7.6%
Revenue Over Expense	$ -11,269,497	$ -101,070	$11,168,427	(1)

(1) Variance equals 5.7% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

OPERATING CASH FLOW

FOR THE PERIOD JULY 1, 1986 TO JUNE 30, 1987

Source of Funds		
Beginning Operating Cash Balance		$9,475
Net Income from Operations	$ -22,073,431	
Non-Operating Revenue	21,972,361	
Excess of Revenue over Expense		-101,070
Items not Requiring the Outlay of Cash:		
Depreciation		16,417,549
University Support: G & A		6,122,497
University Support: KE Utilities		138,837
Decrease in Other Receivables		254,906
Decrease in Prepaid Expenses		644,245
Decrease in Other Assets		332,972
Deferred Third Party Reimbursement		718,332
Renewal Project Interest Expense		8,946,294
Increase in Accrued Expenses		7,359,773
Year End Closing Transfer		2,675,254
Miscellaneous		188,915
Total Funds Provided from Operations		$43,707,979
Funds Applied		
Transfers to Plant:		
Increase in Capital Expenditures	$7,688,336	
Decrease in Capital Encumbrances	249,768	
Total Transfers to Plant from Operations		$7,938,104
Increase in Accounts Receivable		11,600,291
Decrease in Inventories		54,733
Third Party Liabilities Transfer		4,163,019
Investment Income - Trustee Held Assets		1,845,172
Transfer to Reserves - Bond Retirement		2,550,000
Transfer to Reserves - Bond Interest Payable		8,596,226
Total Funds Applied		36,747,545
Operating Cash Made Available from Operations		$ 6,960,434

Current Cash Summary	
Operating Cash	$ 6,960,434
Reserve Cash for Liability to Third Party Payors	14,305,005
Unrealized Appropriation Cash	0
Reserve Cash for Short Term Debt Retirement	2,500,000
Reserve Cash for Bond Interest Payment	4,214,376
	27,979,815
Less Interest Income on Reserves	-6,925,959
Total Current Cash	$21,053,856

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

BALANCE SHEETS

JUNE 30 , 1987 AND JUNE 30, 1986

ASSETS

	6/30/87	6/30/86
CURRENT ASSETS		
Operating Cash	$34,475	$9,475
Reserve Cash- Third Party Payable	14,305,005	10,141,986
Unrealized Appropriation Cash	0	0
Reserve Cash- Short Term Debt	2,500,000	2,500,000
Reserve Cash-Bond Interest Payable	4,214,376	0
Accounts Receivable		
Patient Receivables	72,366,775	55,896,815
Other Receivables	2,018,472	1,813,378
	74,385,247	57,710,193
Less Allowances for Losses in Collection	-5,577,999	-4,710,000
Less Allowances for Discounts to Third Party Payors	-13,623,861	-9,622,191
	55,183,387	43,378,002
Trustee Held Assets	1,020,755	6,549,469
Inventories of Drugs & Supplies	4,863,369	4,670,632
Prepaid Expenses	393,145	1,037,390
Silver Flake	0	138,004
TOTAL CURRENT ASSETS	$82,514,512	$68,424,958
BOARD DESIGNATED ASSETS:		
Board Designated Assets Available for Assignment		
Cash & Investments	$56,443,170	$60,064,655
Accrued Interest	605,020	749,059
	57,048,190	60,813,714
Cash & Investments Assigned to Construction Projects	8,510,966	5,059,360
TOTAL BOARD DESIGNATED ASSETS	$65,559,156	$65,873,074
DEFERRED THIRD PARTY REIMBURSEMENT	$10,172,239	$10,890,571
OTHER ASSETS	258,189	591,161
LAND, BUILDINGS & EQUIPMENT		
Land, Buildings & Improvements	$180,359,060	$174,543,682
Equipment	68,008,620	64,418,269
	248,367,680	238,961,951
Less Accumulated Depreciation	-67,640,664	-55,384,931
	180,727,016	183,577,020
Construction in Progress	7,120,823	7,458,010
TOTAL LAND, BUILDINGS & EQUIPMENT	$187,847,839	$191,035,030
TRUSTEE HELD ASSETS	$51,195,164	$50,143,723
DEFERRED DEBT EXPENSE	$2,023,259	$2,187,659
	$399,570,358	$389,146,176

LIABILITIES AND FUND BALANCES

	6/30/87	6/30/86
CURRENT LIABILITIES		
Accounts Payable	$6,101,515	$3,969,645
Payable to Third Party Contr. Payors	14,305,005	10,141,986
Salaries, Wages and Payroll Taxes	7,080,113	5,405,654
Accrued Vacation	6,706,164	5,957,248
Insurance Premiums Payable	0	0
Accrued Professional Fees and Physician Compensation	1,625,515	2,468,184
Contracts Payable	920,738	2,312,557
Interest Payable	4,263,164	2,407,435
Current Portion of Long-Term Debt	3,796,447	6,155,057
Current Promissory Notes Payable	2,500,000	0
TOTAL CURRENT LIABILITIES	$47,298,661	$38,817,766
LONG-TERM DEBT, LESS CURRENT PORTION	$182,896,903	$185,747,039
UNRESTRICTED FUND BALANCE	$169,374,794	$164,581,371
	$399,570,358	$389,146,176

RESTRICTED ASSETS

Cash and Investments	$4,856,396	$4,243,247

RESTRICTED FUND BALANCES

Fund Balances		
Endowment Funds	$1,846,730	$1,656,445
Gift Funds	3,009,666	2,586,802
	$4,856,396	$4,243,247

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF CHANGES IN FUND BALANCE

FOR THE PERIOD JULY 1, 1986 TO JUNE 30, 1987

	OPERATING FUND	BOARD DESIGNATED FUND	TRUSTEE & PLANT FUND	TOTAL UNRESTRICTED FUNDS
UNRESTRICTED FUNDS				
Beginning Balance	$26,719,221	$60,813,714	$77,048,436	$164,581,371
Net Income				
Excess of Revenue over Expense	6,074,576			
Interest Income on Reserves		6,167,728		
Accrued Interest on Appropriations		758,231		
Depreciation Expense			-16,417,549	
Loss on Disposal of Assets			-161,408	
Interest Expense			2,766,940	
Interest Income on Trustee Held Fund			1,845,172	
Extrordinary Item	-1,134,760			
Total Income				-101,070
Less Expense				
Unrealized Appropriation Revenue	0			0
University Support: G & A	6,122,497			6,122,497
K/E Utilities	138,837			138,837
Transfers Between Funds				
Major Building Projects- Hospital Only	-129,912	-2,309,010	2,438,922	0
Capital Expenditures	-7,391,758	-311,451	7,703,209	0
Capital Encumbrance Change	-249,768		249,768	0
Loan To Ortho Surgery	60,000	-630,000	570,000	0
Major Equipment Requsition	-1,177,146	-69,589	1,246,735	0
Transfer to Trustee- Interest Payment	9,446,804	-9,158,029	-288,772	3
Transfer to Trustee- Principal Payment		-2,470,000	2,470,000	0
Transfer to Reserves- Debt Sinking Fund	-2,550,000	2,550,000		0
Transfer to Reserves- Bond Interest	-4,381,850	4,381,850		0
Year End Closing Transfer	2,675,254	-2,675,254		0
Adjustments to Shared Facilities			-1,416,844	-1,416,844
Unrestricted Donations			50,000	50,000
Ending Balance	$34,221,995	$57,048,190	$78,104,609	$169,374,794
RESTRICTED FUNDS				
Beginning Balance		$2,586,802	$1,656,445	$4,243,247
Income		422,864	190,285	613,149
Ending Balance		$3,009,666	$1,846,730	$4,856,396

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 28, 1987

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period
July 1, 1987 through September 30, 1987

The Hospital's operations through the month of September continued to reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. In addition, we experienced ancillary service utilization that was higher than anticipated. To highlight our position:

Inpatient Census: For the month of September, inpatient admissions totaled 1,602 or 107 above budgeted admissions of 1,495. Our overall average length of stay for the month was 7.5 days. Patient days for September totaled 12,216 and were 422 days under budget. The increase in admission levels is primarily in the area of Surgery.

To recap our year-to-date inpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Admissions	4,752	4,775	5,003	228	4.8
Avg. Lnth. of Stay	8.1	8.3	7.8	.5	6.0
Patient Days	38,883	40,148	39,165	-983	-2.4
Avg. Daily Census	422.6	436.4	425.7	-10.7	-2.5
Percent Occupancy	70.4	75.0	73.1	-1.9	-2.5

Outpatient Census: Clinic visits for the month of September totaled 21,715 or 1,231 (6.0%) above budgeted visits of 20,484. The increase in activity was experienced in most clinic areas with the largest increases occurring in Medicine, Ophthalmology, Surgery, and Dental. The Adult Psych clinic experienced actual visits being less than budget by 304 visits. Community University Health Care Center (CUHCC) visits for the month of September totaled 4,349 or 349 (8.7%) above

budgeted visits of 4,000, while Home Health visits of 776 for the month were 14 (1.8%) above budgeted visits of 762.

To recap our year-to-date outpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Clinic Visits	61,888	64,697	65,554	857	1.3
CUHCC Visits	10,390	12,190	12,852	662	5.4
HHA Visits	2,303	2,336	1,995	-341	-14.6

Financial Operations: The Hospital's Statement of Operations shows total revenues over expense of $1,585,929, a favorable variance of $2,139,228.

Patient care charges through September totaled $65,100,285 and were .5% over budget. Routine revenue was 3.1% under budget and reflected our unfavorable patient day variance. Ancillary revenue was approximately $899,279 (1.9%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,051 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $183 compared to the budgeted average of $184.

Operating expenditures through September totaled $60,902,929 and were approximately $116,600 (0.2%) above budgeted levels. The overall unfavorable variance relates to increased personnel costs (salaries) and patient care related costs (laundry and linen, rental, and medical supplies).

Accounts Receivable: The balance in patient accounts receivable as of September 30, 1987 totaled $79,935,999 and represented 106.95 days of revenue outstanding. The overall increase in our patient receivables in September of .09 days occurred primarily in the BCBSM-PIP, Minnesota Medical Assistance, and Minnesota GAMC categories.

Conclusion: The Hospital's overall operating position is positive and above budgeted levels. Both inpatient and outpatient census levels remain above budget, a trend which continues from the last fiscal year end. We continue to monitor our demand for service closely and make those operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1987 TO SEPTEMBER 30,1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$64,770,266	$65,100,285	$330,019	0.5%
Deductions from Charges	-11,720,268	-9,740,412	1,979,856	16.9%
Other Operating Revenue	1,491,569	1,563,072	71,503	4.8%
Total Operating Revenue	54,541,567	56,922,945	2,381,378	4.4%
Total Expenditures	-60,786,328	-60,902,929	-116,601	-0.2%
Net Operating Revenue	-6,244,761	-3,979,984	2,264,777	0.0%
Non-Operating Revenue and Expenses	5,691,462	5,565,913	-125,549	-2.2%
Revenue over Expense	$-553,299	$1,585,929	$2,139,228	(1)

(1) Variance equals 3.6 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	4,775	5,003	228	4.8%
Patient Days	40,148	39,165	-983	-2.4%
Average Daily Census	436.4	425.7	-10.7	-2.5%
Average Length of Stay	8.3	7.8	0.5	6.0%
Percentage Occupancy	75.0%	73.1%	-1.9	-2.5%
Outpatient Clinic Visits	20,484	21,715	1,231	6.0%

ACCOUNTS RECEIVABLE HIGHLIGHTS
SEPTEMBER 30, 1987

Category	Amount	+ or (-) Prev. Mo.	% Change	+ or (-) 6/30/87	% Change	9/30/87 Days
Total	$78,954,478[a]	$1,207,252	1.55%	$6,704,846	9.28%	106.95
Inhouse	9,580,620[a]	(97,136)	(1.00)%	389,815	4.24%	12.98
DSNFB[b]	- 10,223,990[a]	(286,170)	2.72%	262,179	2.63%	13.85
	- 2,196,336 - four day inpatient hold					
	- 5,029,162 - medical records hold					
	- 2,111,857 - outpatient billing hold					
	- 886,635 - misc. billing holds					
Collections	5,236,810	(125,924)	(2.35)%	(177,015)	(3.27)%	7.09
Follow-up	4,932,412	(91,664)	(1.82)%	(131,936)	(2.61)%	6.68
Net DAR	48,980,646[a]	1,808,146	3.83%	6,361,803	14.93%	66.35

a. These figures are gross amounts or days and do not reflect contractual allowances or discounts. (ie. Net DAR after adjustment would be approximately $38,205,000 or 51.76 days)
b. Discharge not final billed.

Significant Charges

- Increases in the Accounts Receivable were again experienced in the NET DAR (Third Party) with the commercial insurance area increasing $868T. We have moved additional personnel into this area to work both the routine and high dollar accounts. An increase, $655T, was also experienced in the Blue Cross Aware Categories. Blue Cross began an increase of $400T per week in October that should begin to eliminate the first quarters underpayments. Increases of $609T and $272T occurred in the Minnesota Medical Assistance and GAMC programs respectively. We have met with the Dept. of Human Services and are initiating a detailed audit of receivable to resolve some parts of our outstanding problem. DHS is months behind on processing claims and implementing new systems. An increase of $170T was reflected in our industrial compensation area which is not unusual at this time of year ($1.2M was withdrawn from one of our checks.). The Medicare categories increased $143T due to a change in our PIP payment to reflect adjustments in the previous year. A required move to manual outpatient billing may see further increases in this category.

- Significant decreases in receivables during the month were experienced in Out-of-state Blue Cross, $495T; HMO's, $216T; V.A. Hospital, $307T; Agency Pending, $267T (which would shift to third party); External Audits $117T; and County Papers $95T.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 22, 1987

TO: Members, Board of Govenors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Price Comparison Data

When we presented the Hospital's budget to the Board of Regents earlier this year we were asked about the price comparability of services provided at University Hospital compared to other institutions. We indicated at that time that we would follow up with a report to the Regents once the Council of Hospital Corporations (CHC) 1987 Hospital Price Disclosure report was released. We thought it important that the Board of Governors be familiar with the material being shared with the Board of Regents, thus the attached data is provided for information and discussion at the Finance Committee's October meeting. This same information will be discussed with the Board of Regents Finance and Legislative Committee in November.

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

GH/kj

attachment

University Hospital Price Comparison Study

The Board of Regents Finance and Legislative Committee inquired earlier this year about the comparison of charges at University Hospital with other local hospitals. The Council of Hospital Corporations (CHC), a Twin Cities hospital association, recently released hospital price comparison data for the 50 most common reasons for admission (diagnostic related groups, or DRGs) at Twin Cities hospitals in 1986. This data provides information which is helpful in answering price comparison questions.

Table 1 summarizes the "averages" for sixteen hospitals across the fifty DRGs. In this case, 1.000 would be "average". University Hospital's comparison here is 1.169. When educational costs are adjusted out, University Hospital's comparison is 1.062. Thus one can simplistically conclude that University Hospital's charges for these 50 diagnoses are, on the average, 6% - 16% higher than the community.

This conclusion can be deceptive, however, in that it assumes that all diagnostic groups are comparing "apples to apples". This is not always the case. Tables 2, 3, and 4 demonstrate that fact.

Table 2, for pediatric pneumonia cases, shows University Hospital's charges well above the community. Children with pneumonia hospitalized at University Hospital often are post-transplant, have cystic fibrosis, cancer or are otherwise very medically complicated when compared to children with pneumonia at other hospitals. The comparison data is faulty in this case.

Table 3, for major joint procedures, is an example of a homogeneous group of patients, and where University Hospital's charges are very similar to the community average.

Table 4, for transuretheral prostatectomies, is an example of a diagnostic group where University Hospital's charges are lower than the community average, for what appears to be similar kinds of patients.

Table 5 shows comparative data for several very specific tests, procedures, or drugs.

Overall, the study findings can perhaps be summarized as follows:

1. There is a common misperception that charges at University Hospital are substantially in excess of the community average. This is not the case. Looked at in even simplistic terms, University Hospital's charges are, "on the average", higher than the community's by 6% - 16%.

2. A large portion of this higher charge component is a result of differing severity or complexity of cases, even among patients with the same diagnosis. The more complex and severe patients are hospitalized at University Hospital, thus average charges are higher.

3. When similar kinds of patient groups are compared, University Hospital's charges are often similar to or lower than the community average.

4. The charges as shown for the 50 DRGs are also not a true price comparison because most "payors" do not pay full charges. Most payors today have negotiated limits of charges which are always less than full charges. Therefore, these charge comparisons only reflect an individual hospital's gross pricing strategy and do not necessarily reflect what they expect to be paid.

5. The Hospital's medical staff and management must be continually sensitive to the cost issue, and examine in an open manner those areas where our charges appear higher than the community, and should take corrective action where necessary.

TABLE 1

Analysis
Council of Hospital Corporations
1987 Voluntary Price Report

Hospital	Hospital Casemix on System	Adjusted for Education
Abbott Northwestern	1.0644	1.0495
Children's Hospital St. P.	0.9904	
Fairview Riverside	1.1500	1.1300
Fairview Southdale	0.9729	
Hennepin County MC	1.0689	0.9011
Mercy MC	0.9883	
Methodist Hospital	0.7877	
Metropolitan	1.0478	
Midway Hospital	0.8940	
Minneapolis Children's MC	0.9878	
North Memorial MC	0.9902	
St. Joseph's Hospital	1.1512	
St. Mary's Hospital	1.0739	1.0520
St. Paul Ramsey MC	1.0606	0.9864
United Hospitals Inc.	1.0225	1.0072
University of Minnesota	1.1690	1.0615

TABLE 2: DRG 091
SIMPLE PNEUMONIA AND PLEURISY, AGE 0-17

Hospital	Average Charge
UMHC	6,524
Average	2,487
Mpls Childrens	2,732
United	1,690
Fairview Riverside	2,362
North Memorial	1,772
Metropolitan MC	3,845
St. Paul Ramsey	2,966
Hennepin County	1,842

TABLE 3: DRG 209
MAJOR JOINT AND LIMB REATTACHMENT PROCEDURES

Hospital	Average Charge
UMHC	10,321
Average	10,261
Abbott Northwestern	10,424
United	11,621
Fairview Riverside	12,745
North Memorial	10,964
Metropolitan MC	11,484
St. Paul Ramsey	10,297
Hennepin County	11,723

TABLE 4:DRG 336
TRANSURETHRAL PROSTATECTOMY, AGE > 69, AND/OR COMORBIDITY OR COMPLICATIONS

Hospital	Average Charge
UMHC	2,785
Average	3,450
Abbott Northwestern	3,559
United	3,598
Fairview Riverside	3,954
North Memorial	3,456
Metropolitan MC	3,832
St. Paul Ramsey	3,692
Hennepin County	3,961

Table V

UMHC Price Comparison of High Volume Procedures

September 1, 1987

	UMHC	Hospital (1)	Hospital (2)	Hospital (3)
LAB				
Blood Gases, Venous	$ 28.20	$ 39.20	$ 31.00	$ 49.45
Heme Battery/Platelet	28.00	16.35	16.00	42.25*
Glucose Blood	7.90	13.85	12.00	15.45
Prothrombin	11.40	13.95	14.00	17.50
Electrolyte Battery	55.30	32.25	68.00	64.90
Crossmatch	24.80	25.20	35.00	25.75

*Not exactly same test our price close to Hospital No. 3 configuration would be $42.10.

X-RAY				
CT Body with IV and Oral Contrast**	$380.00	$493.00	Not*** Available	Not Available
CT Head without Contrast**	274.10	261.00	$276.00	Not Available

**These prices do not include professional fees.

***Total body not performed.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 19, 1987

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - First Quarter, Fiscal Year 1988

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the first quarter of 1987-88 is $949,327.60, represented by 1,602 accounts. Bad debt recoveries during the period amounted to $7,176.28, leaving a net charge-off of $942,151.32.

The net bad debts of $942,151.32 for the first quarter were 1.45% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($65,100,285).

A statistical summary is attached with a detailed description of losses over $2,000, and recoveries over $200, for each of the month in the first quarter. Additional quarterly reports are also included with a breakdown of bad debts by residence and by admitting clinical service.

attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1987 THROUGH SEPTEMBER 1987

INPATIENT	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	86,430.15	151	259,086.86	32	345,517.01	183
Bad Debt (702) Charity Care	26,857.06	29	86,620.75	11	113,477.81	40
Total	113,287.21	180	345,707.61	43	458,994.82	223
Recoveries	(1,393.54)	16	000.00	0	(1,393.54)	16
Net Total	$ 111,893.67	180*	$ 345,707.61	43*	$ 457,601.28	223*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 4,464.43	14	$ 265,109.49	7	$ 269,573.92	21
Bad Debt (701) Write-Offs	141,851.29	1164	30,308.95	9	172,160.24	1173
Bad Debt (702) Charity Care	38,294.72	179	9,064.90	3	47,359.62	182
Total	184,610.44	1357	304,483.34	19	489,093.78	1376
Recoveries	(3,918.08)	52	000.00	0	(3,918.08)	16
Net Total	$ 180,692.36	1357*	$ 304,483.34	19*	$ 485,175.70	1376*
INPATIENT AND OUTPATIENT TOTAL	$ 292,586.03	1537*	$ 650,190.95	62*	$ 942,776.98	1599*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 1,239.00	3	$ 000.00	0	$ 1,239.00	3
Outpatient (710)	000.00	0	.00	0	000.00	0
Total	1,239.00	3	000.00	0	1,239.00	3
Recoveries	(1,864.66)	2	(000.00)	0	(1,864.66)	2
Net Total	$ (625.66)	3*	$ 000.00	0	$ (625.66)	3*
TOTAL NET BAD DEBT	$ 291,960.37	1540*	$ 650,190.95	62*	$ 942,151.32	1602*

NOTE: More than $2,000 amount includes legal settlements totaling $14,525.36

92 DOLLARS BO[illegible]TED $ 859.468.00

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 198' THROUGH SEPTEMBER 1987

	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	$1,176.58	33	37,978.19	84	47,275.38	34	94,944.21	25	164,142.65	7	345,517.01	183
Bad Debt (702) Charity Care	$72.65	2	$5,170.16	12	$21,614.25	15	$52,190.80	10	$34,439.95	1	$113,477.81	40
Total	$1,249.23	35	$43,148.35	96	$68,889.63	49	$147,135.01	35	$198,582.60	8	$458,994.82	223
Recoveries	($427.62)	12	($965.92)	4	$0.00	0	$0.00	0	0.00	0	($1,393.54)	16
Net Total	$821.61	35 *	$42,182.43	96 *	$68,889.63	49 *	$147,135.01	35 *	$198,582.60	8 *	$457,601.28	223 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$289.70	3	$4,254.73	11	$0.00	0	$17,986.63	4	$247,282.86	3	$269,573.92	21
BAD DEBT (701) WRITE-OFFS	$27,427.04	767	$105,820.36	398	$8,603.89	7	$30,388.95	9	$0.00	0	$172,160.24	1173
Bad Debt (702) Charity Care	$4,824.64	94	$23,699.19	78	$10,570.89	7	$9,864.90	3	$0.00	0	$47,359.62	182
Total	$31,661.38	864	$133,774.28	479	$19,174.78	14	$57,280.48	16	$247,282.86	3	$489,093.78	1376
Recoveries	($1,147.32)	48	($2,770.76)	12	$0.00	0	$0.00	0	$0.00	0	($3,918.08)	16
Net Total	$30,514.06	864 *	$131,003.52	479 *	$19,174.78	14 *	$57,280.48	16 *	$247,282.86	3 *	$485,175.70	1376 *
INPATIENT AND OUTPATIENT TOTAL	$31,335.67	899 *	$173,185.95	575 *	$88,064.41	63 *	$204,485.49	51 *	$445,785.46	11 *	$942,776.98	1599 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$1,239.00	3	$0.00	0	$0.00	0	$0.00	0	$1,239.00	3
Outpatient (710)	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Total	$0.00	0	$1,239.00	3	$0.00	0	$0.00	0	$0.00	0	$1,239.00	3
Recoveries	($64.66)	1	$0.00	0	($1,800.00)	1	$0.00	0	$0.00	0	($1,864.66)	2
Net Total	($64.66)	0 *	$1,239.00	3 *	($1,800.00)	0 *	$0.00	0 *	$0.00	0 *	($625.66)	3 *
TOTAL NET BAD DEBT	$31,271.01	899 *	$174,424.95	578 *	$86,264.41	63 *	$204,485.49	51 *	$445,785.46	11 *	$942,151.32	1602 *
DOLLARS BUDGETED											$859,468.00	

* Net total of accounts do not include recoveries

FIRST QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY STATE

STATE	FIRST QUARTER NUMBER	FIRST QUARTER AMOUNT[1]	TOTAL FSY NUMBER	TOTAL FSY AMOUNT[1]
Alabama				
Alaska				
Arizona	3	384.83	3	384.83
Arkansas				
California	5	1,629.86	5	1,629.86
Colorado	6	284.20	6	284.20
Connecticut	2	374.60	2	374.60
Delaware				
Dist. of Columbia				
Florida	2	517.08	2	517.08
Georgia	2	299.00	2	299.00
Hawaii	1	83.99	1	83.99
Idaho				
Illinois	33	55,769.27	33	55,769.27
Indiana				
Iowa	22	14,409.67	22	14,409.67
Kansas	6	400.12	6	400.12
Kentucky	1	122.90	1	122.90
Louisiana	2	510.13	2	510.13
Maine				
Maryland				
Massachusetts	2	347.07	2	347.07
Michigan	10	10,013.80	10	10,013.80
Minnesota	1339	446,499.77[2]	1339	446,499.77[2]
Mississippi				
Missouri				
Montana	1	2,045.56	1	2,045.56
Nebraska	1	236.34	1	236.34
Nevada				
New Hampshire				
New Jersey	2	556.10	2	556.10
New Mexico	1	2,515.35	1	2,515.35
New York	2	223.21	2	223.21
North Carolina	1	98.23	1	98.23
North Dakota	32	15,172.65	32	15,172.65
Ohio				
Oklahoma				
Oregon	4	1,202.01	4	1,202.01
Pennsylvania	2	215.00	2	215.00
Puerto Rico				
Rhode Island				
South Carolina	1	240.92	1	240.92
South Dakota	30	59,402.55	30	59,402.55
Tennessee				
Texas	10	3,752.62	10	3,752.62
Utah				
Vermont				

FIRST QUARTER FY88
and YTD BAD DEBTS
Page two

STATE	FIRST QUARTER NUMBER	FIRST QUARTER AMOUNT1	TOTAL FSY NUMBER	TOTAL FSY AMOUNT1
Virginia	2	84,824.39	2	84,824.39
Washington	5	664.09	5	664.09
West Virginia				
Wisconsin	47	32,649.71	47	32,649.71
Wyoming				
Out-of-Country	8	128,873.95	8	128,873.95
Unknown	17	85,008.63	17	85,008.63
Total	1602	949,327.60	1602	949,327.60

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

FIRST QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY SERVICE

ADMITTING SERVICE	FIRST QUARTER NUMBER	FIRST QUARTER NUMBER	TOTAL FSY 88 AMOUNT	TOTAL FSY 88 AMOUNT
Anesthesiology				
Clinical Research	1	1,986.81	1	1,986.81
Dentistry	2	1,839.17	2	1,839.17
Dermatology				
Family Practice				
GYN	8	11,588.80	8	11,588.80
GYN-Oncology	5	416.78	5	416.78
Lab Medicine & Pathology				
Medicine-Blue	5	7,654.06	5	7,654.06
Green	7	2,098.77	7	2,098.77
Masonic(onc)	9	51,350.25	9	51,350.25
Purple				
Red A	3	8,593.66	3	8,593.66
Red B				
Rose A	4	2,012.22	4	2,012.22
Rose B				
White A	6	5,644.50	6	5,644.50
White B	4	8,017.32	4	8,017.32
Yellow A	5	20,432.17	5	20,432.17
Yellow B	1	2,229.94	1	2,229.94
Neurology	5	6,054.45	5	6,054.45
Neuro-epilepsy	2	3,031.64	2	3,031.64
Neurosurgery	7	30,318.64	7	30,318.64
New Born-General	4	1,503.53	4	1,503.53
Obstetrics-General	8	10,791.74	8	10,791.74
-Midwife	1	1,756.73	1	1,756.73
Opthalmology	5	3,756.42	5	3,756.42
Orthopaedic Surgery	11	45,115.99	11	45,115.99
Otolaryngology	8	4,464.24	8	4,464.24
Pediatrics-General	20	35,331.58	20	35,331.58
Neurology	1	12,175.23	1	12,175.23
Neurosurgery	2	1,021.80	2	1,021.80
Opthalmology				
Orthopaedics	2	4,635.52	2	4,635.52
Otolaryngology	1	377.78	1	377.78
Surgery Green	2	2,513.42	2	2,513.42
Surgery Orange				
Surg. Transplant				
Urology	4	8,901.05	4	8,901.05
Physical Med. & Rehab.	4	3,745.02	4	3,745.02
Psychiatry-Child				
Adult	8	16,962.10	8	16,962.10
Radiology				
Surgery-Blue	14	85,679.10	14	85,679.10
Orange	4	1,623.34	4	1,623.34
Purple	5	6,088.30	5	6,088.30
Red	4	4,752.80	4	4,752.80
White	16	9,025.70	16	9,025.70
Therapeutic Radiology				
Urology	14	13,730.67	14	13,730.67
Unknown	14	23,012.58	14	23,012.58
Outpatient	1376	489,093.78	1376	489,093.78
Total	1602	949,327.60	1602	949,327.60

2550 University
Avenue West
Suite 221 North
Saint Paul, MN
5 5 1 1 4

MINNESOTA
HOSPITAL
TRUSTEE
XV
CONFERENCE

Creating the New Hospital: Breakthroughs and Breakups!

Minnesota Hospital Trustee Conference XV
Sponsored by:
Metro Hospital Trustee Council

Gordon M. Donhowe
Gordon Donhowe is executive vice president and chief operating officer of Fairview. Prior to joining Fairview in 1985, he was commissioner of finance for the State of Minnesota. Mr. Donhowe serves on numerous boards including the Citizens League, Hospital Education and Research Foundation, Twin Cities Public Television and Fairview Foundation.

Raymond G. Christensen, M.D.
Raymond Christensen, M.D. is a physician at Gateway Family Health Clinic, Limited in Moose Lake. He is president and co-founder of Northern Lakes Health Care Consortium and Northeast Minnesota Emergency Medical Systems Association. Dr. Christensen has memberships in a number of organizations including the National Rural Health Association, American Medical Association and Minnesota Medical Association.

Robert O. Mulhausen, M.D.
Robert Mulhausen, M.D. is chief of medicine at St. Paul-Ramsey Medical Center and Ramsey Clinic. He is a professor of medicine at the University of Minnesota and is chairman of the board, Minnesota Association of Public Teaching Hospitals. He is also a member of the board of Ramsey Clinic.

Conference Committee Members
Robert E. Christenson, Chairman
Vernon Hoium
Geoffrey Kaufmann
Barbara Klemme
LuVerne Molberg
Pat Pardun, Coordinator

General Information

Who Should Attend: The Conference is recommended to all trustees, physicians, chief executive officers, and key hospital administrative staff. Community leaders representing health public policy, government, planning, business, labor, third party payers, health professionals and health service organizations are also welcome to attend.

Registration Fee: $95.00 for the first registration and $75.00 for each additional registration from the same institution. Fee includes continental breakfast, luncheon, coffee breaks and conference materials. This fee is refundable in case of cancellation up to 5 working days prior to the conference. Substitutions may be made anytime.

Hotel: Sheraton Park Place Hotel, Highway 12 and Vernon, St. Louis Park, (612) 542-8600. The conference rate for overnight accommodations is $64.00 single or double occupancy. For reservations, call the hotel and indicate you are with the Minnesota Hospital Trustee Conference.

Clock Hours: Nursing Home Administrators — five clock hours have been applied for.

For Further Information:
Pat Pardun
Conference Coordinator
Minnesota Hospital Trustee Conference
2550 University Avenue West, Suite 221 North
St. Paul, Minnesota 55114
(612) 641-1121

Creating the New Hospital: Breakthroughs and Breakups!

Friday, November 13, 1987

CUT HERE

Please contact Kay Fuecker in the Board Office at 626-0166
if you are interested in attending this conference.

Program

8:00 A.M. Registration & Continental Breakfast

8:30 A.M. Welcome
J. Stanley Hill, Co-President, Metro Hospital Trustee Council, Presiding Host, Minnesota Hospital Trustee Conference XV

8:45 A.M. Creating the New Age Hospital: Breakthroughs & Breakups Anticipation — Innovation — Motivation
Joel A. Barker, President Infinity Limited, Inc.

9:30 A.M. Refreshments

Experiences in Creating the New Age Hospital: Perspectives From Governance — Management — Medical Staff

Moderator: **Robert B. McDonald**, Director Health Care Management Advisory Services Deloitte Haskins & Sells

9:45 A.M. Governance Perspective
Howard Winholtz
Board of Directors
Queen of Peace Hospital, New Prague

Connie Weinman
Board of Trustees
Fairview, Minneapolis

10:45 A.M. Management Perspective
Clayton Peterson
Chief Executive Officer
Memorial Hospital, Cambridge

Gordon Donhowe
Chief Operating Officer
Fairview, Minneapolis

12:00 Noon Lunch

1:00 P.M. Medical Staff Perspective
Raymond Christensen, M.D.
Physician
Gateway Family Health Clinic
Moose Lake

Robert O. Mulhausen, M.D.
Physician
St. Paul-Ramsey Medical Center
St. Paul

2:00 P.M. Round Table Discussions

3:15 P.M. Refreshments

3:30 P.M. Translating Vision into Action
Congressman Richard Gephardt
(D-Missouri) — Invited

4:30 P.M. Reception
Hosted by the Council of Hospital Corporations

Speakers

Joel Arthur Barker
Joel Barker is president of Infinity Limited, Inc., an internationally known consulting firm that invented the concept of *strategic exploration*. Mr. Barker is especially known for one particular presentation on the Power of Paradigms. It is from this lecture that he drew the information and examples on which his first book is based. His book, Discovering the Future: the Business of Paradigms, helps explain how revolutionary change occurs.
Mr. Barker has worked with long range planners and top executives of major world corporations and government agencies.

Robert B. McDonald
Robert McDonald is director, Health Care Management Advisory Services at Deloitte Haskins & Sells and is a member of the Health Care Industry Group. Mr. McDonald's past health care positions have included serving as administrator, director of a large information systems function, management engineer, productivity consultant, and director of material mangement.

Howard M. Winholtz
Howard Winholtz is a member of the board of directors of Queen of Peace Hospital in New Prague. He is dean and instructor at Saint Mary's College in Rochester.
Mr. Winholtz was on the administrative staff of Rochester Methodist Hospital for 28 years, the last 17 years as president and CEO.

Connie G. Weinman
Connie Weinman is a member of the board of trustees of Fairview Riverside Hospital and Fairview Corporation. She is vice president and manager of the Corporate Trust Department at National City Bank of Minneapolis. She is treasurer of the Minnesota Women's Economic Roundtable and on the board of trustees of the Minnesota Counsel on Economic Education.

Clayton R. Peterson
Clayton Peterson is chief executive officer and president of Memorial Hospital in Cambridge. Previously, he was with Immanuel Medical Center in Omaha, Nebraska.
Mr. Peterson is chair-elect of the Minnesota Hospital Association and is also active on the Cambridge Community College Advisory Board.

MINNESOTA
HOSPITAL
TRUSTEE
XV
CONFERENCE

Friday, November 13, 1987

Creating the New Hospital: Breakthroughs and Breakups!

This conference will focus on the hard realities of the tough problems being faced by hospitals today. It will describe various options and models for action successfully used by Minnesota hospitals. Questions to be addressed include:

Is it truly worth it to ensure the survival of the traditional community hospital model?

What alternatives to closure are realistically viable?

What limitations/possibilities must be considered in using existing hospital buildings?

How do we cope with long-term capital debt and deployment of personnel when considering role changes/mergers/closures?

What is the critical path to survival: shrinkage? specialization? linkages? other???

Sheraton Park Place Hotel
5555 Wayzata Boulevard
Minneapolis

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUARTERLY REPORT TO THE REGENTS

SEPTEMBER 11, 1987

INTRODUCTION

Chairman Lebedoff, President Keller, members of the Board of Regents, I am pleased to briefly highlight activities at The University of Minnesota Hospital and Clinic during the summer months of 1987.

UTILIZATION LEVELS

June 30, 1987 marked the end of a busy fiscal year. In fact, the 1986-87 fiscal year represented an interruption to what had been a five year long trend of declining inpatient utilization.

The University of Minnesota Hospital and Clinic
Utilization Levels

Fiscal Years 1980-81 - 1986-87

	'81	'82	'83	'84	'85	'86	'87
Admissions	21,388	20,454	20,991	19,987	18,049	17,694	19,169
Days of Hospital Care	200,465	196,264	198,965	181,794	155,029	145,697	154,282
Average Daily Census	549.2	537.7	545.5	498.1	424.7	399.2	422.7

We believe that this recent growth is, at least in part, attributable to the following factors: a new hospital building, physician recruitment, the

availability of new technologies, attention toward the service elements of care, strengthened relationships with some referring physicians and our advertising efforts. While we recognize this growth as an accomplishment, we also recognize that the challenges of our Twin Cities marketplace and of the health care industry will continue to be significant.

OUR AIDS PATIENTS

Given our recent coverage in the local media, you are likely aware that we are caring for patients infected by the human immunodeficiency virus, the virus that causes acquired immunodeficiency syndrome (AIDS). We believe that as a teaching and research center it is appropriate and necessary that we care for AIDS patients and contribute to a better understanding of the virus through research.

The University of Minnesota Hospital and Clinic is, on average, caring for three inpatients and fifteen outpatients with AIDS. There are currently about seventy-five people who are infected by the virus participating in research protocols through our National Institutes of Health funded AIDS Treatment Evaluation Unit. Almost two thirds of these participants are asymptomatic.

The care of this patient population gives rise to new questions of patient confidentiality, infection control protocol and employee education. Last spring we appointed a multi-disciplinary group, chaired by Dr. Paul Quie, to address these and other issues in a way that safeguards the needs of the patients, the safety of our employees, the abilities of our medical staff and the values of our community.

IMAGE STUDY

In June, Project Research, Inc., a local marketing firm, completed an image study of metro area hospitals. One thousand calls were made to people who proportionately represented the general population.

The University of Minnesota Hospital and Clinic was viewed very positively by respondents. We were rated as having the best overall reputation among hospitals in the metropolitan area. We are reportedly known as the local leader for specialized care, range of services offered, availability of modern technology and for quality of physicians. Several clinical specialties were rated as being leaders in the community. They included eye care, cancer care, cardiovascular care and orthopedics. We were also rated very highly for our critical care and rehabilitation services. We were ranked as being above average for friendliness and convenience.

PRIMARY CARE NETWORK

As you know, the Health Partners health maintenance organization was placed in a "rehabilitation" status on July 31, 1987. This outcome obviously does not meet our original hopes and expectations. The concluding phase of our participation with Health Partners involved careful monitoring by the Board of Governors. The end results of these events remain uncertain.

BOARD OF GOVERNORS RETREAT

The annual retreat of the Board of Governors is scheduled for September 17 and 18, 1987. We will be discussing multi-hospital affiliations, local and