UNIVERSITY OF MINNESOTA
TWIN CITIES

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

CANCELLATION NOTICE

The November, 1987 Board of Governors meeting was cancelled because of attendance problems.

Nancy C. Janda
Secretary
Board of Governors

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

DECEMBER 16, 1987

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****SEPARATE BOARD ATTACHMENT****

Community University Health Care Center Proposal

**** OTHER ATTACHMENTS ***

"Park Nicollet, HMO Head for Showdown", Star Tribune, October 26, 1987
"U Hospital 'Profits' on Loss of Income", Minnesota Daily, October 30, 1987
"Nancy Ascher, M.D.: On The Frontiers of Medicine", MS Magazine, November, 1987
"Hospital Withdraws Special Aware gold Deal for U Employees", Minnesota Daily, November 4, 1987

"Survey: U Hospital Often More Costly", Minnesota Daily, November 4, 1987
"Burke to Give up Control of HMO", Star & Tribune, November 4, 1987
"Average Stay in Area Hospitals Shorter in 1986", Star Tribune, November 25, 1987
"Can Small Insurer Live Up to Big Promises to Hennepin County?", City Business, November 18, 1987
"Hospital Officials Facing Crisis in Care of the Poor", St. Paul Pioneer Press Dispatch, December 10, 1987
Board of Governors Report to the Board of Regents, December 11, 1987
"What Trustees Need to Know About HCFA Mortality Data", AHA Liaison Trustee Briefing Paper

The University of Minnesota Hospital and Clinic
Board of Governors
December 16, 1987
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of October 28, 1987 Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Special Presentation: Applied Research - Dr. Frank Cerra	Information
IV.	Committee Reports	
	A. Planning and Development Committee - Ms. Kris Johnson	
	1. Quarterly Purchasing Report	Approval
	B. Joint Conference Committee - Mr. George Heenan	
	C. Finance Committee - Mr. Robert Nickoloff	
	1. October 30, 1987 Year-to-Date Financial Statements	Information
	2. Magnetic Resonance Imaging Unit II	Approval
	3. CUHCC Building Proposal	Endorsement
V.	Other Business	
VI.	Adjournment to Holiday Reception	

PLEASE NOTE: The holiday reception will begin immediately following the Board of Governors meeting in the 5th Floor Library, Campus Club.

Minutes

Board of Governors

The University of Minnesota Hospital and Clinic

October 28, 1987

CALL TO ORDER:

Chairman Robert Latz called the October 28, 1987 meeting of the Board of Governors to order at 2:38 P.M. in 555 Diehl Hall.

ATTENDANCE:

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

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the August 26, 1987 meeting as written.

CHAIRMAN'S REPORT:

Chairman Latz introduced Ms. Dee Lutz and Ms. Dori Carlson of the Minnesota Daily, and Ms. Jan Brockway, Director of the Quality Assurance Department.

October 1, 1987, Chairman Latz noted, Dr. Neal Vanselow assumed a one-year term as the Chairman of the Board of Directors of the Association of Academic Health Centers. The AAHC is an educational association representing American and Canadian academic health centers based in Washington, D.C.

The November and December Board meetings, Mr. Latz announced, will be held on the third rather than fourth Wednesdays to avoid holiday conflicts.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler briefly summarized the hospital's recent census statistics, noting that UMHC utilization is varying favorably from budget through the first quarter of 1987-88.

The Joint Commission on Accreditation of Healthcare Organizations will be at UMHC to conduct a site visit on November 11, 12 and 13, 1987. Two meetings will be of interest to Board members: the Governing and Management Conference on Friday, November 13 from 12:30 - 2:30 P.M., and the full summation conference scheduled on Friday, November 13 from 3:15 - 5:00 P.M. More specific information will be forwarded to Board members by mail.

Mr. Dickler and the members of the Board of Governors commended Mr. Greg Hart for a job well done as Interim Director.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Mr. Al Dees and Dr. Christopher Kuni, Assistant Professor of Radiology, discussed with the Board the currently available Magnetic Resonance Imaging services and the proposal to purchase a second MRI. Radiology currently staffs 2 full-time shifts five days per week and one shift on Saturday. It is estimated that 10-12 procedures are referred elsewhere each week due to lack of MRI time. The Radiology Department proposes the purchase of a 2.0 Tesla Magnetic Resonance Imaging machine. This machine would be used primarily for magnetic resonance imaging, but would be used for spectroscopy as well. In addition to the capital acquisition, the proposal includes expanding the current MRI suite by 1,000 square feet, and the addition of 3.0 FTE radiological technologists and 1.0 FTE secretary. The total estimated cost for acquisition and installment is $3,600,000, specified as follows: $2,473,867 for equipment; $290,000 for shielding; $171,000 for equipment access, $66,000 for air conditioning; $132,000 for architectural fees; and $468,000 for actual construction.

Mr. Dees noted that the proposal was being brought to the Board of Governors for information only. It will be discussed at the November Planning and Development and Finance Committees for endorsement. Board approval will be sought at the November, 1987 meeting.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan requested that the Board approve the Credentials Reports included in the Board packet that had been endorsed by the Credentials Committee/Medical-Staff Hospital Council on July 10 and September 3, 1987 and the Joint Conference Committee on September 9, 1987. The Board seconded and passed a motion to approve the Credentials report as submitted.

Mr. Heenan also reported that the Joint Conference Committee had discussed the proposed revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff in detail. The proposed changes to the Bylaws included: delete the statement exempting the licensure requirement as licensure is a JCAH requirement; addition of a statement detailing the procedure for initial clinical privileges; revision of the procedure for reappraisal and reappointment; addition of summary suspension of clinical privileges; and defining the reappraisal procedure for individuals on or returning from a leave of absence.

The Committee, Mr. Heenan reported, also endorsed the following proposed changes to the Rules and Regulations of the Medical and Dental Staff: delete utilization review documentation of conduct of patient care; change the requirement to allow verbal orders to pharmacy and cardiorespiratory; changes in pediatric holds as required by Minnesota Statute; process to determine brain death; and change wording of requirement for reporting cases of battered women.

The Board seconded and passed a motion to approve the revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff as presented.

Lastly, Mr. Heenan briefly detailed the history of the Quality Assurance/Utilization Review Plan as approved by the medical staff's Quality Assurance Steering Committee, the Medical Staff-Hospital Council, and the Joint Conference Committee. Mr. Heenan reported that each clinical department is sent a quarterly report containing complications information. The departments use these reports to identify trends and recommend action where appropriate. The Medical Staff-Hospital Council has a new subcommittee, the Quality Assurance Steering Committee, that is responsible for oversight of these functions.

The Board seconded and passed a motion to approve the Quality Assurance/Utilization Review Plan as recommended by the Joint Conference Committee.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reviewed operations for the period July 1, 1986 through June 30, 1987. Admissions totalled 19,169 compared to 17,694 for the previous year, an increase of 8.3%. Patient days for the year totalled 154,282, up by 8,585 (5.9%) from 145,697 days in 1985-86. The average length of stay declined from 8.3 to 8.1 days in 1986-87. The outpatient visits increased from 224,446 to 248,137, representing a 10.6% increase over 1985-86 and an 11.5% increase over 1986-87 estimates. Revenues for the year were 19.5% over budget while total expenditures were 9.3% over budget. Deductions from charges went over budget with the increased utilization levels and non-operating revenue did not meet expectations, due primarily to the loss in equity position of PCN together with our share of outstanding liabilities in the form of loan guarantees. In sum, we had budgeted a negative $11 million bottom line and just about broke even.

Mr. Fearing reported the total amount recommended for bad debts for the first quarter of 1987-88 is $949,327.60 representing 1,602 accounts. Recoveries during the period amounted to $7,176.28, leaving a net charge-off of $942,151.32. This amount is 1.45% of gross charges compared to a budgeted level of 1.33%.

The Board of Governors seconded and passed a motion to approve a net bad debt charge-off in the amount of $942,151.32 for the first quarter of 1987-88 as submitted.

Mr. Greg Hart reviewed the Price Comparison Data from the Council of Hospital Corporations (CHC) 1987 Hospital Price Disclosure report. This report attempts to take takes similar groups of cases and collects charge information for those cases. Mr. Hart reviewed our interpretations of the report. First, UMHC is somewhere between 6-16% more expensive than the community average. The low end estimate assumes an adjustment for educational costs. Secondly, the study assumes that homogeneous groups of patients are being compared. We believe this to be an erroneous assumption. Mr. Hart exhibited a lack of homogeneity through example. Thirdly, Mr. Hart noted that charges are not the most reliable basis for comparison, as most payors negotiate something less than charges. Lastly, Mr. Hart did acknowledge that the Price Disclosure report represents a reminder for our hospital and medical staff that we do function in a price sensitive marketplace and that charges that appear to deviate significantly from the norm warrant review.

OTHER BUSINESS:

Ms. Barbara O'Grady reminded the Board members of the Minnesota Hospital Trustee Conference to be held Friday, November 13, 1987 at the St. Paul Radisson. This occurs the same day as the Joint Commission site survey.

ADJOURNMENT:

There being no further business, the October 28, 1987 meeting of the Board of Governors was adjourned at 4:05 P.M.

Respectfully submitted,

Kay F. Fuecker
Secretary
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 10, 1987

TO: Members of the Board of Governors

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

Dr. Frank Cerra, Professor of Surgery, has agreed to speak to the Board of Governors on December 16, 1987. Dr. Cerra is the Director of our Surgical Intensive Care Unit and Director of the Nutritional Support Services. He will be speaking to the Board of Governors about applied research. A complete biographical sketch of Dr. Cerra is attached.

This presentation is another in a series of presentations that have been scheduled per the January, 1987 Board request that speakers who can broaden or enhance familiarity with current issues be engaged.

I will see you on Wednesday, December 16th at 2:30 P.M.

NCJ/kff

Attachment

CURRICULUM VITAE

FRANK B. CERRA, M.D.

PROFESSOR OF SURGERY
UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
BOX 42 MAYO - 420 DELAWARE ST. S.E.
MINNEAPOLIS, MINNESOTA 55455
(612) 373-7733

BORN:	February 13, 1943 - Oneonta, New York
SOCIAL SECURITY #:	
NATIONALITY:	United States Citizen
MARRIED:	Kathie Krieger Cerra
CHILDREN:	Josh, 10/26/71 Christa, 12/25/72 Nicole, 12/5/79
HOME ADDRESS:	4522 Arden Avenue South Edina, Minnesota 55427
CURRENT POSITION:	Professor of Surgery University of Minnesota Director, Surgical Critical Care, Nutrition and Metabolism Director, Nutrition Support Services University of Minnesota Hospitals and St. Paul Ramsey Medical Center Graduate School Faculty, University of Minnesota, 1982 - Staff Surgeon, University Hospitals and St. Paul Ramsey Medical Center

EDUCATION

State University of New York at Binghamton, B.A., Major Biology	1961 - 1965
Northwestern University School of Medicine, M.D.	1965 - 1969

TRAINING

Research Assistant in Pharmacology, Upstate Medical Center, Dr. Samuel Mallov	1963 - 1964
Research Assistant in Surgery, Northwestern University, Dr. John Bergan	1967 - 1969
Surgical Internship and Residency, Buffalo General Hospital, State University of New York at Buffalo	1969 - 1974
Cardiovascular Fellow with Dr. DeBakey, Texas Medical Center January - April	1972
Chief Residency in Surgery, Buffalo General Hospital, State University of New York at Buffalo	1974 - 1975
Research Associate in Immunology and Cardiovascular Research Laboratories, Buffalo General Hospital, State University of New York at Buffalo	1972 - 1973 1974 - 1975

FELLOWSHIPS AND AWARDS

Clark Foundation Fellowship, Competitive Support for Medical School	1965 - 1969
United Health Foundation Research Training Grant - Immunology and Cardiovascular Research	1972 - 1973 1974 - 1975
ACS Original Research Resident Award	1973, 1974
Diplomat, American Board of Surgery	1976
Fellow, American College of Surgeons	1978
C.P. Chandra Annual Outstanding Teacher Award, Department of Surgery, Buffalo General Hospital	1981
Owen Wangensteen Award for Academic Excellence in Teaching, University of Minnesota Hospitals	1983 - 1984

PRIOR UNIVERSITY APPOINTMENTS

Clinical Assistant Instructor of Surgery, State University of New York at Buffalo	1969 - 1975
Assistant Professor of Surgery, State University of New York at Buffalo	1975 - 1980

Associate Professor of Surgery, State University of New York at Buffalo	1980
Associate Professor of Biophysics, State University of New York at Buffalo	1981

PRIOR HOSPITAL APPOINTMENTS

Attending Staff, Buffalo Veterans Administration Medical Center	1975 - 1977
Reinstated	1980
Attending Staff, Buffalo General Hospital	1975
Director of Organ Preservation Unit of the Buffalo General Hospital	1975
Associate Director, Intensive Care Unit, Buffalo General Hospital	1975
Assistant Surgeon, Department of Surgery, Buffalo General Hospital	1977
Associate Director of Dialysis and Transplant Service, State University of New York at Buffalo and the Buffalo General Hospital	1977
Director, Division of Clinical Nutrition and Metabolism, Buffalo General Hospital	1980
Attending Staff, Erie County Medical Center	1980 - 1981
Associate Surgeon, Department of Surgery, Buffalo General Hospital	1980

CURRENT SOCIETIES

Diplomat of National Board of Medical Examiners	1970 -
American Medical Association	1978 -
American Board of Surgery	1977 -
Stress and Trauma Club of Harvard Medical School	1975 -
Society of Parenteral Alimentation	1978 -
Society for Surgery of the Alimentary Tract	1981 -
American Society of Parenteral and Enteral Nutrition	1978 -
Board of Directors Society Parenteral and Enteral Nutrition	1985 - 86
Society of Critical Care Medicine	1977 -
Executive Council, Society of Critical Care Medicine	
President, Surgical Section, Society of Critical Care Medicine	1983 - 1984
American Association for the Advancement of Science	1977 -

Association for Academic Surgery	1979 -
Association Internationale des Anesthesistes-Reanimateurs D'Expression	1977 -
Society of University Surgeons	1979 -
Executive Council Member - Councilman-at-Large for the Society of University Surgeons	1984 -
Central Surgical Association	1978 -
American Association for the Surgery of Trauma	1978 -
Roswell Park Medical Club	1981 -
Association for Surgical Education	1982 -
American College of Surgeons Pre- and Postoperative Care Committee	1981 -
Chairman - Pre- and Postoperative Care Committee	1985 - 1987
American College of Nutrition	1982 -
Society of Critical Care Medicine Surgical Liaison Committee	1982 -
Saint Paul Surgical Society	1983 -
Surgical Biology Club	1983 -
Shock Society	1984 -
American College of Surgeons - Executive Committee	1984 -
American Institute of Biological Sciences	1986 -
Society International of Surgery	1987 -

UNIVERSITY COMMITTEES

Curriculum Self-Study Subcommittee	1982 -
Graduate Faculty	1982 -
Graduate Studies Committee	1982 -
Minnesota Medical Foundation - Research Grant Committee	1982 -
Phase D Dean's Committee	1983 -
Self-Study for the Liason Committee on Medical Education	1982 -
Chairman - Dean's Committee on Nutrition Program Development	1985 -

HOSPITAL COMMITTEES

Pharmacy & Therapeutics Committee	1982 -
Parenteral Nutrition Subcommittee of the Pharmacy & Therapeutics Committee	1984 -
Cardio-Respiratory Advisory Committee	1982 -
Emergency Room Committee	1982 -
Tranfusion Therapeutics Committee	1982 -
Biomedical Ethics Committee	1982 -
Cardio-Respiratory Advisory Committee's Patient Monitoring Sub-Committee	1982 -
Research Committee - St. Paul Ramsey Medical Center	1982 -
Institutional Review Board - St. Paul Ramsey Medical Center	1982 - 1984
Liver Transplant Committee	1982 -
Course Director's Group for Years 3 & 4 of the Medical Curriculum	1983 -
Discharge Planning and Home Care Task Force	1984 -
Institute for Basic and Applied Research in Surgery - Board of Directors	1984 -
Pharmacy Formulary Task Review for Nutritional Products	1984 - 1985
Planning and Development Committee of the Board of Governors	1985 -

COMMUNITY SERVICES

Foundation for Health Care Evaluation - Acute Care Committee	1983 -

EDITORIAL BOARDS

Drug Intelligence & Clinical Pharmacy Panel on Critical Care	1982 - 1987
Nutrition Support Service Journal	1982 -
Critical Care Medicine	1983 -
Journal International Nutrition	1985
Circulatory Shock	1987 -
Journal of Parenteral and Enteral Nutrition	1987 -

FELLOW AWARDS

1. Thomas Stahl, M.D.
   "Cardiac Function in Starvation and Sepsis"
   NRSA # 1F32 HL07327-01

2. John Mazuski, M.D.
   "Effects of Interleukin-1 and other mediators on hepatic serum amyloid A synthesis in mice"
   Surgical Infection Society

EDUCATIONAL COMMITMENTS

1. Course Director
   a) Surgery 5-500 Basic Surgery
   b) Nutrition Elective for 4th Year Medical Students
   c) Critical Care Elective

2. Surgical Nutrition/Metabolism and Critical Care
   a) 2 Postdoctoral Fellows Yearly Since 1983

3. Laboratory Fellows
   a) John Mazuski, M.D., Ph.D. Candidate in Biochemistry; Co-Sponsor with Dr. Howard Towle
      Project: Molecular Biology of Serum Amyloid A Synthesis in Cultured Hepatocytes

   b) Steven Eyer, M.D., Ph.D. Candidate in Physiology with Dr. Gumm
      Project: Relationship of Hepatic Blood Flow to Region Hepatic Metabolism in an Awake Canine Model

   c) Paul Banke, M.D., Ph.D. Candidate in Physiology with Dr. Lee
      Project: Mechanisms of Activation of Cultured Macrophages

MINUTES
Planning and Development Committee
November 6, 1987

CALL TO ORDER
Committee Chairman, Ms. B. Kristine Johnson, called the November 6, 1987 meeting of the Planning and Development Committee to order at 1:01 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Robert Dickler S. Albert Hanser Clint Hewitt William Jacott, M.D. Geoff Kaufmann Ted Thompson, M.D.
	Absent	Leonard Bienias Peter Lynch, M.D.
	Staff	Fred Bertschinger Al Dees Steve Grygar Greg Hart Nancy Janda Mark Koenig John LaBree, M.D. Lisa McDonald
	Guests	David Coombes Alice Negratti Bruce Work, M.D.

APPROVAL OF MINUTES
The minutes of the October 13, 1987 meeting were approved as distributed.

MAGNETIC RESONANCE IMAGING PROPOSAL
Mr. Dees reviewed the financial implications of purchasing a computerized MRI unit with a 2.0 Tesla (20 Kilogus) magnet. The cost of purchasing and installing the MRI remains at $3,600,000 with a shift in equipment and construction costs. The payback period is expected to be between 2.6 and 4 years depending on the percentage of time the MRI is used for spectroscopy and chemical shift analysis versus imaging. Dr. Thompson felt that there would not be any problems keeping the MRI full given current capacity problems and emerging technologies. His only concern was that there would be enough time for research.

Ms. Johnson asked about the impact of Medicare and other third party reimbursement policies. Mr. Grygar responded that the analysis was based on the current customer profile which is balanced by the mix of inpatients and outpatients.

Mr. Hanser moved that the committee endorse the purchase of the MRI. The vote for approval was unanimous.

DEVELOPMENT ACTIVITIES AND DONATIONS SUMMARY

Mr. Bertschinger reported on 1986/87 donations of $693,595 as well as the activities (Soiree '87, Sigma Chi Derby Days, new annual giving materials, Minnesota Campaign Gala, Commodore Chorus Recognition Luncheon and New Patients Fund solicitation program for friends and former patients) which contributed to the increased donations.

First quarter 1987/88 donations of cash and bequests were $186,999. Major activities to date have been the UMHC Turtle Derby and the Bedpan League/WCCO All Stars charity softball game. Based on performance to date, Mr. Bertschinger expects to meet the annual goal of $800,000. He also reported that the UMHC Patients Fund Solicitation of Employees will shift to spring because of less competition from other fund drives.

QUARTERLY PURCHASING REPORT

Mr. Koenig detailed first quarter purchasing activity of $12,830,250 in purchase and confirming orders which were comparable to last year except for the purchase of the new computer. Purchase awards to other than low bidder of $5,000 or more were reviewed. Many of the low bid items did not meet specifications or were not compatible with existing equipment. Sole source awards totaled $333,682 and there was $104,068 in set aside awards. There were two vendor appeals which were appropriately rejected after careful study. Finally, University Hospital Consortium (UHC) activity generated $19,114 in savings during the first quarter. The majority of savings from UHC will not be realized until the end of the year when volume rebates are calculated.

The quarterly purchasing report was endorsed by the Planning and Development Committee.

DEPARTMENT OF OBSTETRICS GROWTH STRATEGY

Bruce Work, M.D. Professor and Head of the Department of Obstetrics and Gynecology, presented an internal and external analysis of the obstetrics market in the state and seven county metro area. Dr. Work detailed the objectives and strategies he will pursue to increase deliveries from 469 to 1,000 annually. The key objectives are to: 1) expand physician referrals and encourage UMHC delivery by clinical faculty, 2) expand and maintain relationships to serve low income populations, 3) add medical staff on a non-tenure track, 4) increase OB/Gyn clinic patient visits by 20%, 5) develop and expand relationships with current HMO providers, and 6) develop targeted provider relationships.

Dr. Work then summarized the marketing, facility and projected volume review that the hospital is conducting. Dr. Work also asked the group to consider the positive effect that improved services to women has on the teaching, research and patient care missions.

Mr. Dickler thanked Dr. Work for his presentation and discussed UMHC's review process and said that a decision regarding the character of UMHC-based obstetrical services would be made by first quarter 1988.

UMCA UPDATE

Mr. Coombes informed the group that 60% of University of Minnesota Clinical Associate's (UMCA) $600,000 1[illegible] budget was subsidized by the departments and that next year's budget of $8[illegible].000 will require a 30% subsidy. This year the departments will be assessed based on the volume generated through UMCA. Mr. Coombes also commented on their $500,000 debt to the hospital because of PCN's failure and UMCA's commitment to repay those funds.

Mr. Coombes reported that significant progress has been made with Share, PHP, and MedCenters while the relationship with Group Health needs to be improved. He also mentioned that there has been increased interest from national groups and that the Marshfield Clinic agreement has been signed.

Mr. Coombes concluded that the home alimentation joint venture has captured 50% (25) of UMHC eligible patients and that this program will likely extend services to community physicians.

OTHER BUSINESS

1. Mr. Dickler informed the committee that the Community University Health Care Center (CUHCC) is exploring other options since the Mt. Sinai option does not seem viable.

2. Mr. Dickler reported that UMHC has been forced to rescind the deductible waiver for University employees who use Blue Cross and Blue Shield and will be exploring other options to facilitate University employees using UMHC.

3. UMHC's census continues to hold up with increased pressure on the ICUs. Mr. Dickler reported that ICU volume is expected to continue to increase. Therefore, the third floor of Masonic will be renovated for cancer patients in order to free up space in Unit J. The project is scheduled to be completed in a year.

ADJOURNMENT

The Planning and Development Committee adjourned at 1:40 p.m.

Respectfully submitted,

Lisa G McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

MINUTES
Planning and Development Committee
December 3, 1987

CALL TO ORDER
Acting Committee Chairman, S. Albert Hanser, called the December 3, 1987 meeting of the Planning and Development Committee to order at 12:00 noon in Room 8-106 in the University Hospital.

Attendance:	Present	S. Albert Hanser, Acting Chair Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D. Geoff Kaufmann Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	B. Kristine Johnson
	Staff	Cliff Fearing Greg Hart Nancy Janda Mark Koenig John LaBree, M.D. Lisa McDonald Mary Ellen Wells
	Guests	Amos Dienard, M.D. Sue Webber

APPROVAL OF MINUTES
The minutes of the November 6, 1987 meeting were approved as distributed.

STRATEGIC PLANNING COORDINATING COMMITTEE UPDATE
Mr. Dickler reviewed the composition of the Strategic Planning Coordinating Committee and gave an update on the last meeting which focused on the psychiatric facilities. The committee has decided that remodeling the 5th floor is the least attractive option. Therefore they are looking at 1) an expanded Mayo model, 2) a multipurpose facility that would include psychiatry, or 3) a freestanding option.

Mr. Dickler stated that the committee's current focus is to assess UMHC's facility needs for the next 10-15 years. Drs. Chou and Moller will be working with the administrative staff to develop the long-term facility plan. After an internal review the results will be presented to the Planning and Development Committee with updates in the interim.

Ambulatory care will be the focus of the next strategic planning meeting.

CAPITAL PROJECT UPDATE

Mr. Koenig briefed the committee on two projects: 1) the renovation of the surgical pathological suite and 2) the remodeling of the third floor of Masonic for additional nursing beds.

The renovation of the surgical pathological suite in Mayo is planned to be 4,300 square feet of usable space. Preliminary costs for the lab and offices are $800- $900 thousand. The tentative location is 4th floor Mayo adjacent to Unit J. The project is scheduled to begin the first of 1988.

The second project is the remodeling of the 3rd floor of Masonic. This project is not connected with the Mayo renovation and grew out of the need to alleviate the bed shortage from increased intensive care usage. The proposed budget is $1.1 million and the expenses may be partially offset by the Masonic Memorial Fund. The project schedule is pending.

Both proposals will be brought before the committee when plans and costs are finalized.

THE COMMUNITY UNIVERSITY HEALTH CARE CENTER (CUHCC) UPDATE

Mr. Hart stressed that CUHCC has been UMHC's and the medical staff's outreach to the "corridor poor". In past presentations the committee and board were shown and told about the facilities and programs. The discussion was turned over to Ms. Wells to discuss the results of the planning and exploration of a replacement facility.

Program

Ms. Wells detailed the CUHCC program. CUHCC provides mental health, dental, and medical care to 5,610 people. Projected visits for 1988 are 48,000. Seventy residents and students per year train at CUHCC and there are eleven research projects being conducted among the CUHCC population.

Financial Impact

CUHCC's budget is $2,129,642 and it is a break-even operation. Over half of the funds come from grants, patient fees generated from Medical Assistance, and the Vice President's office.

Between 1986 and 1987 there was a 22% increase in referrals to the hospital and clinic. UMHC began writing off CUHCC patients in 1986 due to a change in reimbursement from the state which resulted in write offs of ($445,336) in 1986 and ($746,604) in 1987.

Reason for the increase in write offs are due to: 1) change in the University's write-off period for bad debts from 120 to 90 days, 2) more patients, and 3) patients being treated at UMHC when they might have been treated at CUHCC. The debt write off should be reduced by $230M due to better controls and a reduction in unnecessary visits to UMHC.

The expected write off in 1987 is $500,000. However CUHCC IS anticipating a reduction of grants and Health Sciences financial commitment.

Facilities

The current facility is unsuitable due to its age, lack of handicap accessibility, etc. CUHCC needs 12,221 square feet whereas they now have 7,565 square feet. Results from focus groups and telephone survey indicate that the CUHCC's patients had no problem with the clinic locating further south on Lake Street. Research also indicated that the Clinic would need to move further south of it's current location to attract additional insured/paying clientele.

A review of sites indicated that there is no building available which is ready for occupancy. Four sites were reviewed and the Lake and 31st location was the most viable given its costs. The annual project cost for the next five years would be $750,000 including write-offs and capital expenses.

Mr. Dickler concluded that CUHCC cannot survive at its current site. CUHCC's mission is important to the hospital and community. It also represents an untapped potential in the academic arena.

Ms. Wells indicated that although this item was for information, the recommendation would be that the committee 1) continue to support CUHCC's mission and 2) approve the purchase of the Lake Street and 31st site for up to $1,500,000.

Dr. Jacott stated that he didn't need additional time to deliberate on the recommendations and moved that this item be elevated for endorsement. Dr. Lynch seconded Dr. Jacott's motion for endorsement. The motion passed with Mr. Dickler abstaining due to process considerations of information/endorsement cycle protocol.

UMCA UPDATE

Dr. Lynch reported on current UMCA activity.

1) The board of directors has recognized their responsibility for the PCN debt.
2) David Coombes contract has been extended, but not yet accepted, for two years.
3) UMCA will be reviewing the ambulatory care report.
4) UMCA elections are scheduled for next month.
5) UMCA has extended an offer for the chief operating officer position.

PRACTICE SUBSIDIZATION OF PROGRAM COSTS

Dr. Lynch reviewed his clinical department's income and disbursements to demonstrate the impact of increased overhead and why the current clinic structure does not promote increased clinical activity. His departmental clinic fees are higher than private practice while the income is lower because 1) collection rate is 80% vs 97% for private practice, 2) they see 50% fewer patients because they have to teach and do research, 3) and their fixed costs are constant (malpractice insurance, rent, etc.) despite the lower volume.

ADJOURNMENT
The Planning and Development Committee adjourned at 2:07 p.m.

Respectfully submitted,

Lisa G. McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 9, 1987

TO: Members of the Board of Governors

FORM: Greg Hart
Senior Associate Director

REGARDING: Purchasing Report

Attached is a copy of the Hospital's Purchasing Activity report for the period of July through September, 1987.

This report is being submitted for your approval at the December 16, 1987 Board of Governors meeting. It was reviewed in detail and endorsed by the Planning and Development Committee on November 6, 1987.

If you have any questions regarding the report before the meeting, please feel free to call me.

/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF JULY - SEPTEMBER 1987

I. PURCHASE ORDER ANALYSIS

RANGE	NUMBER OF P.O.'S	TOTAL DOLLAR VALUE
$ 0 - $ 499	5683	$900,023.25
$ 500 - $1,999	1947	$1,995,588.66
$ 2,000 - $4,999	574	$1,747,164.24
$ 5,000 - $9,999	252	$1,741,941.21
$10,000 - OVER	245	$6,138,893.22
TOTAL PURCHASE ORDER	8701	$12,523,610.58

II. CONFIRMING ORDERS

$ 0 - $ 99	104	$5,431.50
$ 100 - $ 499	241	$53,007.04
$ 500 - $ 999	67	$50,348.23
$1,000 - $1,999	42	$84,818.55
$2,000 - OVER	33	$113,034.62
CONFIRMING ORDERS	487	$306,639.94
TOTAL	9188	$12,830,250.52

III. SET ASIDE AWARDS

(Attachment C)

IV. PURCHASE AWARDS TO OTHER THAN APPARENT LOW BIDDER

(Attachment A)

V. SOLE SOURCE

(Attachment B)

VI. VENDOR APPEALS

(Attachment D)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

(Attachment E)

ATTACHMENT A

IV. Purchase Award to Other Than Low Bidder $5,000.00 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
1.	87-616	Colonial Hospital Supply/Disposable Apparel	$ 5,840.00	$ 3,885.00 5,760.00	Materials
		Reason: The disposable aprons were not durable enough, were not fluid resistant and the vendor did not quote a firm price.			
2.	87-440	Colonial Hospital Supply/Irrigation Syringes	$ 7,414.40	$ 6,958.00	Materials
		Reason: Sterility was questionable due to inadequate sealing of the packaging.			
3.	87-441	C.R. Bard/Irrigation Syringes (Uretheral)	$ 14,752.80	$ 11,197.44	Materials
		Reason: The length of the catheter tip was not adequate; the syringe had poor suction quality and too much free movement of the plunger within the barrel.			
4.	H073609	CIBA Corning Diagnos./Radiometer Hemoximeter	$ 22,963.50	$ 21,500.00	Labs
		Reason: The range was too low; sample volume was too large; sample turn around time was too long; and results were affected by cardio green dye.			
5.	H074331	Quinton/Cardiac Cath Recording System	$279,210.00	$182,121.04	Labs
		Reason: Computer software inadequately tested; insufficient sites for O_2 saturation sampling; cannot record full 12 lead and 6 lead ECG simultaneously; system was not a DEC System as specified.			
		PPG Biomedical/Cardiac Cath Recording System	$279,210.00	$260,776.88	Labs
		Reason: Pressures cannot be previewed on monitor; continuous sampling of ECG and pressure data not available; system was not a DEC System as specified; computer storage was not adequate; and speed of data analysis was not adequate.			

IV. Purchase Award to Other Than Low Bidder $5,000.00 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
6.	H075386	Jas Manufacturing/Treadmill	$ 6,402.52	$ 5,000.00	Outpatient
		Reason: Alternate does not meet specifications regarding 350 pound patient weight capacity.			
7.	H074434	Quinton/Bicycle Erogometer	$ 12,400.00	$ 1,295.00	Labs
		Reason: Alternate does not meet specifications regarding adaptability to a cath table and supine use.			
8.	87-541 LN 2-8	Concept/Pennie O'Neil Catheters	$ 8,472.24	$ 2,460.00	Materials
		Reason: Samples not received within ten (10) working days as requested.			
9.	87-541 LN 2-8 LN 19-23	McKesson/Catheters Tieman Foley Catheters Ureteral Whistle Tip Catheters	$ 28,171.44	$ 1,066.80	Materials
		Reason: LN 2-8: Catheters were straight Foley Catheters, not Tieman Catheters. LN 19-23: Catheters were Urethral not Whistle Tip Catheters.			
10.	H075841	PPG/Simultrace Recorder	$ 48,730.00	$ 42,618.50	Labs
		Reason: Annual paper costs of the PPG are $12,000.00 more than the awarded item, far exceeding the difference in price.			
11.	H075838 H075839	Medical Oxygen/Oximeter	$ 39,975.00	$ 39.000.00	Cardio & Outpatient
		Reason: Alternate offered is not compatible with existing probes.			
12.	87-600	U.S. Surgical/Anastomosis & Cutting Instrumentation	$ 16,835.52	$ 16,511.00	O.R.
		Reason: Instrument was too heavy once the staples were inserted.			

IV. Purchase Award to Other Than Low Bidder $5,000 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
13.	87-627 LN 5	AHS/Soap, Bar, 3/4 oz.	$ 5,640.00	$ 5,220.00	Materials
		Reason: Soap was too harsh for sensitive skin, in particular, for newborn/pediatric patients.			
14.	87-850 LN 10	Armour-Dial, Inc./Deodorant, 1.5 oz.	$ 8,462.50	$ 5,000.00	Materials
		Reason: Patients complained the deodorant was too sticky and irritating to the skin.			
15.	87-655	Medix/Thermometers, Oral	$ 24,804.00	$ 23,800.00	Materials
		Reason: Thermometer case is difficult to open causing a potential for thermometer breakage, and the stand tips easily.			
16.	87-611 LN 12	McKesson Medical/Drape, Pack, Basic	$ 13,662.00	$ 9,218.40	Materials
		Reason: Drape sheet was too flimsy, the pack did not include drape towels with adhesive edges and the pack had a very strong odor.			
		Kendall Company/Drape, Pack, Basic	$ 13,662.00	$ 11,978.40	Materials
		Reason: Drape sheet in the pack was too stiff and the top and bottom of the drape were not color coded, potentially compromising aseptic technique.			
		Transhealth/Drape, Pack, Basic	$ 13,622.00	$ 12,254.46	Materials
		Reason: Paper outer packaging is unacceptable for protecting the contents against damp surface damage and splashes.			
		Tekna Med Corp./Drape, Pack, Basic	$ 13,622.00	$ 13,579.20	Materials
		Reason: Pack lacked a suture bag and the top and bottom of the drape were not color coded, potentially compromising aseptic technique.			

IV. Purchase Award to Other Than Low Bidder $5,000.00 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
17.	H069891	Curtin Matheson/Extraction Column	$ 5,904.00	$ 5,760.00	Labs
		Reason: Product offered gave poor precision and has too low a recovery rate of TCAD's.			
18.	87-547	National Med Care/Fistula Needles	$ 6,864.00	$ 6,240.00	Materials
		Reason: Needles are difficult to flip into insertion and have no clamps on needle tubing.			
19.	87-547 LN 14	Terumo/Filter, Transducer	$ 5,760.00	$ 5,742.00	Materials
		Reason: Filters require too frequent changing.			
		Cobe/Filter, Transducer	$ 5,760.00	$ 5,040.00	Materials
		Reason: Filter leaked and may tend to give false readings upon getting wet.			
20.	87-532 LN 4&17	Gambro/Arterial & Venous Lines Travenol	$ 25,089.60	$ 22,176.00	Materials
		Reason: Difficult to transfuse back into the pillow because of location.			
21.	87-532 LN 5	Travenol/Adult Blood Line	$ 22,704.00	$ 19,952.00	Materials
		Reason: Extended funnel into drip chamber makes it difficult to detect spasm, and location of pillow makes it hard to transfuse back back and clear clots.			
22.	87-532 LN 7	Cobe/K-D Cartridges	$ 8,782.40	$ 4,048.00	Materials
		Reason: Product is not compatible with present equipment.			
23.	87-547 LN 11	Terumo/Dialyzer Capillary Flow	$ 17,352.00	$ 14,904.00	Materials
		Reason: Alternate product cannot be tolerated by some patients.			

IV. Purchase Award to Other Than Low Bidder $5,000 or More

	BID # P.O. #	VENDOR/ITEM	TOTAL $ VALUE	$ VALUE LOW BIDDER	DEPT.
		Gambro/Dialyzer Capillary Flow	$ 17,352.00	$ 15,912.00	Materials
		Reason: Alternate product cannot be tolerated by some patients.			
24.	87-532 LN 17	National Med Care/K-D Venous Line	$ 11,342.00	$ 2,366.40	Materials
		Reason: Lines are too stiff and are not compatible with present equipment.			

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ATTACHMENT B

V. SOLE SOURCE

VENDOR	CONTRACT/ P.O. NUMBER	VALUE	DEPARTMENT	PRODUCT
J.P. Sales	H074335	$2,800.00	Cardio	Controller
Datascope	H073612	$8,826.45	Cardio.	Monitors
Narco Medical	H074764	$32,020.00	Cardio.	Bedside Monitors
Narco Medical	H074765	$79,050.00	Cardio.	Arrhythmia Station
A & K Designs	H069862	$3,000.00	CUHCC	Comp. Consulting
A & K Designs	H079869	$9,000.00	CUHCC	Comp. Consulting
Translogic	H075380	$31,674.00	Facilities	MDS Expansion
Facility Systems	H075406	$5,072.00	Facilities	Lab Data Chairs
DSI	H073636	$2,915.00	I.S.D.	ION Cartridges
IBM	H074064	$2,919.00	I.S.D.	Communication Boards
IBM	H074063	$2,100.00	I.S.D.	Controllers
IBM	H074062	$2,125.00	I.S.D.	Upgrade to 3720 Processor
Edwards High Vacuum	H073366	$5,319.54	Labs	Update Spectrophotometer
Hewlett Packard	H069888	$8,178.72	Labs	Lease of Chemstation
Coherent	H075840	$2,395.00	Labs	Part for Laser
Coulter	H076296	$2,074.00	Labs	Software
Rapistan	H075388	$10,098.00	M.S.	Power Conveyors
Bard Interventional	H074334	$4,100.00	M.S./CSP	Quadpolar Cath.
USCI	H074367	$3,470.00	M.S./CSP	Syringe
Colonial Hospital	H067142	$3,525.00	M.S./CSP	Decubitus Care Mattresses
USCI	H339797	$3,114.00	M.S./CSP	Syringes
AMSCO	H075842	$4,876.60	M.S./CSP	Gas Cylinder Control System
Quality X-Ray Illum.	H074457	$2,878.20	O.P.D.	Illuminators
National Biological	H075420	$9,700.00	O.P.D.	Phototherapy System
Concept	H074755	$10,400.00	O.R.	Intra Arc Drive
Codman	H075378	$4,877.00	O.R.	Retractor
Scientific Spinal	H341741	$14,000.00	O.R.	Spinal Implants
Karl Storz	H073385	$3,600.00	O.R./Cysto	Telescope
Stuart Pharm.	87-436	OPEN	Pharmacy	Pharmaceuticals
Synanon Advertising	H340808	$4,685.00	Pln'g/Mktg.	Medical Indexes
Biochem Intern'l	H073367	$2,390.00	Radiology	Respiration Monitor System
Siemens	H075083	$50,000.00	Radiology	MRI Computer
TECA Corp.	H072337	$2,500.00	Rehab.	Maint. Contract
TOTAL		$333,682.51		

ATTACHMENT C

II. SET ASIDE AWARDS

A. AWARDED BIDS

CATEGORY	VENDOR	TOTAL DOLLAR VALUE
Sequential Compression Sleeves	Halcon	$41,253.00
Carpet	DBA Context	$5,582.50
	TOTAL AWARDED BIDS	$46,835.50

B. DEPARTMENTAL PURCHASES

JULY 1987

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H072767	Quality Medical	$381.80
2.	H072708	Quality Medical	$81.00
3.	H072830	Trophy Craft	$135.00
4.	H337649	Audio Visual Wholesalers	$968.20
5.	H337782	Audio Visual Wholesalers	$358.02
6.	H071428	Trophy Craft	$176.70
7.	H338129	Audio Visual Wholesalers	$1,072.00
8.	H338256	Eike Interiors	$660.00
9.	H071431	Trophy Craft	$131.85
10.	H073562	Quality Medical	$49.95
11.	H072789	Quality Medical	$313.20
12.	H071434	Trophy Craft	$144.30
13.	H338762	Sexton Data Products	$46.20
14.	H072717	Quality Medical	$383.85
15.	H073376	Gisela Lee's Upholstery	$1,590.00
16.	H338361	Allanson Business Prod.	$1,392.00
17.	H337334	Halcon	$717.36
18.	H337704	Halcon	$167.52
19.	H337537	Halcon	$747.24
20.	H337599	Halcon	$172.80
21.	H338070	Halcon	$59.76
22.	H338429	Halcon	$537.84
23.	H338454	Halcon	$209.40
24.	H338332	Halcon	$233.16
25.	H338362	Halcon	$2,796.50
26.	H339127	Halcon	$537.84
27.	H337247	Art Materials	$495.00
28.	H338777	Art Materials	$356.40
29.	H337287	Quality Medical	$375.00
30.	H338279	Quality Medical	$85.56
31.	H339202	Quality Medical	$138.25
32.	H337662	Home Hospital Products	$211.68
33.	H337578	Home Hospital Products	$39.38

JULY (cont'd)

34.	H337872	Home Hospital Products	$802.56
35.	H338541	Home Hospital Products	$28.50
		JULY TOTAL	$16,595.82

AUGUST 1987

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H075100	Gisela Interiors	$1,690.00
2.	H075033	Trophy Craft	$54.90
3.	H071440	Trophy Craft	$79.95
4.	H073572	Quality Medical Products	$49.95
5.	H057364	Northern Balance	$68.00
6.	H339609	Humac Engrg. & Equip.	$1,799.64
7.	H071444	Trophy Craft	$115.10
8.	H339725	Audio Visual Wholesalers	$1,072.00
9.	H074402	Quality Medical Products	$300.00
10.	H340130	Audio Visual Wholesalers	$358.02
11.	H071446	Trophy Craft	$116.50
12.	H074405	Quality Medical Products	$593.75
13.	H072821	Quality Medical Products	$336.55
14.	H075028	Trophy Craft	$234.00
15.	H075068	Enrica Fish Books	$29.71
16.	H074411	Quality Medical Products	$115.70
17.	H340797	Your Way Cleaning	$225.00
18.	H071614	Your Way Cleaning	$3,032.00
19.	H074413	Quality Medical Products	$362.50
20.	H341113	H.A. Roberts	$1,512.00
21.	H339948	Kelly Computer	$95.52
22.	H339529	Quality Medical Products	$85.56
23.	H341160	Quality Medical Products	$85.56
24.	H339453	Halcon	$167.52
25.	H339459	Halcon	$2,880.50
26.	H339653	Halcon	$59.76
27.	H339761	Halcon	$268.92
28.	H340247	Halcon	$172.80
29.	H340260	Halcon	$149.40
30.	H340398	Halcon	$2,674.75
31.	H340579	Halcon	$507.96
32.	H340863	Halcon	$83.76
33.	H340948	Halcon	$59.76
34.	H340999	Halcon	$209.40
35.	H075097	DBA Context	$5,582.50
36.	H340127	Home Hospital Equipment	$802.56
37.	H340270	Home Hospital Equipment	$635.04
38.	H340760	Home Hospital Equipment	$410.40
39.	H339331	Allanson Business	$288.00
		AUGUST TOTAL	$27,364.94

III. SET ASIDE AWARDS (cont'd)

SEPTEMBER 1987

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H072838	Trophy Craft	$33.60
2.	H075901	Quality Medical Products	$486.20
3.	H075035	Trophy Craft	$169.80
4.	H074415	Quality Medical Products	$115.70
5.	H074420	Quality Medical Products	$77.75
6.	H075117	Quality Medical Products	$49.95
7.	H352085	Humac Engrg. & Equipment	$1,899.70
8.	H072836	Trophy Craft	$39.30
9.	H074423	Quality Medical Products	$231.85
10.	H072837	Trophy Craft	$156.15
11.	H341113	H.A. Roberts	$1,512.00
12.	H341361	Halcon	$167.52
13.	H341579	Halcon	$2,674.75
14.	H341729	Halcon	$83.76
15.	H341843	Halcon	$179.28
16.	H341930	Halcon	$507.96
17.	H342320	Halcon	$89.64
18.	H341360	Home Hospital Equipment	$349.92
19.	H342274	Home Hospital Equipment	$39.38
20.	H342590	Home Hospital Equipment	$839.04
21.	H342775	Home Hospital Equipment	$635.04
22.	H341493	Allanson Business	$1,252.80
23.	H341169	Halcon	$836.64
24.	H339354	Office Machines Sales	$844.20
		SEPTEMBER TOTAL	$13,271.93

C. QUARTERLY GRAND TOTAL

Awarded Bids	$46,835.50
July Purchases	$16,595.82
August Purchases	$27,364.94
September Purchases	$13,271.93
GRAND TOTAL	$104,068.19

ATTACHMENT D

VI. VENDOR APPEAL

1. VENDOR NAME: Irvine Scientific

NATURE OF PURCHASE: Trypsin-Versene

AMOUNT OF AWARD: $1,200.00

REASON FOR APPEAL: Found unacceptable on the basis of past contamination problems. UMHC maintained costs to pinpoint contamination problems would far exceed potential savings, and awarded the bid for the specified product.

2. VENDOR NAME: PPG Biomedical

NATURE OF PURCHASE: Physiological Recorder

AMOUNT OF AWARD: $48,730.00

REASON FOR APPEAL: Found unacceptable on the basis of higher paper costs. PPG contended that quality features outweighed higher operating costs, but the department justified features on awarded Siemens as preferred by present electrophysiologist staff members.

ATTACHMENT E

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

1.	Nature of Purchase:	Defibrillator
	Consortium Vendor Name:	Hewlett Packard
	Purchase Order #:	H075067
	Value of Purchase:	$ 4,135.40
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 359.60
2.	Nature of Purchase:	Defibrillators
	Consortium Vendor Name:	Hewlett Packard
	Purchase Order #:	H071073
	Value of Purchase:	$53,240.20
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 5,194.80
3.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	9 P.O.'s (July)
	Value of Purchase:	$26,288.45
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 3,568.25
4.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	5 P.O.'s (August)
	Value of Purchase:	$ 5,788.65
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 347.75
5.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register
	Purchase Order #:	3 P.O.'s (September)
	Value of Purchase:	$14,946.00
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 1,159.35
6.	Nature of Purchase:	Contract for Dressings, Gauzes & Sponges
	Consortium Vendor Name:	Johnson & Johnson
	Purchase Order #:	87-595
	Value of Purchase:	$48,646.40 (annual)
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 7,297.37 (annual)

TOTAL SAVINGS THIS QUARTER: $19,114.34

MINUTES
Joint Conference Committee
Board of Governors
November 11, 1987

ATTENDANCE:

Present:
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
Donald Gilmore
George Heenan
James Moller, M.D.
Bruce Work, M.D.

Absent:
Michael Popkin, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Jan Brockway
Adella DeLappe, M.D.
Donald Hansen

1. JCAH UPDATE

As Dr. Moller was involved with the JCAH survey, the meeting began with an introduction of the Committee to Mr. Donald Hansen, the administrative surveyor from the Joint Commission for Accreditation of Healthcare Organizations.

Mr. Hansen described his role in the survey process and briefly outlined the other surveyor's roles. Discussion ensued regarding the Joint Commission's position relative to Board involvement with Quality Assurance. Mr. Hansen stated that there should be some evidence in board minutes that indicated active board involvement, but noted that JCAHO understands the position of university hospitals where board meetings are open to the public.

Mr. Hansen noted that current focus of JCAHO on Quality Assurance is varifying that a process is in place at institutions. As of January 1, 1988 it will be necessary for institutions to demonstrate the efficacy of their program.

Mr. Hansen also disclosed that the future direction of the JCAHO in quality assurance will be the development and implementation of outcome monitoring. He admitted that this is very difficult, but assured the committee that expert teams are working on the problem. Their goal is to have a system in place by 1990.

II. MEETING TIME

Mr. George Heenan solicited committee members opinions of the appropriateness of the time allocated for the monthly meeting and questioned whether or not it was necessary to have a meal served. Discussion ensued and it was concluded that members should block out 4:30 - 6:30 P.M. on the second Wednesday of each month for meeting days and make an effort to notify Nancy Janda if they would be having dinner.

III. MORE JCAH

Dr. Moller returned with Dr. Adella DeLappe, the Joint Commission physician surveyor. Dr. DeLappe was introduced and made a brief presentation that echoed many of the themes that Mr. Hansen had already discussed.

IV. APPROVAL OF THE MINUTES

The minutes of the October 14, 1987 meeting were approved as submitted.

V. MEDICAL STAFF-HOSPITAL COUNCIL REPORT

Dr. James Moller discussed the use of lasers at UMHC and the conclusions of a group that studied their use. These four recommendations were the result of that study:

- There should be a "Laser Safety Officer"
- There should be an advisory committee to the Credentialling Committee that certifies competence with laser procedures
- Residents should not use lasers without supervision from staff physicians
- Some type of on-going committee should be established to investigate and assess new technologies.

VI. PEDIATRIC CARDIOLOGY MULTICENTER QUALITY ASSURANCE PROJECT

Dr. Moller described to the committee a multicenter quality assurance program that monitors 22 separate pediatric procedures at 18 sites

throughout the country. Data is gathered from each site and the data base amassed now holds over 11,000 cases. From this data base hospitals are able to compare their case-mix adjusted mortality rates against a broad based average. Centers that deviate too far from expected mortality then are able to examine their program and learn from other more successful programs.

Discussion ensued concerning the costs and ability to generalize this model to other specialties.

VII. **ADJOURNMENT**

There being no further business, the meeting was adjourned at 7:00 P.M.

Respectfully submitted,

Ted Yank/kff

Ted Yank
Administrative Fellow

TY/kff

Minutes
Meeting of the
Board of Governors Finance Committee
The University of Minnesota Hospital and Clinic
October 28, 1987

MEMBERS PRESENT:	Edward Ciriacy, M.D. Robert Dickler Clifford Fearing William Krivit, M.D. Robert Nickoloff Barbara O'Grady Vic Vikmanis
MEMBERS ABSENT:	Carol Campbell J.E. Meilahn
GUEST:	Christopher Kuni, M.D.
STAFF:	Al Dees Kay Fuecker Greg Hart Nancy Janda Nels Larson Dan Rode

CALL TO ORDER: The meeting of the Finance Committee was called to order by Mr. Robert Nickoloff at 12:17 P.M. in the Board Room (8-106 University Hospital).

MINUTES: A motion was seconded and passed to approve the minutes of the August 26, 1987 meeting of the Finance Committee as written.

JUNE 30, 1987 YEAR-END FINANCIAL STATEMENTS: Mr. Cliff Fearing reviewed the operations for the period July 1, 1986 through June 30, 1987. Admissions totalled 19,169 compared to 17,694 for the previous year, an increase of 8.3%. Patient days for the year totaled 154,282, up by 8,585 (5.9%) from 145,697 days in 1985-86. The average length of stay declined from 8.3 to 8.1 days. The outpatient visits increased from 224,446 to 248,137, representing a 10.6% increase and an 11.5% increase over 1986-87 estimates. The increase in clinic census occurred in nearly all areas, but most significantly in Surgery, Medicine, Dermatology, Urology and the Emergency Room. Patient care revenue totaled $238,045,424 and is an increase

of $39,074,887 (19.6%) over 1985-86. The increase is approximately $38,781,700 above budget and resulted in an overall favorable variance of 19.5%. The increase in expenditures was approximately $19,332,200 over budget and resulted in an unfavorable variance of 9.3%. Much of this variance was associated with the increase in demand for patient services. Personnel costs were over budget by nearly $8,944,000. Expenses and supplies directly related to patient care activities were over budget by more than $8,861,100. Insurance expenses were nearly $717,000 below budget. Interest expense was $4,025,676 under budget. Non-operating revenues totalled $21,972,361 in 1986-87 and represents an unfavorable variance from budget of $1,804,239. This shows our lost equity position in Primary Care Network and our share of outstanding liabilities in the form of loan guarantees. The net loss by UMHC for PCN is $1,134,760. Lastly, interest earnings were lower than anticipated. Capital expenditures during 1986-87 were $11,874,700.

SEPTEMBER 30, 1987 FINANCIAL STATEMENTS:

Mr. Fearing reported that admissions for September totaled 1,602 or 107 above a budgeted level of 1,495. The average length of stay was 7.5 days. Patient days totaled 12,216, 422 days under budget. Outpatient clinic visits totaled 21,715 (6.1%) above budget.

The Hospital's Statement of Operations shows total revenues over expense of $1,585,929 for a favorable variance of $2,139,228. Patient care charges through September were .5% over budget. Routine revenue was 3.1% under budget and reflected our unfavorable patient day variance. Ancillary revenue was 1.9% above budget and reflected the favorable variance in both admissions and clinic visits. The overall unfavorable variance (0.2%) in operating expenditures relates to increased personnel costs and patient care related costs. Patient accounts receivable totaled $79,935,999 and represents 106.95 days of revenue outstanding. This increase of .09 days occurred primarily in the BCBSM, Minnesota Medical Assistance, and Minnesota GAMC categories.

MAGNETIC RESONANCE IMAGING UNIT II:

Mr. Al Dees and Dr. Christopher Kuni, Radiology Department, discussed the current Magnetic Resonance Imaging services and the proposal to purchase a second MRI. Radiology currently staffs 2 full-time shifts five days per week and one shift on Saturday. Approximately 10-12 procedures are referred elsewhere each week due to lack of MRI time available. The Radiology Department proposes the purchase of a 2.0 Tesla Magnetic Resonance Imaging machine. This machine would be used primarily for magnetic resonance imaging, but would be used for spectroscopy as funding is available to pay for the procedures. The proposal includes expanding the current MRI suite by 1,000 square feet of shelled space, the addition of 3.0 FTE radiological technologists and 1.0 FTE secretary. The total estimated installation cost is $3,600,000, specified as follows: $2,473,867 for equipment; $290,000 for shielding; $171,000 for equipment access; $66,000 for airconditioning; $132,000 for architectural fees; and $468,000 for actual construction.

Mr. Dees noted that this proposal is for discussion only in October, with endorsement sought in November.

BLUE CROSS BLUE SHIELD OF MN. WAIVER OF DEDUCTIBLE AND COPAYMENT:

In August of 1987 the University was informed by the Employee Relations Department of the State of Minnesota that the state would no longer be offering the BCBSM Aware Gold insurance plan as an option to employees for the next insurance year, 10/1/87 to 9/30/88. Since the University is a participant in the state insurance plan this was also applicable to all University employees. The decision by the state to eliminate the Aware Gold option was based on increased premiums for this type of insurance coverage which is a full 100% insurance coverage for all inpatient and outpatient services. The State replaced the Aware Gold insurance with Aware Ltd. which carries a $680 deductible and co-insurance payment for inpatient hospitalizations. It was the opinion of UMHC management that this change in coverage would have a negative impact on UMHC in that the $680 cost for admission would be an incentive for employees to drop BCBSM and move to other insurance carriers which either do not permit or restrict admission to UMHC. It was felt this action could be countered by providing an incentive to Unversity employees to use UMHC. Therefore, it was decided to offer to waive the deductible and co-insurance payment to all University employees who chose the Aware Ltd. insurance plan who were subsequently hospitalized at UMHC. This offer was sent in letter form to all University employees in early September.

State officials objected to the University's action and requested that it withdraw its action oor leave the state insurance plan and establish its own plan by 12/31/87. Since it is unrealistic to put together a total insurance plan for the University in the time fram provided the University has decided on November 3, 1987 to withdraw the waiver and remain in the state insurance plan. The University is continuing to pursue the development of its own insurance plan and as new details become availablle they will be shared with the committee.

CUHCC/COMMUNITY INDIGENT CARE COMPARISONS:

Mr. Greg Hart reported on the progress of a CUHCC replacement facility. UMHC is currently pursuing the possibility of locating the facility in a wing of Mt. Sinai Hospital. This possibility would ensure access by the same patient population. More information will be available on this option after consulting with architects.

Per the Committee's request, a comparison of charity care provided by Twin Cities hospitals was prepared and this comparison indicates that indigent care provided by UMHC is comparable to that of other hospitals in the area. Mr. Dickler noted that at the present time much of the charitable care provided by UMHC is provided to patients from CUHCC. As the Board addresses the issue of replacement faciltiies for CUHCC, it will also need to address whether our charitable care focus should remain at CUHCC or if it should become part of a larger strategy. These topics will continue to be discussed as the replacement facility issues for CUHCC become more focused.

HOSPITAL PRICE COMPARISONS:

Mr. Greg Hart reviewed the Price Compaison Data from the Council of Hospital Corporations (CHC) 1987 Hospital Price Disclosure report. This report takes similar groups of cases and collects price and charge information for those cases. Charges at UMHC are generally 6-16% higher than the community due to educational costs and types of illnesses. When the educational component is not included, the charges would have been only 6% higher than the other other hospitals surveyed. The report shows that in 1/3 of the cases UMHC charges were less than the average and in approximately 17% of the cases UMHC charges were higher due to the severity of the cases.

FIRST QUARTER, 1987-88 BAD DEBTS: Mr. Dan Rode reported the total amount recommended for bad debts for the first quarter of 1987-88 is $949,327.60 representing 1,602 accounts. Recoveries during the period amounted to $7,176.28, leaving a net charge-off of $942,151.32. This amount is 1.45% of gross charges compared to a budgeted level of 1.33%.

The Finance Committee seconded and passed a motion to approve the net bad debt charge-off in the amount of $942,151.32 for the first quarter of 1987-88 as submitted.

ADJOURNMENT: There being no further business, the Finance Committee adjourned at 2:10 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

November 30, 1987

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing

SUBJECT: October 31, 1987 Year-to-Date Financial Statements

Enclosed for your information are the financial statements and the Report of Operations for the period ending October 31, 1987, which would have been covered at the November Finance Committee meeting. As you will see, our overall position continues to be positive and above budgeted levels.

If you have any questions with regard to the enclosed material please feel free to contact me at your convenience or raise them at the December Finance Committee meeting.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 18, 1987

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period
July 1, 1987 through October 31, 1987

The Hospital's operations through the month of October 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 October, inpatient admissions totaled 1,561 or 6 above budgeted admissions of 1,555. Our overall average length of stay for the month was 8.1 days. Patient days for October totaled 12,834 and were 443 days under budget. The increase in admission levels is primarily in the area of Medicine.

To recap our year-to-date inpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Admissions	6,348	6,330	6,564	234	3.7
Avg. Lnth. of Stay	8.3	8.3	7.9	.4	4.8
Patient Days	52,284	53,425	51,999	-1,426	-2.7
Avg. Daily Census	425.1	434.3	422.8	-11.5	-2.7
Percent Occupancy	71.0	74.6	72.6	-2.0	-2.7

Outpatient Census: Clinic visits for the month of October totaled 22,595 or 69 (0.3%) below budgeted visits of 22,664. The largest decrease in activity was experienced in the Family Practice clinic area. Areas which experienced actual visits with large increases over budget were A.T.E.U. and Radiation Therapy. Community University Health Care Center (CUHCC) visits for the month of October totaled 4,371 or 10 (0.2%) below budgeted visits of 4,381, while Home Health

visits of 688 for the month were 99 (12.6%) above budgeted visits of 787.

To recap our year-to-date outpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Clinic Visits	84,572	87,361	88,149	788	0.9
CUHCC Visits	14,544	16,571	12,852	662	5.4
HHA Visits	3,234	3,124	2,683	-441	-14.1

Financial Operations: The Hospital's Statement of Operations shows total revenues over expense of $3,721,833, a favorable variance of $4,313,619.

Patient care charges through October totaled $86,861,500 and were .7% over budget. Routine revenue was 2.9% under budget and reflected our unfavorable patient day variance. Ancillary revenue was approximately $1,309,500 (2.1%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,176 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $182 compared to the budgeted average of $184.

Operating expenditures through October totaled $80,268,475 and were approximately $566,656 (0.7%) under budgeted levels. The overall favorable variance relates to decreased patient care related costs (drugs and medical supplies).

Accounts Receivable: The balance in patient accounts receivable as of October 31, 1987 totaled $82,249,971 and represented 111.30 days of revenue outstanding. The overall increase in our patient receivables in October of 4.35 days occurred primarily in the Minnesota Medical Assistance, Agency Pending, and P.H.S. Appeals categories.

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

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1987 TO OCTOBER 31,1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$86,249,182	$86,861,501	$612,319	0.7%
Deductions from Charges	-15,612,606	-13,083,345	2,529,261	16.2%
Other Operating Revenue	1,992,287	2,255,784	263,497	13.2%
Total Operating Revenue	72,628,863	76,033,940	3,405,077	4.7%
Total Expenditures	-80,835,131	-80,268,475	566,656	0.7%
Net Operating Revenue	-8,206,268	-4,234,535	3,971,733	0.0%
Non-Operating Revenue and Expenses	7,614,482	7,956,368	341,886	4.5%
Revenue over Expense	$-591,786	$3,721,833	$4,313,619	(1)

(1) Variance equals 5.4 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	6,330	6,564	234	3.7%
Patient Days	53,425	51,999	-1,426	-2.7%
Average Daily Census	434.3	422.8	-11.5	-2.7%
Average Length of Stay	8.3	7.9	-0.4	-7.8%
Percentage Occupancy	74.6%	72.6%	-2.0	-2.7%
Outpatient Clinic Visits	22,664	22,595	-69	-0.3%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1987 TO OCTOBER 31, 1987

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$86,249,182	$86,861,501	$612,319	0.7%
Deductions from Charges	15,612,606	13,083,345	-2,529,261	-16.2%
Other Operating Revenue	1,992,287	2,255,784	263,497	13.2%
Total Revenue from Operations	$72,628,863	$76,033,940	$3,405,077	4.7%
Expenditures				
Salaries	[illegible]3,983,919	$35,031,102	$1,047,183	3.1%
Fringe Benefits	6,435,126	6,282,593	-152,533	-2.4
Contract Compensation	3,392,232	3,350,959	[illegible].273	-1.2
Medical Supplies, Drugs, Blood	13,772,511	12,7[illegible]521	-[illegible],990	-7.3
Campus Administration Expense	2,174,815	2,1[illegible],315	0	
Depreciation and Amortization	5,649,427	5,657,791	,364	0.1
General Supplies & Expense	15,427,101	14,997,694	-[illegible],407	-2.8
Total Expenditures	$80,835,131	$80,268,475	$-566,656	-0.7%
Net Revenue from Operations	$-8,206,268	$[illegible]234,535	$3,971,733	
Non-Operating Revenues and Expenses				
Appropriations	$4,844,150	$4,903,938	$59,788	1.2%
Interest Income on Reserves	2,039,120	2,389,878	350,758	-12.5
Shared Services	128,545	51,398	-77,147	27.4
Investment Income on Trustee Held Assets	602,667	611,154	8,487	1.4
Total Non-Operating Revenues and Expenses	$7,614,482	$7,956,368	$341,886	4.5%
Revenue Over Expense	$-591,786	$3,721,833	$4,313,619	(1)

(1) Variance equals 5.4% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1987 TO OCTOBER 31, 1987

Annual Budget		Budgeted	Actual	Variance Over/-Under Budget	Variance %
	Patient Care Charges				
$70,025,500	Routine	$24,450,326	$23,753,116	$-697,210	-2.9%
179,592,300	Ancillary	61,798,856	63,108,385	1,309,529	2.1
$249,617,800	Gross Charges	$86,249,182	$86,861,501	$612,319	0.7%
	Deductions from Charges				
$27,750,800	Third Party Contractual Adjustments	$9,588,594	$6,894,027	$-2,694,567	-28.1%
9,219,200	Billing Adjustments & Employee Benefits	3,145,306	3,418,149	272,843	8.7
663,800	Charitable Care	229,359	168,095	-61,264	-26.7
4,355,300	Other Contractual Adjustments	1,504,865	1,450,581	-54,284	-3.6
3,312,300	Provisions for Uncollectables	1,144,482	1,152,493	8,011	0.7
$45,301,400	Total Deductions	$15,612,606	$13,083,345	$-2,529,261	-16.2%
	Other Operating Revenue				
$1,348,500	Food Services	$453,184	$482,874	$29,690	6.6%
500,000	Parking Services	168,033	191,864	23,831	14.2%
78,700	Department Non-Patient	26,448	57,230	30,782	116.4
1,066,700	CUHCC Grants	358,481	358,928	447	0.1
1,543,700	Reference Lab Income	518,784	509,494	-9,290	-1.8
1,352,600	Pro Fees - Net Revenue	467,357	500,259	32,902	7.0
0	X-Ray Silver Sale	0	147,677	147,677	
0	Donations from Restricted Funds	0	7,458	7,458	
$5,890,200	Total Other Revenue	$1,992,287	$2,255,784	$263,497	13.2%
$210,206,600	Total Revenue from Operations	$72,628,863	$76,033,940	$3,405,077	4.7%
	Expenditures				
$101,075,300	Salaries	$33,983,919	$35,031,102	$1,047,183	3.1%
19,139,500	Fringe Benefits	6,435,126	6,282,593	-152,533	-2.4
1,960,300	Academic Contracts	653,433	653,433	0	0.0
5,533,100	Resident Contracts	1,844,366	1,844,366	0	0.0
2,683,300	Physician Compensation	894,433	853,160	-41,273	-4.6
$130,391,500	Total Salary, F.B. & Fees	$43,811,277	$44,664,654	$853,377	1.9%
2,106,000	Laundry & Linen	731,788	770,542	38,754	5.3%
1,688,200	Raw Food	579,028	557,890	-21,138	-3.7
20,236,500	Drugs	6,962,534	5,956,225	-1,006,309	-14.5
5,853,500	Blood & Blood Derivatives	2,013,944	2,116,703	102,759	5.1
13,939,600	Medical Supplies	4,796,033	4,700,593	-95,440	-2.0
4,254,600	Utilities	1,437,222	1,551,165	113,943	7.9
1,007,900	Insurance	338,720	300,961	-37,759	-11.1
2,902,200	Rental	967,400	1,030,294	62,894	6.5
4,252,100	Maintenance & Repair	1,428,984	1,340,182	-88,802	-6.2
1,475,700	Communications	495,932	543,625	47,693	9.6
0	Gain on Disposal of Assets	0	-38,500	-38,500	
6,471,400	Campus Administration Expense	2,174,815	2,174,815	0	
16,693,600	Depreciation and Amortization	5,649,427	5,657,791	8,364	0.1
10,428,000	Interest	3,534,550	3,332,866	-201,684	-5.7
17,596,200	General Supplies & Expense	5,913,477	5,608,669	-304,808	-5.2
$239,297,000	Total Expenditures	$80,835,131	$80,268,475	$-566,656	-0.7%
$-29,090,400	Net Revenue from Operations	$-8,206,268	$-4,234,535	$3,971,733	
	Non-Operating Revenue and Expenses				
$14,414,300	Appropriations & Support	$4,844,150	$4,789,846	$-54,304	-1.1%
0	Accrued Interest on Appropriation	0	114,092	114,092	
5,517,900	Interest Income on Reserves	2,039,120	2,389,878	350,758	17.2
382,500	Shared Services	128,545	51,398	-77,147	-60.0
1,808,000	Investment Income Held by Trustee	602,667	611,154	8,487	1.4
$22,122,700	Total Non-Operating Revenue and Expenses	$7,614,482	$7,956,368	$341,886	4.5%
$-6,967,700	Revenue Over Expense	$-591,786	$3,721,833	$4,313,619	(1)

(1) Variance equals 5.4% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

OPERATING CASH FLOW

FOR THE PERIOD JULY 1, 1986 TO OCTOBER 31, 1987

Source of Funds		
Beginning Operating Cash Balance		$34,475
Net Income from Operations	$-4,234,535	
Non-Operating Revenue	7,956,368	
Excess of Revenue over Expense		3,721,833
Items not Requiring the Outlay of Cash:		
Depreciation		5,657,791
University Support: G & A		2,174,815
University Support: KE Utilities		117,398
Decrease in Other Receivables		491,084
Decrease in Inventories		7,358
Deferred Third Party Reimbursement		179,583
Renewal Project Interest Expense		3,106,805
Transfer for PCN Liability Payment		1,058,268
Total Funds Provided from Operations		$16,549,410
Funds Applied		
Transfers to Plant:		
Increase in Capital Expenditures	$4,809,827	
Decrease in Capital Encumbrances	-188,525	
Total Transfers to Plant from Operations		$4,621,302
Increase in Accounts Receivable		6,384,055
Increase in Prepaid Expenses		680,546
Decrease in Accrued Expenses		302,965
Gain on Disposal of Assets		38,500
Third Party Liablilty Transfer		173,057
Investment Income - Trustee Held Assets		611,154
Transfer to Reserves - Bond Retirement		876,668
Transfer to Reserves - Bond Interest Payable		3,008,645
Miscellaneous		40,052
Total Funds Applied		$16,736,944
Operating Cash Made Available from Operations		$-187,534

Current Cash Summary	
Operating Cash	$-187,534
Reserve Cash for Liability to Third Party Payors	14,478,062
Unrealized Appropriation Cash	9,462,854
Reserve Cash for Short Term Debt Retirement	2,500,000
Reserve Cash for Bond Interest Payment	2,890,185
	29,143,567
Less Interest Income on Reserves	-2,503,970
Total Current Cash	$26,639,597

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

BALANCE SHEETS

OCTOBER 31 , 1987 AND JUNE 30, 1987

ASSETS

	10/31/87	6/30/87
CURRENT ASSETS		
Operating Cash	$-2,691,504	$34,475
Reserve Cash- Third Party Payable	14,478,062	14,305,005
Unrealized Appropriation Cash	9,462,854	0
Reserve Cash- Short Term Debt	2,500,000	2,500,000
Reserve Cash-Bond Interest Payable	2,890,185	4,214,376
Accounts Receivable		
Patient Receivables	82,249,971	72,366,775
Other Receivables	1,527,388	2,018,472
	83,777,359	74,385,247
Less Allowances for Losses in Collection	-5,446,612	-5,577,999
Less Allowances for Discounts to Third Party Payors	-17,254,389	-13,623,861
	61,076,358	55,183,387
Trustee Held Assets	0	1,020,755
Inventories of Drugs & Supplies	4,708,334	4,863,369
Prepaid Expenses	1,073,691	393,145
Silver Flake	147,677	0
TOTAL CURRENT ASSETS	$93,645,657	$82,514,512
BOARD DESIGNATED ASSETS:		
Board Designated Assets Available for Assignment		
Cash & Investments	$59,629,245	$56,443,170
Accrued Interest	1,144,130	605,020
	60,773,375	57,048,190
Cash & Investments Assigned to Construction Projects	7,732,376	7,495,376
TOTAL BOARD DESIGNATED ASSETS	$68,505,751	$64,543,566
DEFERRED THIRD PARTY REIMBURSEMENT	$9,992,656	$10,172,239
OTHER ASSETS	258,190	258,189
LAND, BUILDINGS & EQUIPMENT		
Land, Buildings & Improvements	$180,833,855	$180,359,060
Equipment	74,743,149	68,008,620
	255,577,004	248,367,680
Less Accumulated Depreciation	-72,710,356	-67,640,664
	182,866,648	180,727,016
Construction in Progress	4,753,843	8,136,413
TOTAL LAND, BUILDINGS & EQUIPMENT	$187,620,491	$188,863,429
TRUSTEE HELD ASSETS	$47,734,464	$51,195,164
DEFERRED DEBT EXPENSE	$1,968,463	$2,023,259
	$409,725,672	$399,570,358

LIABILITIES AND FUND BALANCES

	10/31/87	6/30/87
CURRENT LIABILITIES		
Accounts Payable	$3,888,414	$6,101,515
Payable to Third Party Contr. Payors	14,478,062	14,305,005
Salaries, Wages and Payroll Taxes	6,716,695	7,080,113
Accrued Vacation	6,576,827	6,706,164
Accrued Professional Fees and Physician Compensation	1,930,456	1,625,515
Contracts Payable	1,934,296	920,738
Interest Payable	2,931,897	4,263,164
Current Portion of Long-Term Debt	3,785,080	3,796,447
Promissory Notes Payable	2,500,000	2,500,000
TOTAL CURRENT LIABILITIES	$44,741,727	$47,298,661
LONG-TERM DEBT, LESS CURRENT PORTION	$180,053,514	$182,896,903
UNRESTRICTED FUND BALANCE	$184,930,431	$169,374,794
	$409,725,672	$399,570,358

RESTRICTED ASSETS

Cash and Investments	$5,088,708	$4,856,396

RESTRICTED FUND BALANCES

Fund Balances		
Endowment Funds	$1,883,807	$1,846,730
Gift Funds	3,204,901	3,009,666
	$5,088,708	$4,856,396

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF CHANGES IN FUND BALANCE

FOR THE PERIOD JULY 1, 1987 TO OCTOBER 31, 1987

	OPERATING FUND	BOARD DESIGNATED FUND	TRUSTEE & PLANT FUND	TOTAL UNRESTRICTED FUNDS
UNRESTRICTED FUNDS				
Beginning Balance	$33,979,528	$57,048,190	$78,347,076	$169,374,794
Net Income				
Excess of Revenue over Expense	5,575,640			
Interest Income on Reserves		2,389,878		
Accrued Interest on Appropriations		114,092		
Depreciation Expense			-5,657,791	
Gain on Disposal of Assets			38,500	
Interest Expense			650,360	
Interest Income on Trustee Held Fund			611,154	
Extrordinary Item				
Total Income				3,721,833
Less Expense				
Unrealized Appropriation Revenue	9,462,854			9,462,854
University Support: G & A	2,174,815			2,174,815
K/E Utilities	117,398			117,398
Transfers Between Funds				
Major Building Projects- Hospital Only		-400,000	400,000	
Capital Expenditures	-4,411,695		4,411,695	
Capital Encumbrance Change	188,525		-188,525	
Major Equipment Requsition	-343,532		343,532	
Bond Interest Payment	5,081,357	-4,871,950	-209,407	
Bond Principal Sinking Fund	-876,668	876,668		
Short Term Note Funding	2,500,000	-2,500,000		
Bond Interest Expense Funding	-118,460	118,460		
Prior Year End Bond Interest Transfer	-4,214,376	4,214,376		
Reimbursement from Trustee - Bond Interst		4,841,929	-4,841,929	
PCN liability payment	1,058,268	-1,058,268		
Increease in Restricted Gift Fund Committment to Plant			26,328	26,328
Unrestricted Donation			50,000	50,000
Adjustments to Hosptal Shared Buildings			2,409	2,409
Ending Balance	$50,173,654	$60,773,375	$73,983,402	$184,930,431

RESTRICTED FUNDS	Gift	Endowment	Total
Beginning Balance	$3,009,666	$1,846,730	$4,856,396
Income	195,235	37,077	232,312
Ending Balance	$3,204,901	$1,883,807	$5,088,708

ACCOUNTS RECEIVABLE HIGHLIGHTS
OCTOBER 31, 1987

Category	Amount	+ or (-) Prev. mo.	% Change	+ or (-) 6/30/87	% Change	10/31/87 Days
Total	$82,132,887[a]	$3,178,409	4.03%	$9,883,255	13.68%	111.30[a]
Inhouse	11,003,936[a]	1,423,316	14.86%	1,813,131	19.73%	14.91[a]
DSNFB[b]	14,095,495[a]	3,871,505	37.87%	4,133,684	41.50%	19.10[a]
	- 2,638,936 - four day inpatient hold - 8,020,773 - medical record hold - 2,330,444 - outpatient billing hold - 1,105,342 - misc. billing hold					
Collections	5,187,797	(49,013)	(0.94)%	(226,028)	(4.18)%	7.04
Follow-up	5,059,333	126,921	2.57%	(5,015)	(0.10)%	6.85
Net DAR	46,786,326[a]	(2,194,320)	(4.48)%	4,167,483	9.78%	63.40[a]

a. Figures shown are gross dollars or days. They do not reflect contractual allowances or discounts (ie. Net DAR after adjustment would be approximately $36,961,000 or 50.09 days.)

b. Discharge not final billed.

Significant Changes

- While the Net DAR decreased 4.48% in October, a systems change in DRG grouper software coupled with a high census at the end of the month resulted in a receivable increase totaling $3,178,409. Another change experienced in October was the introduction of new out patient Medicare billing requirements. These requirements have forced UMHC to bill manually. The billing also requires manual coding by Medical Records. At month end we estimate that approximately $400T was in the misc. hold waiting for this manual processing.

- Increases in the accounts receivable Net DAR were again experienced in the Minnesota Medicaid Category $919T. As noted last month UMHC has been working with a number of parties at the State for some relief to this problem. An inhouse audit is also under way to reconcile UMHC's accounts with the State's. The only other category with a significant change was our pending agency category. $361T, an increase that is essentially seasonal.

- Decreases during the month included our External Audit Category $411,149; Medicare $1.7M; Blue Cross $985T; GAMC $166T; Out-of-State Medicaid $483T and Special Transplants $177T.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 9, 1987

TO: Members of the Board of Governors

FROM: Robert Dickler RD
Hospital Director

SUBJECT: Magnetic Resonance Imaging (MRI) Project

Mr. Al Dees and Dr. Christopher Kuni presented a proposal for an additional MRI unit for information at both the October Finance and Planning and Development Committee meetings. This was also presented at the November Planning and Development and the December Finance Committee meetings for endorsement.

We are submitting this proposal for consideration and approval at your December 16th meeting. Please note that we have added a brief section on financing, and are recommending that this project be funded from our reserves.

If you have any additional questions, please don't hesitate to contact me.

RD/kff

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.

FINANCIAL RECOMMENDATION

Utilize Hospital reserve funds to purchase equipment and to pay construction costs. This project is included in the approved 1987-88 capital budget.

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.

Park Nicollet, HMO head for showdown

Money strains ties between clinic and MedCenters

By Maura Lerner
Staff Writer

A year ago, Dr. James Reinertsen thought the Park Nicollet Medical Center just wasn't trying hard enough.

The clinic had lost money on operations four years in a row, and Reinertsen, its president, was looking for answers. Maybe the doctors weren't working hard enough; maybe costs were simply out of hand.

But this fall, he's changed his tune: It's not the clinic that's to blame, he said now, but its biggest customer, MedCenters Health Plan.

In his view, MedCenters, the health maintenance organization, has been paying the clinic bargain-basement rates for top-notch care. And Reinertsen believes that can't go on. So the Twin Cities' largest clinic and the HMO, which were once almost inseparable, are headed for a financial showdown.

Park Nicollet, in a rare move, went to court last month to try to force the HMO to pay more. MedCenters offered an 11 percent pay hike for next year, but the clinic said it needed 20 percent, and sued for breach of contract — for trying to impose an unacceptable rate.

MedCenters officials say they're sympathetic, but that they can't pay the doctors more without charging much higher rates to customers. And that, they say, would drive away business.

Park Nicollet tried to get a restraining order that, in effect, would have stopped MedCenters from signing new customers until the pay dispute was settled. But the HMO, which has about 286,000 members statewide, argued such a move would be "catastrophic," and a Hennepin County judge rejected the restraining order. The two sides then agreed to submit the pay issue to binding arbitration, which began this month.

The battle has an irony all its own. Until two years ago, the two organizations were operated in tandem by a team of shared managers. In fact, the HMO was founded in 1972 by Park Nicollet's predecessor, the St. Louis Park Medical Center, as a way of increasing the clinic's business. And Park Nicollet still controls eight of the 15 seats on the HMO's board.

Yet money can strain even the closest of family ties; and Park Nicollet claims it will lose $18.8 million on MedCenters patients in 1986 and 1987 combined.

About two-thirds of the clinic's patients belong to MedCenters, and that, said Reinertsen, is part of the problem. According to him, the clinic lost $9 million on MedCenters patients last year, while earning a profit of $7.6 million on all others — for an operating loss of $1.4 million.

Thanks to the sale of an investment, the clinic was able to post a $1 million profit for the year — which was likened, in a management memo, to being "bailed out by an inheritance from a rich relative." That's one reason the clinic kicked off a major advertising campaign to attract more profitable, non-Medcenters patients.

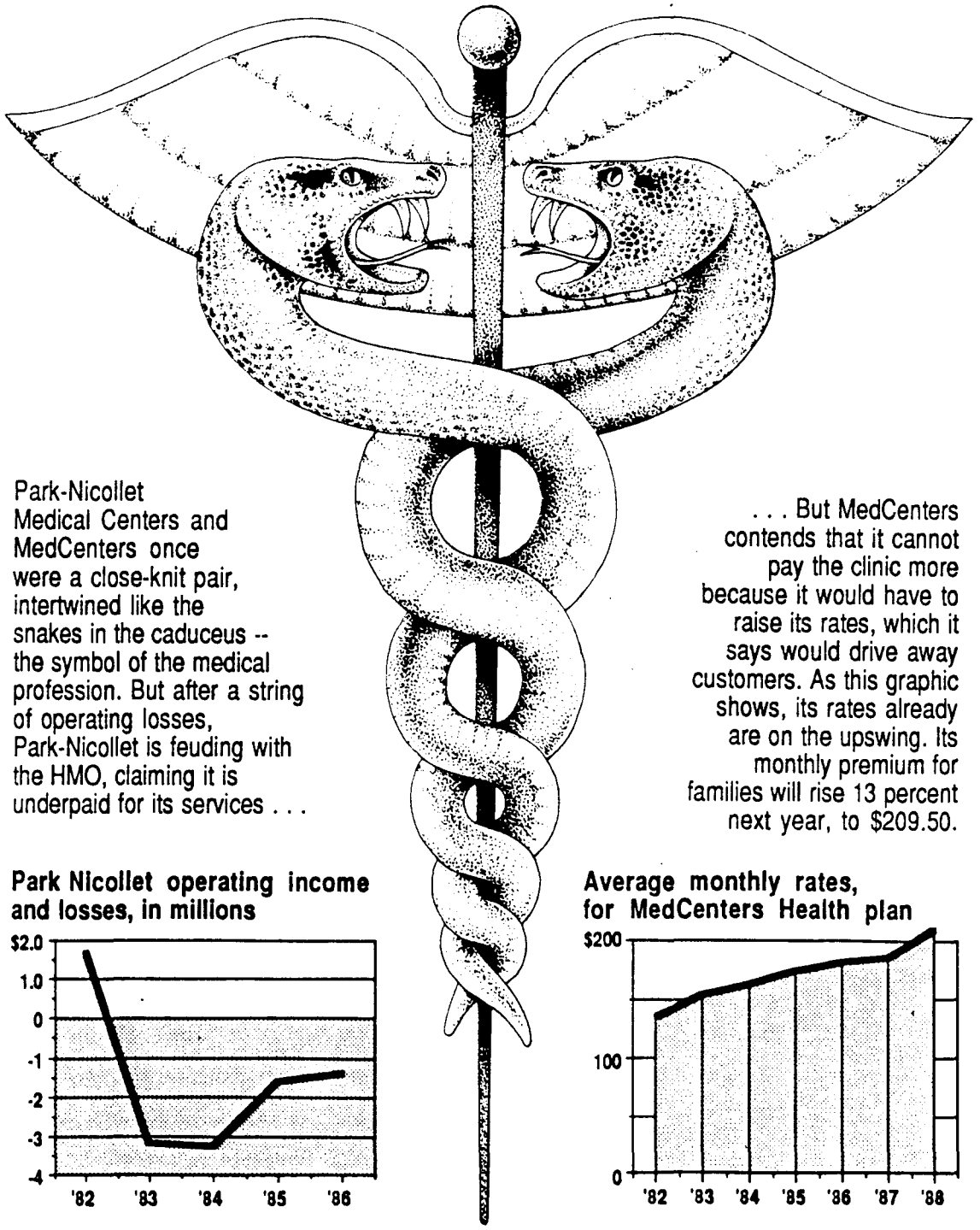
"We're not asking for an excessive amount of pay," Reinertsen said in an interview. "We're simply saying it has to be reasonably competitive. . . . When I say that to most people, they say, 'Oh, that's all those greedy doctors.' That's not the issue. The increase doesn't go to more Eldorados in the doctors' parking lot. The increase is going to make care and service better."

Over the last four years, the clinic's pay increases have ranged from half of 1 percent to 5 percent a year, according to court documents. At the same time, medical costs in general were jumping 7 to 12 percent a year in Minneapolis, according to federal statistics.

Reinertsen said the clinic has done everything it can to eliminate waste

Clinic continued on page 8M

Star Tribune, Monday, October 26, 1987



Park-Nicollet Medical Centers and MedCenters once were a close-knit pair, intertwined like the snakes in the caduceus -- the symbol of the medical profession. But after a string of operating losses, Park-Nicollet is feuding with the HMO, claiming it is underpaid for its services . . .

. . . But MedCenters contends that it cannot pay the clinic more because it would have to raise its rates, which it says would drive away customers. As this graphic shows, its rates already are on the upswing. Its monthly premium for families will rise 13 percent next year, to $209.50.

Park Nicollet operating income and losses, in millions

Source/Park Nicollet Medical Centers

Average monthly rates, for MedCenters Health plan

Source/MedCenters
Star Tribune graphic/Jim Freitag

CLINIC: Employers 'skeptical' of claims

Continued from page 1M

and inefficiency — by reducing hospital stays, freezing doctor salaries and so on. "If you go any further, we know . . . we would incur some drop in the quality of care," he said. "There isn't any more blood to be squeezed out of the stone."

But others have their doubts. "Employers are very skeptical of those kinds of claims," said Patricia Drury, executive director of the Minnesota Coalition on Health, a group of consumers, businesses and others concerned about health costs.

"Certainly they do not wish to push cost control to the point where it seriously jeopardizes quality of care. (But) there's a long history of rhetoric without evidence that's made by both sides."

MedCenters, too, is wary of the claims. "Four and five years ago, it was thought by many professionals, meaning physicians and HMO people, too, that hospital utilization was down to it's minimal level," said Donald Gerhardt, executive director of the HMO. "Well, I think we've proven that wrong, that hospital utilization could still be reduced and quality did not suffer. We still maintain extremely high quality, by any test."

Now, he said, they may have gone as far as they can in cutting hospital costs. But Gerhardt has another suggestion: cut costs in the doctor's office. "We think now is the time to begin looking at outpatient care," he said.

That might mean reducing the number of lab tests, X-rays and office visits offered to patients. But Gerhardt insists that wouldn't mean denying care to those who need it.

"I think it translates more into helping people understand that they don't have to see a doctor when they have a cold," he said. Or making sure that patients who request high-tech procedures, such as Cat scans, really need them.

But Reinertsen, of Park Nicollet, said years of cutbacks already have taken a toll. For one thing, he said, the clinic's "infrastructure" has been neglected. "Those things like records systems and phones and new pieces of ophthalmological equipment . . . it's all of those kinds of things which I believe are gradually being eroded in Minnesota because of the lack of reimbursement."

And doctors' salaries are getting less competitive, he said — at least for the kinds of people the clinic wants. "We are just about to encounter the real break point where we won't be able to attract the top people anymore," he said. He said a majority of the clinic's doctors earn less than the national average for similar-sized medical centers.

The main problem, he said, is that HMOs in the Twin Cities have been waging a price war — with everyone slashing prices. "Look what happened to quality and service in airlines when irrational pricing became the norm," Reinertsen said. "Your baggage is one thing. Your health is another."

But HMO officials say customers have a different view. "You sure don't hear at the Minnesota Coalition or the business groups that prices are too low," said Jan Malcolm, director of government relations at Partners National Health Plan, which runs MedCenters. "We go in with a price increase that is . . .unacceptable to the customer, they don't have any problem in saying 'no, thank you.' "

Drury, of the Minnesota Coalition, agreed. "They're going to react with anger," she said of the HMO's corporate customers. "If it translates into premium increases, which I would predict they would, they would feel very stressed about that. They'll sure try to be tougher buyers."

In fact, prices already have begun climbing. The latest contracts for state employees — a bellwether for the whole area — showed premiums jumping as much as 11.5 percent for single coverage, and 26.8 percent for family coverage. MedCenters has proposed a 13 percent increase, on average.

Does that mean, then, that the era of cost controls is ending? "That's the $64 question," said Roger Feldman, a health economist with the University of Minnesota's School of Public Health. "Is it the beginning of a new trend? I honestly can't answer that."

Reinertsen said he's convinced customers will pay more if quality is at stake. "When faced with the choice between good care and cheap care, (they) are going to be able to make a wise decision," he said.

But Drury said the war to control costs isn't over. "I don't think costs are going to go down, but I think they can be brought closer in line with the general inflation," she said. "I think there's significant doctor distress. (But) I do not think they can stem the tide of change. The war is still in progress."

Minnesota Daily
October 30, 1987

U Hospital 'profits' on loss of income

By Dori Carlson
Staff Writer

Although the University Hospital and Clinic only lost $101,070 in fiscal year 1986-87, administrators were prepared to lose approximately $11.3 million.

The hospital considers the small loss a large profit since it was prepared to lose millions.

The financial equation is simple: More services offered equal more gross revenue, said Cliff Fearing, chief financial officer for the University Hospital and Clinic.

Fearing said an increase in patient admissions improved the hospital's financial situation last year.

Hospital administrators projected 1986-87 patient admissions at 16,950, but patient admissions were 19,169 — a significant increase, Fearing said.

Compared to recent years, the hospital is experiencing an upswing in patient admissions.

Hospital admissions peaked in 1982-83 at nearly 21,000, but the following years showed a steady decline. Last year, 17,694 patients were admitted.

The 1986-87 increase is due to improved and expanded University hospital services, Fearing said.

The hospital is attracting more patients, especially acutely ill ones, because of advanced programs in cardiac surgery and organ transplants, and its lithotripter — a device that disintegrates kidney stones.

Patients might also have been attracted to the hospital by its marketing and advertising campaigns.

One example is the upgraded outreach program intended to send physicians to rural communities, who then refer patients to the University hospital.

More efficient hospital spending also contributed to the prosperous year.

Lower interest rates and prospective payment plans give the hospital incentives to operate more cost-consciously.

Under the prospective payment plan, the hospital receives a set amount of money from a health-care organization, depending on patient diagnosis. So, whether a patient stays in the hospital three or 10 days, the hospital receives the same amount of money from the patient's provider.

Before prospective payment was adopted in 1983-84, the hospital was reimbursed for all costs incurred during a patient's stay.

Fearing said, overall, the hospital is running pretty efficiently, but added, "There's always room for change."

Whether the hospital will continue its more profitable status in the future is speculative, Fearing said.

"We don't see a downturn at the moment. It will either continue to grow or level off in the next few years."

PROFILE

adventure

Nancy Ascher in her office: you have to be athletic *and* stubborn to do transplants.

NANCY ASCHER, M.D.: ON THE FRONTIERS OF MEDICINE

By Mark Dowie

Nancy Ascher has been on her feet for 16 hours. She's been awake for 32, and the hardest part is yet to come. At 3:45 A.M. her aching hands are deep inside the tiny body of Alice Bowen, who lies anesthetized under the cool bright lights of OR 10 at the University of Minnesota Hospital. The tension is palpable as nurses, anesthesiologists, and residents watch their surgeon place a few last critical sutures in the suprahepatic vena cava. They know that Alice Bowen's life is riding on Nancy Ascher's stamina.

"I do not want you to portray me as some kind of superwoman," Ascher tells me later, while I search for a place to set my tape recorder in her office, which is cluttered with medical journals and original prints she has collected over the years. "If you had the training, you could have done that," she adds.

Alice Bowen, a five-year-old first-grade student from Wichita, Kansas, had biliary atresia, a congenital liver disorder that would have killed her had Ascher not found her a new liver. Ascher is a general surgeon and the first woman in the world to perform the long and delicate transplant of a human liver, and one of the few surgeons anywhere who has done more than 50 such operations (she has done about 130).

"You *do* have to be fit for this work," admits the trim and athletic Ascher, who runs between six and 10 miles a day and is training for a marathon. "And you have to be stubborn. But you don't have to be superwoman."

But I know lots of stubborn people in good shape who can't stay alert for 48 hours, I point out, offering myself as an example. There *must* be something else?

"There is," she says. "Adrenaline."

Ascher describes "the high" when a call comes in from St. Somewhere, U.S.A. There is a liver for one of her patients. In a matter of seconds, a helicopter leaves the hospital roof with a specially equipped team of surgeons. In 20 minutes they are at the Minneapolis airport, where a small jet loaned by a local corporation flies them two, maybe three thousand miles to "harvest" the liver from a brain-dead patient—most likely a highway fatality who has been kept on a ventilator after death is declared so that kidneys, heart, liver, corneas, and maybe the pancreas can be removed by transplant teams that have come from all over the country in search of these very scarce medical resources.

If she is not on the flight, Ascher is on the phone with her team throughout the night, checking blood and tissue types, the weight and condition of the liver—all things she needs to know to select the right recipient from the 30 or more of her patients who are waiting for a second chance at life. Adrenaline keeps her alert while she waits for the heart team to harvest their organ. The heart always goes first.

Two hours later it's the liver team's turn. The liver is a delicate and complex organ, much more challenging to remove or transplant than a heart. It will be about three more hours before the Minnesota crew is airborne for Minneapolis with its prize. Just as the adrenaline starts to wear off, a new stimulant kicks in. It's the sight of a common picnic icechest containing the healthy pink liver for a dying patient in Minneapolis who, at that very moment, is in surgery in OR 10.

The University of Minnesota was one of the early centers for liver transplants beginning in 1968. But it did few operations because survival rates among transplanted patients had not been impressive before the discovery of cyclosporine, an immunosuppressive drug that arrests the rejection re-

DANIEL CORRIGAN

sponse without seriously affecting the body's immune system. When cyclosporine was approved for general use in 1982, Chief of Surgery John Najarian proposed that the university reactivate its dormant liver transplant effort and made Ascher clinical director of the program.

It is likely that the liver that comes back from St. Somewhere will be for a small child like Alice Bowen—or Ascher's most famous patient, Jamie Fiske, whose 1982 transplant drew national attention to the chronic shortage of donor organs, when her father made a desperate televised plea for his daughter's life. It seems to be the young that are often afflicted with the kind of liver diseases that call for transplantation.

Ascher has grown close to her patients and their families, remembering them each by first name, talking to them often on the phone. "I am in many ways a family practitioner," says the 1974 University of Michigan Medical School graduate who originally wanted to work in a free clinic. "That was when I first went to school. But I changed. I was drawn to the intellectual challenge of surgery. I wanted the combined challenge of working with my brain and my hands. And I have to confess, for a while I liked the 'walkaway' aspect of surgery as well: you operate; you leave; and the patient is cared for by other physicians. But that was only appealing to me for a while. As it turns out, you can't walk away from a liver transplant. These patients need lifelong care and while I suppose I could turn them over to another physician, I would rather treat them myself. I'm a free clinic doctor after all," she laughs. "It's wonderful."

So as long as Alice Bowen lives, Nancy Ascher will be her "attending physician." And Alice will need the ongoing care, because for the rest of her life she will stay on a complex regimen of cyclosporine and other immunosuppressive drugs, all of which have their own unsavory side effects.

Much of Ascher's time is spent researching the phenomenon of organ rejection. "The ultimate challenge of organ transplanting is in the laboratory, not in the operating room," she says. "I want to know *why* and exactly how the body rejects a new liver," says the author of more than 70 papers on the subject.

"My graduating thesis was about the rejection mechanism. I found that some of the cells that attack a graft actually mature right near it. That's a very exciting discovery." She is currently assisting with research at the University of Minnesota involving a small pump that injects steroids and immunosuppressive drugs directly into the graft, thereby fighting the rejection response locally, rather than generally where it compromises the body's entire immune system.

She is also experimenting with animal liver cell grafting where instead of transplanting an entire liver, a few cells removed from a healthy animal's liver are injected either into the peritoneum or under the skin of another animal deficient in enzymes produced by the liver. "Today, for enzyme deficiencies, we have to transplant," says Ascher. "If this works we will still have to transplant for things like biliary atresia, but it will obviate a lot of transplanting and diminish the shortage of organs."

Organ shortage is the bête noir of transplanters. Despite all the laws that have been changed to make it easier to harvest organs from brain-dead cadavers and the public education campaigns to encourage donation, a scarcity of transplantable organs persists. At present Ascher has about 30 patients waiting for livers, which, unlike hearts and kidneys, have no mechanical substitutes. The work of a kidney can be duplicated by dialysis and an artificial heart can be implanted while a patient waits for the real thing. Not so for the liver, an artificial version of which would require a five-acre chemical factory. With this in mind, Ascher dreams of a day when xenografting—transplanting organs from other species—is viable.

If the liver cell transplant works, Nancy Ascher will have *arrived* in the transplant community—a very male world: in fact the last true patriarchy in medicine, where, by and large, women are nurses or transplant coordinators and transplant surgeons are men. And in the United States, surgeons run transplant units, which at some large medical centers are becoming the dominant practice. It would be ironic if America's first Nobel for a transplant surgeon went to a woman.

Ascher acknowledges the maleness of surgery and particularly of her specialty, but says that medicine is generally much less sexist than it used to be. She says she has never felt discriminated against. "In fact, I've had a very warm reception."

But she is bothered nonetheless, she says, by "*something* in medical school that is turning off women about surgery. I really don't know what it is. But while many more women are entering medicine, fewer are going into surgery." She ponders the problem for a moment, looks out over Minneapolis from her eleventh-story window and laughs. "Maybe they're smart," she says.

Ascher chose liver transplanting because she wanted work that would keep her excited. "I want to feel challenged every single day I go to work," she says. "I al-

Donating Organs

THE LAW

Ninety-four percent of Americans support organ donation, and yet only 17 percent carry organ donor cards, according to The Living Bank, a service organization that was founded in 1968 by a group of women dedicated to educating the public about organ donation.

Becoming an organ donor is very simple. In many states, including Massachusetts, Pennsylvania, New York, and California, you can do it when you renew your driver's license, or simply by signing the back of your present license.

Although your driver's license is the most convenient place to keep your donor information, you can also carry an organ donor card. Either way, you can specify the organs to be donated and you need not write any of this into a will (your survivors can make the donations without authorization in a will). Most cities have independent organ procurement agencies that will furnish you with a card. You can call one of the numbers listed below or contact any hospital, especially those affiliated with universities, for more information. Parental consent is required for donors under the age of 18.

At present, approximately 12,000 people are waiting for organ donations.

—Anne Hardart

The United Network for Organ Sharing, 3001 Hungary Spring Road, P.O. Box 28101, Richmond, Va. 23228; (804) 289-0600; (800) 243-6667 (24-hour donor line)

National Kidney Foundation, 2 Park Avenue, New York, N.Y. 10016; (212) 889-2210. (Has offices in most major cities, and handles donations of other organs as well.)

The Living Bank, P.O. Box 6725, Houston, Tex. 77265; (713) 528-2971; (800) 528-2971 (24-hour referral service)

The Eye Bank for Sight Restoration, 210 East 64 Street, New York, N.Y. 10021; (212) 980-6700

ways wanted to have a job where ten years after I started I would still be excited about coming to work." She is still clearly excited, but admits that the adrenaline has slowed down a little on those long harvesting trips. "I don't go out for livers anymore. Now, whenever I can, I send a fellow. It's part of a larger change I feel coming in my life."

"What are the signs?" I ask.

"Well, I was hoping not to talk about that," she says, flashing a dirty look at my tape recorder.

"My personal life is in a state of flux," she admits. "I am trying to reset some priorities right now—a little less work, a little more play." She had recently returned from a week in Paris, where she spent a lot of time in Claude Monet's garden.

And kids? "Yes, I want children, someday. But I'm a late bloomer like my mother, who was forty when I was born. So I'm not in a big hurry." She is 38. "Can one raise children and transplant livers?" I ask, approaching the denied superwoman question again.

"Of course. The people in offices next to mine will just have to get ear plugs."

In the meantime her children are the Alice Bowens who come through her life. And they are clearly family for her. Not only does she provide their medical care, remembering them all by name, but last year, at great risk to her hands, she worked on a construction project turning a nearby house into a temporary out-of-town residence for families of transplant patients.

Alice is still in guarded condition. If she dies, and she probably won't, Ascher will be at her funeral. She has lost count of the funerals. Some have been for patients she transplanted, but many were for those who died waiting for livers.

Nancy Ascher is living testimony to the fact that American surgery needs more women. ■

MARK DOWIE *is the author of a forthcoming book from St. Martin's Press on the history of human organ transplantation.*

SPORTS

Faster Than a Speeding Bullet

It's Michele Granger on the mound!

When Michele Granger first learned to pitch a softball in grade school, her father told her just to throw hard and not worry about accuracy. The result? "For a long time I threw it over backstops," Granger confesses, laughing at her high balls that topped the cage behind the catcher.

But with a little practice, her father's advice paid off. Just 17, Granger is being touted as the most spectacular softball pitcher since the famed Joan Joyce (who played in a short-lived professional league in the mid-seventies and is now a professional golfer). Her 70+ mph fastball helped the lefty from Placentia (California) High School reach every pinnacle in the sport last year. She was a member of the world champion USA team, outstanding pitcher at nationals, and the U.S. Olympic Committee's Softball Athlete of the Year. And that's not counting the high school records she broke, or the honor of being chosen for this year's Pan American Games team.

To top off that talent, Granger has an engaging smile and a bubbly, teenage demeanor, lending marquee value to a booming sport (there are more than 200,000 high school fast-pitch softball players and more than 10,000 college players). She's confident and competitive on and off the mound, and enjoys flaunting her five foot ten height. "You ever notice how sometimes tall people wear their hair really flat?" she asks. "Well I don't. Plus I like wearing heels . . . and towering over everybody!"

But she insists that her high school friends keep her down to earth despite her growing fame. And she's not overimpressed with predictions that she'll be the most highly recruited collegiate softball player ever, or that she's the new Joan Joyce. Asked if the Joyce comparison is based on the overwhelming speed with which both throw the ball, Granger answers with a shy laugh, "I guess so. I never saw her pitch, so I really don't know. I don't always feel I'm pitching fast."

But what about the opinions of the batters, most of whom whiff helplessly at the ball? "They think I'm fast," Granger admits. "Okay, I'll take their word for it."

—Michele Kort

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Minnesota Daily
November 4, 1987

Hospital withdraws special Aware Gold deal for U employees

By Delores Lutz
Staff Writer

University Hospital, under pressure from state officials, is withdrawing its plan to give some University employees a break on their hospital bills.

In September, University Hospital offered employees with Aware Gold insurance the chance to continue using the hospital without paying their deductibles — parts of bills that patients are required to pay themselves.

But University officials reversed that decision Tuesday because state officials objected to the deal, announced Stephen Dunham, University vice president and general counsel.

University faculty and staff who have the popular Blue Cross Aware Gold Limited insurance soon will have to pay their own deductibles, according to Dunham.

That decision may make Aware Gold less attractive than it was when employees chose it in September. Therefore, they soon will have a chance to switch to another health care plan, he added.

Meanwhile, University Hospital will continue to absorb employees' deductibles. The scheduling and details of the change-over still are being worked out and will be explained in a letter expected to be mailed to faculty and staff at the end of the week, Dunham said.

University employees need not worry that they will be penalized for having Aware Gold during the upcoming enrollment period, said Robert Dickler, University Hospital's director.

"No one will be left out in the cold, out on a limb or disadvantaged," Dickler said.

The hospital's decision is the latest round in an ongoing struggle involving University employee benefits.

That battle heated up last July, when state officials announced they were dropping the full Aware Gold insurance plan from the benefits package offered to the state's 50,000 employees, which includes 16,000 University employees.

Employees had to choose among several health maintenance organizations and Aware Gold Limited, a hospitalization plan that requires patients to pay some of the costs of their care. The deductibles are determined on a sliding scale ranging up to $680, Dunham said.

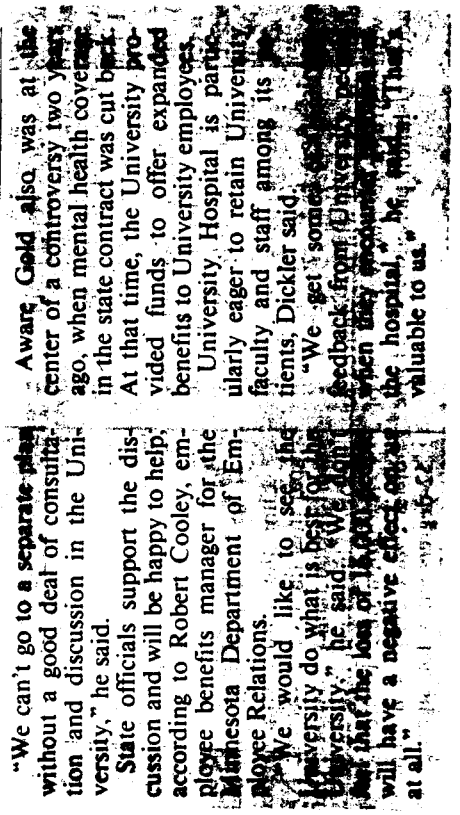
Employees who chose Aware Gold say they prefer it because, unlike other health plans, it allows them to choose their own doctors. Officials said they do not yet have figures on how many employees stayed with Aware Gold or switched to other plans when the first open enrollment period ended Oct. 1.

University Hospital administrators, conscious of competition and eager to retain Blue Cross patients, offered to waive the deductible for Aware Gold-limited patients who were state employees.

"We would have been delighted to make the offer available to everybody," Dickler said. But the state rejected that plan, so University Hospital extended the offer only to University staff.

But state officials argued that the University's action undermined their ability to negotiate insurance contracts.

The ensuing discussions rekindled an old proposal that the University sever itself from the state employee-benefits program and create its own. University officials will continue to explore that option, but that process will require time, Dunham said.



"We can't go to a separate plan without a good deal of consultation and discussion in the University," he said.

State officials support the discussion and will be happy to help, according to Robert Cooley, employee benefits manager for the Minnesota Department of Employee Relations.

Aware Gold also was at the center of a controversy two years ago, when mental health coverage in the state contract was cut back.

At that time, the University provided funds to offer expanded benefits to University employees.

University Hospital is particularly eager to retain University faculty and staff among its patients, Dickler said.

"We get some feedback from [illegible] valuable to us."

Survey: U Hospital often more costly

By Dori Carlson
Staff Writer

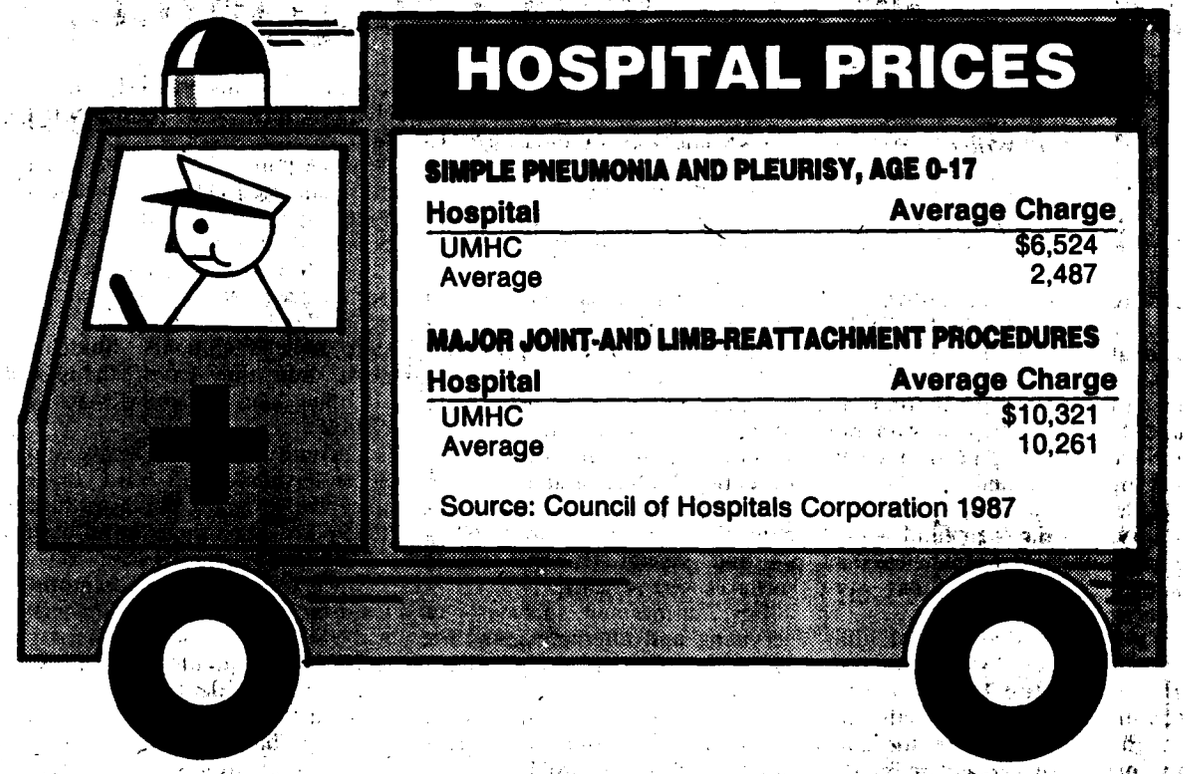
Medical treatment at the University of Minnesota Hospital and Clinic is more expensive than treatment offered by its Twin Cities competitors, according to a new survey.

The study, conducted by the Council of Hospital Corporations, which compared costs at 16 Twin Cities hospitals, found University Hospital's costs 6 to 16 percent higher than costs at other area hospitals.

The survey based its results on the 50 most common reasons patients are admitted to local hospitals.

But a University Hospital official says the survey is misleading.

According to University Hospital Administrative Director Greg Hart, the University Hospital often admits patients with more severe cases, which results in higher costs.



Daily Graphic/Michael Hopp

Other area hospitals often refer their most serious cases to the University because those hospitals do not have adequate equipment, Hart said.

The survey showed that the University Hospital charges nearly $4,000 more than the average $2,487 charged by area hospitals to treat pneumonia. But Hart said that was justified because the University Hospital often treats more complicated types of pneumonia cases.

In some areas, however, University Hospital prices were more in line with other hospitals, according to the survey.

The average cost of major joint and limb reattachments at area hospitals was $10,261, compared to $10,321 at the University.

But cost is not the most important factor patients consider when selecting a hospital, Hart said. They often base their decisions on where they think they can get the best care.

George Ryan, a spokesman for United Hospital in St. Paul, said the University is forced to charge more than United because the University conducts more medical research.

"We can't hope to duplicate the research the University Hospital does," Ryan said.

The [illegible] conducted since 1982, when the state Legislature passed a law mandating voluntary price comparisons among hospitals in an attempt to stem surging health care costs.

Whether this law has increased competition among area hospitals is uncertain, said Ed Van Cleave, spokesman for the Council of Hospital Corporations. "The effects remain to be stud-

Minnesota Daily
November 4, 1987

Burke to give up control of HMO

under of United HealthCare to sell half of his stock

By Maura Lerner and Joe Rigert
Staff Writers

Richard Burke, the controversial founder of United HealthCare Corp., said Tuesday he will step down as chief executive as his Minnetonka-based company moves to close its operations in seven states to cut losses.

In addition, Burke agreed to sell almost half his stock to a New York investment firm. The firm, Warburg, Pincus Capital Co., will replace Burke as the largest single shareholder and inject an additional $10 million into United.

Burke built the company into a nationwide network of health maintenance organizations (HMOs) including Minnesota's largest, Physicians Health Plan. He will step down Jan. 1 but continue as chairman of the board and remain United's second largest stockholder with about 8 percent.

The sale brings Burke's gains from stock sales to $12 million in the past two years. Warburg agreed to pay him $7 million, giving it 11.5 percent of United's common stock. It will invest another $10 million in United in exchange for preferred stock. In addition, it has the option of buying the rest of Burke's stock, and another $10 million in shares from United. If it exercises those options, it would own more than a third of the company.

United also announced yesterday that it was halting efforts to expand, at least for now, by closing one unprofitable HMO in Phoenix and six other start-up operations in other cities. As a result, United will take a one-time write-off of $15.3 million against earnings. Officials say they expect to show a loss for the year.

United said the changes would not affect Physicians Health Plan (PHP) or Share, the other Minnesota HMO that United manages.

Burke recently resigned as chief executive of PHP in the wake of an uprising by doctors, who accused the management of financial improprieties. Burke said that dispute had nothing to do with his decision to sell his United holdings.

The agreement calls for Burke to sell 1.5 million of his remaining 3.2 million shares for $4.50 a share. The price was down sharply from the stock's one-time high of almost $16 in mid-1986, but higher than yesterday's closing price of $3.25, down 75 cents.

Burke, who angered local doctors by cutting their fees while building his HMO organization, received the stock free as a founder of the company. In the last two years, he will have sold a total of $12 million in stock, including $1,457,000 in April 1986, $3,771,000 last March and $6,750,000 under the agreement with Warburg.

Burke said Warburg forced him to sell his stock as a condition of the agreement. "Warburg wanted to be the largest single stockholder," he said., "I did it reluctantly in spite of the price," he said. He said his resignation as CEO was part of management changes begun in April.

By investing in United, Warburg is bucking a trend. In the last year, many investors have shied away from HMOs because of disappointing results. But Warburg, a company with a wide range of investments, is no stranger to the field.

In 1981, it invested $2 million in a deficit-ridden HMO company now known as U.S. Healthcare Systems Inc., in Willow Grove, Pa. Warburg quickly recovered its investment when U.S. Healthcare sold stock that shot up from $20 to $35 a share, according to published reports. It was the first HMO in the country to offer stock publicly, and the sixth largest HMO in the country last year.

Warburg also has invested in other health-care companies, including the Humana Inc. HMO in Louisville, Ky., according to industry sources.

Warburg executives did not return telephone calls for comment on the United investment.

Kennett Simmons, 45, United's vice president and chief operating officer, will succeed Burke as chief executive. Robert Ditmore, 53, the company's president, will become chief operating officer.

The company currently owns or operates 31 HMOs in 21 states, compared with 40 HMOs in 25 states at the end of 1986. It will close HMOs in Phoenix, Dallas and Houston, Las Vegas, Nev., Topeka, Kan., Tulsa, Okla., Libertyville, Ill., and Dunedin, Fla. The write-offs include $3.6 million in loans and investments to HMOs in four other states.

"I wouldn't say it's the end of an era of expansion, but I would say until their profitability improves, it wouldn't be appropriate to expand," said Barbara Santry, a securities analyst for the Minneapolis brokerage of Wessels, Arnold & Henderson. The company's earnings dropped 62 percent in the second quarter, which ended June 30, largely because of unprofitable operations outside Minnesota.

A spokesman said the company has lost $2.8 million this year on its Phoenix HMO, which it purchased last year, and was having trouble raising money to start up the other HMOs.

"We were late in getting into some of those markets," said David Koppe, vice president and treasurer of United. "I think the window of opportunity is closed for us and many others. We really looked at the start-up losses that were facing us and decided to concentrate on our existing operations."

Koppe said the Phoenix HMO had about 13,000 paying customers, who will now have to find new health coverage. Most of the others were just getting started, and had no enrollees, he said.

Paul Ellwood, an HMO expert and consultant in Excelsior, said United was not alone in running into trouble in other states. "I think most of the national HMOs attempted to go into too many markets too fast," he said. "No doubt about that." He said many have run into intense competition or doctor resistance in certain areas, forcing some HMOs out of business.

Earlier this year, another HMO company had signed a letter of intent to make a major investment in United, but the deal fell through. The firm, Lincoln National Administrative Services Corp. of Fort Wayne, Ind., bought 6 percent of United, and would have purchased up to 30 percent under the agreement. Lincoln backed off at a time it was having financial difficulties.

United said it expects to be on sounder footing next year as a result of its restructuring.

"Once we're free of some of these start-up losses ... and large losses from plans such as Phoenix," said Koppe, "our base operations are still very much profitable operations."

Staff writer Gordon Slovut contributed to this report.

Average stay in area hospitals shorter in 1986

By Gordon Slovut
Staff Writer

The average hospital stay for a Twin Cities area Health Maintenance Organization (HMO) member in 1986 was 3.76 days, two days under the area-wide average, according to the Twin Cities Council of Hospital Corporations.

People who had to pay for hospitalization out of their own pockets were the group with the second shortest stay. They left after an average of 4.22 days, down about a day from 1981, the first year for which the hospital industry organization kept HMO records separate from other insurance carriers.

HMOs, which provide or pay for nearly all medical and hospital costs for a monthly fee, cover more than 43.6 percent of the residents of the Twin Cities metropolitan area with their standard plans.

Their customers account for less than 15 percent of the patients in area hospitals on a given day, an indication that they are successfully holding down costs by shifting care to doctors' offices, clinics and one-day surgical centers and by speeding up discharges.

Minnesota Blue Cross-Blue Shield and commercial insurance companies have not been as successful as HMOs in shortening hospital stays. Their customers' average stay last year was 5.8 days, down from 6.2 days in 1980. Blue Cross and the commercial insurance companies don't cover as many people in the metropolitan area as the HMOs, but their clients account for 31 percent of hospitalized patients on a given day, more than double the HMO percentage.

The HMOs were more successful than the federal government's Diagnostic Related Group program, which puts financial pressure on hospitals to discharge Medicare patients, mostly people over 65, early.

The average stay for HMO-Medicare members was 5.6 days; they accounted for 7 percent of hospital patients. The average stay for Medicare patients not covered by HMOs was 7.8 days, down three days in six years; they accounted for 25.7 percent of patients. In 1980, they accounted for 33.6 percent of hospital patients, indicating that the overall percentage of Medicare patients in hospitals — from the standard and HMO plans together — remained fairly constant.

Medicare-HMO plans offer more complete coverage of costs than the standard Medicare program.

Poor people covered by Medicaid, a government program, accounted for 11.8 percent of hospital patients last year, up from 9.7 percent in 1980 and 10.2 percent in 1985. The Medicaid average length of stay was 6.81 days, down from 8.66 days in 1980..

In general, hospital use in the Twin Cities continued its steady, decade-long decline. The number of admissions dropped to 308,374 last year, down 5,000 from the previous year and 58,000 from 1980.

The total number of days patients spent in hospitals dipped 3.4 percent from 1985 to 1986, and 58 percent from 1980.

The study shows that the average length of stays for almost everything from cancer to chemical dependency and the delivery of babies has continued to decline steadily.

Cancer patients, who spent an average of 9.56 days per admission in hospitals in 1980, spent 6.58 days last year; heart patient dropped from 8.86 to 6.13 days, and psychiatric patients from 19.58 days to 15.79 days in the same period.

In 1980 the 11,652 people admitted for chemical dependency treatment averaged 18.4 days. In 1986 the 9,999 admitted for the same treatment averaged 14.48 days.

In 1980 a woman hospitalized for childbirth averaged nearly four days in the hospital; in 1986 it was 2.79 days.

Most growth in hospital use in the 1980s was in obstetrics, from 11.9 percent of all patients in 1980 to 15.4 percent in 1986, and in the care of heart patients, from 8.4 percent of all patients in 1980 to 10.3 percent last year.

Eye surgery was one of the biggest losers, dropping from 2.3 percent in 1980 to .8 percent last year, largely because the lion's share of eye surgery, such as cataract surgery, is now done on a one-day basis.

Orthopedic surgery dropped from 11.1 percent of all patients in 1980 to 8.6 percent last year. Ear, nose and throat operations dropped from 4.1 percent of patients in 1980 to 2.8 percent last year.

On a typical day, according to the study, 31 percent of Twin Cities hospital patients were covered by Blue Cross-Blue Shield or commercial insurance companies; 25.7 percent by standard Medicare; 14.6 percent by HMOs; 11.8 percent by Medicaid; 3.4 percent by other government programs; 2.4 percent by self-pay; 6.7 percent by HMO-Medicare plans, and 4 percent by people with other types of coverage.

NEWS Roundup

A recap of significant events occurring between October 29 - November 11.

OCTOBER 29 – Neiman-Marcus, the Dallas-based department store chain, tentatively agreed to join the three-and-one-half block retail project on Nicollet Mall being developed by La Societe Generale Immobiliere (LSGI).

NOVEMBER 2 – Northern States Power Co. asked the Minnesota Public Utilities Commission to increase electric rates 9.5 percent, or $99 million annually, to recover costs from the recently opened Sherico 3 power plant.

NOVEMBER 3 – French developer LSGI got the go-ahead from the Minneapolis City Council for its retail project for the south end of Nicollet Mall. The council, however, amended the contract to specify that design plans cannot include plans to dome the mall.

NOVEMBER 3 – Richard Burke, founder of United HealthCare, will step down as CEO but will remain chairman of the Minnetonka-based company. New York investment firm Waraburg, Pincus Capital Co. will replace Burke as the largest single shareholder and inject $10 million into United through a purchase of preferred stock.

NOVEMBER 4 – A U.S. Bankruptcy Court judge approved the sale of the historic Nicollet Island Inn for $1.14 million, despite major debts of $7 million against it. The developers, Howard Bergerud and Craig Christenson, are expected to reopen the inn near downtown Minneapolis within three months.

NOVEMBER 6 – Carson Pirie Scott & Co. reported that it has completed the purchase of the Donaldsons Department Stores division from Allied Stores Corp. The retail chain, which includes 15 department stores, was sold for $155 million.

NOVEMBER 6 – The St. Paul office of Farm Credit Services lost $21.4 million on operations during the third quarter, although the farm lending cooperative system nationwide reported its first profit in two-and-a-half years, totaling $4 million.

NOVEMBER 10 – Northwest Airlines' largest union avoided a planned strike and asked the federal government for a mediator to help in contract talks involving 2,700 mechanics.

NOVEMBER 11 – A rural public interest group based in Fergus Falls said it intends to sue Physicans Health Plan (PHP) for dropping 11,500 elderly patients in rural Minnesota from enrollment. The group, Communication for Agriculture, says PHP should not be allowed to drop patients in order to increase profits. ■

—Compiled by Laurie Fink

BRIEFCASES

CAN SMALL INSURER LIVE UP TO BIG PROMISES TO HENNEPIN COUNTY?

HENNEPIN COUNTY commissioners resisted heavy lobbying by Physicians Health Plan (PHP) and county employees when the commission severed an 11-year-old relationship with the giant HMO.

The action will save the county $300,000 and employees another $500,000 on health coverage in 1988. But questions remain about whether the county will save over the four-year period covered by the contract, or whether the county's new insurer, Family Health Plan, simply painted a rosy picture to get a big public client.

Family Health Plan's contract only locks in rates for 1988.

Family Health Plan President Nazie Eftekhari claims the plan will save its client money because it directs patients to the most cost-effective hospitals and truly cuts unnecessary care. That's something Eftekhari and other observers claim that many HMOs have failed to do.

PHP, contending that it does the best job of holding the line on payments to physicians, warned commissioners that Family Health Plan's rates probably will rise steeply in the near future. And PHP staffers said Family Health Plan offers a much smaller choice of doctors and hospitals.

"We've got to be on this thing like a glove, at least until medical school curriculums include risk management for physicians," Eftekhari says. "PHP's position ignores the economic equation. It's fundamentally flawed to think that deep discounting of provider fees is cost containment."

The county commissioners contacted by *CityBusiness* after the vote said they chose to switch to Family Health Plan on January 1, strictly because of price. But none was willing to predict whether Family Health Plan will be able to contain rising costs better than PHP. For Family Health Plan, the contract will constitute about 17 percent of its enrollment, boosting subscriber numbers from 68,000 to around 82,000.

"PHP is a fine plan, but we're a Chevy customer and they're selling Cadillacs," says Commissioner John Derus. "The cost of including everybody under the tent is becoming prohibitive."

Eftekhari says she scrambled to marshal the efforts of her staff, lawyers, and a lobbyist when she noticed that PHP representatives didn't seem worried after the county initially opened the bids. She knew PHP was not the lowest.

She insists she didn't even know the commissioners' names before she decided to go after the contract. Some of her colleagues advised against it. But she knew that if Family Health Plan could show it could contain the county's costs, that would be invaluable in helping to attract new clients. The county has traditionally been an expensive group to cover.

Family Health Plan contracts with 1,000 "preferred" physicians, while PHP contracts with 3,000. Eftekhari says her PPO pays doctors on a fee-for-service basis and doesn't shift any risk onto doctors through capitated payments or withholding a percentage of fees to redistribute later.

Nazie Eftekhari, president of Family Health Plan

Eftekhari predicts "a diminishing influence of HMOs in the market. Those that are true to their mission and design weathering all the changes that are going on."

GREG HELGESON

PHP contracts with all 26 Twin Cities hospitals, while Family Health Plan contracts with 13. Enrollees of both plans can go to any doctor or hospital they choose, but they must pay more outside the plans' networks.

Eftekhari says that Family Health Plan has a quality measurement system that truly cuts costs and helps foster goodwill among doctors. Some health plans have upset doctors by failing to determine how much to pay doctors until they've finished treating patients. But Eftekhari says her staff reviews cases before and while patients are being treated, and doctors know if fees will be covered up front.

Very specific limits are set on hospital stays, based on types of illness and patients' ages and gender.

There is also a follow-up check on the patients once they go home.

"I do think the arrogance with which PHP treats its clients was one of the reasons we prevailed," says Eftekhari. "But there were quite a few commissioners who really understood the issues."

PHP still doesn't understand why it lost the county's business, says the HMO's CEO, George Morrow. "We answered their questions about why our bid was competitive."

According to Morrow, PHP will not suffer big financial or political losses because it lost the county's business. "But we're concerned that somebody we'd stayed with through thick and thin for 11 years would do this."

He says doctors and hospitals go through the same preadmission review process for all insurers. Family Health Plan will have to be intrusive if it intends to scrutinize services more closely than other plans, he adds.

"Anybody new in town is bound to get a better reception," Morrow says. "They have no history to fall back on or be tripped up by."

Several commissioners (six out of seven of whom have PHP coverage themselves) said the decision was especially painful because they were flooded with calls from county employees who didn't want to have to consider switching doctors.

But, as Commissioner Randy Johnson notes, "There were also a large number, who were not as vocal, who could not afford another $60 a month. Their cost will increase $30 a month."

About 75 percent of the county's employees are affected by the health insurance switch, because more than half currently are enrolled in PHP and another 20 percent use MedCenters Health Plan, whose bid did not meet the county's specifications.

PPOs are coming into their own at a time when some HMOs have grown to unwieldy sizes and are losing money as cost of care rises, especially for the burgeoning elderly population.

Many health care industry observers say HMOs have failed to contain health care costs but have grown by charging premiums too low to pay for the far-reaching health care services they cover.

Experts estimate that 30 percent of all enrollees in private health insurance plans in

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St. Paul Pioneer Press Dispatch
December 10, 1987

Hospital officials facing crisis in care of the poor

By Walter Parker
Staff Writer

Many Twin Cities hospitals are backed so hard against the wall financially that they'll soon be forced to stop caring for the uninsured and other marginal patients except in emergencies, a top industry executive predicted Wednesday.

"I really don't see any other way of doing it," said Donald Wegmiller, president and chief executive officer of HealthOne Corp., which owns United Hospital of St. Paul and Metropolitan Medical Center of Minneapolis, among other hospitals and health care companies in several states.

> **"I think the alarm needs to be sounded."**
> **Marlene Marschall**
> St. Paul-Ramsey Medical Center

While year-end financial results aren't available, Wegmiller said his contacts indicate that as many as 20 of 28 Twin Cities area hospitals will finish the year in the red,

Please see Hospitals/22A

Hospitals/ Cost-of-care crisis looms

Continued from Page 1A

with operational losses. That would be up from 13 in 1986. Total losses could well be $20 million, compared to $4 million last year, he said.

His own company will probably break even on Twin Cities operations, though it had a surplus the year before, Wegmiller said in an interview after a Minneapolis conference on health care quality and cost containment sponsored by the Metropolitan Council.

Wegmiller, who is chairman of the American Hospital Association, is a well-known and powerful figure in Twin Cities hospital circles.

Surveys indicate most "charity care" in Minnesota is done by public hospitals, but private non-profit hospitals have also traditionally borne some of the burden. Federal Hill-Burton law provisions require some charity care, but in recent years those obligations have expired for several hospitals, which incurred them 20 and 30 years ago.

Other hospital executives interviewed declined to speculate how many hospitals are losing money, but they agreed with Wegmiller that the problem of finding a way to provide hospital care for the poor has reached a crisis.

"The community needs to sit down and from a public policy standpoint figure out what we're going to do."

She said, however, that Ramsey, a public hospital, has not experienced an *increase* of "dumping," or transfer of non-paying patients from other hospitals who refuse to treat them. That has always occurred occasionally. But there is little room in the hospital's budget to absorb such additional costs, Marschall said. Employees at the hospital have been told not to expect a raise in 1988, which would ordinarily go into effect Jan. 1.

John Reiling, president of HealthEast, which operates five hospitals in the east metro area, said "payors need to recognize hospitals fundamentally need more resources than they're getting" if they're to carry out their traditional mission. HealthEast, which has closed two hospitals in St. Paul in an efficiency drive, "regards operating losses as very serious business" but has no plans to alter its policies on charity care, he said.

Wegmiller said hospitals in the Twin Cities have been forced into such steeply discounted contracts with health maintenance organizations, government and private insurers that they can no longer "cost shift," or spread the cost of treating non-paying patients across other customers.

"The payment structure in the community has effectively excluded anybody who can't pay for himself," Wegmiller said. The process has been occurring steadily over several years but has now reached a critical point that demands public attention, he said.

If the situation doesn't change soon, he said, many hospitals will have to close services of value to the community which tend to lose money — such as neonatal intensive care units.

Wegmiller also predicted that as the squeeze continues, quality of care will inevitably decline for patients who do manage to pay. So-called "soft services" that the public has come to expect such as discharge planning and social work could be reduced sharply in efforts to shore up sagging bottom lines, he said.

Nurses, already relatively hard to find, are increasingly discouraged about committing their careers to an industry that holds such little promise of economic health and advancement for them, Wegmiller said.

He laid a significant part of the blame on HMOs, which he said failed to see the long-term consequences of throat-cutting competition to win market share by pricing their benefits at such a level they couldn't break even as their members aged. They negotiated comparable contracts with hospitals, which had to go along or lose patients enrolled by the HMOs.

"Business and industry loved it," Wegmiller noted, even though now they and their employees are being confronted with steep premium price increases for 1988.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

REPORT TO THE REGENTS

DECEMBER 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 months of September through November.

RETREAT

In September, the Board of Governors spent two days at Riverwood Conference Center in Monticello. We invited Mr. Donald Wegmiller to speak to us about multi hospital affiliations. He is the President and CEO of the locally based HealthOne Corporation and is the Chairman of the Board of Trustees of the American Hospital Association.

You may know that most of the hospitals in the Twin Cities are owned by one of four organizations: Fairview, HealthOne, Healtheast and Lifespan. Only four hospitals in the metro area remain substantially independent. They include North Memorial, St. Paul Ramsey Medical Center, Hennepin County Medical Center and the University. Given the dominance of multi hospital systems in our community, the Board of Governors felt it prudent to better understand the factors influencing these affiliation decisions.

We also devoted a significant amount of time at the retreat discussing whether or not our hospital is responsive to the needs of physicians internal and external to our organization. A practicing internist from Waconia and the medical director from Group Health, Inc. shared their observations of the University of Minnesota Hospital and Clinic with us.

We also reviewed a variety of effects on the academic health center of increased competition among providers and increased regulation in the health care industry. In sum, this discussion provided the Board and Board Committees with several significant issues to consider over the coming months.

STRATEGIC PLANNING COORDINATING COMMITTEE

A group has been reorganized within the hospital called the Strategic Planning Coordinating Committee to analyze some of these major strategic issues. Membership on the Strategic Planning Coordinating Committee includes Vice President Vanselow, Dean David Brown, four physicians, our new Hospital Director Bob Dickler, and two Board members, including myself and the Chair of our Planning and Development Committee.

Over the next several weeks and months we are examining several programmatic issues, including the structure and organization of our ambulatory care services, and will be reviewing several short and long range facility questions that are inevitably tied to strategic deliberations. You may know that we have been questioning the ability of the Mayo Building to accommodate our Psychiatric services and are studying the potential of new construction for Psychiatry alone or for Psychiatry and other patient care areas. We are

also faced with the need to replace the delapidated structure where our Community University Health Care Center resides at Franklin and 16th Avenue in south Minneapolis. We will be back to you as these matters develop and we are prepared to make recommendations for action.

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

In November, the Joint Commission on Accreditation of Healthcare Organizations visited our hospital. They are recognized nationally as the accreditation body for hospitals and conduct site visits every three years.

A team of four surveyors spent three days reviewing our compliance with extraordinarily detailed standards. Compliance is assessed through interviews with staff, by reviewing documentation, and by touring our physical facilities. The official survey findings will be sent to us in February.

CENSUS

We continue to be busy at the hospital. You may recall that the 1986-87 fiscal year marked the first year in five years that we experienced growth in inpatient utilization. We have sustained that higher level of activity through the first five months of this fiscal year.

We have experienced a notable drop in the average length of stay this year. Our budget was built assuming our inpatients would stay, on average, 8.3 days. This fiscal year the average length of stay is averaging 7.9 days. This shortened length of stay is not an unfavorable decline. In fact, third party

payors view this shorter stay favorably. We are satisfied with the decline as long as patients are not adversely effected and, from a financial perspective, as long as the level of admissions is sustained or grows.

PRICE DISCLOSURE

On more than one occasion, you have asked whether prices at The University Hospital compare favorably to prices at other Twin Cities hospitals. Local hospitals voluntarily report and compare prices each year. Recently, price data for 1986 was released, comparing the costs of caring for 50 common diagnoses. A quick review of the data indicates that our charges are somewhere between 6% and 16% higher than the average community hospital.

An in depth review of the data led us to conclude four things:

- First, the commonly held belief that we are always more costly than other hospitals is a misperception. This is not the case.

- Secondly, a large portion of the existing differential is attributable to the severity of illness found in our patients. The price comparisons lump together groups of patients with like admitting diagnoses. It is our belief that these diagnostic groups lack homogeneity. The pneumonia group, for example, compares our post-transplant and oncology patients who are admitted for pneumonia with uncomplicated pneumonia in otherwise healthy patients. When like groups of patients are compared, our charges are often similar or lower than community averages.

- Thirdly, while this annual study reports hospital charges as such, these days prices charged by a hospital are not terribly meaningful. Third party payors routinely negotiate discounts from charges.

- Lastly, this price disclosure does remind the Board, the medical staff and management that we must be sensitive to cost issues. Examination of those areas where charges do appear to be outside of the norm deserve review and corrective action.

CLOSING

We feel a responsibility as members of the Board of Governors to foster an understanding of the complex issues facing the hospital. We are appreciative of the support that the Regents have given us.

Thank you. I would be happy to answer any questions at this point.

American Hospital Association

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WHAT TRUSTEES NEED TO KNOW ABOUT HCFA MORTALITY DATA

An AHA Briefing Paper for Hospital Governing Boards
December 1987

Introduction

The public release of mortality data by the Health Care Financing Administration (HCFA) is scheduled for mid-December 1987. This data release represents a major public relations challenge for the 6,000 U.S. community hospitals that treat Medicare patients. Your hospital's response to the HCFA release can either enhance or detract from its reputation in the community. Therefore, those speaking on behalf of your hospital need to be familiar with the data; its meaning, uses, and limitations; and the results of your hospital's review and analysis of the data.

As a trustee who is ultimately responsible and liable for the hospital's quality of care and who is an important link between the hospital and the community, you should be familiar with the HCFA data and your hospital's planned response to its release. This briefing paper is intended to supplement information you may have already received from your hospital chief executive officer or state hospital association. It discusses the type of information HCFA will release, what this information means, how it should and should not be used, and approaches hospitals can take in responding to inquiries about the information. Together with information from your hospital, this paper can help you, as a trustee, more effectively respond, if you are called upon to address comments or questions about the HCFA data.

The Data

In late September, all hospitals participating in the Medicare program received from HCFA a package of data concerning 1986 Medicare mortality rates in their facilities. Hospitals were given 30 days in which to review, prepare, and submit written comments on the data to HCFA. These comments will be released to the public with the data in mid-December.

For each of 16 diagnostic categories the following information will be released:

- The number of Medicare beneficiaries treated in 1986. This number excludes all but the last admission of beneficiaries admitted more than once during the year.

- o The hospital's mortality rate as measured by the proportion who died within 30 days of admission. This mortality rate will reflect deaths that occurred outside of the hospital as well as inside the hospital, and will exclude all deaths occurring in the hospital for patients staying more than 30 days.

- o The proportion who would be predicted to die if the hospital's mortality rate was the same as the national average for a group of similar patients with respect to diagnosis, age, sex, and other indicators of clinical condition. The predicted mortality rates will be presented as a range of probable values.

This year's data release is conceptually not very different from the mortality data released last year. In both cases HCFA used a statistical method for arriving at estimates of "expected mortality" based on certain selected patient characteristics, and then compared these estimates with actual mortality. This year, HCFA is using a more complicated statistical method for estimating "expected" mortality, and a somewhat different set of patient characteristics to "predict" mortality rates.

Rather than use deaths in the hospital to represent the hospital's actual death rate, HCFA has chosen to identify deaths within 30 days of admission to the hospital. Although the use of a 30-day post-admission mortality rate will reduce apparent variations in mortality due to differences in length of stay, it also will result in the attribution to the hospital of deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility.

The patient characteristics used in this year's analysis include the age and sex of the patient, the number of prior hospitalizations within the year, whether the patient was transferred from another hospital, and whether the patient has other complicating illnesses.

In addition to the 16 diagnostic categories mentioned above, this year's statistical model includes the presence of chronic, underlying or comorbid conditions including cardiovascular disease, cancer, liver disease, renal disease, cerebral degeneration/chronic psychosis, pulmonary disease, hypertensive disease, and diabetes.

The Reliability and Validity of the HCFA Model

The statistical model developed by HCFA measures the relationship between a limited number of patient characteristics and the risk of death. Whether these are the most significant factors influencing the risk of death is unknown, but the limited ability of these factors to explain differences in mortality rates between hospitals suggests that they are not. At best, the model offers crude estimates of the expected risk of death.

In interpreting the data, you should keep two things in mind. First, the reliability of the model is unknown, but appears to be quite limited. That is, the model may accurately reflect the relationship between a small number of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. The model fails to consider a wide range of factors with a significant impact on mortality. Examples include, but are not limited to, the patient's general health status, the stage of the patient's illness, the patient's psychological condition, and family support.

The second, and more serious, limitation of the model is that it has not been validated. As noted above, deviations from the predicted mortality rate could indicate some problem with the quality of care in that hospital, but they could also reflect the exclusion from the model of significant factors influencing the risk of death. Whether the hospitals whose actual mortality rates are outside the predicted range are more or less likely to provide higher or lower quality care is unknown. Statistical analyses of mortality rates can do no more than screen for further review. The data to be released by HCFA raise important questions, but they can not answer them. Quality judgments can only be made after reviewing the information contained in a patient's medical record.

These limitations have significant implications for the way hospitals should view and use the HCFA mortality data. The relationship between a hospital's actual and predicted mortality rate will be unstable from one year to the next. It would be a mistake to conclude that, because you have a "high" or a "low" mortality rate in 1986, you will continue to have a "high" or a "low" mortality rate in future years. Therefore, the AHA urges hospitals not to use mortality rates to market their services or to disparage other hospitals. To pursue such a strategy would erroneously legitimize the notion that these mortality rates should guide consumer behavior.

Your Hospital's Response

In addition to the specific data that will be released about your hospital, you should be familiar with the response your hospital submitted to HCFA to be published with the data. Specifically, that response should have addressed any errors that occur in the data, and should have explained any factors that may be useful to the public in interpreting the data. For example, your hospital may be a burn center, provide hospice care or other types of services that could lead to above average mortality rates. Comments regarding the severity of illness of the patients your hospital treats also would be useful, because the HCFA model does not include measures of severity.

Finally, the response your hospital submitted to HCFA to be released with the data should have emphasized that the HCFA data are not, in themselves, measures of hospital performance. At best, they can be used to better focus quality assurance activities. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals.

How You Can Respond

What your hospital said in formal response to HCFA, as well as what is said to a hospital's employees, community, and local news media, should strive to put the HCFA data into a meaningful context. The real issue is the way the data are used. When responding to questions about the HCFA data, your comments should focus on the interpretation and accuracy of the data, and the efforts of the hospital to ensure the provision of high quality care, rather than on problems with the HCFA methodology. It is important to clearly describe the appropriate uses of the HCFA data.

Mortality data are appropriately used to guide or focus peer review. Quality can only be evaluated through the process of peer review--not through simplistic statistical comparisons. Because mortality data are easily misinterpreted, they can cause confusion and apprehension among Medicare beneficiaries and the public in general.

AHA in its comments to HCFA has emphasized that the HCFA mortality data should be used principally by hospitals to identify or suggest areas for review. The mortality data do not identify areas in which the hospital provides "high quality" or "low quality" care or otherwise measure hospital performance. Actual mortality rates can be higher or lower than predicted because the patients or treatment provided by the hospital differ from the patients or treatment provided in the "average" hospital, or simply because of chance. Comparisons of actual and predicted mortality rates can only suggest that the hospital and its medical staff review an area to determine if a quality problem does exist or if the patients treated by the hospital are unusually complex or have other characteristics not recognized by the HCFA model that would lead to an above average mortality rate.

Most importantly, in responding to inquiries about the HCFA data, you should demonstrate that quality of care is of the utmost concern to the hospital's governing board, management, and medical staff. Clearly state that any indication of potential quality problems, including a mortality rate that is higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. When quality problems are identified, you should indicate that corrective action is swiftly taken. If these assertions are to be credible, you should be prepared to describe the nature of the investigations that are undertaken, including timing and the nature of the corrective actions taken. While protecting the confidentiality of individuals, you should also be prepared to say whether actions have been taken in the past to ensure quality and to state that the hospital will take any and all actions to ensure quality that were identified in the course of responding to the HCFA mortality data.

To help demonstrate its commitment to quality, your hospital should be prepared to provide a short descriptive analysis of all deaths that occurred among your hospitalized Medicare patients in 1986 and the evaluation of those deaths by your quality assurance committee and medical staff, as well as efforts to discuss findings and any need for corrective actions with all

appropriate hospital staff. Such an analysis should emphasize the existing quality assurance structures in place to monitor and evaluate all deaths that occur in the hospital. An analysis of all deaths emphasizes your hospital's commitment to a comprehensive quality assurance program that automatically includes mortality review as one of several components. The public will be looking for assurances that any problem identified, no matter how small, is a cause for your hospital's concern and is dealt with promptly and effectively. Additional information on quality assurance is available in the Liaison Trustee Briefing Paper titled "The Board's Responsibility for Assuring Quality Care."

Although comments on the methodology should be held to a minimum, several "technical" comments on the HCFA data may be appropriate and should be made, although the issue of consumer access to valid and useful information on the quality of hospital care should not be challenged. The principal technical issue is that the ability of the model to detect differences in quality has never been evaluated. The HCFA data assumes that each hospital's patients are "average" except with respect to the few characteristics included in the statistical model. As a result, hospitals treating unusually large numbers of severely ill patients (e.g., referral hospitals) or with specialized programs for the terminally ill may have higher than predicted mortality rates. Describing the kinds of patients that are admitted to the hospital and focusing on the ways in which they differ from the "average" Medicare patients may help the public understand why a higher than predicted mortality rate is not an indication of poor quality care.

Finally, you should note that the HCFA data are not all-inclusive. The mortality rates apply only to Medicare patients, and differ from other indicators of inpatient mortality because they are calculated using only deaths that occurred within 30 days of the last admission of a Medicare beneficiary to a hospital during 1986. You may also want to mention that AHA and other organizations, including the Joint Commission on Accreditation of Health Care Organizations, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates, and that your hospital looks forward to the results of those efforts.

In summary, key points for you to be aware of in responding to questions about the HCFA data include:

- The HCFA data are not, in themselves, measures of the hospital's quality of care. They do not identify areas in which the hospital provides "high quality" or "low quality" care.

- Mortality data are one component of a hospital's quality assurance effort and are appropriately used to guide or focus peer review of selected cases or activities.

- The reliability of the statistical model used by HCFA is unknown, but appears to be quite limited. The model also has not been validated.

- o The relationship between a hospital's actual and predicted mortality rate will be unstable from year to year. Hospitals should not use mortality rates to market their services.

- o If appropriate, emphasize the factors about your hospital that distinguish it from the "average" hospital and that would lead to above average mortality rates.

- o Become familiar with your hospital's data and the comments it forwarded to HCFA to be released with the data.

- o Most importantly, emphasize your hospital's commitment to quality and be prepared to demonstrate how your hospital follows up and responds to any indications of potential quality problems.

Your hospital may have a designated spokesperson who can handle very detailed or technical questions about the HCFA data. You may need to refer inquiries beyond the scope of this briefing paper to such a spokesperson.

Beyond Mortality Review

Death is only one of many possible outcomes of treatment, and mortality review is only one of several important components of a comprehensive quality control program. Effective quality control programs are designed to enhance patient safety, promote appropriate utilization of resources, and reduce the probability of preventable adverse clinical outcomes. This is achieved through the promotion of state-of-the-art diagnostic and therapeutic intervention and through systematic, routine, and comprehensive patient care monitoring and evaluation.

A thorough familiarity with the HCFA data and your hospital's response to it can help prepare you to effectively speak on your hospital's behalf and assist those in your community to gain a more meaningful understanding of what the data do and do not indicate about the care delivered at your hospital. Most importantly, your reinforcement of the hospital's commitment to the delivery of quality care and your ability to demonstrate comprehensive and systematic review and evaluation of the quality of care provided in your facility is the best way of dealing with the disclosure of data that can be so easily misinterpreted. The commitment of your hospital to providing quality care should never be called into question.

For More Information

This Liaison Trustee Briefing Paper was adapted from two AHA briefing packages titled "Understanding Mortality Rates," distributed to AHA member hospitals in September and October. For more information on these or other resources concerning mortality review or quality assurance, contact Mary Totten, Program Director, AHA Division of Hospital Governance, 312/280-6704.