THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

MAY 25, 1988

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""Bout With Cancer Put Woman on a New Life Path", Star Tribune, May 8, 1988
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The University of Minnesota Hospital and Clinic
Board of Governors
May 25, 1988
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of April 27, 1988 Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Special Presentation: Pharmaceutical Services: Past, Present and Future - Paul Abramowitz, Pharm.D.	Information
V.	Committee Reports	
	A. Planning and Development Committee - Ms. Kris Johnson	
	1. Quarterly Purchasing Report	Approval
	B. Joint Conference Committee - Mr. George Heenan	
	1. Medical Staff-Hospital Council Credentials Commitee Recommendations	Approval
	2. Quality Assurance Program	Information
	C. Finance Committee - Mr. Robert Nickoloff	
	1. April Year-to-Date Financial Statements	Information
	2. Personnel Policy Changes	Approval
	3. 1988-89 Employee Pay Plan	Approval
VI.	Other Business	
VII.	Adjournment	

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

APRIL 27, 1988

CALL TO ORDER:

Chairman Robert Latz called the April 27, 1988 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias
	Sally Booth
	David Brown, M.D.
	Carol Campbell
	Robert Dickler
	Kris Johnson
	Robert Latz
	Jerry Meilahn
	James Moller, M.D.
	Robert Nickoloff
	Barbara O'Grady
	Neal Vanselow, M.D.
Not Present:	Shelley Chou, M.D.
	Phyllis Ellis
	Al Hanser
	George Heenan

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the March 23, 1988 meeting as written.

CHAIRMAN'S REPORT:

Mr. Latz reported that Mr. David Lilly is currently on a single quarter leave before retirement. He has resigned from the Board of Governors. Ms. Carol Campbell, Acting Vice President for Finance and Operations, has been appointed to the Board of Governors by the Board of Regents.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler reported that he and Mr. Robert Latz made a presentation on hospital reserves to the Higher Education Subcommittee of the Appropriations Committee on March 24, 1988. It was agreed that a copy of that presentation should be sent to each Board member.

The loan between the Hospital and UMCA, Mr. Dickler reported, had been discussed with each Board members individually. A proposed resolution to that load was approved by the Board of Regents on April 15, 1988.

On April 15, 1988, Mr. Dickler noted, the Board of Regents approved the CUHCC replacement facility proposal as recommended by the Board of Governors.

Mr. Dickler reported that UMHC has experienced major fluctuations in census in 1988. Census peaked at 506 on April 14th. Toward the end of April the census had graviated closer to fiscal year averages.

Dr. Ellis Benson, Head of the Department of Laboratory Medicine and Pathology, is stepping down after 21 years as department head, Mr. Dickler reported. Mr. Al Dees is the hospital representative on the newly appointed search committee to recruit Dr. Benson's successor.

Mr. Al Dees briefly reported on the bills passed by the legislature that may impact the Hospital. A written summary of the 1988 session will be included in the May Board packet.

The Board suggested a letter be forwarded to all members of the tax committees thanking them for upholding the sales tax exemption.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Ms. Kris Johnson noted that the Committee had reviewed the capital expenditure policy for information. It will be discussed in more detail at a later date.

The 1988-89 capital budget, Ms. Johnson reported, was presented to the Committee for discussion on April 12, 1988. The Committee will be asked to endorse the budget in May or June.

Mr. Greg Hart briefly reviewed the development of the kidney stone lithotripsy program. A task force of medical and administrative staff has been evaluating equipment alternatives. Mr. Greg Hart summarized those alternatives. A gallstone program could be initiated here as early as this summer.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. Robert Dickler reported that the Committee had reviewed the Cost Evaluation Committee Report. This report summarized the findings of three work groups that reviewed the hospital's performance. Methods required to improve the hospital's monitoring and evaluation of ancillary utilization,

productivity, and severity were also studied. The Committee's recommendations and work plan will be discussed internally then brought back to the Committee for discussion.

Mr. Dickler overviewed the findings from the 1987 Joint Commission site visit. The Joint Commission, he noted, issued recommendations more liberally than in past years. A number of those recommendations related to quality assurance.

Ms. Nancy Janda reviewed the findings of the Joint Commission in more detail. She highlighted characteristic examples of recommendations that can be corrected swiftly and recommendations that are more complex to respond to. Recommendations that the administrative staff disagrees with were also cited.

The Board asked that they be informed about the management of issues surfaced by the Joint Commission. The hospital will be submitting two progress reports to the Joint Commission. A follow-up focused site visit is also expected this fall.

FINANCE COMMITTEE REPORT:

Mr. Robert Dickler highlighted the 1988-89 Operating Budget. The proposed budget included a 9.8% price increase and a 5.4% average increase in operating costs. The budget was developed assuming 18,350 admissions and 153,000 patient days. Gross patient charges for the year were estimated at $281,419,000 while estimated expenses totaled $258,476,000. Cash from operations is budgeted to fund principal and interest payments on outstanding debt, to provide $8,000,000 for equipment and renovation, and to provide for reserve interest income of $5,258,000 for major capital projects.

The Capital Budget for 1988-89 will be forwarded to the Board for approval after the Board of Regents approval of the Hospital's 1988-89 operating budget.

The Board discussed the community comparability of our price increase and the distribution of a price increase across payor groups. At the conclusion of the discussion, the Board seconded and passed a motion to approve the 1988-89 Operating Budget as presented.

Mr. Cliff Fearing briefly reviewed the March, 1988 financial statements. Both admissions and average length of stay increased in March. The March cash flow, Mr. Fearing noted, was the best of the fiscal year. Account receivables declined by $5.2 million in March.

Mr. Cliff Fearing and Mr. Dan Rode reviewed the Third Quarter, Fiscal Year 1988 Bad Debts. Bad debts totaled $682,453.25, representing 1,710 accounts. Recoveries amounted to $11,413.55, leaving a net charge-off of $671,039.70, on 1.06% of gross charges.

The Board of Governors seconded and passed a motion to approved the Third Quarter, Fiscal Year 1988 Bad Debts in the amount of $671,039.70.

Mr. Cliff Fearing reported that UMHC is paying the University $348,000 within the next 30 days for the space currently occupied by the Lipid Research Center. This space was originally funded by the University with the agreement that the University would be reimbursed if "ownership" was assumed by the hospital.

ADJOURNMENT:

There being no further business, the April 27, 1988 meeting of the Board of Governors was adjourned at 4:25 P.M.

Respectfully submitted,

Kay F. Fuecker
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

May 20, 1988

TO: Members of the Board of Governors

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

Paul W. Abramowitz, Doctor of Pharmacy, joined The University of Minnesota Hospital and Clinic in May of 1986 as Director of Pharmaceutical Services. Dr. Abramowitz will be speaking to the Board of Governors about the changing pharmacy profession and the changing practices in delivering hospital pharmaceutical services.

This presentation is another in a series of presentations designed to broaden or enhance the Board of Governors familiarity with current issues at The University of Minnesota Hospital and Clinic.

NCJ/kff

Attachment

CURRICULUM VITAE

PAUL W. ABRAMOWITZ, PHARM.D.

PERSONAL

Birthdate: September 29, 1950
Married: Elizabeth
Children: Nicole and Sean
Address: 8408 Amsden Ridge Drive
Bloomington, Minnesota 55438
Telephone: Office (612) 626-3200
Home (612) 944-9265

EDUCATION	DEGREE	YEAR
University of Michigan	Doctor of Pharmacy	1979
University Hospital Ann Arbor, Michigan	Certificate of Residency in Hospital Pharmacy (A.S.H.P. accredited)	1979
University of Toledo	Bachelor of Science in Pharmacy (Summa Cum Laude)	1977
Indiana University	Bachelor of Arts (Double Major - Chemistry and Biology)	1972

AWARDS AND HONORS

American Society of Hospital Pharmacist's Award for Achievement in the Professional Practice of Hospital Pharmacy.	1985
Bristol Laboratories Award for Academic Excellence in the Doctor of Pharmacy Program at the University of Michigan.	1979
Roche Hospital Pharmacy Research Award. Presented for a Doctor of Pharmacy Research Project at the University of Michigan.	1978
Merck and Company Award, College of Pharmacy, University of Toledo	1977
Dean's Award for Academic Excellence, College of Pharmacy, University of Toledo	1977
Kappa Psi Award for Academic Excellence, College of Pharmacy, University of Toledo	1976
Rho Chi Pharmaceutical Honor Society	1976

AWARDS AND HONORS (continued)

American Foundation for Pharmaceutical Education Scholarship 1975-76

Chamberlain Memorial Scholarship 1974-75

EXPERIENCE

Director of Pharmaceutical Services (Clinical Chief) May, 1986
University of Minnesota Hospital and Clinic to Present

The University of Minnesota Hospital and Clinic is a 580 bed tertiary care teaching institution consisting of medical, surgical, and pediatric beds. The hospital maintains a high percentage of intensive care beds (20%), pediatric beds (17%), and transplant beds (8%).

Pharmaceutical Services are comprehensive and include a centralized Unit Dose and IV Admixture program with Decentralized Pharmacists providing a full range of clinical services to all patients. The department also provides ambulatory pharmacy services, various specialty clinical services, a drug information center, and residency and fellowship training programs. Inpatient and outpatient pharmacies are supported by automated pharmacy systems. The hospital serves as the primary teaching site for B.S. and Pharm.D. clerkship and externship students of the College of Pharmacy.

Hospital Committee Membership:
- Committee on Pharmacy and Therapeutics (Secretary) 1986-Present
- Outpatient Committee 1986-Present
- Infection Control Committee 1986-Present
- Home Health Care Committee 1987-Present

Associate Professor, Department of Social, Administrative and Hospital Pharmacy and Department of Pharmacy Practice, College of Pharmacy, University of Minnesota May, 1986 to Present

Associate Member, Graduate School, The University of Minnesota January, 1987 to Present

This appointment involves participation in the Graduate Program in Hospital Pharmacy, a 2 year program leading to the M.S. Degree in Hospital Pharmacy and a Certificate of Residency (A.S.H.P. accredited). I teach didactic and experiential coursework, advise graduate students, and serve as preceptor for five residents each year in the hospital pharmacy residency program. In addition, I participate in the undergraduate teaching program.

College Committee Membership:
- Scholarships, Fellowships, and Awards Committee 1987-Present
- Experiential Educational Advisory Committee 1987-Present

EXPERIENCE (continued)

Associate Director of Pharmaceutical Services — July, 1981 to
University of Chicago Medical Center — April, 1986

Assistant Director of Pharmaceutical Services — July, 1979 to
University of Chicago Medical Center — June, 1981

The University of Chicago Medical Center is a 500 bed tertiary care teaching institution consisting of medical, surgical, ob-gyn, and pediatric beds. As Associate Director, I had responsibilities for departmental operations including Unit Dose, IV Admixtures, Outpatient Pharmacy, Manufacturing, Clinical Services, Quality Assurance, Staff Recruitment and Training, and Coordination of Teaching and Research. I was Co-Director of the Pharmacokinetic Dosing Service and on service for three months per year.

Hospital Committee Membership:

- Committee on Pharmacy and Therapeutics — 1979-1986
- Audit/Utilization Review Committee — 1979-1986
- Clinical Investigation Committee — 1980-1986
- Compensation Advisory Committee — 1983-1986
- Cardiopulmonary Resuscitation Committee — 1979-1981

Adjunct Assistant Professor of Pharmacy Practice — January, 19[illegible]
College of Pharmacy, University of Illinois — to April, 1986

This position involved teaching and coordination of the clinical clerkship for students assigned to the University of Chicago Medical Center.

Residency in Clinical Pharmacy, University Hospital — July, 1977 to
Ann Arbor, Michigan — June, 1979
(Chief Pharmacy Resident) — (1978-79)

PUBLICATIONS

Koecheler JA, Abramowitz PW, Swim SE, et al. Development of prognostic indicators for focusing ambulatory care pharmaceutical services. Submmitted for publication.

Mansur JM, Clay DJ, Abramowitz PW. An approach to marketing drug information services. American Journal of Hospital Pharmacy (In Press).

Abramowitz PW. Cost justification - professional services. Hospital Pharmacy 1987; 22:627.

Abramowitz PW, Mansur JM. Moving towards the provision of comprehensive pharmaceutical services in the ambulatory setting. American Journal of Hospital Pharmacy 1987; 44:1155-63.

Wong YY, Abramowitz PW, Mansur JM. Changing use patterns of plasma volume expanders through educational intervention. American Journal of Hospital Pharmacy. 1987; 44:102-5.

PUBLICATIONS (continued)

Abramowitz PW, Fletcher C. The formulary system: Broadening it's applications and renewing it's vigor. American Journal of Hospital Pharmacy. 1986;43:2834-8.

Abramowitz PW, Godwin HN, Latiolais CJ, et al. Developing an effective P&T Committee, Part 2. Hospital Formulary. 1985;20:1071-86.

Abramowitz PW, Godwin HN, Latiolais CJ, et al. Developing an effective P&T Committee, Part 1, Hospital Formulary. 1985;20:827-47.

Mansur JM, Abramowitz PW, Lerner SA, et al. A compatibility, pharmacokinetic, and cost analysis of the administration of clindamycin with gentamicin every eight hours. American Journal of Hospital Pharmacy. 1985;42:332-5.

Abramowitz PW, Nold EG. New directions for hospital pharmacy. American Journal of Hospital Pharmacy. 1984;41:724-6.

Abramowitz PW. Controlling financial variables - Changing prescribing patterns. American Journal of Hospital Pharmacy. 1984;41:503-15.

Abramowitz PW. Controlling financial variables - Purchasing, inventory control and waste reduction. American Journal of Hospital Pharmacy. 1984;41:309-17.

Mansur JM, Ifshin S, Abramowitz PW. A method for familiarizing nurses with the hospital formulary and its evaluation. Hospital Pharmacy. 1983;18:582-7.

Abramowitz PW, Ludwig D, Mansur JM, et al. Using a target drug program to control third generation cephalosporin costs. Hospital Pharmacy. 1983;18:416-20.

Ludwig D, Abramowitz PW. The pharmacist as a member of the CPR team: Evaluation by other health professionals. Drug Intelligence and Clinical Pharmacy. 1983;17:463-5.

Abramowitz PW, Nold EG, Hatfield SM. Using clinical pharmacists to reduce costs associated with cefamandole, cefoxitin, and ticarcillin use. American Journal of Hospital Pharmacy. 1982;39:1176-80.

Abramowitz PW. Developing clinical services with limited staff - Management Consultation Column. American Journal of Hospital Pharmacy. 1982;39:771-2.

Hatfield SM, Ifshin S, Abramowitz PW. Hiring drug information personnel. American Journal of Hospital Pharmacy. 1982;39:288-91.

Abramowitz PW, Perez MM, Johnson CE, et al. The effect of theophilline, terbutaline, and the combination on the immediate hypersensitivity skin test reaction. Journal of Allergy and Clinical Immunology. 1980;66:123-8.

Abramowitz PW. The serum digoxin level. Hospital Pharmacy. 1979;14:672-78.

PROFESSIONAL SERVICE

Editorial Board, Topics in Hospital Pharmacy Management, Aspen Press	1987-Present
Chairman, Council on Administrative Affairs, American Society of Hospital Pharmacists	1987-88
Selection Panel, Demonstration Projects Grants Program, American Society of Hospital Pharmacists Research and Education Foundation	1988
Member, Council on Administrative Affairs, American Society of Hospital Pharmacists	1986-87 1985-86
Member, Council on Administrative Affairs, Minnesota Society of Hospital Pharmacists	1987-88
Chairman, Advisory Working Group on Financial Management, Administrative SIG, American Society of Hospital Pharmacists	1985-86
Grant Selection Committee, Astra Clinical Pharmacy Research Award	1986
Commission on Pharmacy Services and Cost Containment, American Society of Hospital Pharmacists	1985
Health Care Advisory Committee, 13th Congressional District	1985
Delagate, American Society of Hospital Pharmacists Annual Meeting	1985
President-Elect, Illinois Council of Hospital Pharmacists	1985-86
Board of Directors, Illinois Council of Hospital Pharmacists	1985-86 1984-85
Delegate, Illinois Council of Hospital Pharmacists Annual Meeting	1983, 1984, 1985
President-Elect, President, and Immediate Past President, Northern Illinois Society of Hospital Pharmacists	1983-86
Reviewer, American Journal of Hospital Pharmacy	1982-Present

CONSULTANTSHIPS

Consultant to the Department of Pharmaceutical Services at the Veterans Administration Hospital, Minneapolis, Minnesota.	1986-Present
Consultant to the College of Pharmacy of the University of Toledo for the establishment of a Doctor of Pharmacy Degree Program	October, 1987

CONSULTANTSHIPS (continued)

Consultant to the University of Maryland College of Pharmacy for the Project, Developing a Standardized Method for Measuring the Cost Impact of Clinical Pharmaceutical Services, funded by a grant from the Research and Education Foundation of the American Society of Hospital Pharmacists.	1986
Speakers Panel, Educational Institute, Travenol Laboratories,	1984-Present
Speakers Panel, Hoechst-Roussel Pharmaceutical, Inc.	1984-Present
Speakers Panel, Smith Kline and French, Laboratories	1983-Present
Consultant to the Owen Company, Houston, Texas, to review cost containment programs for their managed pharmacy departments.	May, 1984
Consultant to InterQual Inc., Chicago, Illinois, for the purpose of developing an improved controlled substance system for the three John F. Kennedy Memorial Hospitals in Cherry Hill, Stratford, and Washington Township, New Jersey.	September, 1982

INVITED PRESENTATIONS

Pharmacy Practice in the 1990's. Presented at the Annual Awards Assembly of the College of Pharmacy of the University of Colorado, Boulder, May, 1988.

Expanding Clinical Pharmacy Services to the Ambulatory Setting: The New Frontier, Presented at the Spring Meeting of the Northeast Florida Society of Hospital Pharmacists, Jacksonville, May, 1988.

Pharmacy Practice in the 1990's. Presented at the Joint Annual Meeting of the North Dakota Pharmaceutical Association and the North Dakota Society of Hospital Pharmacists, Fargo, April, 1988.

A Comprehensive Approach to the Antibiotic Dilemma. Presented to the Long Island Society of Hospital Pharmacists, New York, March, 1988.

Expanding Clinical Pharmacy Services to the Ambulatory Setting: The New Frontier, Presented at the Midyear Meeting of the American Society of Hospital Pharmacists, Atlanta, December, 1987.

Using a Programmable Total Parenteral Nutrition Computer to Reallocate Personnel for the Provision of Clinical Pharmaceutical Services, Poster Presentation, Midyear Meeting, American Society of Hospital Pharmacists, Atlanta, December, 1987.

Identifying Drug Costs and Patient Demographic Data for a Bone Marrow Transplantation Unit, Poster Presentation, Midyear Meeting, American Society of Hospital Pharmacists, Atlanta, December, 1987.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18, 1988

TO: Board of Governors

FROM: Al Dees AD

RE: Final Summary: 1988 Legislative Session

Enclosed is a final summary of action taken by the Minnesota Legislature during this year's session related to hospital and University operations. This summary displays the same bills and descriptions as the one distributed during the April meeting of the board, but reflects the final action taken by the governor on all bills.

If you would like further information on any of the bills, please contact me at 626-0966.

1988 MINNESOTA LEGISLATIVE SESSION
SUMMARY OF HEALTHCARE AND UNIVERSITY RELATED ACTIONS--FINAL
Prepared by: Al Dees
5/9/88

BILLS PASSED AND SIGNED

H.F. 1493 Tort Reform
Deletes the minimum statutory rate (8%) on verdicts. Requires court hearings where award of more than $100,000 in future damages are made. Limits joint and several liability of persons who are 15 per cent or less at fault (4 times fault). Creates a legislative study commission to study the civil justice system. Repeals Minnesota Statutes Section 604.07, which provided for discounting of future damage awards.

H.F. 1784 Nurse Midwife and other licensed/certified practitioner practice
Allows registered nurses nurses who are certified nurse-midwives to prescribe and administer drugs and therapeutic devices. Allows licensed and certified health care professionals, upon licensed practitioner authority, to prescribe and administer legend drugs and controlled substances.

H.F. 2126 Health & Human Services Omnibus Bill
Sets basis for MA payment rates after 10/1/88 for physician, dental, vision, podiatric, chiropractic, physical therapy, occupational therapy, speech pathology, audiology, mental health, psychology, public health, and independent lab and X-ray services as rates in affect on 6/30/87. Basis for OB care, however, is set at 10% above 6/30/87 rate base. Appropriates $700,000 for FY89 for AIDS prevention grants for high-risk populations including communities of color, adolescents and IV drug users. Extends MA Case Manager system to mental health care. Requires Commissioner to establish procedures to analyze and correct problems associated with MA, GAMC, and Children's health plan claims preparation and processing including designation of a full-time liaison to providers, provision of quarterly reports to hospitals of claims received and identification of and reasons for any suspended claims, and identification and prioritization of hospital claims that are in jeopardy of exceeding time factors that would eliminate payment. Requires the Commissioner of Human Services to develop implementation plan for the healthspan program to provide health coverage to the uninsured.

H.F. 2127 HMO Solvency

Requires new HMO's to show evidence of $500,000 deposit before certificate of authority will be issued and mandates subsequent deposits equal to the difference between the amount on deposit and 33% of uncovered expenditures in preceeding year. Requires net worth for new HMO of 8 1/3% (i.e. equal to 30 days of working capital) of all expenses expected in first 12 months of operation or $1.5 million, whichever is greater. After first year, requires net worth maintenance of 8 1/3% of prior year expenses or $1 million, whichever is greater. Phase-in period for compliance with net worth requirement extends to 12/31/93. Requires HMO's maintain a positive working capital and mandates development of correction plans approved by Commissioner of Health when negative position develops or net worth requirements not met. Requires submission of quarterly financial statements to Commissioner (only final, annual reports will be public data, however.) Prohibits providers from seeking payment from enrollees or their representatives and family members in the event of HMO nonpayment, insolvency or breach of contract but does not prohibit pursuit of payment from others such as employers etc. Requires providers to give HMO's 120 notice of intent to terminate participation agreement. Enables providers to notify Commissioner if an HMO's payments delayed beyond dates specified in contract. Defines rehabilitator/liquidator powers of Commissioner.

H.F. 2344 State Departments Appropriations Bill

Appropriates $100,000 to the legislative auditor to cover the cost of auditing the University's physical plant operations. The U is liable, however, to the auditor for the total cost and expenses of the audit. Appropriates $4,593,300 for transfer to the employee insurance trust fund to cover the Blue Cross losses the state is assuming but requires the Regents to pay $3,956,700 to the insurance trust fund from money previously appropriated for UM operations and maintenance.

H.F. 2559 Hearing Aid Sales and Repair

Extends the 30-day hearing aid guarantee to cover the first 30 days of possession by the buyer. Requires guarantees of hearing aid repairs to be in writing, as specified. Limits itemized repair bill requirement.

H.F. 2590 Omnibus Tax Bill

Includes sales tax exemption for UMHC retrotroactive to June 1, 1987

S.F. 335 Physical Therapist Practice

Requires continuing education for physical therapists. Permits physical therapists to provided treatment for an initial 30 day period without an order or referral by a licensed physician, chiropractor, podiatrist, or dentist. Extends persons authorized to order or refer persons for physical therapy to chiropractors, podiatrists and dentists. Amends standards for denial of certification of and prohibitions on physical therapists.

S.F. 752 Pharmacy Regulation

Modifies regulatory statutes governing pharmacies, drug manufacturers, and others, expanding authority of the Board of Pharmacy to inspect medical gases and veterinary drugs and devices.

S.F. 994 Extension of Workers' Comp. Definition of Occupational Disease
Extends definition to include infectious or communicable disease contracted by a police officer, firefighter, paramedic, emergency medical technician or nurse after exposure while providing emergency medical care outside of a hospital.

S.F. 1388 HMO Enrollee Bill of Rights
Establishes requirements regarding statements of exclusions and limitations in enrollee contracts. Establishes guidelines regarding marketing materials. Requires written statements regarding denial of service when requested by enrollees. Prohibits denial or limitation of coverage for service already received based solely on failure to obtain prior authorization or a second opinion if service normally covered, or for care provided by non-participating provider if care was ordered or recommended by a participating provider, the service would ordinarily be covered and the enrollee was not given prior written notice that service would not be covered. Prohibits withholding or threats of withholding services in attempting to collect delinquent accounts.

S.F. 1861 HMO Coverage, Subscriber Rights, and Cancellation/Coverage
Requires HMO's to clearly define covered and noncovered services in subscriber contracts and to include the enrollee bill of rights. Also requires contracts to explain conditions under which coverage may be terminated and to explain continuation/conversion rights. Requires reporting of intent to cancel or discontinue contracts to the Commissioner of Health 120 days prior to effective date. Requires provision of replacement coverage if contracts discontinued or canceled. Extends authority of Commissioner of Health to mandate replacement coverage plans and to mediate HMO/provider disputes which could result in contract cancellations. Requires Commissioner to promulgate rules addressing issue of appropriate prior authorization requirements. Provides for and details HMO financial responsibility for continuation coverage under Minnesota comprehensive health insurance plan (MCHA).

S.F. 1904 Board of Medical Examiners Amendments
Allows the Board to not publish disciplinary actions based solely on evidence of chemical and alcohol addiction, expands disciplinary actions grounds particularly with regard to fee splitting, Authorizes temporary physical therapist permits, and allows certain data transfers to other states.

S.F. 1958 Employee Restroom Breaks
Requires employers to allow employees adequate time in each four hour work period to use the nearest convenient restroom. Does not affect current collective bargaining agreement.

S.F. 1970 MA/GAMC Reimbursement
Modifies hospital payment rates, exempting computation of rates and relative value of diagnostic categories from Medicare routine service cost limitations, exempting Indian health service facilities from rate establishment methods, and specifying rates for out-of-state hospitals.

S.F. 2122 Data Practices Amendments

Enables provider to exclude speculations regarding a patient's health condition when providing the patient with a copy of all or a portion of the patient's record under previously established law. Classifies outpatient radiology and laboratory results as "permananent" for purposes of record retention.

S.F. 2569 Higher Education Appropriations Bill

Includes request that the Regents employ persons qualified to provide them with fiscal and policy information, oversight, and analysis on matters requiring regents' attention or action. Staff should be independent of the University's administration and responsible solely to the Regents. Requests report to chairs of Senate finance and House appropriations committees by 12/1/88. Establishes 24 member Regent Candidate Advisory Council to determine criteria for and to identify and recruit qualified candidates. Requires Board of Regents to make all available to the commissioner of finance all books, accounts, documents, and property the commissioner wishes to inspect.

BILLS WHICH DID NOT PASS

H.F. 2240/S.F. 1995 Open Meeting Law Amendments
Would have enabled boards of public hospitals to hold closed sessions for strategic planning and trade secret discussions.

H.F. 2517/S.F. 1816 Adult Health Care Decisions Act (Living Will Bill)

MINUTES
Planning and Development Committee
May 9, 1988

CALL TO ORDER
Ms. B. Kristine Johnson, Chair, called the May 9, 1988 meeting of the Planning and Development Committee to order at 1:05 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Leonard Bienias Robert Dickler Clint Hewitt Geoff Kaufmann Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	S. Albert Hanser William Jacott, M.D.
	Staff	Fred Bertschinger Cliff Fearing Greg Hart Nancy Janda Mark Koenig Lisa McDonald

APPROVAL OF MINUTES
The minutes of the April 12, 1988 meeting were approved as distributed.

QUARTERLY PURCHASING REPORT
Mr. Koenig reported that third quarter purchases of $15,541,417 were higher than normal due to the purchase of the second MRI unit at $2.6 million and increased volume. Purchases to other than low bidder were reviewed. Sole source awards totaled $1.5 million. Set Aside Awards totaled $59,390. Mr. Koenig reviewed the results of vendor appeals. Savings from the University Hospital Consortium were $56,779. The third quarterly purchasing report was endorsed by the Planning and Development Committee.

LIPID CENTER SPACE
Mr. Fearing informed the committee that The University of Minnesota Hospital and Clinic (UMHC) is negotiating the repayment of a loan for the Lipid Research Center from University Central Administration. The maximum cost for the clinic would be $348,000.

DEVELOPMENT OFFICE UPDATE
Mr. Bertschinger reported third quarter donations of $720,962. Year-to date donations of $1,305,666 exceed the $800,000 goal. Mr. Bertschinger told the committee about the success of Soiree '88 which raised $13,000 for the Transplant Assistance Fund. He also informed the group that the annual

Patient Assistance Fund solicitation of staff and employees will occur in mid-June. After a brief discussion on the disbursement of funds it was suggested that future reports summarize the Development office's disbursements.

THE CAPITAL EXPENDITURE POLICY

Mr. Dickler told the group that the Capital Expenditure Policy was included for additional discussion after the last meeting. After a brief discussion it was suggested that:

1. Recurring and major capital expenditures which cause the aggregate annual capital budget to be exceeded by more than 5% instead of the proposed 3% shall be brought to the Board for supplemental approval.
2. An updated annual forecast will be presented to the Board quarterly and explanations will be provided for major changes.
3. Approval of Special Projects ($600,000 or above). Additional Board of Governors approval is required for any expenditure which causes a special project to exceed the approved budget by the lesser of 10% or $250,000 of the total project cost.

A revised policy will be presented at the next meeting along with the Revised Regents Policy on Capital Expenditures which is expected to be approved in June.

UMCA UPDATE

Dr. Lynch reported that past difficulties have been resolved with PHP and that their contract is being extended on a month-by-month basis. The other HMO that UMCA was having problems with has started to pay money in advance. UMCA's cash flow still remains below budget.

UMCA has created a new position, Medical Director and Assistant to the Director. One of the duties of that position will be to chair the UMCA Planning and Marketing Committee. Dr. Krivit has been selected to serve in this capacity.

Dr. Ciriacy has recommended that UMCA review its mission and goals. A survey has been sent out to UMCA directors regarding its future goals.

Dr. Thompson commented that physicians feel that the UMCA overhead is too high. Dr. Lynch responded that the overhead issue is being addressed.

OTHER BUSINESS

Mr. Bienias expressed his concern regarding physician charges. Mr. Dickler responded that because the physicians are not employees of the hospital it is outside of the Board's jurisdiction. The Board of Regents has a policy in place regarding the overall physicians' income and there is a third party that monitors compliance. Mr. Dickler concluded that there is no provision for the Board of Governors to regulate the private practice plan or physician charges. Dr. Lynch responded that what a physician charges bears no relation to their reimbursement the majority of the time. Prices are determined by what the market will bear and what third party payers/Medicare will pay.

FUTURE AGENDAS
Mr. Kaufmann requested that any ideas for future agendas be communicated to him or Ms. Janda.

FACILITIES UPDATE
Mr. Dickler discussed the plans for the second phase of UMHC's renovation process. UMHC will be discussing the remodeling and addition plans with various individuals before presenting it to the committee and Board. An in depth presentation will likely be presented at the June P&D meeting.

ADJOURNMENT
Ms. Johnson adjourned the Planning and Development Committee at 2:30 p.m.

Respectfully submitted,

Lisa G. McDonald gk

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

May 18, 1988

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

REGARDING: Quarterly Purchasing Report

Attached is a copy of the Hospital's Purchasing Activity report for the period of January through March, 1988.

This report is being submitted for your approval at the May 25, 1988 Board of Governors meeting. It was reviewd in detail and endorsed by the Planning and Development Committee on May 9, 1988.

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

GH/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF JANUARY - MARCH 1988

I. PURCHASE ORDER ANALYSIS

RANGE	NUMBER OF P.O.'S	TOTAL DOLLAR VALUE
$ 0 - $ 499	5829	$948,648.50
$ 500 - $1,999	1961	$1,992,346.45
$ 2,000 - $4,999	598	$1,863,794.41
$ 5,000 - $9,999	241	$1,717,273.47
$10,000 - OVER	238	$9,019,354.89
TOTAL PURCHASE ORDER	8867	$15,541,417.72

II. CONFIRMING ORDERS

$ 0 - $ 99	120	$5,536.43
$ 100 - $ 499	216	$49,866.81
$ 500 - $ 999	66	$45,319.17
$1,000 - $1,999	45	$65,356.96
$2,000 - OVER	14	$236,423.64
CONFIRMING ORDERS	461	$402,503.01
TOTAL	9328	$15,943,920.73 ***

III. PURCHASE AWARDS TO OTHER THAN APPARENT LOW BIDDER

(Attached)

IV. SOLE SOURCE

(Attached)

V. SET ASIDE AWARDS

(Attached)

VI. VENDOR APPEALS

(Attached)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

(Attached)

***Additional purchase orders totaling $5,618,278.00 were issued for Medicaid/Medicare settlements this quarter.

III. Purchase Award to Other Than Low Bidder, #5,000.00 or More

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
1.	Centrifuges	Baxter Scientific $ 2,420.00	Beckman $ 5,705.80	Labs
		Capillary tubes do not position securely, rotor requires meticulous balancing and would require a change in labeling procedures and increase the chance of mislabeling.		
2.	Catalyst Research Monitor	Medical Oxygen $ 4,200.00	Central Medical $ 6,750.00	Cardio
		Model #5528 monitor does not have necessary warning displays, alarm is not accurate, and display resolution is not in .1% increments.		
		Medical Oxygen $ 5,100.00	Central Medical $ 6,750.00	Cardio
		Model #5590 monitor display resolution is not in .1% increments, anesthetic gases are too interferential, battery life is too short and alarm is not accurate.		
		Narco $ 4,950.00	Central Medical $ 6,750.00	Cardio
		Vendor unwilling to bring in a monitor for evaluation.		
3.	Testosterone Kit	Amersham $ 4,536.00	ICN Micromedic $ 5,184.00	Labs
		Falsely high values are obtained on women with elevated dehydrotestosterone levels.		
		Cambridge Medical $ 3,384.00	ICN Micromedic $ 5,184.00	Labs
		Proficiency survey statistics and/or national user evaluations are not yet available, and staffing restrictions prevent evaluation at this time.		

ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
4. Microscope Drape	Xomed $ 11,918.07	North Central Inst. $ 18,881.10	M.S.
	Drape is too short, eyepiece application is difficult and edges come loose when eyepiece is manipulated.		
	Midwest Surgical $ 10,239.75	North Central Inst. $ 18,881.10	M.S.
	Eyepiece application is difficult, gloves are easily contaminated, instructions are not included and drape has an offensive odor.		
	Richards $ 11,988.00	North Central Inst. $ 18,881.10	M.S.
	Eyepiece application is difficult, edges come loose when eyepiece is manipulated, and lens in lens cover is not removable.		
	Baxter $ 11,784.20	North Central Inst. $ 18,881.10	M.S.
	Drape peels away from lens assembly contaminating sterile field.		
5. Contrast Media Line #1	Mallinckrodt $102,984.00	Squibb $116,340.00	M.S.
	Samples were not received within allotted timeframe.		
Line #8	Mallinckrodt $ 41,500.00	Winthrop $ 44,982.00	M.S.
	Samples were not received within allotted timeframe.		
Line #9	Mallinckrodt $ 41,500.00	Winthrop $ 48,990.00	M.S.
	Samples were not received within allotted timeframe.		

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
6.	Scrub Sponge	C.F.A. $ 6,402.00	McKesson $ 7,392.00	M.S.
		Sponge does not provide an effective scrub.		
7.	Styrofoam Dishes	Clark Products $ 7,932.00	Trio Supply $ 9,499.75	M.S.
		Dishes are unattractive and not sturdy enough.		
		Baxter $ 8,484.18	Trio Supply $ 9,499.75	M.S.
		Dishes do not provide a good cutting surface and are not sturdy enough.		
8.	Segura Basket	Lobdell $ 16,288.80	VanTec $ 17,280.00	M.S.
		Grasping mechanism did not provide an adequate grip.		
9.	Non-Vented Contrast Delivery Set	Biomedical Dynamics $ 5,424.00	Namic $ 6,960.00	
		Set leaked upon pressurization.		
		Abbott Critical Care $ 4,800.00	Namic $ 6,960.00	M.S
		Samples not received in allotted timeframe.		
10.	SOSA Spike Contrast Delivery Set	Abbott Critical Care $ 3,500.00	Namic $ 6,300.00	
		Samples not received in allotted timeframe.		
11.	Tidy Wipe	Environmental Cleanup $ 60,025.00	Cleveland Cotton $ 90,795.60	M.S.
		Cloth has poor absorbency, tears easily, falls apart after minimal use and leaves streaks on glossy surfaces.		

ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
	Environmental Cleanup $ 77,175.00	Cleveland Cotton $ 90,795.60	M.S.
	Cloth falls apart when wet and is not strong enough.		
	Environmental Cleanup $ 89,180.00	Cleveland Cotton $ 90,795.60	M.S.
	Cloth has poor absorbency.		
	Cleveland Cotton $ 63,455.00	Cleveland Cotton $ 90,795.60	M.S.
	Cloth has poor absorbency and tears easily when wet.		
	Environmental Cleanup $ 63,455.00	Cleveland Cotton $ 90,795.60	M.S.
	Cloth is thin, shreds when wet and falls apart with minimal use.		
12. ACTH Assay	Amersham $ 10,175.00	Incstar Corp. $ 11,655.00	Labs
	Evaluation costs estimated at $3,000-$5,000 outweigh cost difference of $130.00.		
	ICN Micromedic $ 7,040.00	Incstar $ 11,655.00	Labs
	Unacceptable due to necessity of a second assay, length of time involved in counting and tubes being too small.		
13. Microscope	Frank Fryer $ 4,779.00	Leeds $ 5,586.00	Labs
	Objectives have inadequate resolution and clarity, a smaller "flat" field and reduced contrast, and focusing stage does not lock.		

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
14.	Centrifuge Tubes	Gibbco Scientific $ 4,977.43	Fisher $ 6,528.60	Labs
		Expense of an evaluation, which would require three months for a medical technologist to conduct, far outweigh the the price difference.		
15.	Microscope	North Central $ 74,609.00	Midwest Surgical $ 80,840.00	OR/Ambulatory
		Microscope will not store 15' from operative site, and to a height of 7'3".		
16.	Resuscitation Bags & Masks	Master Medical $155,000.00	Medical Oxygen $185,000.00	M.S./Cardio
		Reservoir bag would not fill properly without use of a flowmeter.		
17.	Head & Neck Pack	Medical Concepts Development $ 5,625.00	Baxter $ 5,733.00	M.S.
		Gown did not provide a sufficient moisture barrier.		
18.	Surgical Tubing	Transhealth $ 7,605.00	C.F. Anderson $ 7,636.50	M.S.
		Savings of $31.50 annually did not warrant the cost of evaluation.		
19.	Foam Mattress	McKession Medical $ 25,284 $ 23,814 (3 alternates) $ 23,814	Medix $ 26,166.00	M.S.
		Samples were not received in time allowed.		

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
20.	Filters	Fisher Scientific $ 14,448.00	Curtin Matheson $ 14,654.40	Labs
		Filters create too much bubbling in the specimen, causing a possible change in CO_2 results.		
21.	7ml Vials	Fisher Scientific $ 3,841.00	Sarstedt $ 10,564.50	Labs
		Vials are not clear enough to determine specimen clarity and lacked graduations.		
22.	MRI	Elscint $2,195,000.00	Siemens $2,655,000.00	Radiology
		Spectroscopic software is not as well advanced, lacking automatic shimming; the Ethernet interface linking with existing MRI and CT units is not guaranteed; and 3-D image manipulation is not available and was a specified feature.		
23.	Stopcock 3-way Line #2	Medi $ 7, .20	Abbott/Sorenson $ 8,064.00	M.S.
		Handle is difficult to turn, and stopcock is difficult to tighten and disconnect to tubing.		
		Eclipse Medical $ 6,955.20	Abbott/Sorenson $ 8,064.00	M.S.
		Etched plastic does not allow for easy visualization of bubbles and stopcock is smaller, making it more difficult to handle.		

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
	Stopcock 3-way Line #1	Eclipse Medical $ 15,444.00	Baxter $ 21,240.00	M.S.
		Stopcock is not autoclavable.		
		Sherwood $ 14,040.00	Baxter $ 21,240.00	M.S.
		Stopcock is not autoclavable.		
		Namic $ 14,040.00	Baxter $ 21,240.00	M.S.
		Stopcock is not autoclavable.		
		Abbott Critical Care $ 20,160.00	Baxter $ 21,240.00	M.S.
		No samples were received.		
24.	Magnetic Sharps/ Needle Counter	Medix $ 10,752.12	SIA $ 11,783.52	M.S.
		Inner foam pad is not removable to provide additional storage.		
		James Phillips $ 11,077.92	SIA $ 11,783.52	M.S.
		Inner foam pad is not removable to provide additional storage.		
		Transhealth $ 11,219.04	SIA $ 11,783.52	M.S.
		Inner foam pad is not removable to provide additional storage.		
25.	Keane Mobility Bed	Mediscus $ 21,060.00	Kinetic Concepts $ 24,840.00	M.S.
		Vendor could not meet delivery requirements of 24 hours or less.		

	ITEM	UNSUCCESSFUL VENDOR	SUCCESSFUL VENDOR	DEPARTMENT
	Keane Mobility Bed	SMI International $ 24,084.00	Kinetic Concepts $ 24,840.00	M.S.
		Bed lacks essential features including foot pass throughs, tube holders and a security mechanism on the rotation angle.		
26.	Washcloth	Milin Industries $ 7,175.00	Lintex $ 8,500.00	M.S.
		After washing, edges were uneven and frayed.		

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IV. SOLE SOURCE

VENDOR	CONTRACT/ P.O. NUMBER	VALUE	DEPARTMENT	PRODUCT
Diamond Ophir Optics	H080515	$2,515.00	Bio.Eng.	Laser Power Meter
Olympus	H079801	$7,990.00	Cardio	Bronchofiberscope
Advances in Medicine	H082007	$7,350.00	Cardio.	Ventilators
Construction Spec.	H350492	$4,097.90	Facilities	Hand & Bumper Rails
Facility Systems	H080527	$5,503.00	Facilities	Chairs
Quantum Industries	H081074	$5,014.31	Facilities	MTS Repairs
M.S.A.	H080518	$83,100.00	Fin. Acct'g	Software
WMI Corp.	H352229	$19,463.00	Human Res.	Perf. Appraisal Access
KDS	H080451	$5,000.00	I.S.D.	Burroughs Terminals
North Carolina Memorial Hosp.	H082236	$5,000.00	I.S.D.	Referring Physician Software
Continental Health.	H081434	$7,200.00	I.S.D.	Pharmakon Software
Northgate Comp. Sys.	H082233	$14,046.00	I.S.D.	Comp. Network Sys.
Bard Electrophys.	H079977	$92,250.00	Labs	Epicardial/Endocardial Mapping Sys.
Becton-Dickinson	H082228	$70,900.00	Labs	FACScan System
DuPont	H069986	$53,928.00	Labs	Microbial Tubes
Hewlett Packard	H080460	$3,665.00	Labs	Software
Knowledge Data	H066074	$50,000.00	Labs	Disk Drive
*Kodak	H089705	$600,000.00	Labs	EKTACHEM Slides
PPG Biomedical	88-79	OPEN	Labs	Recording Paper & Developer
Radionics	H349448	$9,680.00	M.S./CSP	Electrode Kits
Eclipse Medical	H355232	$71,750.00	M.S./DC	Latex Gloves
Gambro	H079253	$21,750.00	Nursing/KD	Dialysis Machine
3M	88-301	OPEN	O.R.	Ligament Implants
3M	88-321	OPEN	O.R.	Burs & Blades
Aesculap	88-325	OPEN	O.R.	Burs & Blades
Codman	H081159	$65,119.00	O.R.	Intraoperative - Ultrasound
Codman & Shurtleff	H354155	$2,490.00	O.R.	Forceps
Frigitronics	H080533	$4,150.00	O.R.	Nitrous Oxide Console
Karl Storz	H080536	$2,780.00	O.R.	Biopsy Foceps
Medtronic	88-382	OPEN	O.R.	Neuro Implants
Medtronic	H353752	$27,750.00	O.R.	Pumps
Narco Medical	H081473	$6,881.00	O.R.	Spacelab Recorder
North Central Inst.	H081155	$4,480.00	O.R.	Zeiss Observation Tube w/Lense
Olympic Medical	H081146	$4,923.54	O.R.	Clean Dryer
Pharmacia	H355263	$3,650.00	O.R.	Subcutaneous Ports
Sebring & Assoc.	H081472	$2,200.00	O.R.	Diathermy Machine
Shiley/Infusaid	H350700	$25,290.00	O.R.	Pump Implant
Stryker	88-324	OPEN	O.R.	Burs & Blades
Stuart	88-258	OPEN	O.R.	Orthopedic Implants
Twin City Medical	88-49	OPEN	O.R.	Orthopedic Implants
Xomed	H351069	$5,250.00	O.R.	Bone Implant
Zimmer	88-322	OPEN	O.R.	Burs & Blades

(cont'd)

IV. SOLE SOURCE (cont'd)

Loredan Biomedical	H081057	$47,500.00	Outpatient	Isokinetic System
Cybex	H081441	$13,035.00	Outpatient	Back Rehab. Equip.
Acuson Corp.	H080465	$81,750.00	Radiology	Color Doppler for Existing Equip.
D.V.I.	H080469	$5,760.00	Radiology	Catheters
D.V.I.	H355248	$7,590.00	Radiology	Catheters
Physics Associates	H079957	$6,340.00	Ther. Rad.	Radiation Beam Analyzer
TOTAL		$1,457,140.75		

V. SET ASIDE AWARDS

A. AWARDED BIDS

CATEGORY	VENDOR	TOTAL DOLLAR VALUE
Anti-Embolism Stockings (Contract)	Halcon	$22,395.00
Reupholstery	Gisela Interiors	$11,605.00
Ortho Hard Goods (Contract)	Falcon Heights Medical	$8,000.00
	TOTAL AWARDED BIDS	$42,000.00

B. DEPARTMENTAL PURCHASES

JANUARY 1988

1.	H349835	Quality Medical	$900.00
2.	H350324	Quality Medical	$118.50
3.	H349329	Halcon	$687.24
4.	H349332	Halcon	$2,674.75
5.	H349520	Halcon	$149.40
6.	H349634	Halcon	$167.52
7.	H349720	Halcon	$221.16
8.	H350541	Halcon	$2,880.50
9.	H349633	Home Hospital Equipment	$28.50
10.	H349834	Home Hospital Equipment	$410.40
11.	H350025	Home Hospital Equipment	$64.44
12.	H349657	Computer Supply	$384.00
13.	H350119	Kelly Computer	$83.58
14.	H077992	Quality Medical	$356.95
15.	H350836	Audio Visual Wholesalers	$346.00
16.	H350834	Audio Visual Wholesalers	$346.00
17.	H079452	Trophy Craft	$66.15
18.	H079451	Trophy Craft	$71.80
19.	H078395	Quality Medical	$308.60
20.	H350656	Sexton Data Products	$260.50
21.	H079959	Gisela Interiors	$11,605.00
22.	H350300	Home Hospital Equipment	$349.92
23.	H349023	Halcon	$59.76
24.	H350123	Halcon	$418.32
25.	H349021	Home Hospital Equipment	$28.50
		JANUARY TOTAL	$22,987.49

(cont'd)

V. SET ASIDE AWARDS (cont'd)

FEBRUARY 1988

	P.O. NUMBER	VENDOR	DOLLAR VALUE
1.	H351310	Quality Medical	$75.00
2.	H351486	Humac Engrg. & Equipment	$949.85
3.	H351610	Audio Visual Wholesalers	$346.00
4.	H351609	Audio Visual Wholesalers	$346.00
5.	H351603	Audio Visual Wholesalers	$368.70
6.	H079528	Quality Medical	$1,127.50
7.	H079532	Quality Medical	$485.21
8.	H079534	Quality Medical	$239.00
9.	H079453	Trophy Craft	$396.75
10.	H352325	Quality Medical	$326.76
11.	H352469	Northern Balance	$68.00
12.	H352446	Audio Visual Wholesalers	$387.00
13.	H079442	Quality Medical	$18.60
14.	H079454	Trophy Craft	$166.85
15.	H079539	Quality Medical	$102.80
16.	H079965	Audio Visual Wholesalers	$641.03
17.	H080446	Audio Visual Wholesalers	$901.72
18.	H350994	Halcon	$167.52
19.	H350727	Halcon	$537.84
20.	H351423	Halcon	$83.76
21.	H352076	Halcon	$89.64
22.	H351562	Halcon	$3,086.25
23.	H350808	Home Hospital Equipment	$28.50
24.	H351498	Home Hospital Equipment	$39.38
25.	H351715	Office Machine Sales	$844.20
26.	H351143	Quality Medical	$56.25
27.	H352386	Quality Medical	$85.56
28.	H351351	Halcon	$41.88
29.	H351558	Halcon	$418.32
30.	H352246	Halcon	$167.52
31.	H352934	Halcon	$2,674.75
32.	H352641	Home Hospital Equipment	$28.50
33.	H352429	Allanson Business	$144.00
		FEBRUARY TOTAL	$15,440.64

MARCH 1988

	P.O. NUMBER	VENDOR	DOLLAR VALUE
1.	H081061	Context, LTD	$2,152.11
2.	H058554	Gisela Interiors	$183.00
3.	H352934	Halcon	$2,674.75
4.	H354029	Halcon	$537.84
5.	H354215	Halcon	$2,674.75

(cont'd)

V. SET ASIDE AWARDS (cont'd)

6.	H354604	Halcon	$2,020.80
7.	H354568	Halcon	$179.28
8.	H354605	Halcon	$83.76
9.	H355305	Halcon	$2,674.75
10.	H353906	H.A. Roberts	$1,144.80
11.	H353466	Home Hospital Equipment	$662.18
12.	H355021	Home Hospital Equipment	$349.92
13.	H079455	Trophy Craft	$72.15
14.	H080539	Quality Medical	$267.95
15.	H079456	Trophy Craft	$74.10
16.	H079457	Trophy Craft	$91.40
17.	H353977	Audio Visual Wholesalers	$279.45
18.	H354087	Chrom Tech	$336.75
19.	H081830	Quality Medical	$655.50
20.	H079459	Trophy Craft	$144.15
21.	H353714	Budget Paper	$23.85
22.	H354490	Chrom Tech	$80.00
23.	H355146	Commercial Electric	$676.67
24.	H355175	Chrom Tech	$556.40
25.	H355450	Sexton Data Products	$522.75
26.	H079460	Trophy Craft	$79.55
27.	H353467	Quality Medical	$300.00
28.	H354210	Quality Medical	$158.00
29.	H354564	Quality Medical	$106.95
30.	H355403	Office Machine Sales	$844.20
31.	H353833	Halcon	$29.88
32.	H353947	Halcon	$149.40
33.	H354301	Home Hospital Equipment	$174.96
		MARCH TOTAL	$20,962.00

C. QUARTERLY GRAND TOTAL

January Purchases	$22,987.49
February Purchases	$15,440.64
March Purchases	$20,962.00
GRAND TOTAL	$59,390.13

VI. VENDOR APPEAL

1. **VENDOR NAME/$ AMT:** Xomed/$11,918.07
   NATURE OF PURCHASE: Microscope Drape
   INTENDED VENDOR/$ AMT: North Central Instr/$18,881.10
   REASON FOR APPEAL:

   Vendor contended that the reasons for unacceptability were related to improper use. Upon re-evaluation the drape was still found to be unacceptable as it did not properly fit the larger microscopes.

   STATUS: Resolved and award released to North Central Instrument.

2. **VENDOR NAME/$ AMT:** Medical Safety Systems/$119,400.00
   NATURE OF PURCHASE: Sharps Disposal System
   INTENDED VENDOR/$ AMT: Evaluations still on-going.
   REASONS FOR APPEAL:

   Product was found unacceptable due to the instability of the 1.5 gallon container. Vendor then offered to have a stand made and provided to UMHC. Bid was not reconsidered as this would have altered the original bid.

   STATUS: Appeal is resolved. Bid remains unawarded as evaluations of other products are still on-going.

3. **VENDOR/$ AMT:** Barefoot Grass/$2,433.45
   NATURE OF PURCHASE: Grounds Maintenance
   INTENDED VENDOR/$ AMT: Landshapes/$3,600.00
   REASON FOR APPEAL:

   Original bid was not specific as to the services included. Bid was subsequently clarified to the satisfaction of the department.

   STATUS: Awarded to Barefoot Grass.

4. **VENDOR/$ AMT:** Abbott Critical Care/$8,300.00
   NATURE OF PURCHASE: Contrast Media Delivery Sets
   INTENDED VENDOR/$ AMT: Namic/$13,260.00
   REASON FOR APPEAL:

   Vendor requested that late samples be evaluated as the lateness was due to the sets being a custom product. As other vendors were able to comply with the deadline and Abbott never indicated the need for extra time prior to the deadline, request was denied.

   STATUS: Resolved and award released to Namic.

5. **VENDOR/$ AMT:** Charmtex/$34,480.00
NATURE OF PURCHASE: Isolation Gowns
INTENDED VENDOR/$ AMT: Fashion Seal/$35,840.00
REASON FOR APPEAL:

After sample gown submitted was deemed unacceptable, vendor requested UMHC evaluate a custom-made gown. Request was denied in fairness to all vendors, as specifications state that sample must be identical to what will be supplied.

STATUS: Resolved and award released to Fashion Seal.

6. **VENDOR/$ AMT:** Walter H. Mayer Co./$32,760.00
NATURE OF PURCHASE: Isolation Gowns
INTENDED VENDOR/$ AMT: Fashion Seal/$35,840.00
REASON FOR APPEAL:

After sample gown submitted was deemed unacceptable, vendor requested UMHC evaluate a custom-made gown. Request was denied in fairness to all vendors, as specifications state that sample must be identical to what will be supplied.

STATUS: Resolved and award released to Fashion Seal.

7. **VENDOR NAME/$ AMT:** Baxter V. Mueller/$2,024.75
NATURE OF PURCHASE: Surgical Instruments (4 lines)
INTENDED VENDOR/$ AMT: Various/$2,346.45
REASON FOR APPEAL:

Vendor contended instruments were equal in quality to specified products. A re-evaluation was performed and one of four of the instruments deemed acceptable.

STATUS: Resolved and awards released per the above outcome.

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VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

1.	Nature of Purchase:	Defibrillators
	Consortium Vendor Name:	Hewlett Packard
	Purchase Order #:	H 079245
	Value of Purchase:	$ 9,190.00
	Value of Next Lowest Bidder:	Not Bid
	Savings:	$ 799.20
2.	Nature of Purchase:	Single Channel Recorders
	Consortium Vendor Name:	Spacelabs
	Purchase Order #:	H 079027
	Value of Purchase:	$168,528.00
	Value of Next Lowest Bidder:	n/a
	Savings:	17,267.00
3.	Nature of Purchase:	Bedside Monitors
	Consortium Vendor Name:	Spacelabs
	Purchase Order #:	H 078664
	Value of Purchase:	$ 83,000.00
	Value of Next Lowest Bidder:	n/a
	Savings:	$ 9,800.00
4.	Nature of Purchase:	PAR Stretcher
	Consortium Vendor Name:	Trusted
	Purchase Order #:	H 080458
	Value of Purchase:	$ 3,845.63
	Value of Next Lowest Bidder:	No other bids received.
	Savings:	$ 1,038.84
5.	Nature of Purchase:	PTM Search Algorithm & Sequencing Software
	Consortium Vendor Name:	Hewlett Packard
	Purchase Order #:	H 080460
	Value of Purchase:	$ 3,665.00
	Value of Next Lowest Bidder:	Not bid.
	Savings:	$ 365.00
6.	Nature of Purchase:	Color Doppler Option
	Consortium Vendor Name:	Acuson
	Purchase Order #:	H 080465
	Value of Purchase:	$ 81,750.00
	Value of Next Lowest Bidder:	Not bid.
	Savings:	$ 4,250.00
7.	Nature of Purchase:	Electric Patient Beds
	Consortium Vendor Name:	Hill-Rom
	Purchase Order #:	H 081158
	Value of Purchase:	$ 52,579.65
	Value of Next Lowest Bidder:	Not bid.
	Savings:	$ 2,767.35

8.	Nature of Purchase:	Overbed Tables/Env. Serv.
	Consortium Vendor Name:	Hill-Rom
	Purchase Order #:	H 352529
	Value of Purchase:	$ 11,687.00
	Value of Next Lowest Bidder:	Not bid.
	Savings:	$ 0.00
9.	Nature of Purchase:	Forms
	Consortium Vendor Name:	Standard Register Co.
	Purchase Order #:	Various
	Value of Purchase:	$ 43,730.15 (qrtly. total)
	Value of Next Lowest Bidder:	Not bid.
	Savings:	$ 0.00
10.	Nature of Purchase:	I.V. Solution Contract
	Consortium Vendor Name:	Travenol Laboratories
	Purchase Order #:	Various
	Value of Purchase:	-
	Value of Next Lowest Bidder:	n/a
	Savings:	$ 18,419.47 (second quarter rebate)
11.	Nature of Purchase:	Surgical Dressing Contract
	Consortium Vendor Name:	Johnson & Johnson
	Purchase Order #:	various
	Value of Purchase:	n/a
	Value of Next Lowest Bidder:	n/a
	Savings:	$ 140.55 (January discount savings)
12.	Nature of Purchase:	Surgical Dressing Contract
	Consortium Vendor Name:	Johnson & Johnson
	Purchase Order #:	various
	Value of Purchase:	n/a
	Value of Next Lowest Bidder:	n/a
	Savings:	$ 1,932.00 (February discount savings)

TOTAL SAVINGS THIS QUARTER: $ 56,779.41

TOTAL SAVINGS THIS FISCAL YEAR: $ 89,407.32

gov16

MINUTES
Joint Conference Committee
Board of Governors
May 11, 1988

CALL TO ORDER:

Chairman Heenan called the May 11, 1988 meeting of the Joint Conference Committee to order at 4:38 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Sally Booth
Phyllis Ellis
George Heenan
James Moller, M.D.
Bruce Work, M.D.

Absent:
Robert Dickler
Patricia Ferrieri, M.D.
Michael Popkin, M.D.

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

Guest:
Jan Brockway

APPROVAL OF MINUTES:

The minutes of the April 13, 1988 meeting were approved as submitted.

Medical Staff - Hospital Council Report

Dr. James Moller presented the recommendations of the Credentials Committee of the Medical Staff-Hospital Council.

Dr. Moller called to the attention of the Committee the appointment of a physician applying for medical staff appointment who is covered by a malpractice insurance policy with a $300,000 deductible. Jan Halverson, UMHC Legal Counsel, indicated that the physician's group practice had a fund set aside to cover this deductible and that UMHC would not be liable for the deductible if no contributory negligence could be demonstrated on the part of UMHC in any malpractice case against the physician stemming from procedures carried out at UMHC.

A motion was made to accept the recommendations, was seconded and passed by a unanimous vote.

Quality Assurance Report

Dr. James Moller and Jan Brockway, Director of Quality Assurance, provided an overview presentation of Quality Assurance and Utilization Review processes that are being undertaken at UMHC. Dr. Moller described the overall administrative structure of QA activities at UMHC and divided these processes into three categories according to their scope of monitoring activity: External, Hospital Wide, and Departmental. Dr. Moller noted that UMHC has external accountability to about 50 agencies. He noted that overall hospital QA coordination is the responsibility of the Quality Assurance Steering Committee, a committee of the Medical Staff-Hospital Council, supported by the Hospital Department of Quality Assurance. Additionally each clinical department has QA accountability. Clinical Departments are also supported by the Hospital QA Department. Board responsibility for QA monitoring is part of the role of the Joint Conference Committee.

Jan Brockway presented work that has been done with the Pharmacy and Therapeutics (P&T) Committee on drug utilization and Quality Assurance. On the utilization side the committee, through a number of activities, has affected more appropriate utilization and has decreased the cost of drugs per discharge over the past year. The P&T Committee in cooperation with the Pharmacy and Nursing staff have also taken actions that have resulted in a decrease in medication and IV error rates in the past year. Dr. Moller also presented work that had been done in the NICU, monitoring high risk complications (particularly pericardial tamponade) and mortality rates of <1500 gram and >1500 gram babies. The interventions developed through monitoring have had a positive effect on outcomes over the past five years.

Discussion ensued concerning the amount of information that would be necessary for the Joint Conference Committee to adequately carry out its quality assurance responsibilities. Chairman Heenan suggested that the Committee be allowed to deal directly with a number of indicators that could have target rates set by Board policy. Jan Halverson and Greg Hart reminded the Committee of the difficulty in presenting quality assurance data in a public meeting. Concerns include patient confidentiality, the damage that could be done to the reputation of UMHC if data was improperly used in the media, and the negative effect that public disclosure of QA data would have on physician participation in QA efforts.

Mr. Hart indicated to the committee that the administrative staff constantly grapples with the issue of presenting enough QA information to allow the Board to fulfill its role. In the past, an effort has been made to assure the Board that indeed these quality assurance processes are taking place and developing.

Chairman Heenan noted that he would like to see UMHC take a leading role in the development of methodology for boards to become more appropriately involved in managing the QA activities of hospitals, just as they are involved in managing the bottom line. He indicated that the difficult issue is one of effectively overseeing a process, versus setting goals and monitoring against specific outcomes, while at the same time creating an environment which facilitates the support and active involvement of the Medical Staff.

The group agreed that this was a tremendously difficult undertaking given the complexity of measuring quality in health care provision. Dr. Moller suggested that a recommendation regarding Board involvement in Quality Assurance could be developed for the next meeting and brought to the Committee.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work indicated that the primary topics of discussion at recent Chiefs' meetings have been service and space allocation and issues surrounding resident benefits and reimbursement. He also noted that Dr. Paula Clayton had been named the new Chair of the Council and that Dr. Bill Thompson was the new Vice-Chair. Dr. Work also reported that an endorsement from the group has been granted to the Mayo Renovation proposal set forward by Robert Dickler.

Other Business

There was some discussion about a possible change of date for the June 15th meeting. Chairman Heenan indicated that it would be difficult for him to make it. However, it became clear after discussion that the 15th was the only acceptable date to obtain a quorum, given the other members' schedules. Chairman Heenan indicated that he would make every effort to make the 15th meeting.

ADJOURNMENT:

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

Respectfully submitted:

Ted Yank

Theodore J. Yank
Administrative Fellow

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 13, 1988

TO: Members of the Board of Governors

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

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

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

I am forwarding this report to you for your review and approval on May 25. If you should have any questions, please feel free to call on me.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 4, 1988

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

Department of Anesthesiology	Category
Mark T. Sontag	Attending
Department of Hospital Dentistry	
Darla J. Roelofs	Clinical
Charles R. Wilkinson	Clinical
Department of Family Practice and Community Health	
Christopher L. Krogh	Attending
Department of Laboratory Medicine and Pathology	
John G. Strickler	Attending
David F. Stroncek	Attending
Department of Medicine	
Alvin C. Holm	Attending-ER & Internal Medicine
John T. Strony	Attending
Lyle J. Swenson	Clinical
Department of Ophthalmology	
Marian R. Rubenfeld	Clinical

Approval of provisional status and clinical privileges continued:

Department of Pediatrics	Category
Carolyn J. McKay	Clinical
Department of Physical Medicine and Rehabilitation	
LeAnn M. Snow	Attending
Department of Radiology	
Benjamin C.P. Lee	Attending
Department of Urology	
Robert D. Fisher	Clinical

The following physician submitted an application and supporting documentation requesting additional clinical privileges. The Committee has reviewed and considered the request and hereby recommend approval.

Department of Neurosurgery	
Erich Wisiol	Clinical

Privileges: Add-CNS laser for Neurosurgical cases, CO_2

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

Department of Pediatrics	Category	Date Eligible
Ann C. Dunnigan	Attending	December 24, 1988
Ralph S. Shapiro	Attending	December 24, 1988
Department of Urology		
Neil A. Stein	Clinical	December 24, 1988

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Department of Pediatrics	Category
Richard P. Nelson	Clinical
Karen N. Olness	Clinical
Department of Orthopedics	
John E. Lonstein	Attending
Robert Winter	Attending

Resignation of Faculty Appointment/Loss of Medical Staff Appointment

Department of Obstetrics and Gynecology	
Donald Pavelka	Attending

HB/cf

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
Board of Governors Finance Committee
April 27, 1988

MINUTES

CALL TO ORDER:

On April 27, 1988 the Finance Committee meeting was called to order by Ms. Barbara O'Grady at 12:10 P.M. in the Board Room.

ATTENDANCE:

Present:	Edward Ciriacy, M.D.
	Robert Dickler
	Cliff Fearing
	Elwin Fraley, M.D.
	Jerry Meilahn
	Barbara O'Grady
	Roger Peschke
	Vic Vikmanis
Absent:	Robert Nickoloff
Staff:	Kay Fuecker
	Greg Hart
	Nels Larson
	Dan Rode
	Barbara Tebbitt

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the March 11 and April 13, 1988 meetings as written.

YEAR-TO-DATE FINANCIAL STATEMENTS:

Mr. Cliff Fearing reported the March average length of stay was 8.2 days, 4.2% above budget. The average daily census was 425, the year-to-date average daily census is 413. The census peaked at 506 on April 14, 1988. March Outpatient Clinic visits totalled 23,805 (13.5% above budgeted levels). The Home Health visits continued to increase. The Hospital shows a total expenses over revenues of $1,252,354 for a favorable variance of $4,865,828. Patient care charges were 2.4% over budget, ancillary revenue was 4.3% above budget,

and operating expenditures were 2.6% over budget. The Accounts Receivable represent 100.24 days outstanding. This decrease of 12.82 days occurred due to large payments received from Medicare, Minnesota MA and Commercial Insurance.

Mr. Fearing reviewed the hospital reserves of $77,496,000, noting .4 million has been set aside for debt repayment and certain capital projects such as the MRI II and the CUHCC project. A plan to deal with the reserves on an on-going basis will be presented to the Finance Committee duringg the summer. That plan will address the issues of how reserves are determined, how the reserves are used, the process used to determine usage of the funds.

Mr. Dan Rode reviewed the hospital accounts receivable in detail. UMHC experienced a $5.2 million decrease on Medical Assistance receivables due to the State of Minnesota catching up on their backlog. Mr. Rode attributed the impact on receivables to the new State process and "the intenisve follow-up process of UMHC with commercial insurers. Mr. Rode distributed an accounts receivable spreadsheet representing the aging of various types of receivables. These figures show a significant increase in outpatient accounts, an increase in HMO accounts but a decrease in receivables overall or in the last two months. UMHC is working with HMO's to decrease turnaround time with some success.

AUDITORS LETTER TO MANAGEMENT:

Mr. Nels Larson reported the letter from Peat Marwick Main & Co. addresses the internal accounting control policy issues. These issues include reconciliation concerns involving Hospital account balances on the University of Minnesota general ledger, and that these problems were primarily the result of inconsistent information being communicated, and the lack of timely reviews by Hospital and University accounting departments. Mr. Fearing noted that UMHC choose to get the new financial system up and running this past fiscal year rather than developing reconciliation procedures. The changes suggested will be implemented when the new system is completely operational.

THIRD QUARTER BAD DEBTS:

Mr. Dan Rode reviewed the Third Quarter, 1988 Bad Debts. The Bad Debts totalled $682,453.25, representing 1,710 accounts. Recoveries amounted to $11,413.55, leaving a net charge-off of $671,039.70, representing 1.06% of gross charges. Year-to-date bad debts have amounted to $2,321,402.59, representing 4,648 accounts. After recoveries, there was a net charge-off of $2,292,125.46. These debts were 1.20% of gross charges and compares to a budgeted bad debt level of 1.33%.

The Finance Committee passed a motion to endorse the Third Quarter, Fiscal Year 1988 Bad Debts as presented.

1988-89 OPERATING BUDGET:

Mr. Robert Dickler reported that since the Committee approved the budget on April 13, 1988, there is no other information to forward to the Committee.

LIPID RESEARCH CENTER SPACE:

Mr. Cliff Fearing reported that UMHC has been asked to repay the University of Minnesota loan to UMHC for the space by the Lipic Research Center in the Phillips-Wangensteen Building. The cost of this loan is $348,000 and that portion for which UMHC is responsible will be paid in the next 30 days. The exact amount of UMHYC's payment is being determined based on UMHC's share of space occupied. The Lipid Research Center has moved to space in the old Variety Club Hospital and the PWB space is essentially outpatient space now occupied by the Arthritis and Diabetes Clinic and the Department of Medicine.

ADJOURNMENT:

There being no further business, the April 27, 1988 meeting of the Finance Committe was adjourned at 1:20 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
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

May 25, 1988

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period July 1, 1987 through April 30, 1988

The Hospital's operations through the month of April 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 April, inpatient admissions totaled 1,616 or 74 above budgeted admissions of 1,542. Our overall average length of stay for the month was 8.0 days. Patient days for April totaled 13,335 and were 999 days over budget. The increase in admission levels over budget 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	15,805	15,208	15,853	645	4.2
Avg. Lnth. of Stay	8.3	8.4	8.0	-.4	-4.8
Patient Days	128,639	127,613	127,043	-570	-0.4
Avg. Daily Census	423.2	418.4	416.5	-1.9	-0.4
Percent Occupancy	72.1	71.9	71.9	0.0	0.0

Outpatient Census: Clinic visits for the month of April totaled 22,926 or 55 (0.2%) above budgeted visits of 22,871. Areas which experienced actual visits with large increases over budget were A.T.E.U. and the Diabetes Center. Community University Health Care Center (CUHCC) visits for the month of April totaled 3,145 or 1,045 (25.0%) under budgeted visits of 4,190, while Home Health visits of 964 for the month were 202 (26.5%) above budgeted visits of 762.

To recap our year-to-date outpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Clinic Visits	205,204	210,481	217,056	6,575	3.1
CUHCC Visits	39,721	40,000	39,373	-627	-1.6
HHA Visits	7,913	7,720	7,838	118	1.5

Financial Operations: The Hospital's Statement of Operations shows total expenses over revenues of $2,587,270, a favorable variance of $3,737,542.

Patient care charges through March totaled $ 213,459,721 and were 3.1% over budget. Routine revenue was 1.2% under budget and reflects our year to date unfavorable patient day variance. Ancillary revenue was approximately $7,167,400 (4.8%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,270 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $187 compared to the budgeted average of $184.

Operating expenditures through April totaled $205,730,724 and were approximately $6,511,000 (3.3%) over budgeted levels. The overall variance relates to increased salary, fringe benefit and medical supply costs.

Accounts Receivable: The balance in patient accounts receivable as of April 30, 1988, totaled $73,804,168 and represented 97.0 days of revenue outstanding. The overall decrease in our patient receivables in April of 3.2 days occurred in Medicare, Commercial Insurance and Blue Cross (Out-of-State).

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 APRIL 30, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$206,988,513	$213,459,721	$6,471,208	3.1%
Deductions from Charges	(37,582,017)	(36,214,903)	$1,367,114	3.6%
Other Operating Revenue	4,900,487	5,346,741	446,354	9.1%
Total Operating Revenue	174,306,983	182,591,559	8,284,576	4.8%
Total Expenditures	(199,219,575)	(205,730,724)	(6,511,149)	3.3%
Net Operting Revenue	(24,912,592)	(23,139,165)	1,773,427	
Non-Operating Revenue and Expenses	18,587,780	20,551,895	1,964,115	10.6%
Revenue over Expense	($6,324,812)	($2,587,270)	$3,737,542	(1)

(1) Variance equals 1.9% of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	15,208	15,853	645	4.2%
Patient Days	127,613	127,043	(570)	-0.4%
Average Daily Census	418.4	416.5	-1.9	-0.4%
Average Length of Stay	8.4	8.0	-0.4	-4.8%
Percentage Occupancy	71.9	71.9	0	0.0%
Outpatient Clinic Visits	210,481	217,056	6,575	3.1%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 17, 1988

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: Personnel Policy Changes

From time to time recommendations for changes in the Hospital's Personnel Policies are brought to the Board of Governors, consistent with the Board of Regents delegation in 1984. Recommendations for changes in Personnel Policy are reviewed by the Employee Advisory Committee, the Personnel Advisory Committee, and the Human Resources Management Committee, before being forwarded to my office. The attached policy changes have been brought through this review process, and I would recommend them to you for your approval.

A summary of the recommended changes is as follows:

Policy 3: To correct titles, to make wording of Hospital Policy consistent with University Policy (per Director of Office of Equal Opportunity and Affirmative Action), to clarify the process for submission of complaints.

Policy 4: To correct titles, to make Policy 4 consistent with Policy 3, to clarify completion of training and probationary periods as recommended by University Attorney.

Policy 5: To correct titles, to clarify completion of probationary periods as recommended by University Attorney, to specify length of probationary periods for part-time employees.

Policy 15: To correct titles, to make permanent part-time employees eligible to accrue seniority as recommended by the Employee Advisory Committee, to eliminate references to mandatory retirement per change in law.

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

RD/kff

Attachments

Discrimination and Political Activity
Board of Governors

POLICY

The University of Minnesota Hospitals and Clinics shall subscribe to the Equal Opportunity and Affirmative Action guidelines established by the University of Minnesota.

No discrimination shall be exercised, threatened, or promised by any person in The Hospital and Clinic service against or in favor of any employee on the basis of race, creed, religion, color, sex, national origin, ~~sexual or affectional preference, marital status, status with regard to public assistance, disability,~~ veteran status, ~~age (except for mandatory retirement age), national origin, ancestry, political opinions, union or other organizational affiliations, nor shall any employee be subject to any form of sexual harassment.~~ handicap, age, veteran status or sexual orientation. In adhering to this policy The University Hospitals and Clinic abides by the requirements of Title IX of the Education Amendments of 1972; by Sections 503 and 504 of the Rehabilitation Act of 1973; by Executive Order 11246, as amended; 38 U.S.C. 2012, the Vietnam Era Veterans Readjustment Assistance Act of 1972, as amended; and by other applicable statutes and regulations relating to equality of opportu

No discrimination shall be exercised, threatened, or promised by any person in The Hospital and Clinic service against or in favor of any employee on the basis of political opinions, union or other organization affiliations; nor shall any employee be subject to any form of sexual harassment.

No employee of tThe University Hospitals and Clinic shall be required to pay any assessment, make any contribution, or pay any subscription for any political purpose whatsoever; nor shall any employee solicit or receive or be in any manner concerned with soliciting or receiving any assessment, subscription, or contribution for any political purpose whatsoever from any employee in The University Hospitals and Clinic. No officer or employee of tThe University Hospitals and Clinic shall directly or indirectly use his/her authority or official influence to compel any officer or employee ~~in University Hospitals~~ to apply for membership in or become a member of any political organization; or to pay or promise to pay any assessment, subscription, or contribution; or to take part in any political activity. The services of any person who is found to have violated this provision may be terminated.

PROCEDURE

Employees who feel that they have ~~suffered due to~~ encountered discrimination as defined in this policy have the right to submit a complaint to the ~~Affirmative Action Office~~ Human Resources Department. The complaint shall be in writing on a form provided by the ~~Affirmative Action Office~~ Human Resources Department, specifically detailing which element of the discrimination policy has been violated~~, and it will be submitted to the Affirmative Action Office at University of Minnesota Hospitals. As in the case of other grievances, it~~ The form must be submitted to the Human Resources Department within thirty (30) working days after the aggrieved condition became known or should have become known.

The ~~Affirmative Action Office~~ Human Resources Department shall investigate the allegations, and ~~within ten (10) working~~ days respond to the ~~grievant~~ employee.

If the ~~grievant~~ employee is not satisfied with the response of the ~~Affirmative Action Office~~ Human Resources Department, he/she may file a grievance within ten (10) working days according to the ~~Hospitals~~ grievance procedure, policy number 14. If both parties agree, the grievance may be initiated at step 3.

Discrimination grievances shall not be subject to arbitration unless the nature of the discrimination grievance is such that these policies apply but no administrative agency review or legal recourse is available. In such cases, the grievance shall be subject to the binding arbitration process consistent with policy number 14.

jk12-P332

Recruitment and Employment

Board of Governors

POLICY

The University of Minnesota Hospitals and Clinics will provide and administer a ~~fair and orderly~~ system to post and fill vacancies. Employment opportunities will be provided without regard to race, religion, ~~creed,~~ color, sex, national origin, handicap, age, veteran status or sexual orientation, ~~sexual or affectional preference, marital status, status with regard to public assistance, disability, veteran status, age (except for mandatory retirement age), national origin, ancestry,~~ political opinions, or union or other organizational affiliations.

More than one member of a family may work for The University of Minnesota Hospitals and Clinics provided that there will be no immediate supervisory or substantive administrative relationships among the relatives. "Members of a family" shall be interpreted as including:

1. by blood or adoptive relationship: parents, grandparents, children, grandchild brothers, sisters;

2. by marriage relationship: husband, wife, brother(sister)-in-law, father(mother)-in-law, son(daughter)-in-law, stepparent, stepchild.

PROCEDURE

Section 1

Request to Fill New Position or Vacancy

When a new position or vacancy in an old position is to be filled, the department head shall submit a personnel requisition to the ~~Hospital Personnel Director~~ Human Resources Department on the form prescribed. Upon receipt of a requisition, the ~~Hospital Personnel Director~~ Human Resources Department shall have the classification of the position reviewed and shall either approve the requested classification or recommend reclassifying it, as may be appropriate.

Section 2

Announcement of Employment Opportunities

Announcements (postings) of all vacancies in ~~permanent~~ continuing positions shall be posted on the official bulletin boards of the ~~Hospital Personnel~~ Human Resources Department.

An announcement concerning a vacancy in a continuing position shall remain posted for a minimum of five (5) work days. A hiring decision may be made at the end of the posting period.

Temporary positions of less than six (6) months duration need not be posted, but the department must submit a requisition to the ~~Hospital Personnel Director~~ Human Resources Department before the position is filled.

Section 3

Hiring and Certification

The ~~Hospital Personnel~~ Human Resources Department will screen applicants for minimum qualifications and refer qualified applicants to the hiring supervisor.

Applicants who have applied for a specific vacancy and who have been certified as meeting the minimum qualifications of that vacancy shall normally be given consideration for employment in the following order:

1. the incumbent of a position which has been reclassified;
2. former employees whose names appear on the layoff list, under Seniority, Layoff and Resignation policy;
3. current University Hospitals and Clinic employees;
4. current University employees
5. all other applicants.

The order of preference may be changed under special circumstances by the University Equal Opportunity Officer in accordance with Affirmative Action policies of the Board of Regents. Employment decisions will be made by superviors and managers.

No appointment shall be submitted by a department head without prior certification by the ~~Hospital Personnel Director~~ Human Resources Department that the candidate is qualified. All appointments shall be subject to approval by the ~~Hospital Personnel~~ Human Resources Director and the Affirmative Action officer.

Section 4

Procedure in Nepotism Cases

If a nepotism situation exists ~~every~~ reasonable effort will be made to transfer one of the employees to another position.

Any employee who has passed an initial probationary period and who is required to resign from a position in order to comply with the nepotism policy shall have rights to the layoff list as though he/she had been laid off.

Section 5

Employment Procedure and Files

Applications for all University of Minnesota Hospitals and Clinics employment shall be made on forms and in such manner as prescribed by the ~~Hospital Personnel~~ Human Resources Director, and upon submission to the ~~Hospital Personnel~~ Human Resources Department become the property of The University Hospitals and Clinic.

Each employee shall have a right to see his or her personnel file upon request in the ~~Hospital Personnel~~ Human Resources Department in the presence of the ~~Hospital Personnel~~ Human Resources Director or designated member of his/her staff. The official personnel file for each employee is the one maintained by the ~~Hospital Personnel~~ Human Resources Department.

Section 6

Types of Appointment

Trainee appointments may be made when the ~~Hospital Personnel~~ Human Resource Director approves trainee programs to qualify persons for a particular work classification. An employee hired as a trainee shall be hired at a rate below the salary range for the class and may be granted incentive increases as he/she progresses through an organized training program until successfully completing the program and reaching minimum salary of the range for the class. He/she shall then be required to successfully complete the probationary period assigned to the class before receiving a continuing appointment. Successful completion of a training program or probation period is determined by the department head or other appropriate administrator.

Continuing appointments shall be made to any position in which the assigned work time is at least 50 percent of full time and of a continuing nature, when the employee has successfully completed the probationary period for the class of work.

Temporary appointments ~~may be made to any positions~~ (which have a beginning and ending date) may be made to any position. Employees on a temporary appointment, which may be part-time or full-time, shall not serve a probationary period and shall not have the same rights which accrue to an employee on a continuing appointment. Employees on a temporary appointment shall be notified, in writing, of the temporary nature of their appointment. Said document shall state clearly the definition of a temporary appointment and the ending date of the appointment, and shall be given to the employee by the supervisor and to the ~~Personnel~~ Human Resources Department at the time of hiring.

Part-time appointments may be made to any position in which the assigned work time is less than 75 percent time. Such an appointment may be temporary or continuing.

jk12-P376

April 16, 1984

Probationary Period and Orientation 6/85

Board of Governors 6/85

POLICY

The probationary period shall be regarded as an integral part of the selection process for appointment to any position ~~in which the assigned work time is at least 50 percent time~~ and of a continuing nature and shall be used by the supervisor for ~~closely~~ observing the employee's work, for helping the new employee adjust to the position, and for discontinuing the appointment of any employee whose performance does not meet required standards. Supervisors are required to help probationary employees understand their job responsibilities and duties. Successful completion of probation is determined by the department head or other appropriate administrator.

PROCEDURE

Section 1

Application of Probationary Period

A probationary period of employment shall be designated for each classification and shall be served by every employee hired in any a continuing position ~~to work 50 percent time or more,~~ regardless of whether such employment occurs as an original appointment, as a promotion, transfer, or demotion, and shall be successfully completed before the employee can be given a continuing appointment to the position.

No probationary period shall be required of an employee who is an incumbent in a reclassified position, who is assigned to a different position in the same job class in the same department, or who is re-employed in the same class and department following layoff or reinstatement after resignation unless probation is requested in writing by the appointing authority and approved by the ~~Hospital~~ Personnel Human Resources Director.

No probationary period shall be required of an employee who bumps back into any position in a classification in which he/she has previously passed probation.

The ~~Hospital~~ Personnel Human Resources Director shall determine and publish the length of the probationary period for each classification in which University Hospitals is predominant. This period may be not less than three (3) months or more than one year. ~~Related~~

~~and comparable classes shall have probationary periods of the same length. All employees working less than fulltime (but at least 50 percent time) shall work the same number of calendar months as fulltime employees to complete their probationary periods.~~ Employees appointed less than 75 percent time will have probationary periods based on calendar months. The number of months shall be comparable to the number of months served by a full-time employee.

The probationary period shall be automatically extended by adding to it the number of work days the employee has been absent without pay.

Section 2

Orientation

Each supervisor shall develop an orientation plan and shall be responsible for the orientation of each employee. The ~~Hospital Personnel~~ Human Resources Director will develop a plan by which required information will be communicated to new employees.

Section 3

Probationary Rating

Each employee will receive a mid-term probationary evaluation, to be completed by the supervisor and discussed with the employee by the mid-point of the probationary period. At least ten (10) work days before the expiration of the probationary period the department head shall report, by submitting at least one written service rating to the ~~Hospital Personnel~~ Human Resources Department, his/her judgment of the quality and quantity of work of the employee. Failure by a supervisor to complete the written service rating will be construed as an automatic passing of probation. Employees will be provided with progress reports throughout their probationary period.

Section 4

Discontinuance of Employment During Probationary Period

If the department head determines at any time during the probationary period that the employee's performance does not meet required standards, he/she may discontinue the appointment. Such discontinuance is not grievable except under the discrimination policy. Discrimination grievances will not be subject to arbitration.

The department head shall normally give an employee who fails to pass his/her probation period at least ten (10) work days notice before termination, and shall normally attempt to help the employee correct deficiencies before giving termination notice unless unusual circumstances indicate immediate termination.

An employee who is being terminated during the probationary period shall have the right to return to his/her most recent, former position (or if that position no longer exists, to the layoff list) within ten (10) days of notifying the former supervisor, provided he/she:

- has successfully completed the probationary period from the former position; and

- was promoted or transferred from the former position, and notifies the former supervisor of the intent to return on or prior to the termination day.

An employee who is terminated from a position for disciplinary reasons while on probation and who has previously passed probation in another job classification shall be able to return to the previous job classification if a vacancy exists; the employee will again be considered to be in a probationary period, consistent with the usual period for that job classification.

An employee who is being terminated during the probationary period for sub-standard performance, and who chooses not to exercise the option to "bump" another employee from a previously held continuing position, has the option of going on the layoff list.

jk12-P334

April 16, 1984

Seniority, Layoff, and Resignation

Board of Governors

POLICY

There will be a ~~fair and orderly~~ system to identify seniority, conduct lay-offs, and accept resignations. A department head may lay off an employee because of abolition of position, shortage of work or funds, or other reasons beyond the employee's control which do not reflect discredit on the services of the employee.

PROCEDURE

Section 1

Seniority

Seniority shall mean length of service (total paid straight-time hours) in a continuous position. ~~of 50%. or more. Seniority shall be accrued only by those employees whose appointment percentage is 50%-100% in one department.~~ Employees whose ~~appointment percentage is less than 50% in one department,~~ or whose positions ~~is~~ are not continuous, do not accrue seniority. An employee retains seniority in each of the classes in which he/she has worked.

For purposes of layoff, seniority shall be based on the length of service in a particular classification in a department.

For the purposes of required leave days, overtime scheduling, vacation, and hour scheduling, seniority shall be based upon:

1) the length of a service in particular classification in a department, or,

2) the length of service in a particular classification in a work location as designated by the Department Head and with the approval of the Human Resources Management Committee.

Seniority shall be acquired only after the completion of the probationary period, but shall date back to the date of entry into the class in the department or work location.

An employee who is being laid off and "bumps" into a temporary position in the same department will retain the status of a continuing employee and continue to accumulate seniority.

If overtime is required, the employee who usually performs the work shall be given first opportunity to work the overtime (including holidays). If the employee chooses not to accept overtime, other employees who are able to perform the work in an up-to-standard manner shall be permitted to work such overtime. If all employees decline to work such overtime, the person with the least amount of seniority in the work location may be required to work the overtime, providing that he/she is capable to perform the work.

An employee who transfers from one department or cost center to another department or cost center shall have the seniority credit at the time of transfer reinstated upon re-employment in that department or cost center, provided the employee has not terminated employment with Tthe Hospital and Clinic during the interim. ~~or had his/her appointment reduced below fifty (50) percent time for a period of four (4) consecutive calendar months.~~

Seniority credit of a former employee who is re-employed shall begin on the date of re-employment unless seniority is reinstated.

Section 2

Layoff

A layoff is defined as an involuntary reduction of hours across benefit lines that occurs for a period of three (3) or more consecutive pay periods. Benefit lines are:

75-100%
50-74%
0-49%

Employees' hours may be reduced within benefit lines without incurring layoff. A department head may lay off an employee because of abolition of position, shortage of work or funds, or other reasons beyond the employee's control which do not reflect discredit on the services of the employee.

Employees whose jobs have been eliminated and who are not the least senior in their classification and department shall be allowed to:

1. 'Bump' the least senior or probationary employee who is performing essentially the same duties within the same class and department;

2. 'Bump' the least senior or probationary employee in the same class and department if qualified to perform the work, even though the duties are not essentially the same.

An employee retains seniority in each of the classes in which he/she has worked within a department and may choose demotion instead of layoff into positions for which he/she is qualified: (1) if a vacancy exists, or (2) if he/she has greater seniority in a formerly held class than the least senior incumbent in the department where the layoff occurs.

When it is determined that two or more persons have equal seniority in the class and department in which the layoff is to be made, the department head may use discretion to retain the most valuable employee.

Normally four (4) weeks, and at least two (2) weeks before the effective date of a layoff of an employee on a continuing position, the Ddepartment Hhead shall give written notice to the employee, with a copy to the ~~Hospital Personnel~~ Human Resource Department. This notice shall include an explanation of the employee's bumping rights and of the consequences for unemployment benefits if bumping rights are not exercised.

Employees who have successfully completed probation and cannot or do not exercise their bumping rights and are laid off, shall upon request to the ~~Hospital Personnel~~ Human Resource Department, be placed on a layoff list and shall be rehired in seniority order in positions for which they apply, ahead of all other applicants, except for recalled employees, for vacancies within a previously held classification, if qualified to perform the work.

An employee on the layoff list must be recalled when a vacancy occurs in the department and classification from which the layoff occurred, provided the employee is qualified to perform the work.

After receipt of recall notice, the employee shall have five (5) working days during which to indicate intent to return and at least twenty-two (22) additional working days to report to work. Failure to accept recall shall constitute a resignation which will include removal from the layoff list.

Employees on the layoff list are entitled to hiring preference as outlined in policy 4, section 3, Recruitment and Employment. Employees on the layoff list may apply for any vacancy but are not entitled to hiring preference except where the vacancy occurs in a previously held classification. This shall apply to any university employee.

Seniority of a former employee who is re-employed from a layoff list shall begin on the date of re-employment. In the event re-employment is in the same department in which he/she was previously employed, the seniority at the time of termination shall be restored.

When a former employee is re-employed from the layoff list, unused sick leave and time accumulated toward eligibility for vacation allowance based on years of service shall be restored, effective on the date of re-employment.

An employee's name shall remain on the layoff list for a period not to exceed two years or until the employee has returned to work at The Hospitals and Clinic within that time. An employee has the right to refuse re-employment to the first position of equivalent classification, and reasonably close salary offered, but must accept the second, or be removed from the layoff list.

Employees who have exhausted their rights on the layoff list shall be considered as having resigned in good standing.

Section 3

Resignation, Retirement, and Reinstatement

An employee may resign by presenting his/her resignation in writing to the department head. To resign in good standing, an employee must give adequate notice as determined by the department.

A former employee who was employed on a pre-arranged assigned schedule of at least 75 percent time (or 50 percent time if initial three-year criteria have been met), and who is re-employed in a position of at least 50 percent time within one year, may, at the discretion of the department head, have any or all of these items reinstated; unused sick leave, seniority credit, vacation leave accumulation rate and eligibility; and waiver of probationary period within a formerly held class.

Retirement ~~shall~~ be mandatory on June 30 ~~following~~ an employee's ~~70th~~ birthday. ~~Early retirement options are available.~~

nh12-P384

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 17, 1988

TO: Members, Board of Governors

FROM: Robert Dickler RD
General Director

SUBJECT: 1988-89 Employee Compensation Plan

The Hospital's Personnel Policies and Procedures require that the Board of Governors approve an employee compensation plan on an annual basis. We would request approval from the Finance Committee and full Board for the six components of the pay plan outlined below, effective July 1, 1988.

In making these recommendations, we should note that we have considered marketplace salary changes, University pay plans, and union contract pay agreements, and attempted to reach a balance among those factors as we formulated the 1988-89 Hospital pay plan. Because we are in the second year of a biennium and the second year of our own collective bargaining agreements, and because the year two increases therein are very similar to last year's increases, the recommended pay plan for 1988-89 is very similar to that which was approved for 1987-88.

The pay plan recommendations can be implemented within the operating budget which the Board of Governors approved last month.

The recommended pay plan components are as follows:

1. For non-student, non-union employees in Hospital-dominated classifications:

   A. Increase salaries and salary ranges by 2%.

   B. Provide in-range progression increases on a merit basis, to average 1.5%, to those not on "step" plans.

   C. Continue in-range progression increases on a "step" basis, according to existing accumulated hours scheduled for employees in general staff nurse, pharmacist, radiologic technologist, and nurse anesthetist job classifications. The cost of these increases is $637,000.

   D. Implement the comparable worth increases scheduled for year four of the previously approved four year plan. The cost of these increases is $365,000.

2. For non-student, non-union employees in University-dominated classes:

   A. Consistent with allowable University pay plan guidelines, provide in-range adjustments of 2% across the board.

   B. Consistent with allowable University pay plan guidelines, provide an additional 1.5%, to be distributed on a merit basis, in a combination of in-range adjustment and lump sum payments.

   C. Not requiring board approval, pay equity increases will be provided to employees in University-dominated classes, according to the University comparable worth plans. The cost of these increases is $134,000.

The University's base pay plan calls for 2½% increases for employees in University-dominated classes. In addition, the University's guidelines allow for additional lump sum increases based upon the unit's financial ability to provide those increases. As was the case last year, we are recommending that the total increase for Hospital employees in University-dominated classes be 3½% (Items 2A plus 2B). This will result in the same average level of increase as is being provided for Hospital employees in Hospital-dominated classes (Item 1A plus 1B).

An additional comment on pay equity is in order. We are recommending that we complete the original four year comparable worth plan which the Board approved in 1985. The University is changing its pay equity plans, providing an increase for 1988-89 that is larger than in past years, but implementing that increase on January 1, rather than July 1. The net result, after these increases, is that the Hospital will be at 5% from its "target pay line", while the University will be 7%-8% from its target pay line. The Hospital's pay equity actions thus continue to be appropriate relative to the University. The issue of pay equity will require continued Board of Governors discussion over the next six to nine months.

Finally, it should be noted that the 1988-89 budget provides for miscellaneous, not-yet-designated increases based on marketplace needs in the amount of $340,000. As noted earlier, all of the above recommendations can be implemented within the approved budget for 1988-89.

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

/kj

MANAGED CARE 1988: WHO IS WINNING?

"A hospital chief executive and the former head of an HMO discuss the latest developments in the managed care dilemma."

Wednesday, June 8, 1988

A TRUSTEE FORUM • 7:30-9:30 A.M. • HYATT REGENCY HOTEL

The issues driving managed care are complicated and divisive. There will be "winners" and "losers" as these critical issues are resolved — with far-reaching implications for hospitals, physicians, HMOs, employers, patients and the larger community.

MANAGED CARE IN THE BOARDROOM

Governing boards must be aware of all the ramifications of managed care relationships and how their hospitals will be effected in terms of costs, quality of service, accessibility and community image. Boardroom policies will guide the CEO in contract negotiations with HMOs and will also convey important messages to the medical staff.

Vital questions for board members include: "What is the impact on the hospital of HMO legislation recently passed by the State Legislature?" "What are the major trends in managed care and what implications do these trends have for our hospital?" "How important an issue is quality assurance when evaluating managed care relationships?"

MANAGED CARE & THE FUTURE

Are today's HMOs and PPOs the best health care vehicles for the future, or will they evolve into hybrid structures which offer even more efficient health care delivery? Mr. Scott Anderson and Mr. George Morrow are two of the most knowledgeable health care professionals to address this important topic.

Speakers:

Scott Anderson is President and Chief Executive Officer of North Memorial Medical Center. He began his health care career in 1964, working as an administrative assistant for the same organization he heads today.

George Morrow is the former President and Chief Executive Officer of Physicians Health Plan. He also served as Vice President/General Counsel of United Healthcare Corporation and was a practicing trial lawyer for 9 years.

MINNESOTA HOSPITAL TRUSTEE CONFERENCE

General Information

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

Location and Date: The Forum will be held on Wednesday, June 8, 1988, from 7:30 a.m. to 9:30 a.m. in the morning:

Hyatt Regency Hotel
1300 Nicollet Mall
Minneapolis, Minnesota
Breakfast will be served.

Parking: Hyatt Regency ramp.

Registration Fee: $35 — this fee is refundable in case of cancellation up to three (3) working days prior to the Forum. Substitutions may be made anytime.

For Further Information:
Pat Pardun 641-1121.

Conference Committee Members:

Robert E. Christenson, Chairman
Vernon Hoium
Naomi Johnson
Geoffrey Kaufmann
David Hunt
Pat Pardun, Coordinator

The Minnesota Daily

Tuesday, April 26, 1988

Legislature repeals sales tax, saving U over $6 million

By **Jonathan Filas**
Staff Reporter

The University can look forward to saving approximately $6.6 million next year on sales taxes.

The Legislature passed an omnibus tax bill Monday night, which included a repeal of the sales tax on purchases made by state higher-education institutions.

In all, the Legislature enacted $11.1 million in sales-tax cuts, including $1.2 million by repealing the tax on aspirin.

The University Hospital and Clinic will also save $2.2 million of its own next fiscal year, which begins July 1, 1988.

Without the repeal, equipment and supplies would cost University departments an additional 6 percent, said Carol Campbell, acting vice president for finance and operations.

The repeal comes one year after

See **Sales** *page 8*

Sales *from 1*

the Legislature enacted the tax at Gov. Rudy Perpich's request. It was one of several measures designed to help reduce the state's $800 million deficit.

The University paid the tax this year out of its central reserves, but University officials threatened to sue the state if the tax were not repealed. Former University President Ken Keller had made the repeal his top legislative priority.

House tax committee chairman Gordon Voss (DFL-Blaine) said, "We've got a good bill for 1989. The only real problem is the homestead credit, and that is a long-term problem which can be taken care of before it is a problem (next session)."

The tax package retains the homestead credit, at the insistence of House conferees. In 1989, the maximum amount of the credit would be increased from $700 to $725, and the credit would be substantially modified in 1990.

Other provisions of the bill include restoration of 1987 cuts in renters' credit; providing property tax relief, mostly to Twin Cities-area homeowners and to owners of commercial-industrial property outside the metropolitan area; income-tax relief that specifically earmarks Minnesotans who are at least 65 years old; and corporate income tax cuts, including cuts for corporations with income from foreign countries.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 10, 1988

SAMPLE LETTER

Senator Joe Bertram, Sr.
887 Flanders Drive
Paynesville, Minnesota 56362

Dear Senator Bertram:

On behalf of The University of Minnesota Hospital and Clinic (UMHC), thank you for your support during this past legislative session. We were concerned during the session that UMHC would lose its sales tax exemption. However, our exemption was never removed from the bill as it went through both House and Senate Tax Committees and was included in the Omnibus Tax Bill through your efforts.

Maintaining UMHC's tax exempt status is important as we work to provide high quality health care to the people of Minnesota in a competitive environment. At UMHC we strive for leadership in an industry that blends the highest of technology with the caring and compassion of dedicated human beings. All five thousand of our employees and many thousands of patients are grateful that the members of both committees recognized the competitive pressures that UMHC faces and did not add to them.

Earlier this year you received a copy of "Reaching Out," our latest annual report. We view ourselves as a resource to all Minnesotans and the report explains just some of the ways that we do just that.

Thank you again for your support of UMHC this session. If there is any way in which UMHC can support you, or if you would like an additional copy of "Reaching Out," please do not hesitate to contact us.

Sincerely,

Mr. Robert Latz
Chairman, Board of Governors,
The University of Minnesota Hospital and Clinic

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SPECIAL ARTICLE

THE EFFECTS OF REGULATION, COMPETITION, AND OWNERSHIP ON MORTALITY RATES AMONG HOSPITAL INPATIENTS

STEPHEN M. SHORTELL, PH.D., AND EDWARD F.X. HUGHES, M.D., M.P.H.

Abstract We examined the influence of the regulation of hospital rates, state certificate-of-need programs, competition, and hospital ownership on mortality rates among inpatients receiving care under Medicare for 16 selected clinical conditions that were studied as a group. Data were obtained from the records of 214,839 patients who received care in 981 hospitals in 45 states from July 1, 1983, through June 30, 1984.

We found significant associations between higher mortality rates among inpatients and the stringency of state programs to review hospital rates ($P \leq 0.05$), the stringency of certificate-of-need legislation ($P \leq 0.01$), and the intensity of competition in the marketplace, as measured by enrollment in health maintenance organizations ($P \leq 0.05$). Hospitals in the states with the most stringent review procedures for hospital rates had ratios of actual to predicted death rates that were 6 to 10 percent higher than those of hospitals in states with less stringent rate-review programs ($P \leq 0.001$). Hospitals in the states with the most stringent procedures for reviewing applications for certificates of need had ratios of actual to predicted death rates that were 5 to 6 percent higher than those of hospitals in states with less stringent certificate-of-need procedures ($P \leq 0.05$). There was no statistically significant association between mortality rates among inpatients and either the type of hospital ownership or the number of hospitals competing in the market area. Additional analyses, which examined alternative explanations for these findings, failed to change the results.

These findings raise serious concerns about the welfare of patients who are admitted to hospitals in highly regulated areas and those admitted to hospitals in relatively competitive markets. They suggest that it is important to incorporate quality-assurance procedures and systems to monitor patients' outcomes into public and private programs designed to contain costs or promote competition, or both. (N Engl J Med 1988; 318:1100-7.)

THE Institute of Medicine has recently called for increased research on the relation between the pressures on hospitals to reduce costs and the quality of care they deliver.[1] This call results in part from concern that these pressures could lead to adverse outcomes for patients.[2] Some of the discussion of this issue has focused on investor-owned hospitals and the possibility that the care they provide to patients may be particularly vulnerable to such pressures. However, research to date shows no systematic differences in outcomes for patients between investor-owned and not-for-profit hospitals.[3,4] An alternative possibility is that, regardless of the nature of their ownership, hospitals that face severe regulatory constraints, strong competitive pressures in the local markets, or both may respond to these forces in ways associated with poorer outcomes for patients. We investigated this hypothesis by analyzing the variation among 981 hospitals in mortality rates for Medicare inpatients in a group of 16 diagnostic categories as a function of regulatory constraints and the competitiveness of local markets.

From the Center for Health Services and Policy Research, the J.L. Kellogg Graduate School of Management, and the School of Medicine, Northwestern University, Evanston, Ill. Address reprint requests to Dr. Shortell at the Center for Health Services and Policy Research, 629 Noyes St., Evanston, IL 60208.

Supported in part by a grant (HS-05159) from the National Center for Health Services Research and Health Care Technology Assessment (Rockville, Md.), and by a grant (9181) from the Robert Wood Johnson Foundation (Princeton, N.J.).

BACKGROUND

Wide differences in mortality rates among hospitals are well documented, although not well understood.[5-12] As noted above, the few studies that have examined the effect of hospital ownership on patients' outcomes have generally found no differences between investor-owned and not-for-profit hospitals.[3,4] There is some evidence, however, that hospitals that belong

to a system (i.e., two or more hospitals with a common ownership) perform better on certain criteria, measuring structure and procedures, developed by the Joint Commission on the Accreditation of Health Care Organizations.[13]

There is growing concern that, as hospitals are increasingly buffeted by external pressures to reduce costs, they may be forced to allocate resources in ways that could adversely affect patients' care. Under the Medicare prospective payment system, for instance, hospitals have incentives to discourage the admission of beneficiaries with high costs, to reduce the diagnostic and therapeutic resources used for these beneficiaries, and to discharge them sooner.[14] Any one of these responses could result in adverse outcomes. Anecdotal evidence suggests that such adverse outcomes may already be occurring.[2]

Hospitals that face severe regulatory constraints and constraints on payment, operate in highly competitive markets, or both appear to be at greater risk of responding to such incentives in a way that could result in adverse outcomes. Severe regulatory constraints, such as strict programs to review hospital rates and stringent requirements for the granting of certificates of need, create incentives for hospitals to contain costs and may act as barriers to the development of innovative services that might improve the quality of care and thereby patients' outcomes.[15,16] Additional pressures may be felt by hospitals in states with low payment levels for Medicaid patients.

Similarly, patients admitted to hospitals in highly competitive markets, where their market share is threatened, may be at relatively greater risk of poor outcomes.[17,18] Given consumers' relative lack of knowledge and information about the quality of medical care, such hospitals may compete more by offering lower prices and more amenities than by improving their performance on outcome-oriented technical measures of quality.[19] In particular, hospitals facing both greater regulatory or payment constraints and a highly competitive market may be most likely to have poorer patient outcomes.

Methods

To test this hypothesis, we examined the mortality rates among Medicare patients for a group of 16 clinical conditions at 981 hospitals. These hospitals were part of a larger study of eight multihospital systems (three investor-owned and five not-for-profit) and their competitors in the same market areas.[20] Forty-six percent of the hospitals (n = 448) belonged to investor-owned systems; 21 percent (n = 205) belonged to not-for-profit systems; 21 percent (n = 206) were independent nongovernmental hospitals, either for-profit or not-for-profit; and 13 percent (n = 124) were public hospitals. The average number of beds was 213; the sample ranged from hospitals with fewer than 100 beds to several teaching institutions with more than 700 beds. Approximately 17 percent of the hospitals had approved residency-training programs. The hospitals in our sample were located in 45 states and were similar to the group of all community hospitals in the United States, except that the percentage of investor-owned hospitals was higher in our sample and the percentage of hospitals located in the Northeast section of the country was lower.

To investigate differences among these hospitals in the outcomes for Medicare patients, we chose 16 clinical conditions (defined in the *International Classification of Diseases, Adapted* [ninth revision]) for analysis. These conditions were judged to occur with sufficient frequency as a group to allow for statistically valid analysis and to include conditions of sufficient clinical severity for their outcomes to be sensitive to pressures for cost containment. The patients with these 16 conditions represented nearly 40 percent of the 981 hospitals' Medicare discharges.

The 16 conditions and the in-hospital death rates (i.e., not including deaths after discharge) for patients with these conditions are shown in Table 1. They include 10 operative and 5 nonoperative conditions. The 16th condition combines "preventable complications and other misadventures in medical care" and "other complications"; this group of conditions was chosen because we thought that death due to these causes might be particularly sensitive to pressures on hospitals to contain costs. The outcomes for five of the operative conditions (cholecystectomy, transurethral resection of the prostate, repair of inguinal hernia, mastectomy, and excision or destruction of a local lesion of the bladder) were previously analyzed by Gaumer.[3] These five categories were selected for inclusion in that study by a multispecialty physician panel. We used yet another multispecialty physician panel both to review the appropriateness of these 5 categories for our study and to select the other 11 categories.

For each of the 981 hospitals, mortality rates were calculated for the 16 conditions as a group on the basis of the Health Care Financing Administration's Medical Provider Analysis and Review (MEDPAR) data set for the period from July 1, 1983, through June 30, 1984. Overall, data from 214,839 patients' records were available for analysis. The MEDPAR tape lists up to five diagnostic categories and three surgical procedures for each case. Each case was classified by its first or principal diagnosis. In cases in which a surgical procedure was listed, the case was classified according to the principal surgical procedure. The patient's age and sex, the presence or absence of other medical conditions (comorbid conditions), and the length of stay were directly entered into the equation as covariates in order to assess the magnitude of their influence on death rates. A comorbid condition was defined as one or more secondary diagnoses or operative procedures. We also controlled for the percentage of cases in each of the 16 conditions in each hospital in order to take into account the possibility that some hospitals may have had a higher percentage of patients in categories with higher mortality (see the Technical Appendix for this calculation). We

Table 1. Death Rates for Patients with 16 Conditions.

Condition*	In-Hospital Death Rate (%)
Nonoperative	
Acute myocardial infarction (410–410.9)	23.8
Acute tubular necrosis (584.5)	31.2
Congestive heart failure (428.0)	9.2
Cholecystitis and cholangitis, without mention of calculus (575.0, 575.1, 576.1)	2.7
Pulmonary embolism (415.1)	16.9
Operative	
Primary lens procedure (13.1, 13.11, 13.19, 13.59, 13.71, 13.72)	0.4
Cholecystectomy (51.22)	5.1
Transurethral resection of prostate (60.2)	3.0
Repair of inguinal hernia (53.00, 53.01, 53.02)	2.2
Mastectomy (85.41, 85.43)	1.2
Excision or destruction of local lesion of bladder (57.49)	3.0
Coronary bypass surgery (36.11, 36.12, 36.13, 36.14)	10.5
Laminectomy (80.5)	1.5
Total hip replacement (81.51, 81.59)	5.0
Total knee replacement (81.41)	2.5
Complications and misadventures	
Preventable intraoperative complications (998.2, 998.4, 998.6)	2.3
Potentially preventable intraoperative and postoperative complications (998.0, 998.1, 998.3, 998.5)	
Misadventures in medical care (999.0)	
Complications of surgical procedures (997.0)	
Other complications (995.2, 995.3, 995.4, 998.9)	

*Numbers in parentheses denote codes from the *International Classification of Diseases, Adapted* (ninth revision).

examined in-hospital mortality rates, rather than mortality rates 30 days after admission or after discharge or 60 days after admission or after discharge, in order to evaluate the portion of patient outcome most directly influenced by hospital care. Analysis of the mortality rates 30 days after admission resulted in findings virtually identical to those reported here.[21]

Two additional measures of hospital case mix were included in the analysis: the percentage of hospital days made up of days in the intensive care unit and the Health Care Financing Administration (HCFA) 1984 case-mix index for the hospital. It can be argued that the percentage of hospital days spent in the intensive care unit may reflect a hospital's tendency to fill up high-cost units to gain more revenue from patients for whom payment is based on the hospital's costs, rather than the severity of patients' conditions. Our data, however, indicate some association between this measure and the severity of patients' conditions, as supported by a correlation of 0.45 ($P<0.0001$) between the percentage of hospital days in the intensive care unit and the HCFA case-mix index. The case-mix index is based on the intensity of resources (labor and nonlabor) used in patient care. An HCFA case-mix index score of 1.0 indicates that a hospital's case mix is equal to the average for all hospitals in the MEDPAR file. A score above 1.0 indicates a more severe case mix; a score of less than 1.0, a less severe case mix. The range for the 981 hospitals we studied was from 0.85 to 1.92, with a mean of 1.09. There are limitations to our adjustments for case mix and severity. Ideally, one would want to measure the degree of severity of the principal diagnosis. Such measures, however, are not available in the MEDPAR data base.

Two characteristics of the communities in which the hospitals were located were also examined by means of data from the Area Resource File (sociodemographic and health policy data compiled by the Department of Health and Human Services): the median income for the county in which the hospital was located, adjusted for the county's manufacturing-wage index, and the median number of years of education for those age 25 and older in the county. These variables were included in order to control for characteristics of the communities that may have influenced patients' outcomes. For example, higher-income, better-educated consumers may demand higher-quality services, which, in turn, may be associated with better outcomes.

Regulatory constraints and constraints on payment were measured in terms of the stringency of the state's certificate-of-need program, the stringency of the state's programs to review hospital rates, and the state's Medicaid payment level. The measures of stringency of certificate-of-need and rate-review programs were based on previous research.[22] The stringency of programs to review applications for certificates of need was measured as a composite variable, including the number and types of facilities and services covered; the dollar value of threshold limits for the review of capital expenditures, purchases of major equipment, and new programs or services; the degree of enforcement, measured in terms of review criteria and penalties for violation; and the length of time the programs had been in existence. These items were summed for each hospital, on the basis of the factor-score coefficients, which indicate the importance of each item to the overall scale.

The stringency of review of hospital rates was also measured as a composite variable, including whether the program was mandatory or advisory; whether hospitals were required to repay excess revenue; the extent to which specific rate-setting formulas and departmental screens were used; the extent to which cross-subsidization by departments and payers was allowed; and whether or not adjustments were made for patient volume on the basis of admissions or by other methods. Again, the items were summed for each hospital, on the basis of the factor-score coefficients. Medicaid payment levels were calculated as payments per recipient of hospital inpatient and outpatient care divided by the average hospital expense per adjusted patient day for the state. This adjustment was made to control for differences in hospital costs among states.

Competition was measured in two ways. First, we used ZIP codes to identify all hospitals within 15 miles of the hospitals in our study.[23] For large metropolitan areas, the chief executive officers of the hospitals in the study were then asked to indicate which specific hospitals they perceived as competitors. On the basis of the resulting frequency distribution of the number of competing hospitals, hospitals with two or more competitors were categorized as operating in more competitive markets, whereas those with one competitor or none were classified as operating in less competitive markets. Second, we used the percentage of a state's population enrolled in health maintenance organizations (HMOs) as another indicator of the intensity of competition. The assumption underlying this measure was that hospitals located in states where HMOs have enrolled a higher proportion of the population face more pressure to compete with each other for patients on the basis of price.[24]

Finally, hospital ownership and related characteristics were entered into our analysis. The four ownership categories we used were as follows: independent for-profit and not-for-profit nongovernmental hospitals; investor-owned hospitals belonging to systems; not-for-profit hospitals belonging to systems; and public hospitals. In the analysis, all the other ownership categories were compared with the independent nongovernmental for-profit and not-for-profit hospitals.

In addition to ownership, we included in the analysis the percentage of hospital employees who were registered nurses, the presence or absence of an approved residency-training program, and the number of nursing home beds per capita in the county where each hospital was located. The percentage of registered nurses on the staff and the presence of an approved residency-training program were included as measures of the hospital's clinical skill level, on the assumption that hospitals that employed a higher percentage of registered nurses and that had residency-training programs might have better patient outcomes, when differences in case mix were controlled for. The number of nursing home beds per capita was included to control for the possibility that hospitals located in areas with fewer nursing home beds might have higher in-hospital mortality rates because fewer patients would be discharged to nursing homes. The location of the hospital and its number of beds were excluded from the analysis because these variables were highly correlated with the variables for case mix and competitiveness of the market.

This model was tested with hierarchical ordinary least-squares analysis with natural log transformation of the mortality-rate variable. Findings for the untransformed variable and logistic transformation were the same as for the natural log transformation. All characteristics of patients and case-mix variables were entered first, followed next by the variables for the characteristics of the community; then by regulation, competition, and payment; and finally by ownership and related variables. The results were not sensitive to the order of entry of the variables. To account for differences in patient volume among hospitals, the data were weighted by the number of patients with the 16 conditions at each hospital divided by the average number of patients with the 16 conditions for all the hospitals in the study.

Results

The means and standard deviations for all the variables are shown in Table 2. The overall in-hospital mortality rate for patients in the 16 categories we examined was approximately 11 percent, with a standard deviation of about 4 percent; the range was from 0 to approximately 30 percent. Although this range is large, the standard deviation of 4 percent results in a relatively small coefficient of variation (0.37), indicating that the amount of variation to be explained is not large.

As shown in Table 3, the hospitals' mortality rates were positively and significantly associated with the percentage of patients aged 75 to 84 and age 85 and older, with the percentage of patients with comorbid conditions, and with length of stay. Similarly, the percentage of patient days spent in the intensive care unit was also significantly associated with higher mortality rates. Two of the three measures of regulatory constraints and constraints on payment, the stringency of certificate-of-need programs and the stringency of rate-review programs, were also positively and significantly associated with higher mortality rates.

Table 2. Means and Standard Deviations for Study Variables (Unweighted).

VARIABLE*	MEAN	STANDARD DEVIATION
In-hospital mortality rates for 16 selected conditions	11.2%	4.1
Logarithm of mortality expected on the basis of distribution of cases	−2.34	0.16
Patient age		
65–74	41.6%	9.7
75–84	38.4%	6.9
≥85	20.1%	7.1
Male patients	43.9%	8.0
Patients with comorbid conditions	35.5%	8.7
Length of stay (days)	9.2	2.01
Percent of hospital-patient days in ICU	6.5%	4.6
HCFA case-mix index (1984)	1.09	10.9
Median income adjusted for manufacturing-wage index for county	$20,483	$7,061
Logarithm of median years of education for people ≥25 yr old in county	2.47	0.06
Medicaid payment index	2.08	0.65
Stringency of certificate-of-need review (score)	−1.93	4.54
Stringency of rate-review program (score)	−2.40	8.15
Hospitals with ≥2 competitors	64.2%	48.0
HMO enrollment in state	6.31%	7.12
Investor-owned system hospitals	45.7%	49.8
Not-for-profit system hospitals	20.9%	40.6
Independent nongovernmental hospitals	21.0%	40.8
Public hospitals	12.8%	33.4
RNs among hospital employees	20.5%	6.2
Hospitals with approved residency-training program	17.1%	46.8
Nursing home beds in county/1000 population	6.45	3.75

*ICU denotes intensive care unit, HCFA Health Care Financing Administration, HMO health maintenance organization, and RNs registered nurses.

Medicaid payment levels were not associated with mortality, probably because most hospitals derive a relatively small percentage of their total revenue from Medicaid patients.

Competition among hospitals in the same market area, as measured by the presence of competing hospitals, was not significantly associated with mortality rates. Market penetration by HMOs, however, was significantly and positively associated with higher mortality rates. Additional analysis of interaction terms assessing the combined effect of the competition and the regulatory variables revealed no significant associations with mortality rates. There were no significant differences in mortality rates among investor-owned hospitals in multihospital systems, not-for-profit hospitals in multihospital systems, or public hospitals, as compared with independent nongovernmental hospitals. Additional analysis comparing mortality rates in investor-owned hospitals in multihospital systems with those in not-for-profit hospitals in multihospital systems also revealed no statistically significant difference. The percentage of registered nurses among a hospital's employees was associated with lower mortality rates, as expected, but the relation was not statistically significant. The educational level of the county's population, the adjusted median income in the county, the presence of a residency-training program at the hospital, and the number of nursing home beds per capita in the county were not significantly associated with mortality rates.

Overall, the model explains 11 percent of the variation in mortality rates. More refined measures of the severity of patients' conditions, as discussed earlier, could increase its explanatory power.

DISCUSSION

In our analysis, three types of variables were found to be positively and significantly associated with hospital mortality rates: measures of regulatory stringency; competition in the marketplace as measured by the percentage of the population enrolled in HMOs; and indexes of the severity of patients' conditions and of case mix. The type of ownership was not associated with variation in mortality rates.

Regulation and Competition

Although the magnitude of the coefficients is not large, the statistically significant relations between in-hospital mortality rates and selected measures of hospital regulation and competition are noteworthy. Our findings suggest that, when faced with either type of external threat, hospitals may respond in ways associated with an increase in their mortality rates. Examples may include attempts to cut costs through reductions in staff (such as reductions in the number of nurses assigned to the intensive care unit), elimination of selected services, consolidation of services, and postponement of capital improvements. Hospitals may also forgo the development of new programs and services that could improve the quality of care. Some of these initiatives, undertaken in the name of efficiency, could have a negative impact on patient care, which, in turn, could lead to poorer outcomes for patients.

Because these findings may be the first documented evidence that hospitals operating in more highly regulated states and more competitive markets have higher mortality rates among Medicare inpatients, we considered two alternative explanations for our findings: the influence of the location of hospitals and the relative shortage of nursing home beds in highly regulated states. We also undertook two additional analyses to examine (1) the possibility that the finding regarding the association of the stringency of certificate-of-need programs and mortality rates would not hold for a subset of conditions most likely to be affected by stringent enforcement of certificate-of-need regulations and (2) the possibility that the findings would not be consistent if we randomly divided our sample of hospitals in half.

One possibility is that our findings regarding the effects of regulation and competition are due to other variables excluded from the analysis, which, if we included them, would negate the effects of the measures of regulation and competition. Hospital location is one such factor. For example, inner-city hospitals may have higher mortality rates because they treat more severely ill patients, and such hospitals may be located in states that are highly regulated. Analysis of this possibility, however, indicated no significant difference in mortality rates between urban and central-city hospitals and hospitals located in "collar counties" (counties contiguous to a U.S. Census standard metropolitan statistical area and with 20,000 or fewer

Table 3. Association of Variables with In-Hospital Mortality Rates.*

VARIABLE	UNSTANDARDIZED COEFFICIENT†	STANDARD ERROR	STANDARDIZED COEFFICIENT‡
Logarithm of expected mortality on the basis of distribution of cases	0.005	0.09	0.002
Percentage of patients 75–84 yr old	0.47§	0.21	0.07
Percentage of patients ≥85 yr old	0.44§	0.22	0.07
Percentage of male patients	0.23	0.18	0.04
Percentage of patients with comorbid conditions	0.45¶	0.16	0.10
Length of stay	0.047‖	0.007	0.24
Percentage of patient days in ICU	0.61§	0.27	0.08
HCFA case-mix index (1984)	0.20	0.12	0.07
Median income adjusted for manufacturing-wage index for county	0.00	0.00	0.02
Logarithm of median years of education for people ≥25 yr old	−0.026	0.22	−0.003
Medicaid payment index	−0.011	0.019	−0.021
Stringency of certificate-of-need review	0.008¶	0.003	0.10
Stringency of rate-review program	0.003§	0.001	0.06
Percentage of hospitals with ≥2 competitors	0.028	0.03	0.03
HMO enrollment in state	0.004§	0.002	0.07
Investor-owned system hospitals	0.003	0.03	0.003
Not-for-profit system hospitals	−0.002	0.03	−0.004
Public hospitals	−0.017	0.037	−0.016
Percentage of RNs among hospital employees	−0.32	0.21	−0.05
Percentage with approved residency-training program	0.003	0.03	0.004
No. of nursing home beds in county/1000 population	0.002	0.004	0.02
Intercept	−3.34	0.59	—

*R^2 = 0.13; adjusted R^2 = 0.11; F = 7.00; P≤0.00001.

†Indicates the relation between the independent variable and the dependent variable, independent of the effects of the other variables in the analysis.

‡Expresses the relation between the independent variable and the dependent variable in standardized units of measurement. The higher the standardized coefficient, the stronger the relation between the independent variable and the dependent variable.

§P≤0.05. ¶P≤0.01. ‖P≤0.001.

urban residents and noncore counties of metropolitan areas of 1 million or more population). Hospitals located in rural areas did, however, have lower mortality rates than hospitals located in collar counties (beta = 0.10; P≤0.01). However, the variables for stringency of certificate-of-need programs (beta = 0.01; P≤0.0001) and the stringency of rate-review programs (beta = 0.003; P≤0.04) remained positively and significantly associated with higher mortality rates, even when location was considered in the analysis.

A second possible explanation for the relation between a high degree of regulation and high mortality rates is a relative shortage of nursing home beds in highly regulated states. This shortage may be associated with longer hospital stays.[21] We did find a positive relation between length of stay and mortality rates. However, we controlled for the number of nursing home beds per 1000 population, and there was no statistically significant relation between the supply of nursing home beds and inpatient mortality rates. More specifically, the significant association of the stringency of certificate-of-need and rate-review programs with higher mortality rates was independent of the supply of nursing home beds or, for that matter, length of stay.

The influence of the stringency of certificate-of-need programs is of particular interest because it can be argued that stricter certificate-of-need legislation should be associated with lower mortality rates, since many reviewing agencies explicitly evaluate whether patient volume is sufficient to produce positive outcomes when they consider certificate-of-need applications. The contrary argument is that the requirement for a certificate of need serves as a barrier to the development of innovative programs and the possible upgrading of hospitals' physical plants and equipment. Thus, patients at hospitals whose applications for a certificate of need have been rejected and those who may not have applied because of the stringent review criteria may have poorer outcomes because the hospitals continue to provide care with outdated facilities and technology. If so, we would expect to find that the effects of certificate-of-need programs on mortality rates are strongest for conditions that are most sensitive to the process for reviewing applications for certificates of need. To the extent that the development or upgrading of intensive care or coronary care units is influenced by certificate-of-need review, we would expect patients who require such care — i.e., the sickest patients — to be the most affected.

To examine this possibility, we split the 16 conditions into two groups: a group of 5 conditions thought to be most susceptible to the effects of the certificate-of-need program (acute myocardial infarction, acute tubular necrosis, congestive heart failure, coronary bypass surgery, and total hip replacement) and 11 less susceptible conditions. We then examined the model for the two groups. The association of higher mortality rates with more stringent certificate-of-need programs was indeed stronger and had a higher level of significance for the 5 conditions defined as most susceptible (beta = 0.01; P≤0.002) than for the remaining 11 conditions (beta = 0.003; P not significant). These findings indicate that regulation of capital expenditures appears to have particularly adverse effects on outcomes for patients with the conditions most directly affected by the regulation.

In order to test the robustness of our findings, we randomly divided the hospitals into two equal groups and examined the model for each subgroup. The results revealed that the stringency of rate-review and certificate-of-need programs was significantly associated with mortality rates in both halves of the sample. (For certificate-of-need programs in the first half, beta = 0.01 and P≤0.008; for rate-review programs, beta = 0.004 and P≤0.02. For certificate-of-need programs in the second half, beta = 0.01 and P≤0.002; for rate-review programs, beta = 0.005 and P≤0.03.) The findings pertaining to the percentage of the popu-

lation enrolled in HMOs were less robust; this variable was significantly associated with mortality rates in one half of the hospitals (beta = 0.16; P≤0.003) but not in the other (beta = 0.013; P≤0.80).

Finally, as an additional test of the findings regarding regulation, we calculated ratios of actual to predicted death rates for each hospital. Predicted death rates were calculated on the basis of the patient's age and sex, the presence of comorbid conditions, the percentage of total hospital days spent in the intensive care unit, and the 1984 HCFA case-mix index. Hospitals were then grouped into those falling approximately into the top third, the middle third, and the lower third in terms of the stringency of state rate-review regulation, and they were categorized similarly in terms of the stringency of state certificate-of-need regulation. The results, shown in Table 4, indicate that hospitals located in states in the top third in terms of the stringency of rate-review and certificate-of-need regulation had significantly higher ratios of actual to predicted death rates than those in the less regulated states. These data are consistent with the results reported above.

Penetration of the Market by HMOs

Although less robust, the relation between penetration of the market by HMOs and higher mortality rates merits further study. In more intensely competitive markets, characterized by a high degree of managed-care programs, the pressure for hospitals to contain costs may be particularly acute. Furthermore, hospitals in such markets have incentives to develop alternatives to inpatient care. These alternative programs may divert resources from acute inpatient care services and may therefore increase the probability of adverse outcomes for patients.[21]

Additional measures of competition will be needed as future research examines hospitals' responses to competition and the implications of these responses for both the quality of care and patients' outcomes. In addition, it will be important to rule out the possibility that our finding regarding penetration of a state by HMOs and higher hospital mortality rates is due to clinical care provided by the HMOs themselves.

Table 4. Ratios of Actual to Predicted Mortality Rates, According to the Stringency of Rate-Review and Certificate-of-Need Regulations.*

Stringency of State Programs†	Actual to Predicted Mortality Rate
Certificate of need	
High	1.06
Medium	0.966
Low	0.999
	F = 6.74; P≤0.001
Rate review	
High	1.04
Medium	0.989
Low	0.981
	F = 2.86; P≤0.05

*Predicted death rates are based on patients' age and sex, the presence of comorbid conditions, the percentage of hospital days spent in the intensive care unit, and the 1984 Health Care Financing Administration case-mix index for the hospital.

†Divided into approximately equal thirds, on the basis of the overall distribution of scores according to state.

Profitability and Occupancy Rates of Hospitals

Given our findings regarding regulation and competition, we were interested in whether hospitals in financial distress might be particularly likely to have higher mortality rates among inpatients. We examined this possibility by using a subset of 193 hospitals for which complete data on costs and revenue could be validated. This analysis revealed no statistically significant relation between profit margins and mortality rates. A more realistic assessment of the influence of profitability on patients' outcomes would need to take into account a hospital's profitability several years before the assessment of patients' outcomes. In brief, hospitals that have been unprofitable for a long time may be most likely to have higher mortality rates or other adverse outcomes. Our data did not permit such an examination.

An alternative approach to identifying hospitals that may be having long-term financial problems is to examine changes in occupancy rates over a defined period. We analyzed such changes for the period from 1979 to 1983 but found no significant relation between a decline in occupancy rates during this period and higher inpatient mortality rates. The influence of a hospital's financial viability on patients' outcomes merits further study.

As previously noted, we also tested the hypothesis that hospitals faced with both stringent regulation and a high degree of market penetration by HMOs might have even higher mortality rates than those affected by either strict regulations or competition from HMOs. The results indicated that hospitals affected by both forces did not have higher death rates than those affected by either force alone. Because competitive forces are increasing, however, the combined effects of competition and regulatory constraints on patients' outcomes may be more pronounced in the future.

Patient Characteristics and Case-Mix Adjustment

For the 16 conditions we studied, the presence of a comorbid condition and the length of stay were more strongly correlated with mortality rates than were patients' age or sex.[25] The percentage of total hospital days spent in the intensive care unit was also significantly associated with mortality. As stated above, we could not adjust for clinical severity on a case-specific basis.[9,26-29] These findings must be viewed in the context of this limitation. It is possible that the findings pertaining to certificate-of-need and rate-review programs and market penetration by HMOs could be due to unmeasured differences among the study hospitals in the severity of patients' conditions. For this to be true, however, the differences in severity would have to be highly correlated with the stringency of certificate-of-need and rate-review programs and with market penetration by

HMOs. In addition, the results cannot be explained by differences among the hospitals' expected mortality rates on the basis of the distribution of patients among the 16 conditions, since this factor was controlled for in the analysis.

Type of Ownership and Affiliation with Multihospital Systems

There were no significant differences in mortality according to type of hospital ownership. This finding held true not only for the results of the multivariate analysis of mortality rates, but also for individual comparisons between not-for-profit and investor-owned hospitals in regard to mortality rates for the 16 conditions combined, the 5 conditions that were sensitive to the stringency of certificate-of-need programs, the remaining 11 conditions, the percentage of patients with comorbid conditions, the patients' ages, the percentage of hospital days spent in the intensive care unit, the percentage of registered nurses among the hospital's employees, and the distribution of cases among the 16 conditions. Not-for-profit hospitals did have a slightly longer average length of stay (9.5 vs. 8.9 days) and a slightly higher 1984 HCFA case-mix index (1.11 vs. 1.06) than investor-owned hospitals.

Similarly, we observed no differences related to affiliation with a multihospital system. As stated earlier, there is some evidence from other research that hospitals that belong to systems do perform better in meeting certain standards for structure and procedures as established by the Joint Commission on the Accreditation of Health Care Organizations.[13] We found no differences between independent hospitals and those affiliated with a multihospital system in terms of the outcomes for patients with the conditions we examined. Clearly, additional research is needed to identify specific clinical and managerial practices associated with differences in the quality of care and in patients' outcomes and to assess the extent to which these practices vary as a function of the type of hospital ownership or affiliation with a multihospital system.

Conclusion

Our findings regarding regulatory constraints, competition, type of ownership, and inpatient mortality rates are exploratory. Measures of outcome, such as inpatient mortality rates, should be viewed as only one measure of the quality of care provided by hospitals.[29] Furthermore, the present data cover only 16 clinical conditions and only Medicare patients. The findings, however, are particularly important because they are based on data from a relatively large number of hospitals located in numerous markets throughout the country. Another study, although based on data on fewer markets, has also found a generally positive relation between higher mortality rates and hospitals located in states with strict prospective reimbursement programs.[30]

The goal of this study has been to examine some of the environmental factors (e.g., regulatory constraints and competition) and institutional factors (e.g., affiliation with multihospital systems and type of ownership) that may influence patients' outcomes in hospitals. The present findings underscore the need for improved monitoring of the issue of the quality of care and patients' outcomes as regulatory and competitive approaches to hospital cost containment continue to become more stringent.[31] Such surveillance will require the longitudinal analysis of changes in patients' outcomes over time as a function of hospitals' responses to tightening of prospective payment rates, increased competition, and evolving regulatory programs. On the basis of the present findings, we suggest that particular attention be focused on hospitals in highly regulated environments or in intensely competitive markets.

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Technical Appendix

The distribution of cases among the 16 conditions is corrected for by the following equation:

$$H = \sum_{i=1}^{16} C(MR)$$

where H denotes each hospital's expected mortality rate, C each hospital's percentage of patients with each condition, and MR the overall mortality rate for all hospitals for that condition. The natural logarithm of H is then entered directly into the analysis as a control variable.

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MEDICAL INTELLIGENCE

DRUG THERAPY

JOHN A. OATES, M.D., *Editor*
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ENCAINIDE

RAYMOND L. WOOSLEY, M.D., PH.D.,
ALASTAIR J.J. WOOD, M.D.,
AND DAN M. RODEN, M.D.

THE antiarrhythmic properties of quinidine and digitalis were recognized as early as the 19th century, but it was not until the recognition in the 1960s of the antiarrhythmic actions of drugs for local anesthesia, such as lidocaine and procaine, that a systematic search was begun for similar agents with better antiarrhythmic efficacy and less toxicity. In the early 1970s Dykstra et al.[1] described the synthesis of a series of analogues of lysergic acid that had antiarrhythmic activity. The activity of one of these agents, MJ 9067, or encainide, was characterized in experimental models of arrhythmias by Byrne et al.[2] In these early studies, this benzanilide compound (Fig. 1) demonstrated approximately 5 to 10 times the antiarrhythmic potency of procainamide; in effective doses it had no unwanted effects on blood pressure, heart rate, or intracardiac conduction. In 1979 Vesteloot and Stroobandt[3] described the antiarrhythmic efficacy of single intravenous doses of encainide in patients with ventricular extrasystoles and supraventricular arrhythmias, and in 1980 Roden et al. showed that oral encainide therapy could totally suppress ventricular ectopy in 10 of 11 patients with stable, high-frequency, nonsustained ventricular arrhythmias.[4] Over the next seven years, extensive testing revealed that encainide was one of the most potent antiarrhythmic agents available.

In the earliest study of pharmacokinetics in patients, by Roden et al.,[4] it was apparent that in 1 of the 11 patients studied the pharmacokinetics and pharmacologic effects of encainide were very different from the effects in the other subjects. This patient had high plasma concentrations and prolonged elimination of encainide, a minimal change in electrocardiographic intervals, and a lack of suppression of ventricular arrhythmias. Subsequent studies[5,6] have shown that the aberrant kinetics and response in this patient reflected a genetically determined deficiency in encainide metabolism, a defect present in 7 percent of the general population. Careful study of the response of patients with either of the two phenotypes has shown that antiarrhythmic efficacy and prolongation of electrocardiographic intervals can be seen in either group. However, these actions are mediated by encainide in the group with

From the Department of Pharmacology, Clinical Pharmacology Center, Georgetown University School of Medicine, Washington, D.C., and the Departments of Medicine and Pharmacology, Division of Clinical Pharmacology, Vanderbilt University School of Medicine, Nashville, Tenn. Address reprint requests to Dr. Woosley at the Department of Pharmacology, Clinical Pharmacology Center, Georgetown University School of Medicine, 3900 Reservoir Road, N.W., Washington, DC 20007.

Supported in part by a grant (GM-31304) from the Public Health Service and by a grant (RR-0095) from the General Clinical Research Center.

AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

A course entitled "Modern Strategies in the Treatment of Headache and Facial Pain" will be offered in conjunction with the Association's 13th Annual Scientific Meeting in San Francisco, June 17–19.

Contact A.A.S.H., P.O. Box 5136, San Clemente, CA 92672; or call (714) 498-9346.

EPIDEMIOLOGY

The Johns Hopkins Graduate Summer Program in Epidemiology — 1988 will be offered in Baltimore, June 20–July 8.

Contact Helen Walters, Grad. Summer Program in Epidemiology, 615 N. Wolfe St., Baltimore, MD 21205; or call (301) 955-7158, ext. 3462.

AMERICAN SOCIETY OF HYPERTENSION

The 3rd Annual Meeting will take place in New York, June 22–26.

Contact Carol Verneuil, CPC Communications, Box 4010, Greenwich, CT 06830; or call (203) 661-0600.

ADVANCES IN CLINICAL PEDIATRICS

The 11th Annual Black Hills Seminar will be held in Custer, S.D., June 22–24.

Contact Dr. Lawrence R. Wellman, USD School of Med., 1100 S. Euclid, P.O. Box 5039, Sioux Falls, SD 57117-5039; or call (605) 333-7178.

MYOCARDIAL PROTECTION VIA THE CORONARY SINUS

The 3rd International Symposium will meet in Cambridge, Mass., June 23 and 24.

Contact Barbara W. Alpert, Dept. of CME, Boston Univ. School of Med., 80 E. Concord St., Boston, MA 02118; or call (617) 424-5429.

INTERNATIONAL LACTATION CONSULTANT ASSOCIATION

The annual conference entitled "Health Care Professionals Working Together: The Team Approach to Breastfeeding" will take place in Philadelphia, July 9 and 10.

Contact Kay Hoover, 613 Yale Ave., Morton, PA 19070; or call (215) 543-5995.

CLINICAL GENETICS CONFERENCE

The conference, subtitled "Heritable Disorders of Connective Tissue and Skeletal Dysplasias," will take place in Baltimore, July 10–13.

Contact Program Coordinator, Office of Cont. Educ., The Johns Hopkins Medical Insts., Turner 22, 720 Rutland Ave., Baltimore, MD 21205; or call (301) 955-3168.

PSYCHONEPHROLOGY 1988

Abstracts are now being accepted for the 6th International Conference on Psychonephrology. Deadline for submission is July 1.

Contact Dr. Norman B. Levy, Psychonephrology 1988, Westchester County Medical Ctr., Valhalla, NY 10595; or call (914) 285-8424.

THOMAS JEFFERSON UNIVERSITY HOSPITAL

A training program including physics, anatomy, abdomen, obstetrics and gynecology, and echocardiography, will be offered in Philadelphia, July 11–August 12.

Contact Judith Superior, Div. of Diagnostic Ultrasound, Thomas Jefferson Univ. Hosp., 7th Floor Main Bldg., Philadelphia, PA 19107; or call (215) 928-8533.

BIOSAFETY CONFERENCE FOR INDUSTRIAL HYGIENISTS

The conference will be held in Chapel Hill, N.C., July 11–14.

Contact Occupational Safety and Health Educ. Resource Ctr., Univ. of North Carolina, 109 Conner Dr., Suite 1101, Chapel Hill, NC 27514; or call (919) 962-2101.

INFECTIOUS DISEASES TODAY

The meeting will take place on an Alaskan cruise, July 13–20.

Contact The Medical Coll. of Pennsylvania, Div. of CME, 3200 Henry Ave., Philadelphia, PA 19129; or call (215) 842-4095.

DESIGN AND ANALYSIS OF SCIENTIFIC EXPERIMENTS

The course, with applications to the physical, chemical, biological, medical, and industrial sciences, will take place in Boston, July 11–16.

Contact Director, Summer Session, Room E19-356, MIT, Cambridge, MA 02139.

LA LECHE LEAGUE INTERNATIONAL

A seminar entitled "Breastfeeding: Science Behind Success" will take place in Walt Disney World Vlg., Fla., July 13 and 14.

Contact Carol Kolar, CME, La Leche League Intl., 9616 Minneapolis Ave., Franklin Park, IL 60131; or call (312) 455-7730.

CONGRESS ON CANCER PAIN

The congress will take place in Rye, N.Y., July 14–17.

Contact Mary Callaway, Memorial Sloan-Kettering Cancer Ctr., Box 52, Room C799, 1275 York Ave., New York, NY 10021; or call (212) 794-7456.

UNIVERSITY OF MICHIGAN

The following courses will be offered: "Controversies and Medical Management of Post-Menopausal Years" (Southfield, Mich., June 11); "14th Annual Mackinac Island Course: Advances in the Management of Infectious Diseases" (Mackinac Island, Mich., July 8–11); "2nd Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management" (Mackinac Island, Mich., July 24–27).

Contact Gayle Fox, CME Office, Towsley Center-Box 0201, Univ. of Michigan Medical School, Ann Arbor, MI 48109-0201; or call (313) 763-1400.

SPECIAL REPORT

SETTING THE RECORD STRAIGHT

The Provision of Uncompensated Care by Not-for-Profit Hospitals

In recent years, questions have been raised about the role of not-for-profit hospitals in providing care to the uninsured and underinsured poor. Traditionally, private hospitals have financed such care largely by charging and collecting more from privately insured patients. This mechanism received relatively little scrutiny until two important trends emerged in the 1980s: an increase in the number of persons without health insurance and increasing price consciousness on the part of both public and private purchasers. The rise in the number of uninsured and underinsured people has increased our nation's dependence on the private sector to finance large increases in charity care. As price competition develops, it will reduce the ability of hospitals to shift the burden of uncompensated costs onto insured patients, and it may impose serious penalties on those who are forced to do so.

As a result of these pressures, the financing of care for indigent patients is now a major issue facing health care providers and policy makers. Not-for-profit hospitals find themselves at the center of this growing

problem. Policy makers are asking how much care is provided to indigent patients by not-for-profit hospitals as compared with other hospitals, and what the implications of these differences are. These questions have emerged in the form of three specific policy issues: how care for indigent patients should be financed, how hospitals with a substantial burden of uncompensated care can avoid unfair competition, and whether not-for-profit hospitals should continue to be exempted from taxes. In connection with the first of these issues, as cross-subsidies from privately insured patients are eroded, many are asking whether and to what extent the "cost shift" should continue to be the principal mechanism by which the uninsured receive care in hospitals not operated by the government. In connection with the second issue — unfair competition — hospitals with heavy burdens of uncompensated care are less able to modify their prices in the face of price competition, and they thus risk losing insured patients. The movement toward containing costs through price competition — a strategy that includes further deregulation, such as the elimination of certificate-of-need programs, has the effect of placing socially responsible hospitals at a serious competitive disadvantage. As for tax exemption, some federal, state, and local officials are questioning whether it should continue without evidence that not-for-profit hospitals are providing "appropriate" levels of uncompensated care (and other charitable and community services).

The Problem: Misinformation

Unfortunately, the debate over these issues is often misinformed. There is a growing perception among some policy makers that there is little or no difference between investor-owned and not-for-profit hospitals in the amount of uncompensated care they provide. This misconception stems from several past studies — some that were flawed in their approach and some that have been misinterpreted.

The greatest source of misinformation has been an inappropriate reliance on national averages. National averages are poor reflectors of performance, for two reasons. First, they mask the fact that the vast majority of investor-owned hospital beds are located in only 13 states. Any generalization to a "national average," therefore, results in an artificial and statistically inaccurate construct.

Secondly, national averages do not account for substantial differences among states in the need for charity care from private hospitals. Medicaid eligibility and benefits are much broader in some states than in others; there is considerable variation in the percentages of state populations that are uninsured, even apart from differences caused by variations in Medicaid programs; and some states and localities depend much more heavily than others on public hospitals and universities to serve the poor. As a result of these differences, national comparisons seriously understate the difference between not-for-profit and investor-owned hospitals in the amount of uncompensated care provided.

We report here on a research project recently completed and soon to be published that critically examines past and present comparative studies and current findings, and suggests better measures for assessing hospitals' contributions to the care of those unable to pay. This study was conducted by Lewin and Associates, commissioned by Volunteer Trustees of Not-for-Profit Hospitals, and supported by a coalition of voluntary hospitals, health care associations, and the Commonwealth Fund. It was designed to develop an improved framework for more accurately defining and measuring uncompensated care, to review and assess the literature on comparisons of uncompensated care among hospitals, and to examine the actual differences in amounts of uncompensated care in five states: California, Florida, North Carolina, Tennessee, and Virginia. These states were selected for study on the basis of three criteria: they are states in which investor-owned and not-for-profit hospitals engage in substantial competition; they represent diversity in size and geographical location; and they have data available to permit the analysis of uncompensated-care burdens.

The Lewin study found that the perception that there is "little or no difference" in the provision of uncompensated care between investor-owned and not-for-profit hospitals is clearly wrong. The study revealed substantial differences in the amount of uncompensated care provided at the state and local levels where not-for-profit and investor-owned hospitals are in competition.

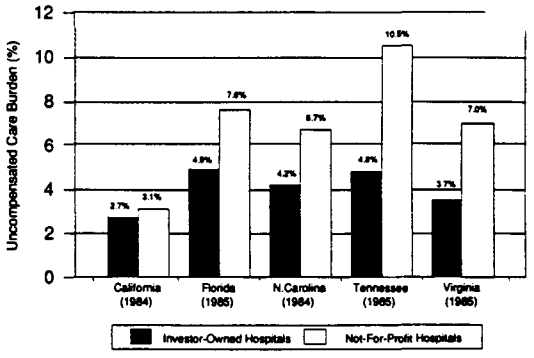

Figure 1. Comparison of Uncompensated-Care Burdens in Five States.

Costs of uncompensated care were estimated by applying each hospital's cost-to-charges ratio to its charges for charity care and bad debts. Identifiable appropriations designated for the care of indigent patients were deducted from the costs of uncompensated care. If a $27 million county subsidy to the Regional Medical Center at Memphis that is not earmarked for indigent care is deducted from uncompensated costs, the not-for-profit burden in Tennessee becomes 8.8 percent.

Values were calculated from data provided to the California Health Facilities Commission, the Florida Cost Containment Board, the Tennessee Department of Health and Environment, the Virginia Health Services Cost Review Council, and (for North Carolina) the American Hospital Association Annual Survey.

Figure 1 compares the burden of uncompensated care borne by investor-owned and not-for-profit hospitals in the five states. The burden is expressed as the cost of charity care and bad debts divided by total hospital expenses, expressed as a percentage. Not-for-profit hospitals commit substantially more of their resources to uncompensated care than do investor-owned hospitals in four of the five states studied. The figure shows that not-for-profit hospitals have uncompensated-care burdens that are 50 to 90 percent higher than investor-owned facilities in Florida, Virginia, and North Carolina. In Tennessee, the burden borne by not-for-profit facilities is more than twice as high. The difference is much smaller in California, where the extensive availability of publicly financed care (through Medi-Cal and California's public-hospital system) leaves relatively little charity care to be provided by any of the private institutions. Neither investor-owned nor not-for-profit hospitals as a group bear a cost burden of more than 3 percent on average, as compared with up to 10 percent in other states.

The study also found that not-for-profit hospitals are more likely than investor-owned hospitals to have large amounts of uncompensated care. Figure 2 shows, for example, that investor-owned hospitals in Florida not only have lower average burdens of uncompensated care (4.9 vs. 7.6 percent), but their distribution is heavily skewed on the low side as compared with not-for-profit hospitals. About half of all investor-owned hospitals devote less than 4 percent of their total expenses to uncompensated care, as compared with a statewide average of 6.4 percent for all nongovernment hospitals. In contrast, more than 80 percent of not-for-profit hospitals are above the 4 percent level. Similar patterns were found in three of the other states studied. Looking at the data in another way, not-for-profit hospitals in four of the five states carry uncompensated-care loads that are comparable to their overall market share; investor-owned facilities provide proportionately much less than their market share. In California, public hospitals carry the largest

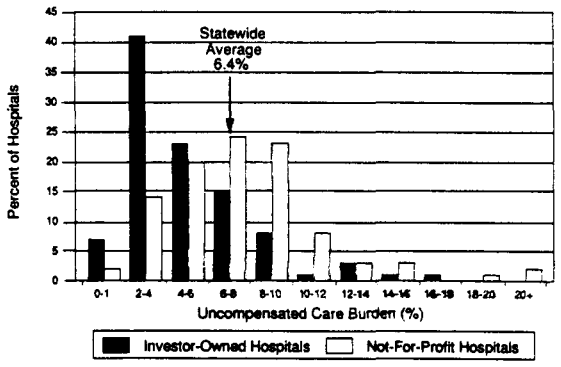

Figure 2. Distribution of Uncompensated-Care Burdens in Florida, 1985.

See legend to Figure 1 for explanation. Values were calculated from data reported to the Florida Cost Containment Board in 1985.

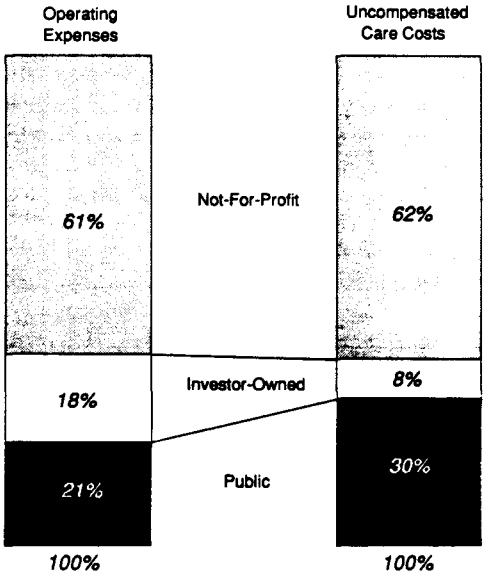

Figure 3. The Share of Statewide Uncompensated Care in Tennessee in 1985 as Compared with the Share of Statewide Operating Expenses.

See legend to Figure 1 for explanation. If a $27 million county subsidy to the Regional Medical Center at Memphis that is not earmarked for indigent care is deducted from uncompensated costs, the share becomes 57 percent for not-for-profit hospitals, 10 percent for investor-owned hospitals, and 33 percent for public hospitals.

Values were calculated from data in the Joint Annual Report of Hospitals, compiled by the Tennessee Department of Health and Environment in 1985.

share. Figure 3 shows that investor-owned hospitals in Tennessee provide 18 percent of hospital care in that state, but only 8 percent of all uncompensated care. The share of uncompensated care provided by not-for-profit hospitals, on the other hand, is slightly higher than their share of all the hospital care in the state.

In local communities marked by direct competition between investor-owned and not-for-profit hospitals, the share of uncompensated care is frequently disproportionately high for not-for-profit hospitals, creating a competitive pricing handicap and greater upward pressure on prices at such facilities. Local communities with few or no public hospital beds were examined in Florida and Tennessee. These are communities where private facilities must serve most or all of the uninsured poor, but where the ability to do so may be weakened in the face of active price competition. In all but one of the 18 communities examined, not-for-profit hospitals as a group had higher uncompensated-care burdens than the investor-owned facilities. In several of the communities, the burden on not-for-profit hospitals was more than twice as high as that on investor-owned facilities.

Not-for-profit hospitals with disproportionately high burdens of uncompensated care often face a substantial competitive handicap. In price-competitive markets, such hospitals have greatly diminished price flexibility and run a greater risk of losing paying pa-

tients and the revenues they generate. This further erodes the capacity of these not-for-profit hospitals to finance care for the poor through cross-subsidization, and creates a distinct competitive advantage for the hospitals that are able to compete unencumbered by heavy burdens of care for the indigent. (This competitive advantage is offset to some extent by the taxes paid by investor-owned hospitals.)

These differences in uncompensated-care burdens take on special importance in the current policy debate about the financing of uncompensated care. Not-for-profit hospitals as a group continue to provide most of the uncompensated hospital care in this country (62 percent in 1984, according to the American Hospital Association). More important, they do so despite the fact that they are often at a price-competitive disadvantage. As states move toward deregulation and the dismantling of the certificate-of-need requirement, the potential for this unfair disadvantage intensifies. Many policy makers are beginning to recognize this disadvantage and are debating ways to neutralize it or account for it in the process of deregulation.

Another policy debate revolves around the tax-exempt status of not-for-profit hospitals. In Utah, a state Supreme Court decision denied the state's not-for-profit hospitals an automatic exemption from county property taxes and required them to apply annually for an exemption to be based substantially on their ability to meet general notions of charity care established by the court. This decision went beyond the federal requirements for tax-exempt status, specifying — as the Internal Revenue Service does not — particular charity care requirements. Tax-exempt status is coming under serious scrutiny in other states and at the federal level as well.

Measuring Uncompensated Care

Although the stakes in these policy choices are obviously high, the debate is often distorted by the way uncompensated care is measured and reported, and by the way hospitals are compared. This report finds that serious errors in the literature result from the use of national comparisons of uncompensated care between investor-owned and not-for-profit hospitals. These comparisons tend to understate the real differences between investor-owned and not-for-profit hospitals.

The current literature also tends to define and measure uncompensated care in a misleading fashion. Traditionally, the cost of uncompensated care has been the sum of charity and bad-debt deductions from gross patient revenues or charges. This definition, a byproduct of traditional accounting practices, overstates the amount of money involved and distorts differences among hospitals. Specifically, the traditional definition (1) is based on charges rather than costs, artificially exaggerating the dollar value of uncompensated care, especially for hospitals with a high markup of charges over costs; (2) includes charges for patients who are financially capable of paying their bills (i.e., charges for care that should be classified as bad debt rather than charity); (3) excludes care that is provided with charitable intent but for which reimbursement is often below costs, such as Medicaid (in some states) and many state and local programs of care for the indigent; and (4) excludes "nonrevenue" services, such as educational programs for pregnant teenagers and transportation and meal programs for the indigent, often provided by hospitals as a community service but missing from the "uncompensated care" figure because there is no bill or charge associated with a particular patient.

As public policy focuses directly on the issue of care for the indigent, there is a need for state commissions to collect more accurate and uniform information on hospitals' charitable activities. Hospitals need to join in this effort by working toward accounting methods that are practical yet more informative. A first step is to move from the traditional but flawed definition of uncompensated care currently in use to a definition that is more relevant to policy. Such a definition, of a kind of care that could be called "unsponsored charity care," should include the cost of all care for low-income uninsured patients above the amount they could reasonably be expected to pay; include the unreimbursed costs of Medicaid and other public programs that result from specific coverage limits or extremely low payment rates (e.g., hospital outpatient rates); include the uncollectible portion of catastrophic expenses; exclude traditional bad debts for insured patients or for self-paying patients who are not poor (unless their expenses reach defined "catastrophic" levels); and recognize the value of non-revenue-producing services that are provided for charitable rather than commercial reasons. This definition of unsponsored charity care requires some adjustment to existing accounting and reporting practices, but it is technically feasible and would greatly clarify both absolute and relative levels of charity care in response to the public demand for more accountability.

Conclusion

The Lewin study finds real differences between types of hospital in the level of care provided to persons who cannot afford to pay. The study also demonstrates the problems involved in traditional methods of measuring and comparing uncompensated care, and it suggests a more policy-relevant alternative. It finds that not-for-profit hospitals frequently provide much more care to the low-income uninsured than do investor-owned facilities; this is a role that should be monitored and measured more precisely in the future, and one that is consistent with the mission of the voluntary hospital sector and its continuing responsibility to care for those unable to pay.

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2. Bearn AG. Wilson's disease. In: Stanbury JB, Wyngaarden JB, Fredrickson DS, eds. The metabolic basis of inherited disease. New York: McGraw-Hill, 1972:1033-50.
3. Pellegrin FA, Ramcharan S, Fisch IR, Phillips NR. The noncontraceptive effects of oral contraceptive drugs: the Kaiser-Permanente Study. In: Ramcharan S, ed. The Walnut Creek Contraceptive Drug Study: a prospective study of the side effects of oral contraceptives. Vol. 1. Bethesda, Md.: National Institutes of Health, 1974:1-19. (DHEW publication no. (NIH) 74-562.)

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Review and Action

Manuscripts are examined by the editorial staff and are usually sent to outside reviewers. We encourage authors to suggest the names of possible reviewers, but we reserve the right of final selection. Authors are usually notified within six weeks about the acceptability of a manuscript, but longer delays are sometimes unavoidable.

Bout with cancer put woman on a new life path

By Jon Jeter
Staff Writer

Staff Photo by Richard Sennott

Kathy Norman, left, hugged nurse Neva Hanson. For Norman, nursing means touching people's lives the way Hanson touched hers.

Catherine Norman threw a party Friday.

She invited some friends and family to her south Minneapolis bungalow, broke out the chips, dip and beer, put on the old tunes and celebrated life.

Norman's life could have been very different. Fifteen years ago, when she was 21 years old, doctors in Oregon discovered she had a grapefruit-sized malignant tumor on an ovary. They gave her between six months and two years to live if she didn't begin chemotherapy treatments, and there was no guarantee that therapy would prolong her life.

She returned to Minnesota to begin once-a-month therapy treatments at the University of Minnesota Hospital. Solemn and sickly, Norman was befriended by the head nurse of the hospital's oncology unit, Neva Hanson.

It wasn't the traditional friendship, Hanson said; they didn't talk incessantly like some friends do.

"I was just there," said Hanson, 52. "We didn't bother her a lot. She didn't want to be bothered."

But "she always seemed to be there for me when I needed her," said Norman.

For nearly two years, Hanson and Norman crossed paths one Friday each month as Norman arrived at the hospital for her 4 a.m. treatments.

"It was a rough time," said Norman's father, Carl. Family members say she served as a guinea pig for doctors developing new forms of treatment, including the early-morning sessions synchronized to her bio-rhythyms.

But Norman endured and battled the cancer into remission. She renewed her career as a costume designer for theater productions, taking a job with the Minnesota Opera.

her hair, made it hard for her to keep food in her stomach and introduced the once free-spirited Norman to her mortality, changed her.

As she sat with coworkers in the costume design shop, she realized: "I just couldn't see myself gossiping in a costume design shop the rest of my life. I guess I just started to take life a little more seriously.

"I guess I just needed something a little more concrete," said Norman, with a smile that seems never to disappear.

She called Hanson and invited her to an evening of Mexican food and brainstorming.

They discussed health care professions and Hanson ran through the advantages and disadvantages of being a nurse.

"The pay is low. I don't work an eight-hour day and the work is hard," Hanson recalled saying. But Hanson sold Norman on the rewards of helping people. "Being a nurse isn't a job; it's a life," Hanson said.

Hanson attended Norman's graduation from the University of Minnesota's nursing school in 1980.

She says she doesn't become as close to all her patients as she did to Norman. "But I often think about all the lives I've influenced," she said.

Norman is now a registered nurse at tal, working in the department that treats leukemia and other cancers. She is a good nurse, due in part to her experience as a cancer patient, say her peers.

"Catherine can relate to many patients," says Bev Crosby, a nurse who works alongside her. "We can't say 'I know what you're going through.' Catherine can."

For Norman, nursing means touching people's lives the way Hanson touched hers.

"Some people are so vulnerable when they come in there," Norman said.

"They come in there so often you just feel like you're a part of their family," said Norman, who has attended the funerals of former patients.

Seeing the sick and dying, realizing that there is a chance, albeit small, of her cancer recurring, prompted Norman to throw the "celebration of life" bash.

"This party is more or less a thank you to all the people who have helped me along the way," she said.

She said there was no particular reason to have the party when she did (although it did coincide with National Nurses Week), other than the arrival of spring, "that symbolized the renewal of life," she said.

STAR TRIBUNE

Minnesota Daily
May 13, 1988

Regents to extend deadline on search for new U president

By **Mark Fischenich**
Staff Reporter

The University Board of Regents voted to lengthen the application deadline for the president's position by one month to Sept. 1, during a search committee meeting Thursday in Morris.

The move was the only substantial change the regents made in their strategy to select a new president.

Several regents also voiced displeasure with problems the Minnesota Open Meetings Law will cause them as they work to replace former University President Ken Keller.

The open meetings law requires all state and local government agency, board, committee or department meetings to be open to the public except as "expressly prohibited by law."

University Attorney Stephen Dunham said he would be proud to represent the University in any potential legal battle with media organizations if the regents decide to hold closed meetings with candidates despite the law.

The deadline for candidate applications was pushed back after Regent Elton Kuderer expressed concern that the process was being rushed.

The regents were under pressure to conclude the search as quickly as possible because interim University President Richard Sauer was considering a position in North Dakota which begins Sept. 1.

But Sauer withdrew his candidacy for the North Dakota State University presidency following his apparent plagiarism in a speech during an interview at NDSU. His withdrawal has given the regents more time.

Kuderer first proposed setting the application deadline back to Oct. 1, the date Regent Chairman David Lebedoff set to make the final selection. Lebedoff's timetable was too tight, Kuderer said.

Several other regents agreed. "The summertime is a very difficult time to (recruit candidates)," said Regent Elizabeth Craig.

Lebedoff argued it would be better for the University to name a new president as soon as possible, but was part of a unanimous vote on the compromise date of Sept. 1.

The regents also questioned Dunham extensively about holding closed meetings during the search.

The regents are worried that public disclosure of the candidates would discourage people

See **Search** *page 12*

Search *from 9*

from applying.

The regents eventually voted to follow Dunham's proposal to open all meetings, but to develop list of finalists by having the chairman and vice chair discuss candidates with individual regents.

Because this would not qualify as an official meeting of the regents, it would not be covered under the open meetings law, Dunham said.

The list would then be pared down, and finalists contacted and asked if they would be willing to undergo a public interviews. The final list of candidates would then be released, and the regents would hold public meetings on the search.

Regent Wenda Moore was particularly frustrated the board wouldn't be able to meet to discuss the candidates privately. "I'm frustrated," Moore said. "This document may satisfy our attorney, but I'm not sure it's going to satisfy our needs.... I'm really angry that we're being put in this box."

University Radisson faces foreclosure

Hotel blames administration for not upholding informal agreement

By Dori Carlson
Staff Reporter

Morris, Minn. — Radisson University Hotel officials told Board of Regents members Thursday that the University does not keep its promises.

The hotel is going broke and may face a June 8 foreclosure, said Radisson officials, who charged the University with backing out on informal guarantees made to refer hospital and departmental clients to the hotel.

During a specially scheduled meeting, William Maddux, a partner of the Radisson Hotel, requested that the board make a commitment to guarantee revenues to the hotel, so it could begin operating at a profit.

Hotel managers also requested the University to eliminate guest parking fees, which they claim push guests to other area hotels that provide free parking.

Currently, hotel managers are projecting a 1988 operating cash deficit of $1.5 million. Maddux said in a prepared statement that the hotel has operated at a loss from the start.

Hotel owners have financed the deficit from their own pockets, which has amounted to an excess of $6 million since 1985, according to Maddux. That figure is in addition to a $5.5 million initial investment.

Last March, hotel owners could not pay the mortgage interest from their own funds. Citicorp Real Estate Inc., which holds the mortgage on the property, demanded payment and the hotel was given 90 days to pay. If the June 8 deadline is not met, foreclosure proceedings will begin and the property will be sold.

Regent David Roe said if Citicorp forecloses on the hotel, it will be a loss for the University because it has no alternative use for the land. The University owns the land, while Citicorp owns the building.

If the University agrees to refer more business to the hotel, the Radisson could accumulate approximately $2 million a year from increased occupancy, food service and telephone sales. Reduced parking rates also would save the hotel $164,000 annually, Maddux said.

Hotel managers believe the University owes them.

In 1981, the University administration entered into an agreement with private developers, who would finance, build and operate a hotel to accommodate University Hospital and Clinic referrals. The University in turn would not be responsible for risks of hotel operating losses, but would generate business for the hotel.

At that time, the University said a 308 room hotel would be needed to accommodate its needs. Of these rooms, 116 were to be at reduced rates for Univer

See **Radisson** *page 9*

Minnesota Daily
May 13, 1988

Radisson *from 1*

sity hospital use, and the rest of the rooms at a market rate of $55.00 a night for general University and community service.

In 1986, financial difficulties forced hotel leaders to refinance their mortgage. The refinancing was necessary because University estimates were too low, Maddux said.

Acting Vice President for Finances Carol Campbell said that out of six contracts with the University travel services department, which coordinates accommodations for University clients and guests, 69 percent of the money is now going to the University Radisson Hotel.

Regent Elizabeth Craig said the University has a "moral responsibility" to help the hotel. "The University did make implications that University support would be 100 percent because of (the hotel's) importance to the University community."

Said Regent David Roe: "I want to do what's proper, I want to do what's right," but added that if there were administrative promises, they were not presented to the regents.

University attorney and General Counsel Stephen Dunham said he does not believe there were any guarantees or commitments by the administration.

The regents will take action on the issue at next month's meeting.

The Dignity of Nursing

The American ideal of a doctor—kindly, caring, reassuring Dr. Welby—was essentially a nurse

Lytton Strachey dipped his pen in the acid of his malice in order to etch word sketches of "Eminent Victorians." However, one of his subjects proved impervious to his considerable powers of disparagement. She was Florence Nightingale, the founder of nursing as a modern profession. Strachey, unable to suppress an emotion strange to him—admiration—wrote that in the filth and carnage of the Crimean War she was "a rock in the angry ocean." She profoundly influenced hospital construction and management and nurses' education. Amazing, said Strachey, for someone who was "merely a nurse."

Well. A nurse is a remarkable social artifact, and there are not nearly enough nurses, in part because of backward attitudes packed into phrases like "merely a nurse." Today's nursing shortage is not just another crisis *de jour*. By the end of this century—in just 12 years—the demand for nurses will be double the supply. Fourteen percent of hospitals in large urban areas and 9 percent in small urban areas are delaying admissions because of the shortage. The shortage has strange aspects. More nurses are needed because Americans are healthy longer. And although we have more nurses than ever—about 2 million—more are needed because people are sicker when admitted to hospitals.

The advance of medicine and public health accelerated in the late 19th century with improved control of infectious diseases. Then the 20th century's characterizing phenomenon—war—brought progress in surgery and trauma control. Next came rapid strides in diagnosis and pharmacology. Today, and partly as a result of these advances, the most pressing medical problem is care for the chronically ill. This usually requires intense application of nursing skills. And because demography is destiny, we know that the need will intensify. The number of Americans 85 or older is rising six times as fast as the rest of the population.

Important basic needs of the chronically ill are emotional and social. But the intense specialization and technological emphasis of modern medicine have diminished the ability and willingness of doctors—once upon a time they were esteemed for their "bedside manner"—to satisfy such needs. The American ideal of a doctor—kindly, caring, reassuring Dr. Welby—was, says Lucille Joel, essentially a nurse. She is one. She also is a Rutgers professor and a forceful advocate of the proposition that nursing should be accorded the dignity of a profession parallel to that of doctors.

The crux of today's deteriorating physician-nurse relations is that many physicians cannot understand, or will not accept, that nurses can, should and want to do more than carry out doctors' orders. Nurses should be regarded by physicians more as complementary and less as subordinate professionals. Physicians are an episodic presence in the life of a patient. Nurses control the environment of healing. Assisting the rehabilitation of a stroke victim or monitoring and coping with chronic disease is essentially a nurse's, not a physician's function. A nurse—a mere nurse—superintends complex technologies, dispenses information and health education and strives for a holistic understanding of patients' needs, which include empathy.

For various reasons, ranging from AIDS (in New York City AIDS patients occupy about 5 percent of all hospital beds) to the use of toxic substances in treatments, nursing is still a dangerous profession. It also is increasingly demanding, physically and emotionally. Most people in hospitals are hurting and frightened and their families are in distress. This is increasingly true because, for cost-containment reasons, hospitals are increasingly reluctant to admit people unless they are quite ill. More and more patients are older and sicker and require more nursing. There is an 86 percent higher ratio of nurses to patients than 12 years ago. Then there were 58 per 100 patients, now there are 91 (spread over three shifts).

Patients progress quicker when they can get ample assistance in walking, eating and other elemental matters when they need it. Because of the nursing shortage many patients either take longer to heal or are discharged feeling more unwell than they would if given needed nursing. Furthermore, cost-cutting hospitals are trimming the staff (ward clerks, secretaries, transport and laboratory aides) that supports nurses, who now do extra duties. Nurses are paying a price for their reputation for versatility and dependability.

Sensibilities required: The nursing profession has a supply-side tradition of generating a high flow of highly motivated nurses and not worrying about retention. However, the emancipation of women, opening careers to talents, has enlarged women's choices while making nursing, a female-dominated profession (only 3 percent are male), less attractive to young women. There are, Joel believes, severe limits to the ability to attract male nurses, partly because of the difference between the sensibilities required for nursing and those produced by the socialization of men.

Nurses' salaries are low, starting, on average, at $21,000, and the ceiling can be hit in less than seven years. Many 20-year nurses make less than $30,000. An attorney in private practice can reasonably hope to increase his or her salary more than 200 percent in a career. A nurse can expect an increase of less than 40 percent. Add to monetary deprivation the denial of the psychological income of status, respect and intellectual growth and you have a recipe for a shortage.

Nightingale set a tone of brisk practicality for the nursing profession when she noted dryly that whatever else can be said of hospitals, this must be said: they should not spread disease. They should not be dangerous places, but they are becoming more so because of society's neglectfulness regarding nurses. Such neglect can have consequences for you, mortal reader. "If we live long enough, something wears out. I don't care how much oatmeal you eat," says Joel, viewing the columnist's breakfast with as much distaste as he does. The nursing profession must be nurtured with financial and emotional support. Otherwise, someday when you are in a hospital and are in pain or other need you will ring for a nurse and she will not come as soon, or be as attentive, as you and she would wish. And the chances are, aging reader, that the day will come when you will ring.

Handout
5/26/88

PHARMACEUTICAL SERVICES, PAST, PRESENT, AND FUTURE

Paul W. Abramowitz, Pharm.D.
Clinical Chief of Pharmaceutical Services
The University of Minnesota Hospital and Clinic

I. Pharmacy Practice - The Past

A. "1940's" Community Pharmacist

1. Preparation of drugs
2. Dispensing of advice
3. Direct care

B. Hospital Pharmacy Practice Prior to 1960

1. Formulation and manufacturing
2. Nuclear pharmacy
3. Drug distribution

C. The Two Revolutions in Hospital Pharmacy of the Sixties and Seventies

1. Systems enhancement

a. Unit dose and I.V. admixtures
b. Automation of production
c. Drug use control (cost, inventories, waste)

2. Transition from a product based to a product and information based profession

a. Drug interaction monitoring/patient medication profiles
b. Drug information services
c. Therapeutic individualization-pharmacokinetic dosing
d. Drug therapy monitoring
e. Parenteral nutrition teams, I.V. therapy
f. Decentralization-satellite pharmacies
g. The Formulary

D. Pharmacy Education

1. Bachelor of Science, 5 years with Internship
2. Post-Graduate Doctor of Pharmacy (Pharm.D.), 2 years
3. Pharmacy Residencies

II. Pharmacy Practice of Today

A. Community Pharmacy

1. Patient information
2. Compliance
3. Drug interaction detection
4. Problems: Access to information, education, reimbursement

B. Hospital Practice

1. Centralization of drug distribution

   a. Technical support staff
   b. Enhanced automation
      - Drug preparation
      - Drug administration devices
      - Management systems
   c. New drugs and dosage forms

2. Maturation of clinical pharmacy practice

   a. Coordination and monitoring of drug therapy
   b. Individualization
   c. Prevention of adverse drug effects
   d. The formulary as a book becomes a system
   e. Decentralization of pharmacists
   f. Specialization
   g. Teaching and research

3. Shifting resources from preparation and distribution to direct patient care services

C. The Outcome of Changes in Practice

1. Improvement of quality of care
2. Decreases in drug costs
3. Decreases in length of hospital stay and admissions related to drug therapy problems
4. Improved acquisition costs, decreased inventories, and decreased waste

D. Pharmacy Education Today

1. Five year B.S. and six year Pharm.D.
2. General and specialty residencies
3. Fellowships

III. Pharmacy Practice 1990 to 2000

A. Enhanced Automation

1. Drug preparation, distribution, and administration
2. Expert systems, therapeutic selection and monitoring
3. Patient information
4. Mail order prescriptions

B. New Drugs and Drug Delivery Systems

1. Sustained release injections
2. Monoclonal antibodies, liposomes
3. Transdermals and implantable drugs
4. Others

C. Complete Decentralization of Hospital Pharmacists

D. Certification of Pharmacy Technicians

E. Ambulatory Pharmacists

1. Direct patient care services
2. Compliance clinics
3. Medication monitoring clinics
4. Home care, hospice care, life center care
5. Self directed care
6. Consumer diagnostic testing
7. Prevention of hospitalization

F. Pharmacy Education

1. Pharm.D. as single degree
2. Required post-doctoral residency training

IV. Other Issues

Handout
5/26/88

Proposed

Board of Governors Resolution

on

Radisson University Hotel Subsidy

Whereas - It is the understanding of the Board of Governors of the University of Minnesota Hospital and Clinic that the Regents of the University of Minnesota have been requested to subsidize the operation of the Radisson University Hotel to forestall the mortgage foreclosure on the present hotel owners.

Whereas it is also the understanding of the Board of Governors that a large component of the requested subsidy would be from University Hospital revenues.

Whereas it is also the understanding of the Board of Governors that there is no contractual agreement obligation of the University of Minnesota to subsidize the hotel.

Whereas such a subsidy would increase the cost of patient care at the University of Minnesota Hospital and Clinic.

Therefore the Board of Governors of the University of Minnesota Hospital and Clinic urges the Board of Regents to not commit revenues of the University of Minnesota Hospital and Clinic to support the Radisson University Hotel. If the Board of Regents deems it necessary to consider supporting the subsidy, the Board of Governors urges that the Board of Regents take no formal action until communication between the Board of Governors and the Board of Regents has occurred.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JUNE 22, 1988

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*** OTHER ATTACHMENTS ***

The University of Minnesota Hospital and Clinic
Board of Governors
June 22, 1988
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of May 25, 1988 Meeting Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Special Presentation: Report of the Cost Evaluation Committee - Michael Steffes, M.D.	Information
IV.	Hospital Director's Report - Robert Dickler	Information
V.	Committee Reports	
	A. Planning and Development Committee - Mr. Robert Dickler	
	1. Masonic III Remodeling	Information
	2. Surgical Pathology Remodeling	Information
	B. Joint Conference Committee - Ms. Phyllis Ellis	
	1. Medical Staff-Hospital Council Report	
	o Credentials Committee Report	Approval
	o Appointment of Medical Staff-Hospital Council Committee Chairmen	Approval
	2. Annual Appointmment of Chiefs of Clinical Services	Approval

C. Finance Committee

- Mr. Robert Nickoloff

1.	May Year-to-Date Financial Statements	Information
2.	1988-89 Capital Budget	Approval
3.	Personnel Policy Changes	Approval

VI. Other Business

VII. Adjournment

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

MAY 25, 1988

CALL TO ORDER:

Chairman Robert Latz called the May 25, 1988 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Sally Booth
	David Brown, M.D.
	Carol Campbell
	Robert Dickler
	Phyllis Ellis
	George Heenan
	Robert Latz
	James Moller, M.D.
	Robert Nickoloff
	Barbara O'Grady
	Neal Vanselow, M.D.
Not Present:	Leonard Bienias
	Shelley Chou, M.D.
	Al Hanser
	Kris Johnson
	Jerry Meilahn

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the April 27, 1988 meeting as written.

SPECIAL PRESENTATION:

Mr. Robert Dickler introduced Dr. Paul Abramowitz, Director of Pharmaceutical Services. Dr. Abramowitz reviewed the history of pharmacy practice from the 1940's. Two revolutions in Hospital Pharmacy in the 1960's and 1970's involved packaging and delivery systems enhancement and the transition from a product base to a product and information base that enhanced the role of the

pharmacist as a consultant. Current hospital practice is characterized by a centralized drug distribution system complemented by decentralized pharmacists. The shifting of resources from preparation and distribution to direct patient care services is intended to improve quality of care and drug costs. Lastly, Dr. Abramowitz views pharmacy practice of the future to include enhanced automation, new drugs and drug delivery systems, more extensive decentralization of hospital pharmacists, certification of pharmacy technicians, increased demand for pharmacists in the outpatient setting and additional post-doctoral residency training for pharmacists.

CHAIRMAN'S REPORT:

Mr. Robert Latz introduced Mr. Duane Wilson who is replacing Barbara Muesing as the Secretary to the Board of Regents during her 6 month leave of absence.

Mr. Latz directed Board members' attention to two items included in the Board packet; the sample letter sent to the Tax Committee members and the flyer announcing the Minnesota Hospital Trustee Conference on July 8-10, 1988 in Brainerd, Minnesota.

Lastly, Mr. Latz reported that the Board will meet throughout the summer months. These meeting will be on June 22, July 27, and August 24, 1988.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler reported that the May census has been high and stable. The average daily census was over 450 as compared to a budgeted average daily census of 418.

The University of Minnesota Hospital and Clinic will host the Board meeting of the University Hospital Consortium in July. The UHC Nursing Directors will meet concurrently.

The University of Minnesota Hospital and Clinic, Mr. Dickler reported, is currently hosting a visit from representatives of the Association of American Medical Colleges. Staff members from the AAME are visiting to familiarize themselves with key medical centers of the United States. UMHC is the first site of such a visit.

The recommendations of the Cost Evaluation Committee will be discussed at the June meeting of the Board of Governors, Mr. Dickler reported.

Mr. Dickler noted that Mr. Latz will be presenting the Quarterly Report to the Board of Regents at the June 10, 1988 Regents meeting. The 1988-89 Operating Budget will also be presented for information with approval sought in July, 1988.

The legislative session ended, Mr. Dickler noted. A summary of the bills of interest to UMHC are included in the packet. Members were encouraged to contact Mr. Al Dees if additional information is needed.

Mr. Dickler reported that the nurses at United and Children's hospitals had filed a strike notice. The union agreement for these nurses expires one year earlier than the contract covering the nurses in many other metropolitan hospitals.

Dr. Chou, Mr. Dickler reported, announced his intent to step down as Chairman of the Neurosurgery Department in 1989. Mr. Greg Hart is UMHC's representative on that search committee.

Lastly, Mr. Dickler reported that Dr. Paula Clayton, Department Head and Clinical Chief from the Department of Psychiatry, will replace Dr. Shelley Chou as Chairman of the Clinical Chiefs. Dr. William Thompson was elected Vice Chairman. Dr. Clayton will assume her position on the Board of Governors in July, 1988.

PLANNING AND DEVELOPMENT COMMITTEE:

Mr. Robert Dickler noted that The University of Minnesota Hospital and Clinic is negotiating the repayment of a loan for the Lipid Research Center space on the 6th floor of PWB with University Central Administration. The cost to the Hospital is expected to be $348,000.

Mr. Dickler noted that the third quarter donations as reported by Mr. Fred Bertschinger were $420,962. The 1988-89 fiscal year-to-date donations of $1,305,666 exceed the annual $800,000 goal.

The Committee, Mr. Dickler reported, reviewed the Capital Expenditure Policy. This policy will be submitted for endorsement when the Board of Regents policy is finalized.

Lastly, Mr. Dickler reported, the Committee reviewed the Third Quarter Purchasing Report in detail. Total purchases of $15,541,417 were higher than average due to the purchase of the second MRI unit at $2.6 million. Third quarter savings associated with University Hospital Consortium purchases totaled $56,779.

The Planning and Development Committee seconded and passed a motion to endorse the third quarter Purchasing Report as submitted.

JOINT CONFERENCE COMMITTEE:

Mr. George Heenan reported that the Committee had reviewed the recommendations of the Credentials Committee of the Medical Staff-Hospital Council. The Committee discussed the effects to UMHC of a physician malpractice coverage with deductibles. In theory, UMHC would not be liable for the physician's deductible unless contributory negligence on the part of the Hospital could be demonstrated.

The Joint Conference Committee seconded and passed a motion to endorse the Credentials report as submitted.

Dr. James Moller and Ms. Jan Brockway had presented an overview of Quality Assurance and Utilization Review processes to the Joint Conference Committee. A number of monitoring tools were reviewed as a way of exhibiting criteria and standards upon which quality is assessed.

Lastly, Mr. Heenan reported that Dr. Work gave a brief overview of recent Clinical Chief's meetings. The primary topics of discussion were space allocation and issues related to resident benefits and reimbursement.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reported that the May average daily census was 458 compared to the April average daily census of 445. Overall average length of stay was 8.0 days. Year -to-date patient days are 999 days over budget. Operating expenditures through April were 3.3% over budgeted levels. The Hospital's Statement of Operations shows total expenses over revenues of $2,587,270, a favorable variance of $3,737,542.

Mr. Fearing reported that the auditor's letter to management addresses the internal accounting control policy issues. These recommendation will be addressed now that the new financial system is up and running.

Mr. Al Dees presented the recommended changes to the Hospital's Personnel Policies. The recommended changes were: Policy 3 - to correct titles and change statements to conform with University policy in clarifying the process for submission of complaints; Policy 4 - to correct titles, making it consistent with policy 3 to clarify completion of training and probationary periods; Policy 5 - to correct titles, clarify completion of probationary periods and specify length of probationary periods for part-time employees; and Policy 15 - to correct titles and make permanent part-time employees eligible to accrue seniority and eliminate references to mandatory retirement per change in law. The Board recommended that Policy #3 and #4 be laid over until more information on use of non-descrimination terms can be obtained.

The Board of Governors seconded and passed a motion to approve Personnel Policies #5 and #15 as submitted and review Policies #3 and #4 when more information can be obtained.

Mr. Al Dees presented the 1988-89 Employee Compensation Plan to the Board of Governors. The pay plan for non-student, non-union employees in Hospital-dominated classifications includes: increase salaries and salary ranges by 2%; provide in-range progression increases on a merit basis to average 1.5% to those not on "step" plans; continue in-range progression increases on a "step" basis according to existing accumulated hours; and implement the comparable worth increases scheduled for year four of the plan. The pay plan for non-student, non-union employees in University-dominated classes includes: provide a 2% across-the-board increase; provide 1.5% of budget merit increase; and pay equity increases according to the University's comparable worth plan. The average increases for all employees will be 3- 1/2% exclusive of pay equity increases.

The Board of Governors seconded and passed a motion to approve the 1988-89 Employee Compensation Plan as presented.

Lastly, Mr. Fearing reviewed the status of the Radisson University Hotel. Maddox and Associates were served a foreclosure notice on March 8, 1988 by Citicorp and are now facing a July foreclosure. Mr. Maddox asked the University to assist in stabilizing hotel utilization by guaranteeing 116 rooms per night. The University could face loss of the land if the hotel is foreclosed. The Board of Regents will discuss the proposal at their July meeting. The Board of Governors discussed the following resolution:

> "Whereas - It is the understanding of the Board of Governors of The University of Minnesota Hospital and Clinic that the Regents of the University of Minnesota have been requested to subsidize the operation of the Radisson University Hotel to forestall the mortgage foreclosure on the present hotel owners.
>
> Whereas it is also the understanding of the Board of Governors that a large component of the requested subsidy would be from University Hospital revenues.
>
> Whereas it is also the understanding of the Board of Governors that there is no contractual agreement obligation of the University of Minnesota to subsidize the hotel.
>
> Whereas such a subsidy would increase the cost of patient care at The University of Minnesota Hospital and Clinic.
>
> Therefore the Board of Governors of The University of Minnesota Hospital and Clinic urges the Board of Regents to not commit revenues of The University of Minnesota Hospital and Clinic to support the Radisson University Hotel and/or take no formal action until communication between the Board of Governors and the Board of Regents has occurred."

The Board of Governors seconded and passed a motion to approve the above resolution as presented.

ADJOURNMENT:

There being no further business, the May 25, 1988 meeting of the Board of Governors was adjourned at 4:07 P.M.

Respectfully submitted,

Kay F. Fuecker
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

June 16, 1988

TO: Members of the Board of Governors

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

Michael W. Steffes, M.D. joined The University of Minnesota Hospital and Clinic in 1971. Dr. Steffes is currently a Professor of Laboratory Medicine and Pathology and serves as Director of the Laboratory Medicine and Clinical Laboratories. Dr. Steffes served as the Chairman of the Cost Evaluation Committee. He will be speaking to the Board of Governors about that committee's final report and recommendations.

This presentation is another in a series of presentations designed to broaden or enhance the Board of Governors familiarity with current issues at The University of Minnesota Hospital and Clinic.

NCJ/kff

Attachment

CURRICULUM VITAE

MICHAEL WILLIAM STEFFES

Personal

Date of Birth:	October 19, 1943
Place of Birth:	St. Cloud, Minnesota
Social Security Number:	
Present Address:	Department of Laboratory Medicine and Pathology Box 198 Mayo Memorial Building University of Minnesota Minneapolis, Minnesota 55455
Telephone:	(612) 625-2661
Home address:	1583 Fulham Street St. Paul, Minnesota 55108

Education

Undergraduate:	Harvard College, Cambridge, Massachusettes Major: Biology Degree: A.B.; June 1965
Graduate:	University of Minnesota, Minneapolis, Minnesota Major: Anatomy Minor: Biochemistry Degree: Ph.D.; December 1970
Professional:	University of Minnesota, Minneapolis, Minnesota Degree: M.D.; December 1970
Fellowships:	M.D.-Ph.D. trainee and teaching assistant, Department of Anatomy, University of Minnesota Diabetes Training Fellowship (NIH) June 1966 - June 1967 Life Insurance Medical Research Fund Fellow July 1967 - December 1970 Fogarty Senior International Fellowship (NIH) September 1979 - June 1980

Professional Training

Internship:	Laboratory Medicine University of Minnesota Hospitals Minneapolis, Minnesota October 1971 - June 1972
Residency:	Laboratory Medicine University of Minnesota Minneapolis, Minnesota July 1972 - June 1974

Professional Experience

Department of Anatomy
University of Minnesota
Minneapolis, Minnesota

Instructor
January 1971 - June 1974

Department of Laboratory Medicine and Pathology
University of Minnesota
Minneapolis, Minnesota

Assistant Professor
July 1974 - June 1977

Director, Division of Clinical Chemistry
1976 - 1984

Associate Professor
July 1977 - June 1981

Professor
July 1981 - Present

Director, Laboratory Medicine and
Clinical Laboratories
1984 - Present

Board Certification

American Board of Pathology
Clinical Pathology; November 1974
Radioisotope Pathology; May 1975
Chemical Pathology; May 1979

American Board of Nuclear Medicine
September 1975

Societies and Professional Organizations

American Association of Clinical Chemists
American Diabetes Association
American Diabetes Association of Minnesota
Member, Research Committee
Endocrine Society
European Diabetes Association

REPORT OF THE

COST EVALUATION COMMITTEE

December, 1987

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Thomas Green, M.D.
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STAFF SUPPORT:

Jan Brockway
Vincent R. Netz

COST EVALUATION COMMITTEE
EXECUTIVE SUMMARY OF FINDINGS AND RECOMMENDATIONS

BACKGROUND

The University of Minnesota Hospital and Clinic has undergone significant growth and change in recent years, most notably since early 1986. During this time a number of factors suggested a need to evaluate ancillary utilization, productivity and patient severity. Among the factors were:

- Substantial increases in ancillary utilization per admission since early 1986 which have led to increased personnel requirements in ancillary departments.

- Continuing pressures from third party payors to reduce costs, most notable was the Blue Cross AWARE contract which threatened to reduce reimbursement by over $1 million per year.

- Increasing evidence that UMHC's casemix adjusted charges per admission had grown further away from the community norm, substantiated by the November, 1986, Council of Community Hospitals price comparison report.

- A growing belief that UMHC's patient acuity level has been increasing, coupled with growing community and payor interest in severity measurement systems, potentially to be used as quality assessment and reimbursement tools.

At the same time the hospital and medical staffs addressed the need to improve our interaction with patients, their friends and families and referring physicians. Several successful programs and the new hospital enlarged our image as a purveyor of excellent and highly specialized medical care in a warm and supportive environment. This report covers the years in which this transaction took place.

At the time of the formation of the Cost Evaluation Committee, the Hospital was concerned about the rise in the number of full-time equivalents per admission, particularly since the beginning of 1986. The rationale behind the staffing increases related to increased use of ancillary services, driven by an increasingly

more severely ill patient population. Given the competitive environment and increasing constraints on reimbursement, it has become important for the Hospital to constructively challenge this rationale and to develop improved systems to monitor and evaluate changes in severity levels, ancillary utilization and productivity among other factors contributing to health care costs.

CHARGE OF THE COMMITTEE

The Cost Evaluation Committee was charged with the responsibility to review the University of Minnesota Hospital and Clinic's performance from a productivity, ancillary utilization, and patient severity perspective. In addition, the Committee was asked to identify system needs required to monitor and modulate change on an ongoing basis.

METHODS AND LIMITATIONS:

The Cost Evaluation Committee's evaluation follows that of the previous Cost Containment Committee, chaired by John Najarian, MD, whose analysis spanned five years ending in fiscal year 1982-83. For this reason and because fiscal year 1984-85 marked the beginning of the Medicare prospective payment system at UMHC, we chose fiscal year 1983-84 as the baseline period to consider trends in the utilization of resources at UMHC.

The Cost Evaluation Committee's methods were shaped by several limitations and assumptions. First, while some efforts of the committee and its work groups addressed outpatient as well as inpatient activities, others were limited to inpatient activity only. Specifically, the analysis of ancillary utilization did not include outpatient utilization because of data and system limitations. However, the staffing analysis did factor in outpatient activity by using the Financial Accounting Department's formula to index its additive impact on hospital-wide staffing. Further, the recommendations of the Productivity Work Group are intended to address outpatient as well as inpatient activity.

Second, while quality of care and quality of services were recognized by the Committee as critical variables related to both productivity and ancillary utilization, the Committee did not attempt to evaluate quality. However, the Productivity Work Group concluded that methodologies and procedures aimed at improv-

ing quality will actually increase productivity and thereby reduce costs. Thus, a major recommendation of theis Work Group is for an across-the-hospital effort to monitor and evaluate quality of services.

Third, the Committee did not attempt to evaluate programs or ancillary services from a profitability standpoint. Questions of program subsidy or profitability were deemed to be more appropriately reviewed in other forums. While resource utilization is one factor that goes into a profitability analysis, other factors such as pricing, reimbursement, volume, indirect costs, and allocation methodologies are variables outside of the charge to the Committee.

Fourth, the evaluation was organized by ancillary categories rather than by clinical departments because organization of data by clinical departments results in low numbers of patients in many DRGs. This would compromise the statistical validity of the casemix analysis and adjustments required for overall trending. Further, review by ancillary category, with subsets of data by DRG and Major Diagnostic Category, provided the Ancillary Work Group and the ancillary departments with a methodology that allowed them to identify the success of previous and existing utilization monitoring efforts, both hospital-wide and by major clinical groups.

Fifth, the Committee used charges for services and procedures utilized rather than costs since there is no uniform procedure that allows for identification of costs by DRG. Since charges for each ancillary category increased in a well-documented manner for the years covered in this report (1983-84 to 1986-87), charges specific to each DRG for each fiscal year were adjusted using the annual price increases for each ancillary category. These individual adjustments, therefore allowed for all charges to be expressed in fiscal year 1986-87 dollars. The price increases for each ancillary category and for total hospital charges can be found in the Appendices of this report. (See Charges Summarized for Each Category section.)

METHODS USED TO ADJUST FOR CHANGES IN CASEMIX

In order to evaluate staffing and ancillary utilization changes since the 1983 Cost Containment Committee's report, this Committee used an analysis which depends heavily upon two techniques that adjust for changes in "casemix." The techniques

were based on Diagnostic Related Groups (DRGs). Although the Committee hoped that other weighting factors would be available (see Severity Measurement Work Group section), the DRG system was the only available option to measure long-term changes in patient mix and severity. Below is a general description of what casemix is and the two methods used to adjust for changes in it:

It is generally understood that utilization (i.e., number of laboratory tests, respiratory therapy procedures, etc.) per admission will vary with the nature of cases being treated. Changes in the nature of cases being treated are referred to as changes in "casemix." For example, a hospital whose casemix consists of normal deliveries and uncomplicated pneumonia cases will use fewer resources than a hospital whose casemix consists of transplantation and open-heart cases. Likewise, a given hospital can monitor changes in its own casemix over time, in a manner which may reflect the need for greater or lesser resource utilization per admission. In order to make utilization comparisons over different time periods, changes in casemix need to be taken into account; in other words, "casemix adjustment" calculations are applied.

In this report, one method for casemix adjustment uses what are referred to as "DRG relative weights." These are numbers, or weights, assigned to each diagnostic group. DRGs which consume more resources are assigned higher weights than those consuming lesser resources. The relative weights of each DRG are multiplied by the percent of discharges in the DRG and the products are summed to arrive at a "casemix index," a single number which can be thought of as representing all the relative weights. Thus, when a category under study, such as total hospital charges, is multiplied by casemix index, increases or decreases in resource consumption due to changes in casemix are factored in. The DRG relative weights used are the same as those used in the Medicare DRG reimbursement system.

The second method uses what are referred to as "weighted averages." The distribution of cases (i.e. casemix) for one of the Fiscal Years (FY 85-86) is selected as representative of all years. This distribution then becomes the baseline used to neutralize changes in casemix from year to year. With this method, the number of cases in each DRG is divided by the total number of cases for the "baseline year" to arrive at a ratio or "weight." These ratios are then applied to the average charges for each of the fiscal years to arrive at a "weighted average" charge per

discharge, effectively eliminating variations in the distribution of cases from year to year. Thus, changes in the average charges will reflect changes in utilization instead of casemix.

Throughout this report, then, an attempt is made to accommodate changes in the mix of cases seen over time by using either the DRG relative weights or weighted average calculations. While those calculations are complex, the concept is relatively simple. This concept is also very important, as it can have a major effect on the conclusions which are drawn about changes in the hospital's utilization levels and resource consumption.

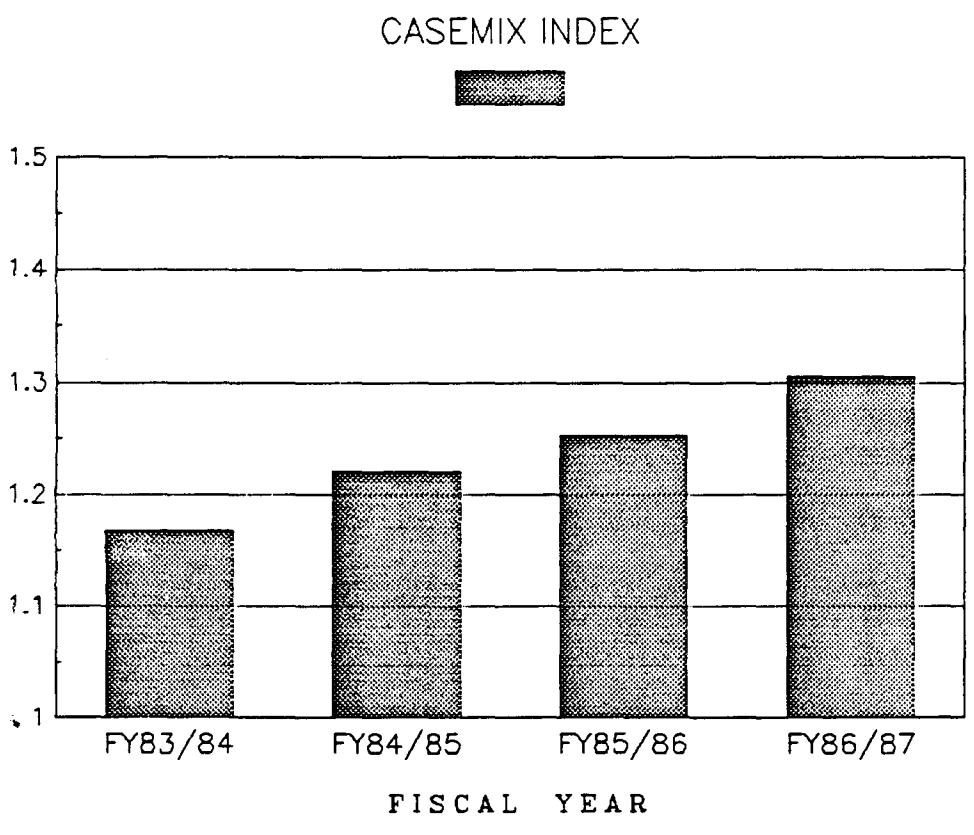
REVIEW OF CASEMIX, UTILIZATION, AND STAFFING SINCE FISCAL YEAR 1983-84

Casemix Index

As indicated above, the casemix index is calculated by multiplying the relative value or weight of each DRG times the percent of discharges in that DRG and summing the products over all DRGs. Thus the casemix index represents the estimated average relative historical cost of the cases in the hospital. A hospital with a casemix index of 1.100 on Year 2 would have patients who, on average, should require 10% more resources than the average patient during Year 1 with a casemix index of 1.000.

As is shown on Figure 1, UMHC's casemix index has increased each year. Overall, it has increased by more than 10% since FY 1983-84.

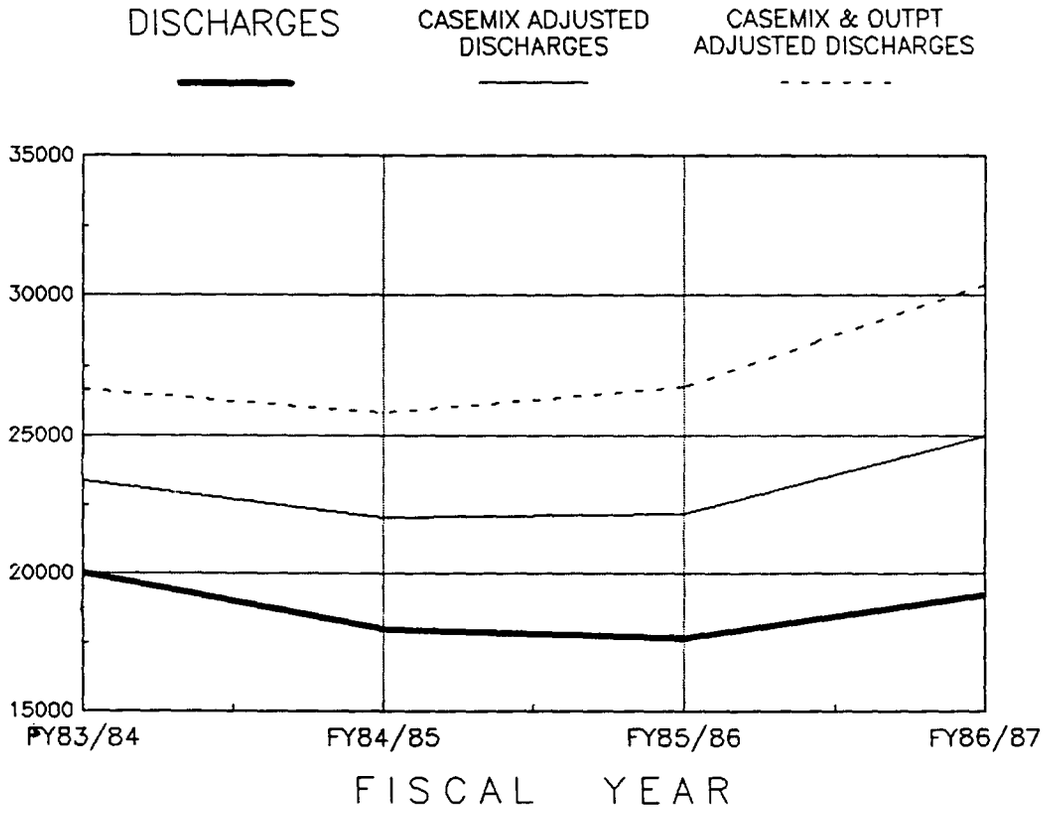
FIGURE 1



Casemix and Outpatient Adjusted Discharges

In order to determine the impact of the increasing casemix index, we multiplied the number of discharges times the casemix index for each year to arrive at casemix adjusted discharges. As is shown on Figure 2, although the number of discharges decreased slightly (4.1%) between FY 1983-84 and July-December, 1986, there was an increase (7.1%) in the number of casemix adjusted discharges. Further, the steady increase in outpatient activity was factored in by using the Financial Accounting Department's formula to index its additive impact on hospital-wide staffing. With this calculation, there was a sharper increase (nearly 12%) in the number of casemix-and-outpatient adjusted discharges. This adjustment for outpatient-related activities was applied only in Figures 2 and 3 and Tables 2, 4, and 5 of the Appendices.

FIGURE 2



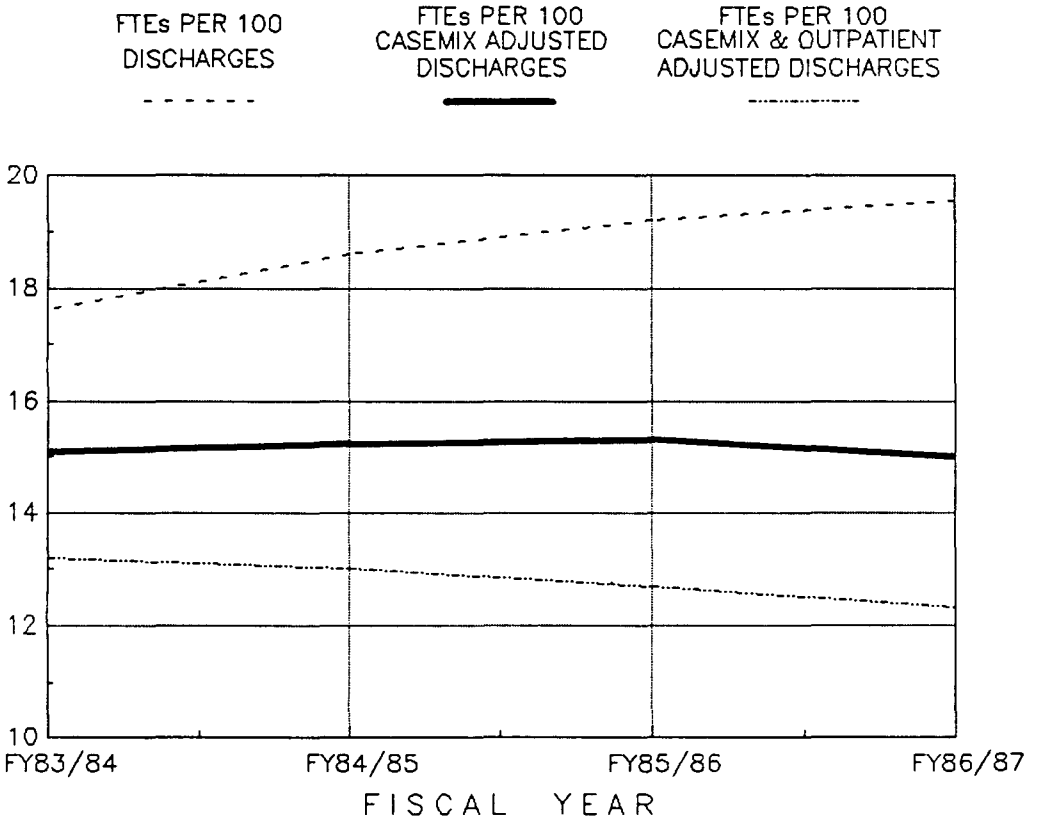
Staffing

Hospital-wide staffing changes were reviewed (Figure 3 and Table 2 of Appendices). Excluding the Community University Health Care Center (CUHCC), the number of full-time equivalents increased by 6.4% between FY 1983-84 and FY 1986-87. However, when the number of full-time equivalents (FTEs) is reviewed in relationship to casemix-and-outpatient adjusted discharges, staffing has actually decreased by more than 6%.

FIGURE 3

The University of Minnesota Hospital and Clinic

HOSPITAL-WIDE STAFFING TRENDS



Staffing by Departmental Groupings:

Staffing was grouped into three broad categories for review: Inpatient Nursing, *Other Patient Related Services, and All Other Services. Inpatient Nursing Staffing per 100 discharges increased by 12.8% but when the casemix adjustment was made there was essentially no increase in Nursing staffing (less than one percent). Likewise, for the Other Patient Related Services category, staffing per 100 discharges increased by 11.6% but when the casemix adjustment was made there was no increase. Further, when the adjustment for increased outpatient activity was made, the staffing for the Other Patient Related Services category actually decreased by 6.1%. The third category, All Other Staffing, which is less directly effected by casemix changes, showed an increase of 7% with no adjustments; a 4.2% decrease with the casemix adjustment; and a 9.9% decrease with the casemix and outpatient adjustment (Tables 3, 4, and 5 of Appendices). Thus, based on the casemix adjustment, staffing either remained the same or decreased for each of the three categories.

* Other Patient Related Services = Laboratories, Blood Bank, Diagnostic Radiology, Patient Monitoring, Respiratory Therapy, Pharmacy, Admissions, Medical Records, Radiation Therapy, Outpatient/Emergency Room, Operating Rooms, Rehabilitation, and Social Work (Inpatient and Outpatient).

Overall Hospital Charges:

The Committee reviewed total hospital charges, average hospital charge per discharge, and *weighted average hospital charge per discharge. All charges were adjusted to Fiscal Year 1986/87 dollars so that the charges could be used as a proxy measure of overall utilization. Total charges and, therefore, overall utilization increased by 3.6% between FY 1983-84 and July-December, 1986. The average charge per discharge and therefore utilization per discharge increased by 13.4%. However, when changes in casemix are taken into account by comparing the weighted average hospital charge per discharge, there was essentially no change in the weighted average charge (less than one percent). Thus, overall utilization, whether appropriate or inappropriate, had not changed from 1983-84 to July-December, 1986 (Table 1).

Charges by Charge Category:

As shown on Table 1, the weighted average charges for room and board and the ICU surcharge decreased by 10% and 12% respectively between 1983-84 and July-December, 1986. In contrast, with the exception of blood product administration, the weighted average charges of the ancillary categories increased. Thus, the Committee endorsed further review of the six ancillary categories accounting for the greatest proportion of the average hospital charge per discharge: laboratory, blood product administration, pharmacy, diagnostic radiology and nuclear medicine, respiratory therapy, and patient monitoring (Figure 4).

* The average charges per discharge were weighted to the Fiscal Year 1985-86 casemix. That is, the weighted average charge for each year was computed by multiplying the average charge of each DRG for that year by the proportion of discharges in the DRG in FY 1985-86 and then summing the products. This process was used to adjust for differences in the distribution of DRGs from year to year to allow for comparison of charges and therefore utilization over time.

TABLE 1

ALL DIAGNOSTIC CATEGORIES

CHARGE CATEGORY	TOTAL CHARGES (expressed in millions and in FY 86/87 dollars)							WEIGHTED AVERAGE CHARGE PER DISCHARGE (weighted to FY 85/86 case mix)						
	FY83/84	FY84/85	FY85/86	FY86/87 (est)	% Chg. 83/4-85/6	% Chg. 85/6-86/7	% Chg. 83/4-86/7	FY83/84	FY84/85	FY85/86	FY86/87 (est)	% Chg. 83/4-85/6	% Chg. 85/6-86/7	% Chg. 83/4-86/7
# of Disch.	19,926	17,871	17,229	18,200	-13.5%	5.6%	-8.7%							
Room and Board	58.637	50.376	47.391	52.784	-19.2%	11.4%	-10.0%	3,144	2,894	2,749	2,842	-12.6%	3.4%	-9.6%
ICU Ancillaries	13.250	13.499	13.051	12.946	-1.5%	-0.8%	-2.3%	698	745	756	614	8.3%	-18.7%	-12.0%
Operating Room/ Anes/PAR/Del	15.411	14.061	14.539	17.342	-5.7%	19.3%	12.5%	NA	NA	NA	NA	—	—	—
Laboratory	28.448	26.309	27.468	30.654	-3.4%	11.6%	7.8%	1,518	1,500	1,596	1,572	5.1%	-1.5%	3.6%
Blood Administration and Blood Take Home	6.407	6.077	5.750	6.489	-10.3%	12.8%	1.3%	347	341	335	309	-3.4%	-7.7%	-11.0
Pharmacy & Pharmacy Take Home	21.405	23.090	23.170	26.049	8.2%	12.4%	21.7%	1,157	1,306	1,347	1,308	16.4%	-2.9%	13.1%
Diagnostic Radiology & Nuc. Medicine	8.981	8.454	8.804	9.190	-2.0%	4.4%	2.3%	486	492	511	497	5.1%	-2.8%	2.3%
Therapeutic Radiology	0.706	0.630	0.689	0.847	-2.4%	22.9%	20.0%	39	33	40	36	1.8%	-9.3%	-7.7%
Respiratory Therapy	3.867	NA	3.934	4.866	1.7%	23.7%	25.8%	202	NA	228	250	12.5%	10.0%	23.8%
Patient Monitoring	4.346	NA	5.651	6.507	30.0%	15.1%	49.7%	243	NA	327	313	34.6%	-4.3%	28.8%
Other	21.662	NA	18.253	20.820	-15.7%	14.1%	-3.9%	NA	NA	NA	NA	—	—	—
TOTAL HOSPITAL	181.944	170.459	168.572	188.494	-7.3%	11.8%	3.6%	9,770	9,709	9,791	9,719	0.2%	-0.7%	-0.5%

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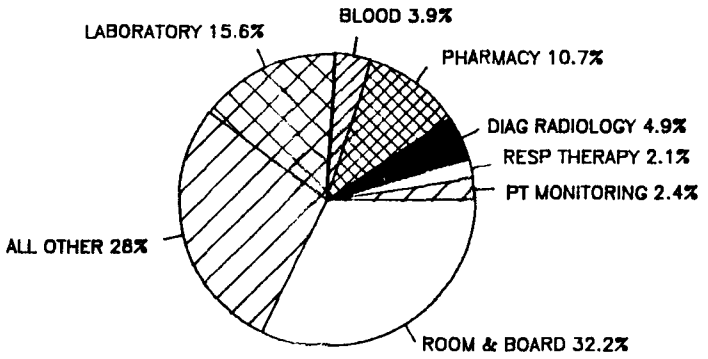
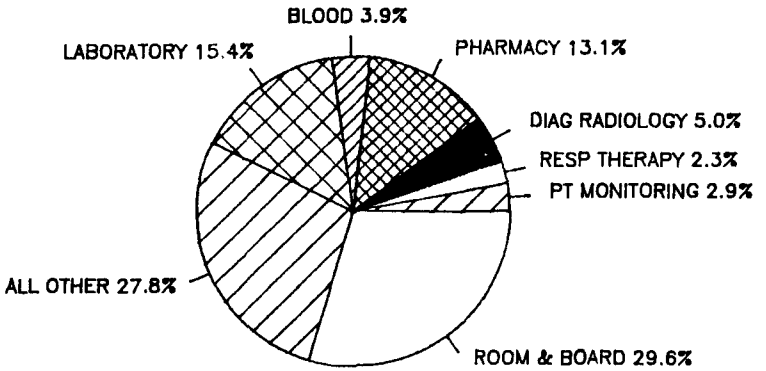
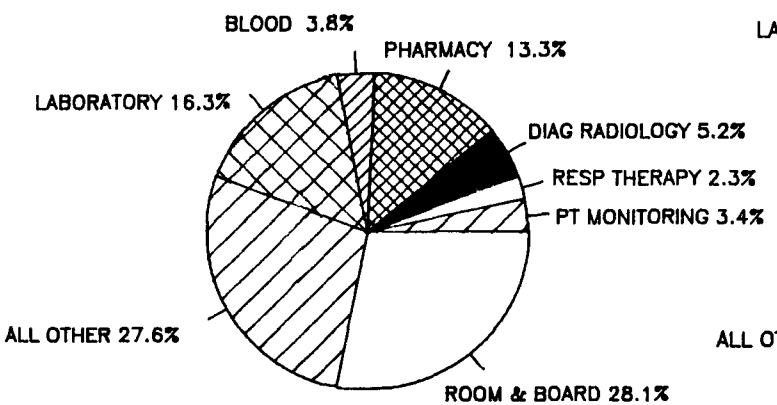
FIGURE 4
AVERAGE HOSPITAL CHARGE PER DISCHARGE



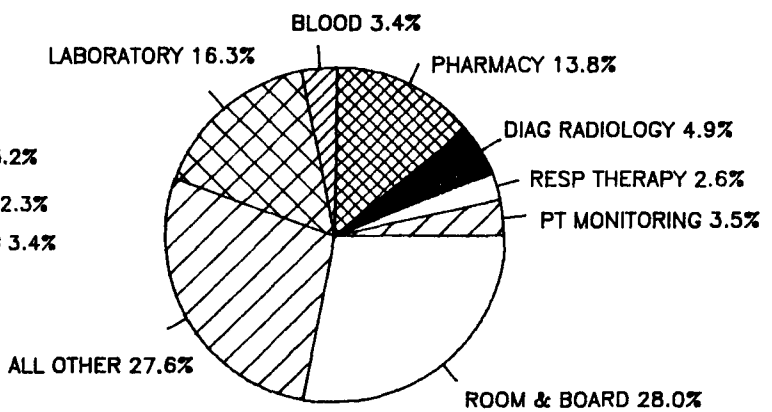
AVG CHARGE = $9,131
FY 83/84



AVG CHARGE = $9,538
FY 84/85



AVG CHARGE = $9,784
FY 85/86



AVG CHARGE = $10,357
FY 86/87
(BASED ON 6 MONTHS: JUL–DEC, 1986)

PREPARED BY V. NETZ, QUALITY ASSURANCE SERVICES, 12/4/87

THE WORK GROUPS

To address the manner in which the medical staff and hospital departments could improve their evaluation of costs factors (i.e. severity, productivity, and utilization), the Committee formed three work groups: Productivity Work Group, Severity Measurement Work Group, and Ancillary Intensity Work Group.

The Ancillary Work Group

The group addressing the utilization of ancillary services looked at several ancillary areas within the hospital and identified three in which the utilization has risen in a greater than average manner: respiratory therapy, patient monitoring, and pharmacy. In addition, the work group identified one area where a significant decrease in utilization relative to the patient population was achieved: use of blood products. The work group decided that the success or problems of these areas fundamentally relate to the application of educational efforts and monitoring systems to control the ordering or provision of services by the physicians. Thus, they felt that physician education and/or careful monitoring of ordering practices would be most effective in controlling the utilization of these different services. The marked reduction in the use of blood products followed a careful implementation and monitoring of blood products (especially platelet utilization) using a desk-top computer-based system in the Blood Bank. This system was put in place with the active involvement of the faculty on the oncology and hematology services and the medical staff in the Blood Bank.

The Productivity Work Group

The Productivity Work Group concluded that methodologies and procedures aimed at improving patient care services will actually increase productivity of the staff and reduce costs. Specifically, they identified the need for an across-the-hospital effort to monitor and evaluate accuracy and timeliness in the delivery of health care. Resultant changes would improve productivity by eliminating ineffectual activities and duplicate efforts among personnel. Since productivity, as expressed in FTEs per casemix-and-outpatient adjusted discharges, appears to have improved (Figure 4) over the period covered by this report, the new hospital and programs aimed at improving our interaction with patients, their families and friends, and the referring physicians were made possible without a discernable negative impact on hospital-wide productivity.

The Severity Measurement Work Group

The Severity Measurement Work Group fundamentally felt there are no systems to measure changes in intensity or severity across our patient population other than the DRG-based relative weights and DRG-based casemix analysis that were used for the Cost Evaluation Committee and Ancillary Work Group. They did identify several systems that are applicable to the intensive care units and have been used, to some extent, by these units to measure severity of their populations. It is possible that these systems could be employed in a limited manner within our intensive care areas to maximize delivery of care and monitor costs within that setting.

RECOMMENDATIONS

1. Emphasis on physician education is imperative to maintain or improve the control of utilization and, thereby, costs in our Hospital. Newly enlisted house staff and house staff rotating back to the University of Minnesota Hospital and Clinic should, with the existing house staff, receive careful instruction regarding the use of services within the institution. While the attending staff has assumed responsibility to educate resident physicians in the utilization of services and resources, an additional step to increase the effectiveness would involve a greater interaction among physicians from all departments. Specifically, specialists in individual areas (respiratory therapy, laboratory, radiology, and pharmacy) should provide more information to the physicians ordering these services. This effort can be facilitated through existing committees such as the Pharmacy and Therapeutics Committee and Cardio-Respiratory Advisory Committee and improved review of laboratory and radiology services.

2. As a corollary to the need to maintain a strong educational program at all levels in the hospital, we should continue to implement systems that monitor ordering practices by the clinical services. The success of the effort to reduce platelet utilization directly resulted from a conjoined effort by Oncology, Hematology, and the Blood Bank to monitor ordering patterns for

platelets and other blood products. Although there were some difficulties to overcome in implementing this process, the success of this effort in the reality of an increasingly difficult-to-manage patient population underlines the importance of creating such tools.

3. The Cost Evaluation Committee's efforts to review utilization has produced a potential methodology (i.e., casemix adjustment) to improve our ability to monitor and manage costs associated with utilization. Several ancillary departments that have attempted to control utilization have not had the tools to monitor the success of their efforts using a casemix adjusted methodology. Specifically, the recent success on the part of the new leadership in Pharmacy and the Pharmacy and Therapeutics Committee to optimize drug utilization was not revealed until the analysis that was performed for the Cost Evaluation Committee. Thus, the Committee strongly recommends that tools to facilitate casemix adjustment and analysis be fashioned to permit all hospital and medical services to monitor the success of newly implemented decisions and strategies. These tools should be available, not only to administration and such oversight committees as the Cost Evaluation Committee, but also to those providing the service and needing feedback as to the success of their strategies to control utilization and costs. The Cost Evaluation Committee strongly believes that the provision of tools to allow for casemix adjustments and analyses will be well worth the small added cost.

4. As an adjunct to the provision of tools to facilitate casemix adjustments and analyses, efforts to improve the usefulness of the DRG system, at least internally, are needed. Specifically, we need to develop the capability to remove outliers and special groups of patients with complex underlying diseases (e.g., cancer, AIDS, status post organ transplants). The impact of these factors should be evaluated and documented periodically until the Health Care Financing Administration's (HCFA) efforts to refine the DRGs results in a system that adequately reflects our patient population or until there is an acceptable severity measurement system. This effort should be facilitated through improved data management. Further, the results of this effort should be well integrated into the hospital information system reporting capabilities.

5. From the above discussions there is obviously a clear need for better data management tools at all levels for those who must manage resources and provide patient care within this institution. The Cost Evaluation Committee's need for information was addressed through active and involved procurement of data fashioned only in response to the needs of the Committee. As stated above and as is evidenced in the reports of the Ancillary and Productivity Work Groups, managers and physicians within the hospital require more comprehensive, readily available data to make decisions and to evaluate the efficacy in implementing those decisions. This is the major recommendation of the Committee, and one which may be implemented through reorientation of our current data management services.

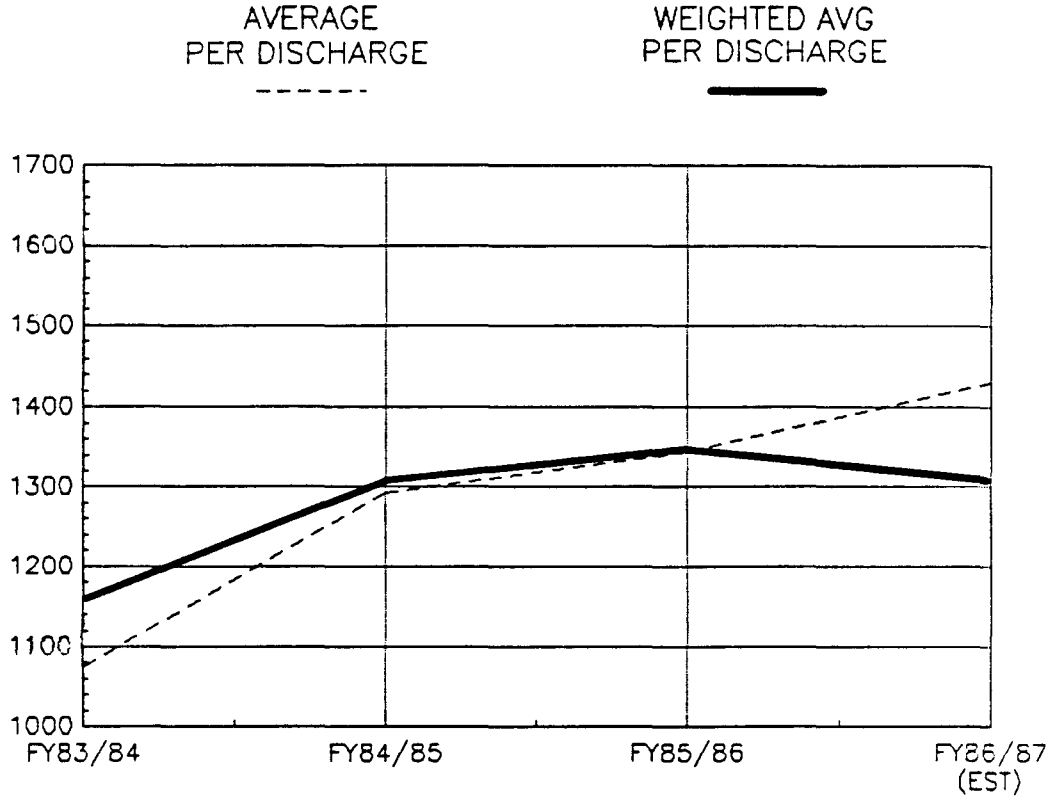
6. While the provision of data recommended above will help in monitoring and implementing decisions concerning patient care, there needs to be hospital-wide encouragement of innovative programs to improve the utilization of resources in providing patient care. These programs can be hospital-wide, or in many instances can target specific areas within the hospital. The smaller, demonstration programs may be especially important in pointing the way towards policies or tools that may be brought to bear upon our total patient population. The desk-top computer-implemented service of the Blood Bank, Pharmacy's program to address ordering of drugs, and Respiratory Therapy's new concurrent monitoring system are three examples of such pilot programs which should be endorsed and supported. Additionally at this time, the success of the Intensive Care Units (ICUs) in monitoring their costs and optimizing patient care can specifically be addressed by increasing support for a computer service to monitor provision of therapy, to optimally display data on each patient and to induce significant savings by closely monitoring utilization of ICU services.

7. Similar to the efforts aimed at improving the medical staff's utilization of services, all hospital departments should develop methodologies to monitor and evaluate accuracy and timeliness of the delivery of services. This effort should be facilitated through improved data management aimed at more timely and efficient availability of information.

SUMMARY OF RECOMMENDATIONS:

In summary, all recommendations made by the Committee devolve upon the need to provide readily useable information to those who make decisions. Computer system costs have decreased; connectability through networks has increased. Therefore services to support the gathering of data can be implemented much more efficiently than in the past. Optimally, individual computer systems provided to separate units within the Hospital (e.g., Radiology, Pharmacy, Intensive Care Units, and the Clinical Laboratories) may be interconnected through networks including the hospital information system, to provide the important monitoring and service-utilization data recommended by this Committee.

PHARMACY UTILIZATION



CHARGES ARE ADJUSTED FOR INFLATION

CONCLUSIONS:

The weighted average charge decreased by 2.9% from 1985-86 to July-December, 1986. This was in sharp contrast to the 16.4% increase seen during the prior two-year period. The significant change appears to be the result of expanded utilization and cost reduction efforts implemented during 1986-87.

RECOMMENDATIONS:

The Work Group agreed that the activities that were in place during FY86/87 likely contributed to the decrease in the weighted average charge per discharge for the July - December, 1986 discharges. Given this, the Work Group recommends:

1. Continuation of the types of cost and utilization reduction activities outlined by Dr. Abramowitz.

2. Periodic updating of this study's comparison of total charges, average charge per DRG, and weighted average charge per DRG for all discharges and by Major Diagnostic Category (MDC).

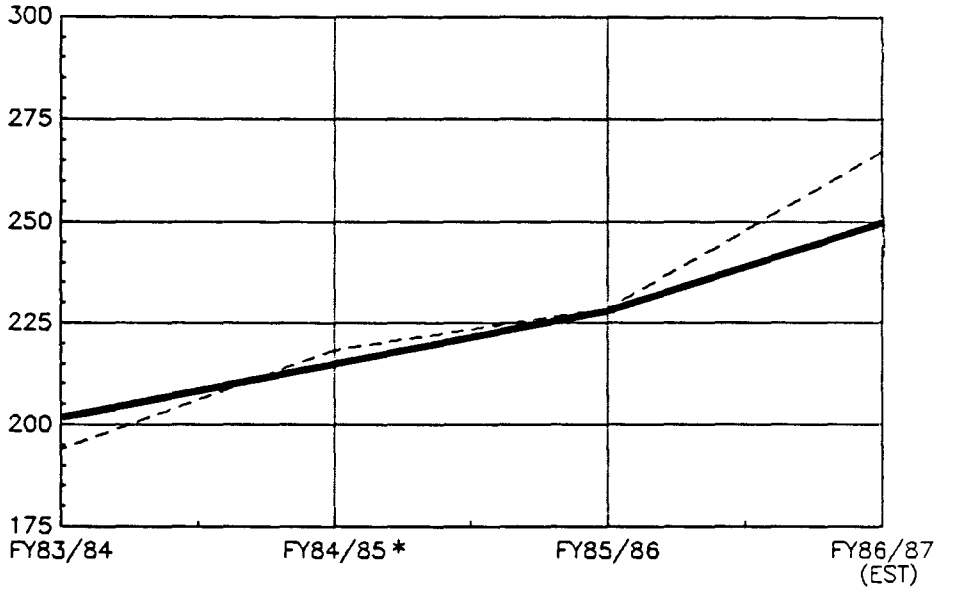
3. Development of additional DRG-based reporting designed to facilitate the monitoring of pharmacy charges and to identify patterns that suggest the need for focused utilization review activities. To facilitate this, the Pharmacy and Therapeutics Committee should identify "thresholds for action" such as DRGs with significant (greater than 20%) increases in pharmacy utilization or DRGs with charges in excess of specific dollar amounts. This effort could initially be focused on the DRGs that are responsible for the largest proportion of pharmacy charges.

COST EVALUATION COMMITTEE
EXECUTIVE SUMMARY

RESPIRATORY THERAPY UTILIZATION

AVERAGE PER DISCHARGE (- - - - -)

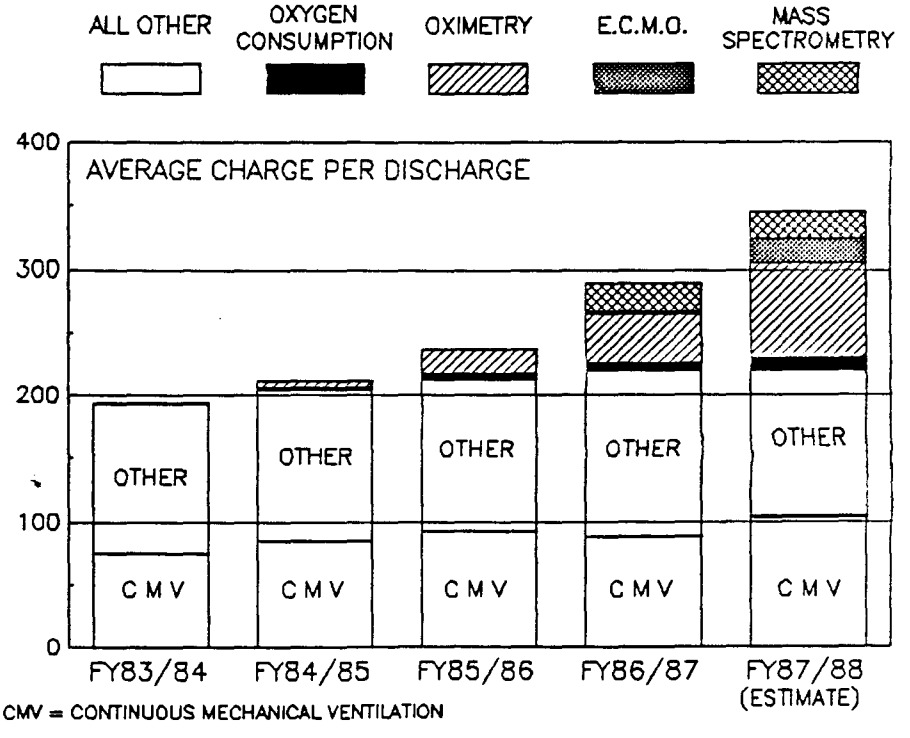
WEIGHTED AVG PER DISCHARGE (———)



CHARGES ARE ADJUSTED FOR INFLATION

*FY84/85 AVERAGES ARE ESTIMATED

EFFECT OF NEW MODALITIES



CMV = CONTINUOUS MECHANICAL VENTILATION

CONCLUSIONS:

The weighted average charge per discharge continues to increase with the 10.0% increase from FY 1985-86 to July-December, 1986, being the highest of the ancillary categories. While the higher costs associated with the new modalities and increases in patient acuity are not adequately reflected in the DRG casemix analysis, there likely had not been any significant decreases in inappropriate utilization because it was only in May, 1987, that the concurrent monitoring program for respiratory therapy modalities was implemented.

RECOMMENDATIONS:

The work group agreed on the need for the new order sheet and recommends the following:

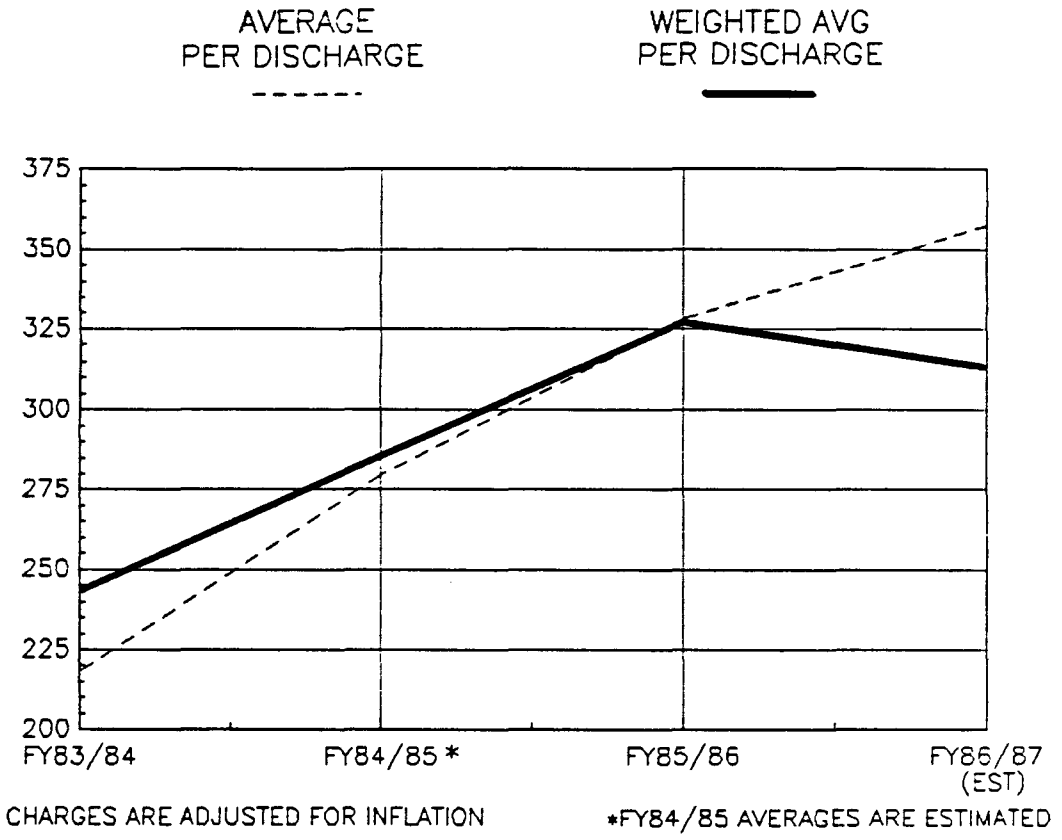
1. Continued expansion of educational programs designed expressly for the medical staff to better understand the indications for respiratory therapy.

2. A comparative analysis, by DRG, comparing time periods before and after implementation of the new order sheet should be carried out to determine its impact and the need for any additional efforts aimed at the modalities which are monitored.

3. Periodic updating of this study's comparison of total charges, average charge per DRG, and weighted average charge per DRG for all discharges and by Major Diagnostic category (MDC).

4. Further attempts to develop guidelines for the use of oximetry and other new modalities should be conducted.

PATIENT MONITORING UTILIZATION



CONCLUSIONS:

There has been a substantial increase in the volume of patient monitoring ordered; however, as shown above, there is a slowing rate of increase in the average charge per discharge and a decrease in the weighted average charge per discharge.

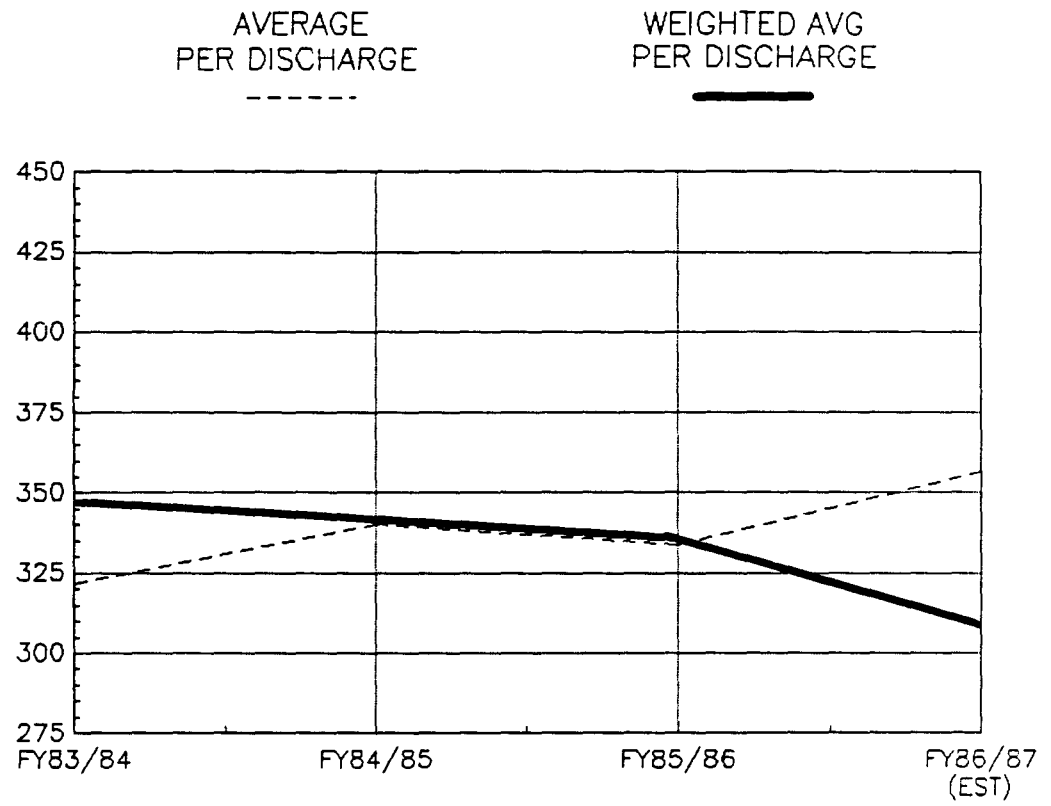
RECOMMENDATIONS:

The work group endorses the Cardio-Respiratory Advisory Committee's current efforts in developing criteria or indications for the use of patient monitoring and recommends the following:

1. A comparative analysis, by DRG, comparing time periods before and after implementation of the new order sheet should be carried out to determine its impact and the need for any additional efforts.

2. Periodic updating of this study's comparison of total charges, average charges per DRG, and weighted average charge per DRG for all discharges and by Major Diagnostic Category (MDC).

BLOOD PRODUCT UTILIZATION



CHARGES ARE ADJUSTED FOR INFLATION

CONCLUSIONS:

The Work Group concluded that the 11.0% decrease in the weighted average charge per discharge since 1983-84 demonstrates that reduction in utilization has occurred as a result of the efforts of the Blood Bank and Transfusion Therapeutics Committee.

RECOMMENDATIONS

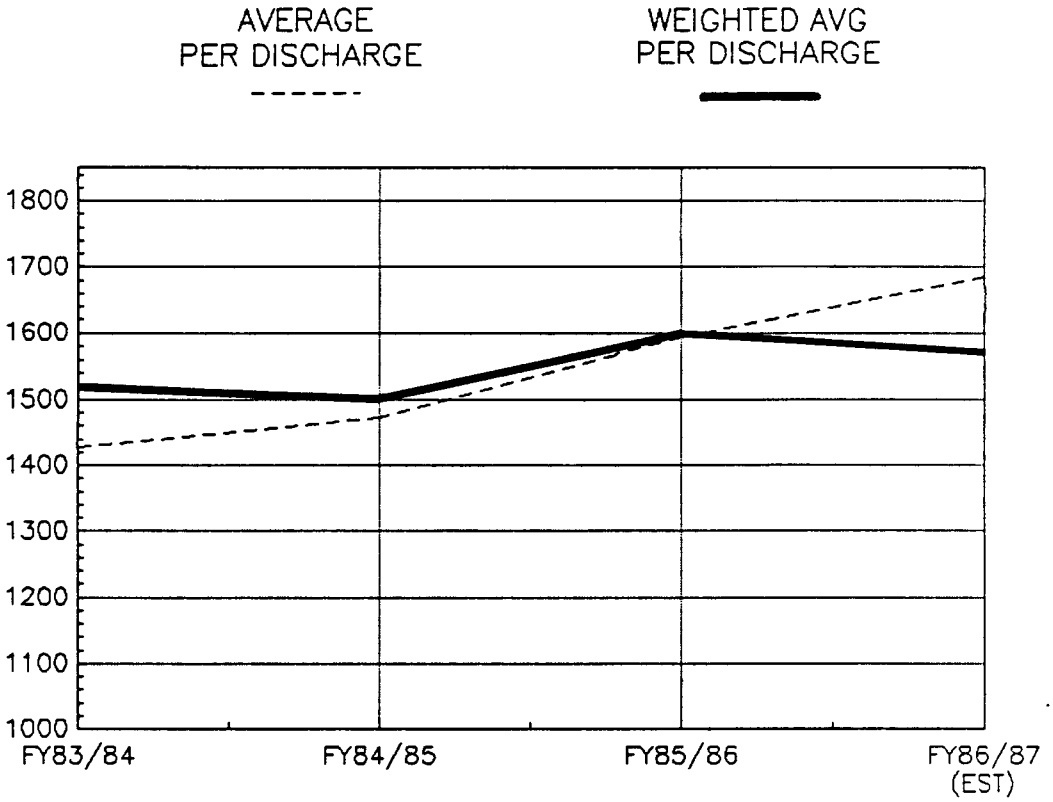
The Work Group recommends:

1. Continuation of the types of activities that have been carried out by the Blood Bank and Transfusion Therapeutics Committee to reduce unnecessary utilization.

2. Periodic updating of this study's comparison of total charges, average charge per DRG, and weighted average charge per DRG for all discharges and by Major Diagnostic Category (MDC).

3. Development of additional DRG-based reporting designed to facilitate the monitoring of blood product use and to identify patterns that suggest the need for focused utilization review activities. To facilitate this, the Transfusion Therapeutics Committee should identify "thresholds for action" such as DRGs with significant (greater than 20%) increases in blood utilization or DRGs with charges in excess of specific dollar amounts. This effort could initially be focused on the DRGs that are responsible for the largest proportion of blood charges.

LABORATORY UTILIZATION



CHARGES ARE ADJUSTED FOR INFLATION

CONCLUSIONS:

The weighted average charges for laboratory services have remained essentially unchanged since 1983-84 (i.e. they have not varied by over 5%). This suggests that inappropriate utilization of these services has likely not increased.

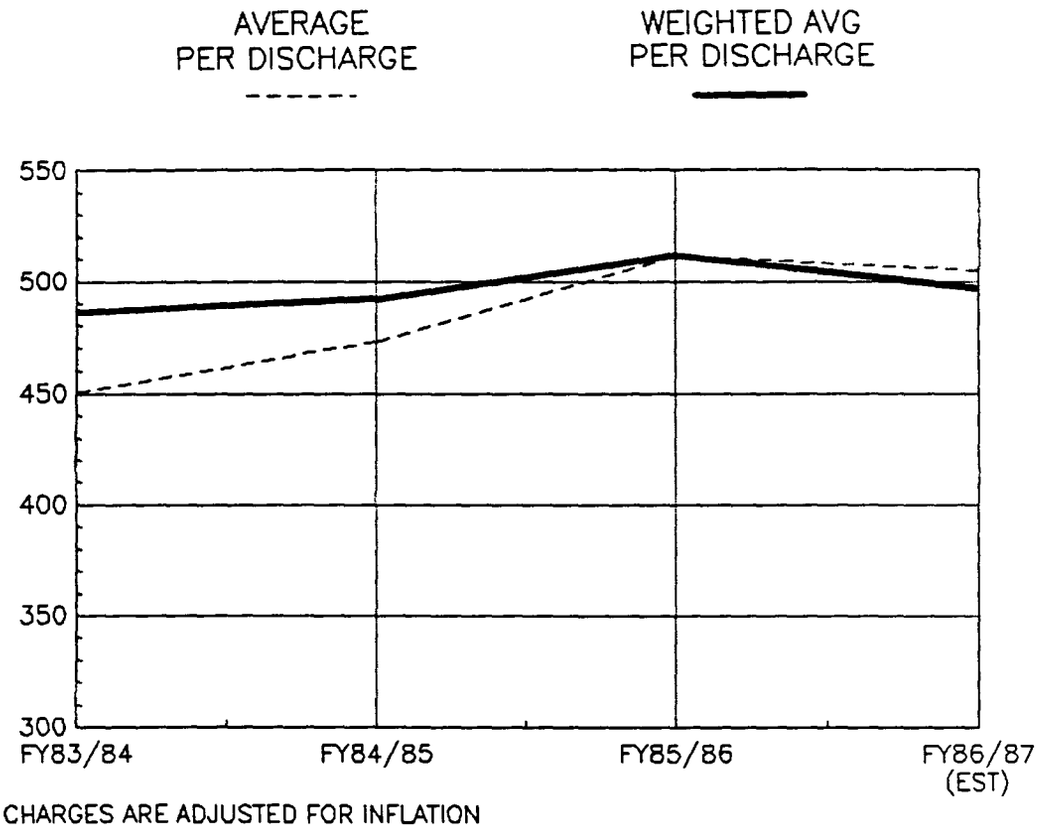
RECOMMENDATIONS:

The Work Group recommends the following:

1. The 1983 Cost Containment Committee's recommendation for an ongoing review of laboratory services analogous to the review process and/or committee structure now utilized for Respiratory Therapy, Patient Monitoring, Pharmacy and Blood Bank should be reconsidered.

2. Clinical services should be encouraged to review laboratory utilization as a part of their quality assurance systems.

DIAGNOSTIC RADIOLOGY UTILIZATION



CHARGES ARE ADJUSTED FOR INFLATION

CONCLUSIONS:

The weighted average charges for radiology services have remained essentially unchanged since 1983-84 (i.e. they have not varied by over 5%). This suggests inappropriate utilization of these services has likely not increased.

RECOMMENDATIONS:

The Work Group recommends the following:

1. The 1983 Cost Containment Committee's recommendation for an ongoing review of radiology services analogous to the review process and/or committee structure now utilized for Respiratory Therapy, Patient Monitoring, Pharmacy, and Blood Bank should be reconsidered.

2. Clinical services should be encouraged to evaluate appropriateness of radiology exams and procedures as a part of their quality assurance systems.

va6-2W224

MINUTES
Planning and Development Committee
June 6, 1988

CALL TO ORDER
Mr. S. Albert Hanser, Acting Chair, called the June 6, 1988 meeting of the Planning and Development Committee to order at 12:26 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	S. Albert Hanser Robert Dickler William Jacott, M.D. Peter Lynch, M.D.
	Absent	Leonard Bienias Clint Hewitt B. Kristine Johnson, Chair Geoff Kaufmann Ted Thompson, M.D.
	Staff	Al Dees Cliff Fearing Greg Hart Nancy Janda Mark Koenig Lisa McDonald Barbara Tebbitt
	Guests	B.J. Kennedy, M.D. Louis Dehner, M.D.

APPROVAL OF MINUTES
The minutes of the May 9, 1988 meeting were approved as distributed.

CAPITAL BUDGET
Mr. Hart reviewed the proposed 1988-89 capital budget of $7,991,163 which had been reduced from original requests of $18,000,000. The majority of the funds, $6,443,513, is for equipment purchases while the remainder is for equipment installation and remodeling. Equipment costing between $100,000 - $600,000 was discussed and additional information will be provided to the Board prior to purchase. Remodeling projects over $5,000 totaled $475,000. A discussion followed on the physical conditions of the outpatient clinics.

Five year (1989-1993) capital expenditure projections were discussed with a review of 1) annual equipment and remodeling requirements, 2) major capital expenditures, 3) principle on debt for equipment, and 4) Phase II of the Renewal Project. All major expenditures will be presented to the committee for approval.

Mr. Hanser inquired about the lithotripter's volume and if community physicians were using it. Mr. Hart said that there had been good participation from the medical community although it had fallen off with the installation of

a second lithotripter at a Twin Cities hospital, and that an invitation will be extended to gastroenterologists to use the biliary lithotripter.

Given there was no quorum Mr. Dickler requested that any concerns about the capital budget be passed on to the Finance Committee.

SURGICAL PATHOLOGY PROJECT

Mr. Hart reviewed the Surgical Pathology Project relocation and renovation which is preceding the Mayo renovation due to the increased volume, location and the inefficiency of its current facilities. Dr. Dehner discussed the problems that surgical pathology has had in serving Unit J since they are not located in or near Unit J. He estimated that 1 1/2 hours per person/day has been consumed in travel time not to mention the inconvenience to the clinical staff when they need to consult with pathology.

Mr. Dickler informed the group he has moved ahead in planning the Surgical Pathology project even though the Mayo renovation was put on hold when he arrived. Dr. Lynch expressed the Chief's support of expediting the Surgical Pathology Project.

The project is estimated to cost $1,029,[illegible]d will be relocated on the southeast corner of the fourth floor of [illegible], providing the closest possible adjacency and accessibility to the Unit J operating rooms. Additional costs for redesign and other related Renewal Project design efforts would be accommodated in the Renewal Project budget. The internal fixtures and furnishings will be paid for by the department. The project will be presented again the next P&D meeting for an endorsement.

MASONIC III REMODELING

Ms. Tebbitt provided background information on the Masonic III Nursing Unit and the original decision to move Med/Surg ICU patients to Unit J because of the hospital's census decline. She then reviewed the hospital's proposal to renovate and reactivate the Masonic III nursing unit given UMHC's consistently high med/surg occupancy, increasing patient placement difficulties and the revised master plan for obstetrics (locating postpartum beds in Unit J). The proposed unit would consist of 26 inpatient beds with a high number of private rooms to meet the protective isolation needs of patients. The majority of renovations will be in the support area and includes a nourishment room, medication room, teaching/conference site, family lounge and nutrition galley. The project is estimated to cost around $1.1 million.

Dr. Kennedy provided additional information on the Masonic Building and the relationship with the Masons. He said that the remodeling of Masonic III will facilitate outpatient and inpatient care since the staff can take care of patients at one site. Also, the location is very accessible to the ancillary services located in Unit J and should not disrupt patient care.

The Masons are supportive of the remodeling and will be contributing $500,000 toward the $1.1 M project. While the project will cause an increase in overall operations cost, it should be off-set by increased bed capacity, greater patient convenience and the potential for increased volume.

Mr. Dickler concluded that Masonic III is being designed as a medical surgical unit for general and immunosuppressed patients. While it's a stand alone project, it has been planned within the parameters of the Phase II remodeling project as has the Surgical Pathology project. Prior to approving the project, the committee will be informed of the Phase II remodeling project.

UMCA UPDATE

Dr. Lynch provided the following UMCA update:

1) UMCA is working with PHP on a month by month basis.

2) UMCA's Board of Directors signed a transplant contract with UMHC. This is the first time the physicians have signed a single contract.

3) UMCA is currently reviewing it's goals and budget.

OTHER BUSINESS

Mr. Dickler responded to Dr. Lynch's inquiry about newspaper articles on Minnesota hospitals operating losses. Mr. Dickler concluded that UMHC was financially sound and that the report did not take into consideration investment income and the state subsidy for medical education.

ADJOURNMENT

Mr. Hanser adjourned the Planning and Development Committee at 2:54 p.m.

Respectfully submitted,

Lisa G McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

Office of the Hospital Director and
Assistant Vice President for Health Sciences

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
B-313 Mayo Memorial Building, Box 604
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

June 17, 1988

TO: Members of the Board of Governors

FROM: Robert Dickler
Hospital Director

The attached proposal calls for the remodeling and reactivation of the nursing unit on Masonic III. This project is consistent with the Hospital Master Facilities Plan and is justified by current and projected adult medical surgical census. The remodeling and patient move will provide greater flexibility in allocating adult medical surgical beds and will facilitate the implementation of the tentative OB renovation plan.

Cost estimates for this project have been obtained from two firms based on design development drawings. Because both estimates are over the $600,000 threshold, we will be sharing the proposal for your information in June and action in July.

Barbara Tebbitt, Senior Associate Director and Director of Nursing Services, will be available for your questions. Thank you for your consideration.

bd.1.060188

MASONIC III NURSING UNIT
PROJECT PROPOSAL

This document outlines a proposal for renovation and reactivation of a Medical Surgical nursing unit on the third level of the Masonic building.

BACKGROUND

The University Hospital Renewal Project master plan developed in 1979-1980 recommended that no renovation and no change in bed numbers or configuration take place in the Masonic building. At that time three nursing units, totaling approximately 90 beds, were operational in Masonic.

Significant revisions were made to the Renewal Project Master Plan in 1981-82. Most significant were: (1) the deferral of the renovation (non-Unit J) portion of the master plan; and, (2) the down sizing of the planned new hospital facility (Unit J). During 1981-82 census projections continued to justify the operation of all Masonic beds in addition to the beds in Unit J.

In 1985, as final occupancy planning for Unit J was underway, revised census levels indicated that Medical/Surgical/ICU beds in Unit J would be sufficient to accommodate all adult Med/Surg/ICU patients. At that point, bed allocation was modified to enable the closing of the Masonic Nursing units except the Clinical Research Center (CRC) which continues to operate on Masonic II today. This bed allocation decision facilitated a reduction in projected operating costs as well as a desirable centralization of Med/Surg patients in Unit J.

In response to an increasing demand for one day medical surgical procedures for both adults and children, Masonic I was renovated to accommodate the Masonic Day Hospital which opened in March, 1987. This left only the third floor on Masonic for renovation in the event that more medical surgical beds would be needed at some future date.

CURRENT NEEDS

Several variables changed between 1985 and 1988 causing the hospital to evaluate the usefulness of reactivating the remaining nursing unit in the Masonic building.

1. Since the move to Unit J, UMHC has experienced a consistent Med/Surg occupancy in the high 70 to mid 80% range. (See Attachments) Mid week occupancy for Med/Surg beds frequently ranges from 90-95%. The high average daily census for adult Med/Surg patients has led to significant patient placement problems. These problems have been compounded by the high

demand for single rooms, male/female bed conflicts, smoking and non-smoking preferences and the number of isolation cases causing double rooms to be converted to singles. The Same Day Surgery program, which accounts for approximately 45% of UMHC surgical admissions, increases the burden on the patient placement. Allocating beds in this manner has caused significant patient, family, physician and staff inconveniences as well as operating cost increases. Renovating and adding Medical/Surgical beds on Masonic III would ease significantly patient placement problems.

2. Though Masonic III will be renovated to house any segment of the medical surgical patient population, the patients who currently would be excellent candidates are now allocated beds on 7D. This patient population is largely immunosuppressed as a result of chemotherapy and requires single rooms. These patients are also often in the end stage of their illness which supports their need for privacy.

3. Additional conceptual planning for the renovation portion of the Renewal Project has been reinitiated and, at present, is substantially complete. A major clinical component of this renovation planning is the Department of Obstetrics. Originally (1979) planned in Unit J, the Obstetrics units were rezoned to Mayo as part of the 1982 cost saving measures. Current renovation planning will restore a portion of OB, (the post partum unit) into Unit J. Since all Unit J nursing units are currently allocated to capacity, this plan necessitates the relocation of 12-16 Med/Surg beds to a unit outside of Unit J. Renovating and reactivating the 26 bed unit in Masonic III would provide the additional bed flexibility required to accommodate the OB plan.

In summary, the increases in Adult Med/Surg census, increasing difficulties in patient placement and the revised master plan for Obstetrics (locating post partum beds in Unit J) have resulted in this proposal to renovate and reactivate the Masonic III nursing unit.

FUNCTIONAL PROGRAM NARRATIVE

DEPARTMENTAL DESCRIPTION

This 26 bed inpatient care unit will provide services for a variety of adult medical surgical patient populations. The average length of stay of these patients is approximately 8 days. A high percentage of the patient populations who will be assigned to Masonic III will be immunosuppressed due to various therapies and will generally be at some phase in a care continuum including diagnosis, active treatment or palliative care.

The medical staff will function in teams. Each team will consist of a staff physician, a fellow, two medical residents, two interns and one to two medical students. The team members are responsible for directing patient care, making patient rounds, and interactive teaching to other team members. Residents and interns provide twenty-four hour a day service to the unit.

The nursing staff provides care twenty four hours a day using a system of primary nursing. Shift report occurs three times each twenty-four hours and involves all professional team members. Nursing care on this unit consists of routine activities of daily living as well as providing nutritional support, administering complex oral and IV medications and blood products, pain management, and providing end stage care for patients. Patient and family teaching is a continual focus for staff nurses as is the provision of psychological and social support.

The nursing unit provides a clinical setting for students in most health team disciplines. It is an active setting for nursing students as well as for interns and resident physicians.

DEPARTMENTAL AFFINITIES

The unit requires major support from Pharmacy, Hospital Laboratories, Central Sterile Supply, Cardiorespiratory Services and Blood Bank. Other affinities include Admissions, Medical Records and Radiology.

DESIGN CRITERIA

The unit should provide a high number of private rooms to meet the protective isolation needs of the immunocompromised patients and privacy needs of end stage patients. There is a need for a unit based nourishment facility. This unit operated nourishment room will provide food supplements to patients 24 hours a day. Because of the complex medication protocols a well designed medication room is necessary. It is extremely

important to provide space for the medical teams to do teaching rounds and for nursing staff to conduct their care conferences, shifts reporting and new employee orientation. A family lounge is an important asset for the program of end stage care. A nutrition galley that will be equipped to provide food service equal to that service in the new hospital is essential.

Functions that can be separated from the unit are staff lockers, on-call space, and pharmacy services.

SPACE ALLOCATION

ROOM ELEMENT	PROPOSED NSF	COMMENTS
21 Private patient rooms with bathrooms @ 235	4,935	
1 Isolation room @ 195	180	
1 Isolation anteroom	50	
2 Double patient rooms with bathrooms @ 260	520	
Nursing station	290	
Medication room	120	
Nourishment room	80	
Exam room	120	
Tub room	100	
Report/Conference	200	
Food Service Galley	325	
Resident Team Rooms (2 @ 200 NSF ea)	400	
Soiled utility	180	
Clean utility	200	
Unit storage	200	
Janitor	35	
Consultation Room	100	
Family Lounge	150	
Head Nurse Office	80	
Assistant Head Nurse Office (2 @ 60 NSF)	120	
Staff lockers	150	May be located off unit
Staff bathroom	35	
Public bathroom	40	Handicap accessible
On-call room	120	May be located off unit
Pharmacy Services	400	Located off unit
	9,130	

ESTIMATED PROJECT COST

Cost estimates on this project have been provided by two firms based on design development drawings. The total project cost (based on an average of the two estimates) is 1,160,973. Detailed cost information is as follows:

	Ellerbe	CPMI
Demolition	92,972	26,570
General Construction	378,682	332,309
Mechanical Construction	121,652	81,840
Electrical Construction	142,735	99,994
Subtotal	$688,510	$540,713
General Conditions	138,032	81,107
Subtotal	$826,542	$621,820
Design Contingency	38,556	31,091
Pharmacy on Level B	33,200	33,200
Asbestos Removal	5,000	5,000
Duct Cleaning	15,000	In above
Elevator Upgrade	25,000	In above
MDS	31,360	In above
PTS	16,800	In above
Total Building Cost	$991,458	$691,111
Non Building Cost	$376,754	$262,622
	1,368,212	953,733

FUNDING SOURCES

Funding for this project will be provided from the following sources:

University Hospital Masonic Memorial Cancer Funds (Reserves)	$ 600,000
Non-Hospital Funds	$ 500,000
Total	$1,100,000

OPERATING COSTS

Several factors will impact the net effect this project will have on overall hospital operating costs. First, the operation of two nursing units (Masonic III and one-half of 7D) instead of one will increase staffing costs by 3-5 full time equivalents because of loss of economies of scale. In addition, the provision of ancillary and support services to a nursing unit in a separate building will increase costs but to a lesser degree.

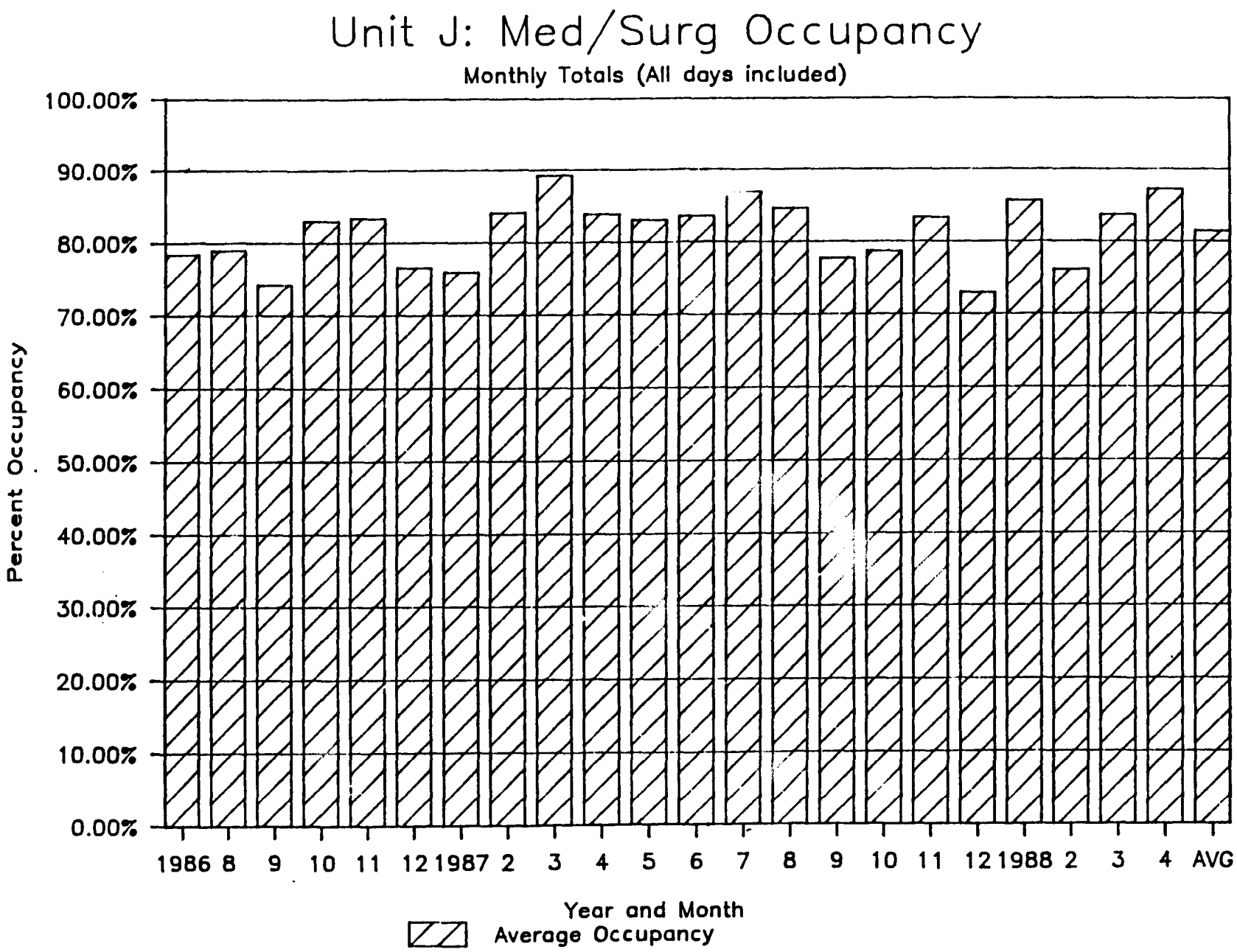
Less tangible but real operating cost savings facilitated by this project are: (1) increased flexibility in providing Adult Medical Surgical beds without multiple bed reassignment; (2) lower costs associated with fewer room preparations due to fewer multiple bed reassignments; and, (3) a potential for increased revenue from additional available Adult Med/Surg beds.

Patient benefits of this project are: (1) decreased time waiting for a room due to increased bed capacity; and, (2) an increase in total number of single rooms.

In summary the project will cause an increase in overall operating costs which will be off-set by increased bed capacity, greater patient convenience due to bed availability and the potential for increased volume.

SUMMARY AND CONCLUSIONS

The remodeling and reactivation of the Nursing Unit on Masonic III is consistent with the Hospital Master Facilities Plan and justified by current and projected adult med/surg census. The remodeling and patient move will provide greater flexibility in allocating adult med/surg beds as well as facilitate the implementation of the tentative OB renovation plan. It is therefore recommended that this project proceed at a total project cost not to exceed $1,100,000.


Unit J: Med/Surg Occupancy
Monthly Totals (All days included)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Percent Occupancy
1986 8 9 10 11 12 1987 2 3 4 5 6 7 8 9 10 11 12 1988 2 3 4 AVG
Year and Month
Average Occupancy

Medical Surgical B
From May 1986 to A

Unit	Bed Capacity	July	Aug	Sept	Oct	Nov	Dec	1987 Jan	Feb	Mar
5b	28	22.1	24.9	23.9	24.5	24.5	21.8	23.4	24.8	24.7
5c	28	26	24.6	21	25.2	25.9	25.4	27.3	26.8	27.4
5d	28	26.3	21.7	20.7	24.8	23.8	24	26.7	24.2	25.8
6b	28	16.8	19.1	20.3	20.9	21	18.5	15.2	21.6	22.5
6c	28	21.6	22.1	21.8	23.5	23.5	23.3	20.8	24.9	25.8
6d	28	24.2	21.8	23.1	24.3	23.9	22.1	20.5	24.9	26.2
7b	28	21.4	21.5	19.6	20.2	23.3	20.8	19.2	21	24.3
7c	28	18	19.2	18.5	21	19.8	15.9	17.2	19.4	23.2
7d	28	21.3	24.2	18.2	24.7	24.4	21.2	21.1	24.3	25
Total	252	197.7	199.1	187.1	209.1	210.1	193	191.4	211.9	224.9
Occupancy	100.00%	78.45%	79.01%	74.25%	82.98%	83.37%	76.59%	75.95%	84.09%	89.25%

Unit	Bed Capacity	April	May	June	July	August	Sept	Oct	Nov	Dec
5b	28	23.2	21.7	20.8	25.3	25.2	22.7	17.5	24.3	19.9
5c	28	27.1	24.5	24.5	24.4	23.7	22.9	23.9	23.3	19.2
5d	28	24.1	23.6	23.7	25.2	24.8	26.2	22.8	23.6	24.1
6b	28	21.3	24.6	26.2	24.7	24.3	20.4	21	23.5	18.6
6c	28	25.7	23.9	23.7	24.9	22.9	23.1	24.9	23.7	23
6d	28	24.2	23.4	22.7	22.8	24.8	23.8	22.7	23.7	20.3
7b	28	19.5	20.5	23.3	26	22.5	19.2	22	25	21.1
7c	28	21.1	22.7	22.1	22.5	20.9	17.2	19.6	19.3	17.3
7d	28	25.2	24.3	23.5	23.2	24.1	20.4	24	23.5	20.4
Total	252	211.4	209.2	210.5	219	213.2	195.9	198.4	209.9	183.9
Occupancy	100.00%	83.89%	83.02%	83.53%	86.90%	84.60%	77.74%	78.73%	83.29%	72.98%

Unit	Bed Capacity	1988 Janu	Feb	March	April	Average
5b	28	23.5	20	24.4	26.6	23.17
5c	28	25.2	26	24.3	24.3	24.68
5d	28	26.4	23.8	26.5	24.6	24.43
6b	28	22.4	23	22.3	27.3	21.61
6c	28	24.3	24.4	25.2	23	23.64
6d	28	24.1	19.1	23.1	23.2	23.13
7b	28	23	13	20.6	24.3	21.42
7c	28	23.1	19.2	21.2	23.6	20.09
7d	28	23.9	23.3	23.3	23	23.02
Total	252	215.9	191.8	210.9	219.9	205.19
Occupancy	100.00%	85.67%	76.11%	83.69%	87.26%	81.42%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 15, 1988

TO: Members, Board of Governors

FROM: Robert Dickler RD
General Director

SUBJECT: Surgical Pathology Project

Attached please find a description of the Surgical Pathology remodeling project. This project is brought to you this month for information.

Please note that this is the first major project within the broader Mayo remodeling program (Renewal Project II) to be brought to the Committee. Because the location for the department has never been disputed and is firmly fixed on the southeast corner of Mayo 4, the planning and approval process for Surgical Pathology is somewhat ahead of the rest of Mayo remodeling. At this point we are anticipating requesting Committee and Board approval for the Surgical Pathology project in July.

Appropriate staff members will be present at the June meeting to present the project and answer your questions. Thank you for your consideration of this proposal.

/kj

attachments

Surgical Pathology

Project Proposal

This document outlines a proposal for relocation and renovation of space for the Division of Surgical Pathology. The document is organized into two sections: history, background, and need; and facility plan.

History, Background and Need

The Division of Surgical Pathology is part of the Department of Laboratory Medicine and Pathology, and within the Hospital's organizational structure, part of the Hospital Laboratories Department. The Division has an outstanding national reputation for its clinical, education, and research programs.

Surgical Pathology is an integral part of many clinical programs at University Hospital. This is particularly true for a number of the surgical specialty and sub-specialty programs, and the Operating Rooms. For this reason Surgical Pathology was originally planned for location within Unit J. When Unit J was downsized for financial reasons, Surgical Pathology was one of the functions rezoned to the Mayo Building. Mayo renovation planning located Surgical Pathology on the southeast corner of the fourth floor of Mayo, providing the closest possible adjacency and accessibility to the Unit J Operating Rooms.

Surgical Pathology's activity levels over the past five years have been as follows:

Year	Cases
1987-88	159,845
1986-87	160,952
1985-86	148,627
1984-85	135,098
1983-84	137,650

Surgical Pathology currently provides the above volumes of services from several locations. The disjointed facility arrangement has made it difficult for the Division to provide services in an optimal manner. This has been particularly true since the opening of Unit J.

Unit J does have a small satellite Surgical Pathology area whose purpose is exclusively intra-operative frozen section work. Given the limited function of this satellite, the final tissue review function and consultation with the clinical staff has been made substantially more difficult since the Operating Rooms relocated to Unit J, which created greater distance between the OR, the

clinical ser es, and Surgical Pathology. It is this distance consideration, and the resu ng effects on ability to provide service, which leads to the recommendati to relocate and consolidate the service on the fourth floor of Mayo.

As noted earlier, the plan for several years has been to locate Surgical Pathology adjacent to the Mayo 4 link to Unit J. The location is vital, and there has been no dispute among the other programs in Mayo as to the appropriateness of this location for Surgical Pathology. Given that all iterations of Mayo planning have located Surgical Pathology on Mayo 4, it is recommended that Surgical Pathology be the first project within the broader Mayo remodeling program to move forward.

In addition to location and service delivery problems, Surgical Pathology is undersized in its current locations. Laboratory, support, and office areas all require additional space. No significant additions to the space available for Surgical Pathology have been made since the 1950s. The current net square footage utilized by Surgical Pathology is 2800; the recommended program for Surgical Pathology has approximately 4800 net square feet allocated.

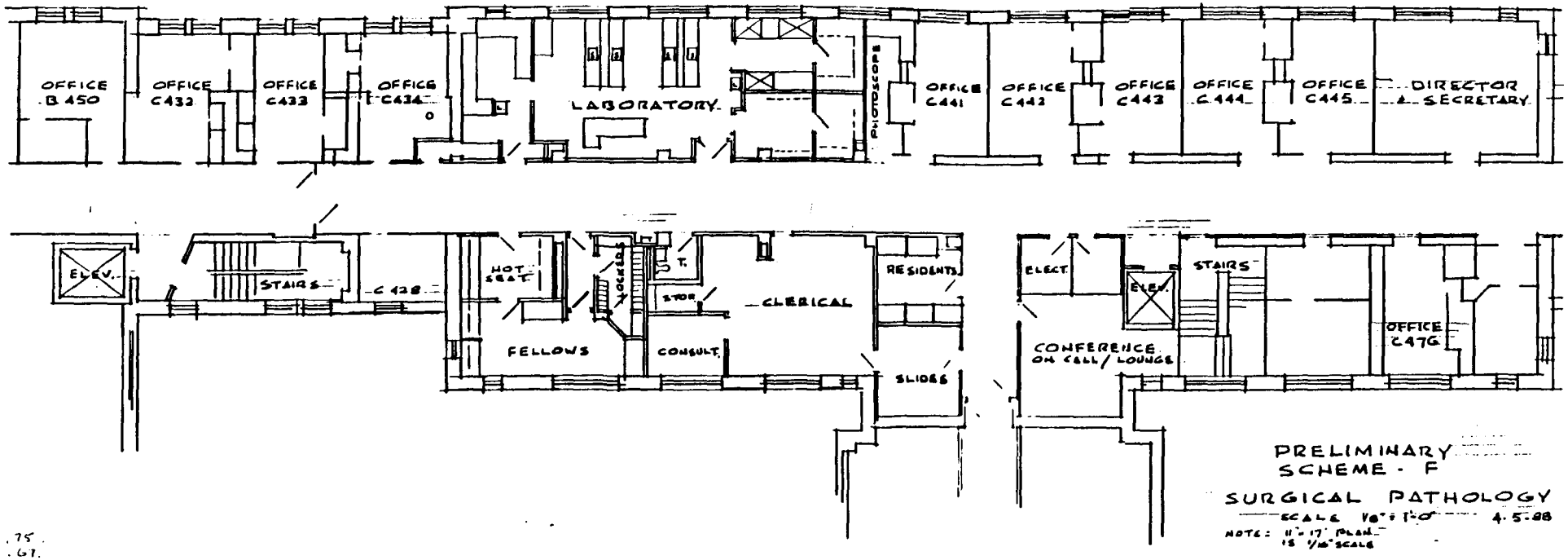
Facility Plan

A proposed facility plan for Surgical Pathology is attached. The three primary components of the program include the laboratory area; support space for clerical staff, storage, lockers, residents, etc.; and faculty offices. The consolidation of these functions will allow for improved operation of the Division.

The estimated cost for this project is $1,029,350. The project was at one point designed with an estimate several hundred thousand dollars higher than the current estimate. The degree of remodeling in the office areas has been decreased substantially from that originally proposed, resulting in the decrease from the original estimate. Whereas the laboratory and support area remodeling will involve substantial demolition, the vast majority of the office areas will be utilized without removal of walls. Some degree of interior upgrade to the rooms to be used for offices is necessary, given that they were formerly patient rooms. The Department of Laboratory Medicine and Pathology will be providing funding for the furnishing (carpet, drapes, etc.) for the office areas.

Part of the project cost involves new air conditioning and ventilation for most of the remodeled area. This is consistent with the overall plan to upgrade utilities in the Mayo complex, required by code. A few of the offices will continue to require window air conditioning, however, as they are located in a section of the building which operates off of a different set of building systems. This problem will be corrected at the time of the remodeling of the east part of the Mayo complex, presumably primarily for Obstetrics.

A detailed cost estimate is attached as Appendix II. It is recommended that the financing for the project come from Hospital reserves consistent with the overall capital financial plan.



PRELIMINARY
SCHEME - F

SURGICAL PATHOLOGY

SCALE 1/8" = 1'-0" 4.5.88

NOTE: 11" x 17" PLAN
15 1/16" SCALE

.75
.61

5

Appendix II

Surgical Pathology Project Estimate

Construction	$309,150
Mechanical	187,000
Electrical	82,000
Asbestos	15,000
Contingency	66,000
Non-Building	79,200
Design	100,000
Office Remodel	191,000
	$1,029,350

MINUTES
Joint Conference Committee
Board of Governors
June 15, 1988

CALL TO ORDER:

In the absence of Chairman Heenan, Phyllis Ellis called the June 15, 1988 meeting of the Joint Conference Committee to order at 5:20 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Sally Booth
Phyllis Ellis
Patricia Ferrieri, M.D.
James Moller, M.D.
Bruce Work, M.D.

Absent:
Robert Dickler
George Heenan
Michael Popkin, M.D.

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

APPROVAL OF MINUTES:

The minutes of the May 11, 1988 meeting were approved as submitted.

Medical Staff - Hospital Council Report

Dr. James Moller presented the recommendations of the Credentials Committee of the Medical Staff-Hospital Council.

Dr. Moller first presented the annual recommendations for reappointment to the Medical and Dental Staff. He noted that the physicians in some departments have an insurance policy with a deductible and that this type of coverage is probably going to become more common in the future. He then presented recommendations for Delay of Reappointment, Termination of Medical/Dental Staff Appointments because of lack of application or evidence of professional liability coverage or Regents endorsement, Resignation of Faculty Appointments, Regular Medical/Dental Staff Appointments, Provisional Medical/Dental Staff Appointments, Addition and/or Deletion of Clinical Privileges, Change in Staff Category, Resignations from the Medical/Dental Staff, Medical/Dental Staff - Deceased, Reappointments Specified Professional Personnel-Psychology Staff, and Terminations of Specified Professional Personnel-Psychology Staff Appointments.

A motion was made to endorse the recommendations, was seconded and passed unanimously.

Dr. Moller presented the recommendations for appointments of the Chairmen of the Medical Staff-Hospital Council Committees. A motion was made to endorse the Recommendations, was seconded and passed with one negative vote registered.

CLINICAL CHIEFS REAPPOINTMENT

Dr. Moller presented the recommendation for the annual reappointments of Chiefs of Clinical Serivces. A motion was made to endorse the recommendations, was seconded and approved by a unanimous vote.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work reviewed the topics of discussion at recent Chiefs' meetings which included the RFP for Perinatal services at Health East, Resident and Fellow issues of benefits, specialty reviews, allocation and reimbursement, difficulties with the affiliation agreement with SPRMC, and concerns with Unrelated Business Income Tax (UBIT). He also noted that the Chiefs endorsed the expanded venipuncture service that will be put in place at the hospital.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 5:55 P.M.

Respectfully submitted:

Theodore J. Yank
Administrative Fellow

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 17, 1988

TO: Members of the Board of Governors

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

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

The Medical Staff-Hospital Council on June 14 and the Joint Conference Committee on June 15 have endorsed the attached Credentials Committee Report and Recommendations.

I am forwarding this report to you for your review and approval on June 22. If you should have any questions, please feel free to call on me.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 8, 1988

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee having considered the reappointment of medical staff in Unit II eligible for reappointment for 1988 through 1990, hereby recommend all those included in the Credentials Committee report (pages 63-77) for reappointment to the medical staff.

Also included are the Credentials Committee's recommendations for delay of reappointments (page 78); termination of medical staff appointments (page 79); loss of medical staff appointment (page 80); regular medical staff appointments (page 81); provisional medical staff appointments (page 82); addition and/or deletion of clinical privileges (page 83); change in staff category (page 84); resignations from the medical staff (page 85); deceased (page 86).

The Credentials Committee has also considered the reappointment of Specified Professional Personnel-Psychology Staff eligible for reappointment for 1988 through 1990 and hereby recommend all those included in the report (pages 87-88); termination of specified professional personnel-psychology staff (page 89); loss of specified professional personnel-psychology staff appointment (page 89); and, resignations of specified professional personnel-psychology staff (page 89).

HB/cf
Attachment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
LABORATORY MEDICINE AND PATHOLOGY		
ARTHUR, MD, DIANE C.	Attending Staff	Pediatrics
BACH, MD, FRITZ	Attending Staff	
BALFOUR, MD, HENRY	Attending Staff	Pediatrics
BENSON, MD, ELLIS	Attending Staff	
BOWMAN, MD, ROBERT J.	Clinical Staff	
BRADLEY, MD, G. MARY	Attending Staff	
BROOKER, MD, DORIS C.	Attending Staff	Obstetrics and Gynecology
BROWN, MD, DAVID M.	Attending Staff	Pediatrics
BRUNNING, MD, RICHARD	Attending Staff	
BURKE, MD, BARBARA	Attending Staff	
CHOPEK, MD, MICHAEL W.	Attending Staff	
CONNELLY, MD, DONALD P.	Attending Staff	
DALMASSO, MD, AGUSTIN P.	Clinical Staff	
DEHNER, MD, LOUIS P.	Attending Staff	
ECKFELDT, MD, JOHN H.	Attending Staff	
EDSON, MD, J. ROGER	Attending Staff	
ESTENSEN, MD, RICHARD D.	Attending Staff	
FERRIERI, MD, PATRICIA	Attending Staff	Pediatrics
FURCHT, MD, LEO.	Attending Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
LABORATORY MEDICINE AND PATHOLOGY		
GAJL-PECZALSKA, MD, K.	Attending Staff	
GARRY, MD, VINCENT F.	Attending Staff	
HASEGAWA, MD, DUANE	Attending Staff	Pediatrics
KERSEY, MD, JOHN	Attending Staff	Pediatrics
LASKY, MD, LARRY C.	Attending Staff	
MASTRI, MD, ANGELINE R.	Attending Staff	
MCCULLOUGH, MD, JOHN J.	Attending Staff	
O'LEARY, MD, JAMES J.	Attending Staff	
OKAGAKI, MD, TAKASHI	Attending Staff	Obstetrics and Gynecology
PERRONE, MD, THERESA L.	Attending Staff	
SNOVER, MD, DALE C.	Attending Staff	
STEFFES, MD, MICHAEL W.	Attending Staff	
SUNG, MD, JOO HO	Attending Staff	Neurology
VINE, MD, WILLIAM H.	Attending Staff	
WATTENBERG, MD, LEE W.	Attending Staff	
WHITE, MD, JAMES G.	Attending Staff	Pediatrics
WICK, MD, MARK R.	Attending Staff	
YUNIS, MD, JORGE J.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
ORTHOPEDICS		
ARENDT, MD, ELIZABETH	Attending Staff	
BRADFORD, MD, DAVID	Attending Staff	
CRAIG, MD, EDWARD V.	Attending Staff	
HOUSE, MD, JAMES H.	Attending Staff	
HUNTER, MD, ROBERT E.	Attending Staff	
OGILVIE, MD, JAMES W.	Attending Staff	
PRIEST, MD, JAMES D.	Clinical Staff	
ROBINSON, MD, HARRY J.	Attending Staff	
THOMPSON, MD, ROBY C.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
OTOLARYNGOLOGY		
ADAMS, MD, GEORGE	Attending Staff	
BOIES, MD, LAWRENCE R.	Clinical Staff	
COHEN, MD, JAMES I.	Clinical Staff	
DUVALL, MD, ARNDT J.	Attending Staff	
HILGER, MD, PETER A.	Attending Staff	
HUFF, MD, JOHN S.	Clinical Staff	
KOOP, MD, SEVERIN H.	Clinical Staff	
LEVINE, MD, SAMUEL C.	Attending Staff	
LISTON, MD, STEPHEN L.	Attending Staff	
MAISEL, MD, ROBERT	Attending Staff	
MARENTETTE, MD, LAWRENCE	Clinical Staff	
SIEGEL, MD, LEIGHTON G.	Clinical Staff	
SIGEL, MD, MELVIN E.	Clinical Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
ANDERSON, MD, ARNOLD S.	Emeritus Staff	
AREY, MD, STUART L.	Emeritus Staff	
BASS, MD, JOHN	Attending Staff	
BECKER, MD, LOWELL	Clinical Staff	
BERRY, MD, SUSAN A	Attending Staff	
BESSINGER, MD, F BLANTON	Clinical Staff	
BLAZAR, MD, BRUCE R.	Attending Staff	
BLUM, MD, ROBERT WM.	Attending Staff	
BOSTROM, MD, BRUCE C.	Attending Staff	
BRAUNLIN, MD, ELIZABETH A.	Attending Staff	
CHAVERS, MD, BLANCHE M.	Attending Staff	
CHUN, MD, KARL H.	Attending Staff	
CICH, MD, JOHN A.	Clinical Staff	
CLAWSON, MD, C. CARLYLE	Attending Staff	
DEINARD, MD, AMOS	Attending Staff	
EINZIG, MD, STANLEY	Attending Staff	
ELLIOTT, MD, GREGORY R.	Attending Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
ETZWILER, MD, DONNELL D.	Clinical Staff	
FILIPOVICH, MD, ALEXANDRA	Attending Staff	
FISCH, MD, ROBERT O.	Attending Staff	
FISH, MD, ALFRED J.	Attending Staff	
FISH, MD, LLOYD	Clinical Staff	
FREESE, MD, DEBORAH K.	Attending Staff	
GEORGIEFF, MD, MICHAEL K.	Attending Staff	
GIEBINK, MD, G. SCOTT	Attending Staff	
GREEN, MD, THOMAS P.	Attending Staff	
HORROBIN, MD, J. MARGARET	Clinical Staff	
HOSTETTER, MD, MARGARET K.	Attending Staff	
JOHNSON, MD, DANA	Attending Staff	
KAPLAN, MD, EDWARD L.	Attending Staff	
KIM, MD, YOUNGKI	Attending Staff	
KLEIN, MD, DAVID J.	Attending Staff	
KOSINA, MD, HELENA B.	Clinical Staff	
KRIVIT, MD, WILLIAM	Attending Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
LUCAS, MD, RUSSELL V.	Attending Staff	
MAUER, MD, S. MICHAEL	Attending Staff	
MICHAEL, MD, ALFRED F.	Attending Staff	
MIRKIN, MD, BERNARD L.	Attending Staff	
MOLLER, MD, JAMES H.	Attending Staff	
NESBIT, MD, MARK E.	Attending Staff	
NEVINS, MD, THOMAS	Attending Staff	
O'DEA, MD, ROBERT	Attending Staff	
PESCOVITZ, MD, ORA H.	Attending Staff	
PIERPONT, MD, MARY ELLA	Attending Staff	
PLATT, MD, JEFFREY L.	Attending Staff	
PRIEST, MD, JOHN R.	Clinical Staff	
QUIE, MD, PAUL G.	Attending Staff	
RAMSAY, MD, NORMA KC	Attending Staff	
REGELMANN, MD, WARREN E.	Attending Staff	
REMAFEDI, MD, GARY J.	Attending Staff	
SATRAN, MD, LEON	Attending Staff	
SCHWARZENBERG, MD, SARAH	Attending Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
SEELIG, MD, STEVEN A.	Attending Staff	
SHARP, MD, HARVEY L.	Attending Staff	
SINAIKO, MD, ALAN R.	Attending Staff	
SINGHER, MD, LAWRENCE J.	Clinical Staff	
SMITH, MD, CLARK M.	Attending Staff	
SMITH, MD, THEODORE S.	Emeritus Staff	
SOCKALOSKY, MD, JOSEPH J.	Clinical Staff	
STEINHORN, MD, DAVID	Attending Staff	
STONE, MD, FREDERIC M.	Clinical Staff	
TEN BENSEL, MD, ROBERT W.	Attending Staff	
THOMPSON, MD, THEODORE R	Attending Staff	
TUCHMAN, MD, MENDAL	Attending Staff	
ULSTROM, MD, ROBERT A.	Attending Staff	
VACCARELLA, MD, R. JAMES	Clinical Staff	
VERNIER, MD, ROBERT L.	Attending Staff	
WARWICK, MD, WARREN J.	Attending Staff	
WEISDORF, MD, SALLY A.	Attending Staff	
WHITELY, MD, CHESTER B.	Attending Staff	
WOODS, MD, WILLIAM	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PHYSICAL MEDICINE AND REHABILITATION		
AWAD, MD, ESSAM A.	Attending Staff	
BATEMAN, DO, RONALD M.	Clinical Staff	
BENNINGHOFF, MD, KAREN S.	Attending Staff	
BENSMAN, MD, ALAN S.	Clinical Staff	
BISTEVINS, MD, RITA	Clinical Staff	
DYKSTRA, MD, DENNIS D.	Attending Staff	
GULLICKSON, MD, GLENN	Emeritus Staff	
KNAPP, MD, MILAND	Clinical Staff	
KOTTKE, MD, FREDERIC	Emeritus Staff	
MORET, MD, MARK A.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PSYCHIATRY		
BERNSTEIN, MD, GAIL A.	Attending Staff	
CLAYTON, MD, PAULA J.	Attending Staff	
COLON, MD, EDUARDO A.	Attending Staff	
ECKERT, MD, ELKE	Attending Staff	
GARFINKEL, MD, BARRY D.	Attending Staff	
GREENBERG, MD, LAWRENCE	Attending Staff	
HALIKAS, MD, JAMES A.	Attending Staff	
HESTON, MD, LEONARD	Attending Staff	
JENSEN, MD, JONATHAN B.	Attending Staff	
KROLL, MD, JEROME L.	Attending Staff	
LAWTON, MD, JAMES J.	Clinical Staff	
LENTZ, MD, RICHARD	Clinical Staff	
MACKENZIE, MD, THOMAS B.	Attending Staff	Medicine
MEISCH, MD, RICHARD	Attending Staff	
MITCHELL, MD, JAMES E.	Attending Staff	
POPKIN, MD, MICHAEL K.	Attending Staff	
PYLE, MD, RICHARD L.	Attending Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PSYCHIATRY		
REALMUTO, MD, GEORGE M.	Attending Staff	
RITTBERG, MD, BARRY R.	Attending Staff	
WESTERMEYER, MD, JOSEPH J.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOITMENT
RADIOLOGY		
AMPLATZ, MD, KURT	Attending Staff	
BOUDREAU, MD, ROBERT J.	Attending Staff	
CASTANEDA, MD, WILFRIDO R.	Attending Staff	
DAY, MD, DEBORAH L.	Attending Staff	
DRAKE, MD, DAVID G.	Attending Staff	
DU CRET, MD, RENE P.	Attending Staff	
FEINBERG, MD, SAMUEL B.	Attending Staff	
GOLDBERG, MD, MARVIN E.	Attending Staff	
HUNTER, MD, DAVID W.	Attending Staff	
KUNI, MD, CHRISTOPHER C.	Attending Staff	
LETOURNEAU, MD, JANIS G.	Attending Staff	
LOKEN, MD, MERLE	Attending Staff	
MCGEACHIE, MD, ROBERT E.	Attending Staff	
THOMPSON, MD, WILLIAM M.	Attending Staff	
WILCOX, MD, WILLIAM A.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
SURGERY		
AHRENHOLZ, MD, DAVID H.	Clinical Staff	
BUCHWALD, MD, HENRY	Attending Staff	
BULS, MD, JOHN G.	Clinical Staff	
CERRA, MD, FRANK B.	Attending Staff	
CUNNINGHAM, MD. BRUCE L.	Clinical Staff	
DELANEY, MD, JOHN P.	Attending Staff	
DRESSEL, MD, THOMAS D.	Clinical Staff	
DUNN, MD, DAVID L.	Attending Staff	
FOKER, MD, JOHN E.	Attending Staff	
GOLDBERG, MD, STANLEY	Clinical Staff	
GOODALE, MD, ROBERT L.	Attending Staff	
GRAGE, MD, THEODOR B.	Attending Staff	
HELSETH, MD, HOVALD	Clinical Staff	
JAMIESON, MD, STUART M.	Attending Staff	
KNIGHTON, MD, DAVID R	Attending Staff	
LEONARD, MD, ARNOLD S.	Attending Staff	
MCPARLAND, MD, FELIX A.	Clinical Staff	

Continued on next page.....

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
SURGERY		
MOLINA, MD, J. ERNESTO	Attending Staff	
NAJARIAN, MD, JOHN S.	Attending Staff	
PAYNE, MD, WILLIAM D.	Clinical Staff	
ROTHENBERGER, MD, DAVID	Clinical Staff	
SHEAREN, MD, JOHN G.	Clinical Staff	
SUTHERLAND, MD, DAVID E.R.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
THERAPEUTIC RADIOLOGY		
KIM, MD, TAEHWAN	Attending Staff	
LEE, MD, CHUNG KYU KIM	Attending Staff	
LEVITT, MD, SEYMOUR	Attending Staff	
MONYAK, MD, DAVID J.	Attending Staff	
POTISH, MD, ROGER A.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Delay of Reappointment

SABBITICAL LEAVE OF ABSENCE

DEPARTMENT	CATEGORY
LABORATORY MEDICINE AND PATHOLOGY	
FRIZZERRA, MD, GLAUCO	Attending Staff

MEDICAL LEAVE OF ABSENCE

SURGERY	
GILBERTSEN, MD, VICTOR A.	Attending Staff-without clinical privileges

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Termination
of Medical/Dental Staff Appointments

NO REAPPRAISAL REAPPOINTMENT APPLICATION SUBMITTED

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
LABORATORY MEDICINE AND PATHOLOGY		
FRANTZ, MD, IVAN D.	Emeritus Staff-with clinical privileges	Medicine

NO REAPPRAISAL REAPPOINTMENT APPLICATION OR EVIDENCE OF PROFESSIONAL LIABILITY COVERAGE SUBMITTED

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
BLOOM, MD, DAVID	Clinical Staff	Medicine
BROWN, MD, DAVID R.	Clinical Staff	
TATE, MD, DOUGLAS Y.	Clinical Staff	

NO EVIDENCE OF PROFESSIONAL LIABILITY COVERAGE SUBMITTED

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
PEDIATRICS		
MATUS, MD, RICHARD	Clinical Staff	

NO EVIDENCE OF REGENTS ENDORSEMENT

PEDIATRICS	
FERRARA, MD, T. BRUCE	Clinical Staff
LEONARD, MD, STANLEY	Clinical Staff
RING, MD, JOHN C.	Clinical Staff
SINGH, MD, AMARJIT	Clinical Staff

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Loss of Medical Staff Appointments

Resignation of Faculty Appointment

DEPARTMENT	CATEGORY
OBSTETRICS AND GYNECOLOGY	
STAISCH, MD, KLAUS, J.	Clinical Staff
OTOLARYNGOLOGY	
BERLINGER, MD, NORMAN T.	Attending Staff

Retired - Faculty Appointment Terminated

PSYCHIATRY	
HAUSMAN, MD, WILLIAM	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Regular Medical/Dental Appointments

DEPARTMENT	CATEGORY	DATE ELIGIBLE
DENTISTRY		
HERZBERG, DDS, MARK C.	Attending Staff	April 28, 1988
FAMILY PRACTICE AND COMMUNITY HEALTH		
FONTAINE, MD, PATRICIA C.	Attending Staff	April 28, 1988
MEDICINE		
RAUSCH, MD, DOUGLAS J.	Attending Staff	December 24, 1987
OPHTHALMOLOGY		
HOLLAND, MD, EDWARD J.	Attending Staff	April 28, 1988
ORTHOPEDICS		
BOACHIE-ADJEI, MD, OHENEBA	Attending Staff	April 28, 1988
TRANSFELDT, MD, ENSOR E.	Attending Staff	April 28, 1988
PEDIATRICS		
KRABILL, MD, KIMBERLY A.	Attending Staff	April 28, 1988
MILLER, MD, LAURIE C.	Attending Staff	April 28, 1988
NEGLIA, MD, JOSEPH P.	Attending Staff	April 28, 1988
RADIOLOGY		
BEVILLE, MD, LEE	Attending Staff	April 28, 1988
TASHJIAN, MD, JOSEPH H.	Attending Staff	April 28, 1988
UROLOGY		
McELLISTREM, MD, GERALD	Clinical Staff	April 28, 1988

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Provisional Medical/Dental Staff Appointments

DEPARTMENT	CATEGORY
MEDICINE	
GLICKSTEIN, MD, SCOTT	Clinical Staff
MULVAHILL, MD, AMY S.	Attending Staff
OBSTETRICS AND GYNECOLOGY	
CRUIKSHANK, MD, STEPHEN H.	Clinical Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Addition and/or Deletion of Clinical Privileges

DEPARTMENT	CATEGORY
OTOLARYNGOLOGY	
ADAMS, MD, GEORGE L.	Attending Staff
Add: YAG laser for bronchial and laryngeal endoscopic surgery	
DUVALL, MD, ARNDT J.	Attending
Add: YAG laser for bronchial and laryngeal endoscopic surgery	
PHYSICAL MEDICINE AND REHABILITATION	
GULLICKSON, MD, GLENN	Emeritus Staff
Delete: All clinical privileges	
SURGERY	
BUCHWALD, MD, HENRY	Attending Staff
Add: Gastro-intestinal surgery - esophagostomy Implantation of a continuous flow pump or infusion port or chronic access catheter.	
MEDICINE	
GILBERSTADT, MD, MARK	Attending Staff
Add: Arterial puncture, arthrocentesis, bone marrow aspiration, cardiac monitoring, cardiac pacemaker (transvenous), electrocardiographic interpretation, gastric lavage (with NG or Ewald tube), lumbar puncture, needle biopsy of bone marrow, paracentesis (spirometry with interpretation), sigmoidoscopy (without biopsy), thoracentesis (aspiration only).	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Change in Staff Category

DEPARTMENT	PRESENT CATEGORY	RECOMMENDED CATEGORY
PHYSICAL MEDICINE AND REHABILITATION		
KNAPP, MD, MILAND	Clinical Staff	Emeritus Staff-without clinical privileges
RADIOLOGY		
LOKEN, MD, MERLE	Attending Staff	Emeritus Staff-without clinical privileges
SURGERY		
PAYNE, MD, WILLIAM	Clinical Staff	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Resignations from the Medical/Dental Staff

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
FAMILY PRACTICE AND COMMUNITY HEALTH		
COLE, MD, PATRICIA	Clinical Staff	
LABORATORY MEDICINE AND PATHOLOGY		
MICHELS, MD, SHERYL D.	Attending Staff	
MEDICINE		
CHRISTIANSEN, MD, NEAL	Attending Staff	
GUIDOT, MD, DAVID	Attending Staff	
STANDIFORD, MD, CONNIE	Attending Staff	
WHITMER, MD, DOROTHY I.	Attending Staff	
ORTHOPEDICS		
BEHRENS, MD, ALFRED F.	Clinical Staff	
OTOLARYNGOLOGY		
POLLAK, MD, KURT	Attending Staff	
PSYCHIATRY		
CLINE, MD, DAVID W.	Clinical Staff	
HICKS, MD, FREDERICK G.	Attending Staff	
PEARSON, MD, JOANNE	Clinical Staff	
SONIS, MD, WILLIAM A.	Attending Staff	
STAPLETON, MD, THOMAS R.	Clinical Staff	
SURGERY		
SULLIVAN, MD, W. ALBERT	Attending Staff	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Medical/Dental Staff - Deceased

DEPARTMENT	CATEGORY
MEDICINE	
SPINK, MD, WESLEY	Emeritus Staff
ORTHOPEDICS	
MOE, MD, JOHN H.	Emeritus Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
Specified Professional Personnel-Psychology Staff

July 1, 1988 - June 30, 1990

DEPARTMENT	CATEGORY
HOSPITAL DENTISTRY	
HATHAWAY, PH.D, KATE	Attending Staff
FAMILY PRACTICE AND COMMUNITY HEALTH	
COLEMAN, PH.D, EDMOND	Attending Staff
DWYER, MA, MARGRETTA	Attending Staff
HOUGE, PH.D, DONALD	Attending Staff
IRETON, PH.D, HAROLD	Attending Staff
METZ, PH.D, MICHAEL	Attending Staff
NEUROLOGY	
SHAPRIO, PH.D, ELSA	Attending Staff
NEUROSURGERY	
BENIAK, PH.D, THOMAS	Attending Staff
HUNG, PH.D, JOHN	Attending Staff
MEIER, PH.D, MANFRED	Attending Staff
ROBINER, PH.D, WILLIAM	Attending Staff
PEDIATRICS	
CHANG, PH.D, PI-NIAN	Attending Staff
PHYSICAL MEDICINE AND REHABILITATION	
MEADOWS, M.ED, GARLAND	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Specified Professional Personnel-Psychology Staff
Recommendations for Reappointment Continued

DEPARTMENT	CATEGORY
PSYCHIATRY	
AUGUST, PH.D, GERALD	Attending Staff
ERBAUCH, PH.D, SUSAN	Clinical Staff
GROVE, PH.D, WILLIAM	Attending Staff
HATSUKAMI, PH.D, DOROTHY	Attending Staff
SCHOFIELD, PH.D, WILLIAM	Attending Staff
SINES, PH.D, LLOYD	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Termination of Specified Professional Personnel-Psychology Staff Appointments

Unable to Obtain Regents Endorsement

DEPARTMENT	CATEGORY
PHYSICAL MEDICINE AND REHABILITATION	
ATHELSTAN, PH.D, GARY	Attending Staff
PUBLIC HEALTH	
WILLIAMS, PH.D, CAROLYN	Attending Staff

No Faculty Appointment/Loss of Specified Professional Personnel-Psychology Staff Appointment

DEPARTMENT	CATEGORY
PUBLIC HEALTH	
PETZEL, PH.D, SUE	Attending Staff

Resignations from the Specified Professional Personnel-Psychology Staff

DEPARTMENT	CATEGORY
PSYCHIATRY	
PICKENS, PH.D, ROY	Attending Staff
YELLIN, PH.D, ABSALOM	Attending Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 17, 1988

TO: Board of Governors

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

SUBJECT: Appointment of Medical Staff-Hospital Council Committee Chairmen

The Medical Staff-Hospital Council has endorsed the attached list of committee chairmen appointments for 1988/1989 on June 14, and the Joint Conference Committee on June 15, and are forwarding these recommendations to you for your approval on June 22.

The Bylaws of the Medical and Dental Staff, Article VI, Part A, Section 1, (s), sets forth the requirement that the appointment of all Medical Staff-Hospital Council committee chairmen be made by the Board of Governors after receiving recommendations from the Medical Staff-Hospital Council.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA HOSPITALS & CLINICS

MEDICAL STAFF-HOSPITAL COUNCIL COMMITTEE CHAIRMEN APPOINTMENTS

1988/1989

1. **Bed Allocation Committee.**

   Seymour Levitt, M.D.

2. **Bylaws Committee**

   Robert Ulstrom, M.D.

3. **Biomedical Ethics Committee**

   Theodore Thompson, M.D.
   Susan Pappas-Varco RN, Co-Chair

4. **Cardiorespiratory Advisory Committee**

   Russell H. Larsen, M.D.

5. **Cardiovascular Advisory Committee**

   Michael W. Steffes, M.D.

6. **Credentials Committee**

   Henry Buchwald, M.D.

7. **Disaster Committee**

   Charles Andres, M.D.

8. **Emergency Department Committee**

   Randall Moore, M.D.

9. **Infection Control Committee**

   Frank Rhame, M.D.

10. **Operating Room Committee**

    Roby Thompson, M.D.

11. **Outpatient Committee**

    Amos Deinard, M.D.

12. **Pharmacy & Therapeutics Committee**

    Russell Lucas, M.D.

13. **Product Evaluation & Standardization Committee**

    Jon F. Berlauk, M.D.

14. **Quality Assurance Steering Committee**

    James H. Moller, M.D.

15. **Tissue & Procedure Review Committee**

    Robert Maxwell, M.D.

16. **Transfusion Therapeutics Committee**

    Jeffrey McCullough, M.D.

17. **Medical Record and Patient Care Information Committee**

    Marvin Goldberg, M.D.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 15, 1988

TO: Members of the Board of Governors

FROM: Robert Dickler, General Director
James Moller, M.D., Chief of Staff

SUBJECT: Annual Reappointments of Chief of Clinical Services

The Bylaws of the Board of Governors of The University of Minnesota Hospital and Clinic were amended in November, 1982, requiring the following:

Article V. Section 5 (B)

> After consultation with the Joint Conference Committee, at its June meeting each year, the Board of Governors shall appoint the chief of each clinical services of the Medical Staff to serve at the discretion of the Board for an initial term of three years, except in the case of a chief of a clinical service who is an individual other than the Head of the corresponding medical or dental school clinical department, in which case the initial appointment shall be for one year. Reappointment thereafter by the Board of Governors shall be yearly. Vacancies in the office of the chief of a clinical services may be filled at any time by the Board. In the event that a chief of a clinical service is appointed at some time other than the June meeting, and if the appointment is made no longer than December, for purposes of determining the time of reappointment the appointment shall be deemed to have commenced the preceding June. In the event that the appointment is made after December, for purposes of determining the time of reppointment the computation of time shall be deemed to commence at the next succeeding June.

The Hospital Director, in consultation with the Chief of Staff, hereby recommends the reappointment of the following Clinical Chiefs for 1988-89:

NAME	DEPARTMENT
Dr. Ellis Benson	Laboratory Medicine & Pathology
Dr. Joseph Buckley	Anesthesiology
Dr. Shelley Chou	Neurosurgery
Dr. Edward Ciriacy	Family Practice
Dr. Paula Clayton	Psychiatry
Dr. Donald Doughman	Ophthalmology
Dr. Thomas Ferris	Medicine
Dr. Elwin Fraley	Urololgy
Dr. Essam Awad	Physical Medicine & Rehab.
Dr. Arthur Klassen	Neurology
Dr. Seymour Levitt	Therapeutic Radiology
Dr. John Najarian	Surgery
Dr. Arndt Duvall	Otolaryngology
Dr. Roby Thompson	Orthopaedic Surgery
Dr. Mark Jaspers	Dentistry

Dr. William Thompson (Radiology), Dr. Peter Lynch (Dermatology), Dr. Bruce Work (OB/Gyn.) and Dr. Alfred Michael (Pediatrics) were initially appointed in July, 1986 and are in their three year initial appointment period. Reappointment is thus not required this year.

These appoinntments were endorsed by the Joint Conference Committee on June 15, 1988 and are being presented for approval by the Board of Governors on June 22, 1988.

RD/JM/kff

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
Board of Governors Finance Committe
May 25, 1988

MINUTES

CALL TO ORDER:

On May 25, 1988 the Finance Committee was called to order by Mr. Robert Nickoloff at 12:30 P.M. in the Board Room.

ATTENDANCE:

Present:	Robert Dickler
	Cliff Fearing
	Elwin Fraley, M.D.
	Robert Nickoloff
	Barbara O'Grady
	Roger Paschke
	Vic Vikmanis
Not Present:	Edward Ciriacy, M.D.
	Jerry Meilahn
Staff:	Al Dees
	Kay Fuecker
	Greg Hart
	Nancy Janda
	Nels Larson
	Dan Rode

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the April 27, 1988 meeting as written.

YEAR-TO-DATE FINANCIAL STATEMENTS:

Mr. Cliff Fearing reported that the May average daily census was 458 compared to the April average daily census of 445. Year-to-date patient days are 999 days over budget. Outpatient clinic visits are .2% above budgeted levels for April. CUHCC visits for April were 8% under budgeted levels. Patient Charges through March were 3.1% overbudget. Operating expenditures through April were 3.3% over budgeted levels.

The Hospital's Statement of Operations shows total expenses over revenues of $2,587,270 for a favorable variance of $3,737,542.

Accounts Receivable represent 97 days of revenue outstanding. The overall decrease in April of 3.2 days occurred in Medicare, commercial insurance and Blue Cross (out-of-state).

PERSONNEL POLICIES:

Mr. Al Dees reviewed the recommended changes to the Hospital's Personnel Policies as reviewed by the Employee Advisory Committee, the Personnel Advisory Committee and the Human Resources Management Committee. The changes recommended were: Policy 3 - to correct titles and change statements to conform with University policy in clarifying the process for submission of complaints; Policy 4 - to correct titles, making it consistent with policy 3 to clarify completion of training and probationary periods; Policy 5 - to correct titles, clarify completion of probationary periods and specify length of probationary periods for part-time employees; and Policy 15 - to correct titles and make permanent part-time employees eligible to accrue seniority and eliminate references to mandatory retirement per change in law.

The Finance Committee seconded and passed a motion to endorse the personnel policy changes as presented.

1988-89 EMPLOYEE COMPENSATION PLAN:

Mr. Al Dees presented the 1988-89 Employee Compensation Plan. Mr. Dees noted that it conforms with the budget parameters approved in April, 1988. The plan for non-student, non-union employees in Hospital-dominated classifications includes: increase salaries and salary ranges by 2%; provide in-range progression increases on a merit basis to average 1.5% to those not on "step" plans; continue in-range progression increases on a "step" basis according to existing accumulated hours; and implement the comparable worth increases scheduled for year four of the plan. The pay plan for non-student, non-union employees in University-dominated classes includes provide a 2% across-the-board increase; provide 1.5% of budget merit increase; and pay equity increases according to the University's comparable worth plan. The average increases for all employees will be 3 1/2% exclusive of pay equity increases.

Mr. Greg Hart briefly noted that the above plan keeps nursing salaries in line with current contracts in the community. The current expiring union contract covering the nurses at Children's and United Hospitals is being renegotiated. Mr. Hart noted that UMHC would closely follow these negotiations as that contract will impact negotiations next year of the MNA contract covering nurses in many other metropolitan hospitals.

The Board of Governors Finance Committee seconded and passed a motion to endorse the 1988-89 Employee Compensation Plan as presented.

RADISSON UNIVERSITY HOTEL:

Mr. Cliff Fearing reviewed the status of the University Radisson Hotel. The Hotel's owners, Maddox and Associates were served a foreclosure notice on March 8, 1988 by Citicorp and are now facing a July foreclosure. Mr. Maddox is asking the University Hospital to guarantee 116 rooms per night, eliminate parking fees for hotel guests, and forego further profit from the lease rent. Mr. Paschke reported that the University Finance and Operations Office is gathering factual information on occupancy rates, etc. to be submitted to the Board of Regents at their June meeting. The Board of Governors Finance Committee discussed a resolution to be forwarded to the the Board of Governors. After a discussion and changes to the original resolution, the Committee considered the following resolution:

> "Whereas - It is the understanding of the Board of Governors of the University of Minnesota Hospital and Clinic that the Regents of the University of Minnesota have been requested to subsidize the operation of the Radisson University Hotel to forestall the mortgage foreclosure on the present hotel owners.
>
> Whereas it is also the understanding of the Board of Governors that a large component of the requested subsidy would be from University Hospital revenues.
>
> Whereas it is also the understanding of the Board of Governors that there is no contractual agreement obligation of the University of Minanesota to subsidize the hotel.
>
> Whereas such a subsidy would increase the cost of patient care at the University of Minnesota Hospital and Clinc,
>
> Therefore the Board of Governors of the University of Minnesota Hospital and Clinic urges the Board of Regents to not commit revenues of The University of Minnesota Hospital and Clinic to support the Radisson University Hotel and/or take no formal action until communication between the Board of Governors and the Board of Regents has occurred."

The Board of Governors Finance Committee seconded and passed a motion to endorse the resolution pertaining to the University Radisson Hotel as written above.

ADJOURNMENT:

There being no further business, the May 25, 1988 meeting of the Board of Governors Finance Committee was adjourned at 1:15 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
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

June 22, 1988

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period July 1, 1987 through May 31, 1988

The Hospital's operations through the month of May 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 May, inpatient admissions totaled 1,698 or 145 above budgeted admissions of 1,553. Our overall average length of stay for the month was 8.5 days. Patient days for May totaled 13,998 and were 1,173 days over budget. The increase in admission levels over budget 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	17,458	16,761	17,551	790	4.7
Avg. Lnth. of Stay	8.2	8.4	8.0	-.4	-4.8
Patient Days	141,647	140,438	141,041	603	0.4
Avg. Daily Census	422.8	418.0	419.8	1.8	0.4
Percent Occupancy	72.1	71.8	72.5	0.7	1.0

Outpatient Census: Clinic visits for the month of May totaled 23,266 or 939 (4.2%) above budgeted visits of 22,327. Areas which experienced visits with large increases over budget were A.T.E.U., OB/GYN and the Diabetes Center. Community University Health Care Center (CUHCC) visits for the month of May totaled 4,072 or 262 (6.9%) over budgeted visits of 3,810, while Home Health visits of 805 for the month were 18 (2.3%) over 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	225,926	232,808	240,322	7,514	3.2
CUHCC Visits	43,420	43,810	44,118	308	0.7
HHA Visits	8,401	8,507	8,643	136	1.6

Financial Operations: The Hospital's Statement of Operations shows total expenses over revenues of $2,453,849, a favorable variance of $9,409,715.

Patient care charges through May totaled $ 36,743,035 and were 3.8% over budget. Routine revenue was .3% under budget. Ancillary revenue was approximately $8,758,552 (5.3%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,256 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $189 compared to the budgeted average of $184.

Operating expenditures through May totaled $226,685,829 and were approximately $7,196,919 (3.3%) over budgeted levels. The overall variance relates to increased salary, fringe benefit and medical supply costs.

Accounts Receivable: The balance in patient accounts receivable as of May 31, 1988, totaled $77,048,651 and represented 98.0 days of revenue outstanding. The overall increase in our patient receivables in May of 1.0 day occurred in Minnesota Medical Assistance and the addition of several large individual accounts.

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 MAY 31, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$228,178,956	$236,743,035	$8,564,079	3.8%
Deductions from Charges	41,427,835	35,943,916	($5,483,919)	-13.2%
Other Operating Revenue	5,396,468	5,859,004	$462,536	10.6%
Total Operating Revenue	192,147,589	206,658,123	14,510,534	7.6%
Total Expenditures	(219,488,910)	(226,685,829)	(7,196,919)	3.3%
Net Operting Revenue	(27,341,321)	(20,027,706)	7,313,615	27.2%
Non-Operating Revenue and Expenses	20,385,455	22,481,555	2,096,100	9.7%
Revenue over Expense	($6,955,866)	$2,453,849	$9,409,715	(1)

(1) Variance equals 4.4% of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	16,761	17,551	790	4.7%
Patient Days	140,438	141,041	603	0.4%
Average Daily Census	418	419.8	1.8	0.4%
Average Length of Stay	8.4	8.0	-0.4	-4.8%
Percentage Occupancy	71.8	72.5	0.7	1.0%
Outpatient Clinic Visits	232,808	240,322	7,514	3.2%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 15, 1988

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: 1988-89 Capital Budget

Enclosed please find the proposed 1988-89 capital budget. As we indicated to you in April, we have been reviewing equipment and remodeling requests which were submitted in March, totaling in excess of $18,000,000. Our operating budgets assumed cash flow for equipment and remodeling of $8,000,000.

As the attached summary indicates, we are recommending an equipment and remodeling budget next year of $7,991,163. Of this amount, $6,443,513 is for equipment purchases, the remainder is for equipment installation and remodeling. A departmental breakdown of the equipment budget and remodeling budgets in excess of $5,000 is also attached.

The third attachment identifies those equipment purchases which are anticipated which are in excess of $100,000, but less than the $600,000 threshold requiring project-specific Board approval. Presuming the Board approves the contemplated changes in the capital expenditure policy, we will be presenting brief reports to the Planning and Development Committee on the $100,000 - $600,000 purchases during the upcoming year.

The last attachment presents a five-year capital expenditure plan, as we have provided in past years. This five-year plan does not require Board approval, but is informational in nature. The five-year plan includes projects which have been identified as part of the capital needs analysis done in conjunction with the major Mayo remodeling plan (Renewal Project-Phase II). Please note major expenditures for Renewal Project II are tentatively included as category IV in the five-year plan.

We would request Board approval of the recommended $7,991,163 capital budget at your June meeting. Major capital expenditures (i.e Surgical Pathology, Masonic III, and Neuroradiology) will be brought forward individually for approval at later dates.

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

/kj

attachments

1988-89 Capital Budget Summary

Equipment Purchases	$6,443,513
Equipment Installation	275,000
Remodeling Over $5,000	475,000
Remodeling Under $5,000	797,650
Total	$7,991,163

1988-89 Capital Budget Summary

Items Between $100,000 and $600,000

Therapeutc Radiology	Hyperthermia System	$204,771
Information Services	2X4 cartridge tape system	129,200
	Hyperchannel-IBM to Unisys communication	120,000
	Interface software-IBM to Unisys communication	200,000
Clinical Laboratories	Chemistry random access analyzer	145,000
	Automated differential instrument	120,000
Medical Records	Central dictation system	200,000
Diagnostic Radiology	Digital imaging unit	350,000
	Ultrasound unit	193,650
	Kontron processor	256,800
	Fluoro C-arm-portable	139,100
	Fluoro C-arm-portable	139,100
	Fluoro C-arm-portable	139,100
Nuclear Medicine	Scintillation camera	164,800

Department	Amount
Admissions	15000
Ambulatory Care	55481
Biomedical Engineering	3500
Cardio-Respiratory	435779
Central Sterile Processing	165000
Chaplaincy	2850
Environmental Services	100000
Home Health	1000
Closed Circuit T.V.	45000
Attorney	12000
Hospital Automation	17000
Hospital Facilities Office	1000
Human Resources	4000
Information Services Department	690000
Labs	827228
Maintenance and Operations	3133
Day Hospital	6100
Materials Services	100000
Medical Records	290000
Nuclear Medicine	300000
Nursing	192642
Nutrition	18000
Operating Rooms	753863
Patient Accounting	13000
Pharmacy	14700
Physical Medicine & Rehab.	2366
Protection Services	1500
Radiology	1992000
Social Work	4300
Therapeutic Radiology	321071
Volunteers	35000
Quality Assurance	25000
Total	6443513

Remodeling (over $5000)

Ambulatory Care	95000
Hospital Facilities Office	70000
Information Services	12000
Labs	50000
Maintenance & Operations	5000
Nursing	145000
Radiology Film File Remodel	50000
Therapeutic Radiology	50000
Total	475000

Five Year Capital Expense Projections

		1989	1990	1991	1992	1993
I.	Annual Equipment and Remodeling Requirements	7,991,163	8,300,000	8,550,000	8,990,000	9,150,000
II.	Anticipated Major Capital Expenditures(funded from reserves/borrowings)					
	Surgical Pathology	1,029,350				
	Masonic patient care unit	600,000				
	MRI-I replacement					3,100,000
	Lithotripter I Upgrade		400,000			
	Lithotripter II		1,000,000			
	Lithotripter III				1,216,000	
	Computer upgrade	850,000	4,000,000	1,500,000	1,500,000	1,500,000
	Neuroradiology upgrade	909,000				
	Replace CT scanner		1,000,000		1,100,000	
	Replace linear accelerator		3,000,000		3,100,000	
III.	Principle on debt for lithotripter I, A9 computer and peripherals, CT scanner	3,949,000	2,843,000	2,552,000	2,548,000	2,650,000
	TOTAL	15,328,513	20,543,000	12,602,000	18,454,000	16,400,000
IV.	Renewal Project II design and construction	7,140,000	16,000,000	19,600,000	8,900,000	6,300,000

*Timing of projected expenditures for Renewal Project II are preliminary estimates. Timing of equipment replacements are likely to vary from that presented above based upon actual obsolescence and need for "smoothing" of expenditures.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 15, 1988

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: Personnel Policy Changes

During its May meeting, the Board of Governors considered recommendations for changes to Policies 3 and 4. The Board did not act on the recommendations but requested the staff to further investigate the need and rationale for the following recommended changes to the non-discrimination statements contained in the two policies: deletion of marital status, deletion of status with respect to public assistance, and substitution of sexual orientation for sexual or affectional preference.

After further discussion, Patricia Mullen, Director of the University's Office of Equal Opportunity and Affirmative Action, has agreed that addition of marital status and status with respect to public assistance in statements of the University's non-discrimination policy within University Hospital and Clinic policies is acceptable. Given the gay community's clear preference for use of the term sexual orientation, Ms. Mullen believes that the wording in Hospital policies should be consistent with the University's.

In light of the above, the staff has revised the recommended changes to these two policies. A summary of the changes as they are represented to you for consideration is as follows:

Policy 3: To correct titles, to make the non-discrimination statement consistent with the University Policy (except that "marital status" and "status with regard to public assistance" are retained), to clarify the process for submission of complaints.

Policy 4: To correct titles, to make Policy 4 consistent with Policy 3, to clarify completion of training and probationary periods as recommended by University Attorney.

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

Attachments

April 16, 1984
10/86

Discrimination and Political Activity
Board of Governors

POLICY

The University of Minnesota Hospitals and Clinics shall subscribe to the Equal Opportunity and Affirmative Action guidelines established by the University of Minnesota.

No discrimination shall be exercised, threatened, or promised by any person in The Hospital and Clinic service against or in favor of any employee on the basis of race, ~~creed~~ religion, color, sex, national origin, ~~sexual or affectional preference, marital status, status with regard to public assistance, disability,~~ veteran status, ~~age (except for mandatory retirement age), national origin, ancestry, political opinions, union or other organizational affiliations; nor shall any employee be subject to any form of sexual harassment.~~ handicap, age, veteran status, ~~or~~ sexual orientation, marital status or status with regard to public assistance. In adhering to this policy The University Hospital and Clinic abides by the requirements of Title IX of the Education Amendments of 1972; by Sections 503 and 504 of the Rehabilitation Act of 1973; by Executive Order 11246, as amended; 38 U.S.C. 2012, the Vietnam Era Veterans Readjustment Assistance Act of 1972, as amended; and by other applicable statutes and regulations relating to equality of opportunity.

No discrimination shall be exercised, threatened, or promised by any person in The Hospital and Clinic service against or in favor of any employee on the basis of political opinions, union or other organization affiliations; nor shall any employee be subject to any form of sexual harassment.

No employee of ~~t~~The University Hospitals and Clinic shall be required to pay any assessment, make any contribution, or pay any subscription for any political purpose whatsoever; nor shall any employee solicit or receive or be in any manner concerned with soliciting or receiving any assessment, subscription, or contribution for any political purpose whatsoever from any employee in The University Hospitals and Clinic. No officer or employee of ~~t~~The University Hospitals and Clinic shall directly or indirectly use his/her authority or official influence to compel any officer or employee ~~in University Hospitals~~ to apply for membership in or become a member of any political organization; or to pay or promise to pay any assessment, subscription, or contribution; or to take part in any political activity. The services of any person who is found to have violated this provision may be terminated.

PROCEDURE

Employees who feel that they have ~~suffered due to~~ encountered discrimination as defined in this policy have the right to submit a complaint to the ~~Affirmative Action Office~~ Human Resources Department. The complaint shall be in writing on a form provided by the ~~Affirmative Action Office~~ Human Resources Department, specifically detailing what element of the discrimination policy has been violated~~.~~ ~~and it will be submitted to the Affirmative Action Office at University of Minnesota Hospitals. As in the case of other grievances, it~~ The form must be submitted to the Human Resources Department within thirty (30) working days after the ~~aggrieved~~ condition became known or should have become known.

Robert Dickler, Hospital Director

The ~~Affirmative Action Office~~ Human Resources Department shall investigate the allegations, and ~~within ten (10) working~~ days respond to the ~~grievant~~ employee.

If the ~~grievant~~ employee is not satisfied with the response of the ~~Affirmative Action Office~~ Human Resources Department, he/she may file a grievance within ten (10) working days according to the ~~Hospitals~~ grievance procedure, policy number 14. If both parties agree, the grievance may be initiated at step 3.

Discrimination grievances shall not be subject to arbitration unless the nature of the discrimination grievance is such that these policies apply but no administrative agency review or legal recourse is available. In such cases, the grievance shall be subject to the binding arbitration process consistent with policy number 14.

jk12-P332

Recruitment and Employment

Board of Governors

POLICY

The University of Minnesota Hospitals and Clinics will provide and administer a ~~fair and orderly~~ system to post and fill vacancies. Employment opportunities will be provided without regard to race, religion, ~~creed,~~ color, sex, national origin, handicap, age, veteran status, sexual orientation, marital status, status with regard to public assistance, ~~sexual or affectional preference, marital status, status with regard to public assistance, disability, veteran status, age (except for mandatory retirement age), national origin, ancestry,~~ political opinions, or union or other organizational affiliations.

More than one member of a family may work for The University of Minnesota Hospitals and Clinics provided that there will be no immediate supervisory or substantive administrative relationships among the relatives. "Members of a family" shall be interpreted as including:

1. by blood or adoptive relationship: parents, grandparents, children, grandchildren, brothers, sisters;

2. by marriage relationship: husband, wife, brother(sister)-in-law, father (mother)-in-law, son(daughter)-in-law, stepparent, stepchild.

PROCEDURE

Section 1

Request to Fill New Position or Vacancy

When a new position or vacancy in an old position is to be filled, the department head shall submit a personnel requisition to the ~~Hospital Personnel Director~~ Human Resources Department on the form prescribed. Upon receipt of a requisition, the ~~Hospital Personnel Director~~ Human Resources Department shall have the classification of the position reviewed and shall either approve the requested classification or recommend reclassifying it, as ~~may be~~ appropriate.

Section 2

Announcement of Employment Opportunities

Announcements (postings) of all vacancies in ~~permanent~~ continuing positions shall be posted on the official bulletin boards of the ~~Hospital Personnel~~ Human Resources Department.

An announcement concerning a vacancy in a continuing position shall remain posted for a minimum of five (5) work days. A hiring decision may be made at the end of the posting period.

Temporary positions of less than six (6) months duration need not be posted, but the department must submit a requisition to the ~~Hospital Personnel Director~~ Human Resources Department before the position is filled.

Section 3

Hiring and Certification

The ~~Hospital Personnel~~ Human Resources Department will screen applicants for minimum qualifications and refer qualified applicants to the hiring supervisor.

Applicants who have applied for a specific vacancy and who have been certified as meeting the minimum qualifications of that vacancy shall normally be given consideration for employment in the following order:

1. the incumbent of a position which has been reclassified;
2. former employees whose names appear on the layoff list, under Seniority, Lay and Resignation policy;
3. current University Hospitals and Clinic employees;
4. current University employees
5. all other applicants.

The order of preference may be changed under special circumstances by the University Equal Opportunity Officer in accordance with Affirmative Action policies of the Board of Regents. Employment decisions will be made by superviors and managers.

No appointment shall be submitted by a department head without prior certification by the ~~Hospital Personnel Director~~ Human Resources Department that the candidate is qualified. All appointments shall be subject to approval by the ~~Hospital Personnel~~ Human Resources Director and the Affirmative Action officer.

Section 4

Procedure in Nepotism Cases

If a nepotism situation exists ~~every~~ reasonable effort will be made to transfer one of the employees to another position.

Any employee who has passed an initial probationary period and who is required resign from a position in order to comply with the nepotism policy shall have rights to t layoff list as though he/she had been laid off.

Section 5

Employment Procedure and Files

Applications for all University of Minnesota Hospitals and Clinics employment shall be made on forms and in such manner as prescribed by the ~~Hospital Personnel~~ Human Resources Director, and upon submission to the ~~Hospital Personnel~~ Human Resources Department become the property of The University Hospitals and Clinic.

Each employee shall have a right to see his or her personnel file upon request in the ~~Hospital Personnel~~ Human Resources Department in the presence of the ~~Hospital Personnel~~ Human Resources Director or designated member of his/her staff. The official personnel file for each employee is the one maintained by the ~~Hospital Personnel~~ Human Resources Department.

Section 6

Types of Appointment

Trainee appointments may be made when the ~~Hospital Personnel~~ Human Resource Director approves trainee programs to qualify persons for a particular work classification. An employee hired as a trainee shall be hired at a rate below the salary range for the class and may be granted incentive increases as he/she progresses through an organized training program until successfully completing the program and reaching minimum salary of the range for the class. He/she shall then be required to successfully complete the probationary period assigned to the class before receiving a continuing appointment. Successful completion of a training program or probation period is determined by the department head or other appropriate administrator.

Continuing appointments shall be made to any position in which the assigned work time is at least 50 percent of full time and of a continuing nature, when the employee has successfully completed the probationary period for the class of work.

Temporary appointments ~~may be made to any positions~~ (which have a beginning and ending date) may be made to any position. Employees on a temporary appointment, which may be part-time or full-time, shall not serve a probationary period and shall not have the same rights which accrue to an employee on a continuing appointment. Employees on a temporary appointment shall be notified, in writing, of the temporary nature of their appointment. Said document shall state clearly the definition of a temporary appointment and the ending date of the appointment, and shall be given to the employee by the supervisor and to the ~~Personnel~~ Human Resources Department at the time of hiring.

Part-time appointments may be made to any position in which the assigned work time is less than 75 percent time. Such an appointment may be temporary or continuing.

jk12-P376

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUARTERLY REPORT TO THE BOARD OF REGENTS

JUNE 10, 1988

INTRODUCTION:

Chairman Lebedoff, President Sauer, members of the Board of Regents, ladies and gentlemen, I would like to take about ten minutes this morning to talk to you about the Hospital's financial position and budget, three personnel related issues, our physical facilities and lastly, about one of the Board of Governors most important responsibilities, the responsibility for ensuring that the care provided at the University Hospitals is of high quality.

1987-88 BUDGET STATUS AND 1988-89 OPERATING BUDGET:

Utilization at The University of Minnesota Hospital and Clinic continues to be strong. You will recall that the fiscal year ending last June 30th represented an interruption to what had been a five-year long trend of declining utilization. Those heightened 1987 levels have been sustained during the current fiscal year. We had budgeted 18,350 admissions and expect to end the year well over 19,000. Our average length of stay is shorter than expected by almost half a day at 8 days. Our outpatient clinic volumes continue on a steady upward climb and are expected to reach 266,000 before the year is over.

Last week the St. Paul Pioneer Press Dispatch and the Minneapolis Star Tribune accurately reported that our hospital's expenses exceeded operating revenues by $22 million last year. We do rely on non-operating income such as interest income and state appropriations to balance our budget. Each year our budget is put together with an "operating loss" which is offset by the state appropriation and interest income. The $22 million "loss" referred to in the newspapers was essentially a planned loss, offset by other sources of income. Despite the impression which may have been created in the newspapers, University Hospital continues to be financially healthy, as our past reports to the Board of Regents have indicated.

The 1988-89 budget was presented at yesterday's Finance and Legislative Committee. The budget is strongly influenced by current year experience but is adjusted for several specific changes. That budget projects operating revenue and non-operating revenue totalling over $262 million. Expenses are estimated at $258 million. A positive $4 million bottom line is projected. The Board of Governors endorsed that budget on April 27, 1988. It will be presented to you next month for action.

PERSONNEL:

We employ just under 4,000 full-time equivalents at the University Hospitals. That number does not include the 413 full-time physicians on the University Hospital medical staff. Almost one-third of our hospital employees are nurses. Retaining our nurses has become particularly important because a nursing shortage is being experienced nationally. The American Hospital

Association reports that about 18% of the hospitals in the U.S. are in the midst of a severe shortage, another 35% indicate a moderate shortage. Seventy per cent of all hospitals in New England are reporting shortages. Only about one-quarter of all hospitals report being unaffected by the shortage. To date, we have not experienced difficulty in filling our positions. This is probably attributable most directly to our being located in the upper midwest and to our institutional reputation.

In 1985 the Board of Governors approved a four-year pay equity plan for the Hospital that would bring all classifications within 5% of our target pay line. The 1988-89 fiscal year represents the fourth year of that plan; $365,000 has been budgeted for pay equity increases. Toward the end of our four year implementation schedule, the Board of Governors will be evaluating the results of our comparable worth program.

The Board of Governors continues to review and approve personnel policy in those areas where delegated authority was granted five years ago. In those areas where maintenance of centralized authority was deemed appropriate, such as benefit administration, labor relations and affirmative action, we duplicate University policy very closely.

FACILITIES:

As you know, in April of 1986 we moved about 75% of the inpatient beds and some of our support services into the new University Hospital. The new building represents approximately 40% of our square footage. Options for

updating the remainder of the hospital facilities are being studied. The Board of Governors will be forwarding our facility recommendations to you in late summer or early fall.

QUALITY:

Overseeing the quality of care at our hospital is among the Board of Governors most important roles. It is also among our most difficult roles. The Board of Governors meets its responsibility for assessing quality of care in several specific ways. Examples include the credentialling of medical staff and review of data gathered by the Hospital's Quality Assurance Department.

The Hospital also undergoes quality reviews by external bodies. The Chicago-based Joint Commission on Accreditation of Healthcare Organizations is the best known hospital review body. They currently accredit about 80% of the nation's 6,100 hospitals, including our hospital. In March, we received a renewal of our accreditation for the maximum allowable term, three years.

Recently, discussions of quality have gone beyond the walls of the individual hospital and beyond the auspices of the accreditation bodies. Insurance companies, governmental agencies and public interest groups are seeking inter-hospital and even inter-physician comparisons of quality. In sum, the Board of Governors takes great interest in the development of comparisons, but views those currently in place as being overly simplistic and, consequently, not very accurate. We are interested in influencing the shape of these developing systems and are participating in local and national discussion forums on quality of care.

OTHER:

In closing, I would like to express the Board of Governors satisfaction with having had a hospital representative over at the legislature this past session. It allowed us to keep more closely abreast of those issues affecting the Hospital.

Thank you.

Minnesota Daily, May 26, 1988

Hospital board opposes subsidizing Radisson hotel

The University Hospital Board of Governors went on record Wednesday opposing any subsidy of the financially ailing Radisson University Hotel.

Such a subsidy would increase patient care costs at University Hospital and Clinic, according to a resolution unanimously approved by the board.

Facing foreclosure by Citicorp June 8, hotel developer William Maddux has asked the University Board of Regents to guarantee that 116 of the 308 rooms in the Radisson University will be occupied by University Hospital patients or visitors.

The University would foot the bill for unoccupied rooms. The proposed deal could cost the University $1.7 million per year, according to Clifford Fearing, a senior associate director at the hospital.

Because the hotel is built on University-owned land, the University could lose the land in the event of a foreclosure and sale of the hotel. But the land, leased to Maddux for 15 years, is worth less than the University might have to spend annually on the subsidy, Fearing said.

University counsel concluded the University has no legal obligation to provide the subsidy, said Carol Campbell, University acting vice president for finance. Campbell is a member of the hospital board.

The regents will act on Maddux's proposal during their June meeting.

University officials encouraged developers to build economical accommodations near the hospital when Powell Hall was torn down in 1980 to make way for the new hospital building, said Fearing.

Powell Hall, originally a nurses' dormitory, was used during the 1970s for offices, clinics and low-cost housing for clinic patients.

"But the hotel turned out to be quite a bit different from what we had conceived of for our patients," Fearing told the board.

The Radisson University charges patients $35.95 per night and is asking the University to guarantee $39.95, he said. The usual rate is $55 per night, according to a report to the regents.

While the hotel's discount was an effort to accommodate the hospital, several other hotels in the area offer lower rates, according to University Hospital Director Robert Dickler.

— Delores Lutz

Star Tribune
June 3, 1988

Hospitals report declining economics

Health care quality in rural areas a concern

By Gordon Slovut
Staff Writer

The Minnesota Hospital Association reported Thursday that 69 of 160 hospitals in the state were unprofitable in fiscal 1987 and that the consequence could be deterioration of health care and closing of needed rural hospitals.

The hospitals' losses totaled $6.8 million, according to the association, but that figure was inflated by a $22 million paper loss at the University of Minnesota Hospital.

The $22 million loss reflected only the cost of running the hospital minus income from patient care. It didn't include the $13.8 million the hospital received last year for providing training for doctors and other health care professionals or the more than $8 million in income from investments.

Stephen Rogness, president of the hospital association, said that excluding the university figure, even though it would turn a $6.8 million loss into a $15 million profit, would not invalidate the association's main point: that many of the state's hospitals are in financial trouble and that unless their income levels improve Minne-

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sotans face a potential deterioration of the quality of care and the closing of small but needed rural hospitals.

For example, the number of hospitals showing operating losses last year, 69, was up from 55 the previous year. Also, 39 had operating losses of 5 percent or greater last year.

Robert Dickler, chief executive officer of University Hospital, said the hospital's actual loss, when total income is included, was about $100,000. He said the university doesn't expect patient revenues to offset costs because "We have other roles."

Rogness, president of the hospital association, said that he was aware of the university's accounting method, but that his organization chose to use operating income in its calculations. And, he said, the main points are that more hospitals are losing money every year and that the amount of their losses is increasing.

Patti Anderson, the association's communications director, said that last year 52 hospitals had net losses after taking nonoperating income, such as gifts and tax subsidies, into account.

Most of the troubled hospitals are in the Twin Cities metropolitan area and in rural Minnesota, Rogness said.

The primary reason for the financial trouble is that Medicare, Medicaid, health maintenance organizations (HMOs), Blue Cross and other insurers are not paying the full cost of the care they cover, according to the association.

Even some hospitals that finished the year with substantial gains, based on hospital income over hospital expenses, had margins that their administrators considered uncomfortably low.

The Fairview system was $10 million in the black. Gordon (Gus) Donhowe, its chief executive officer, said that figures out to only 3.8 percent.

Abbott Northwestern Hospital, with a booming heart surgery program and growing laser treatment center, was $5.1 million in the black. Robert Spinner, one of its executives, said the profit margin was just 2.5 percent.

Donhowe said the solution is for the hospitals to negotiate better contracts with HMOs and other insurers, get the government to improve Medicare and Medicaid payments to hospitals and eliminate any remaining excess capacity in the system.

He said the excess capacity is rapidly being eliminated, especially in the metropolitan area, which has gone through a series of mergers and closings. Negotiating better contracts with insurers is going to be difficult because many of the HMOs say that they already are losing money and that they are meeting resistance from industry about premium increases, Donhowe said.

He said there will be a continued increase in health care costs because Americans are unwilling to ration health care the way it is rationed in many European countries and Canada, and because expensive technological improvements, which are remarkable in what they do in sustaining life and curing disease, will continue to be developed and desired.

Malcolm Mitchell, director of the Metropolitan Health Planning Board, said the hospitals must have profit margins of 3 to 5 per cent if they are to replace obsolete equipment and provide new, improved services.

'Registered care technologists' proposed to ease nurse shortage

Minnesota Daily June 3, 1988

Photo/Randall Eaton

Sue Thomas Hegyvary, dean of the School of Nursing at the University of Washington-Seattle, criticized a proposal that would seek to eliminate nurse shortages by filling them with "registered care technologists."

Nursing educators voice concerns about care quality

By **Delores Lutz**
Staff Reporter

The doctors of the American Medical Association have decided how to eliminate the country's crisis shortage of nurses.

They want to establish a new occupation called "registered care technologist." Workers who seek such licenses would train for nine months at a vocational-technical school before finding nursing jobs in the nation's hospitals, clinics and nursing homes.

Nursing educators are appalled.

"Would knowledgable administrators hire these people? The liability risk is going to be substantial," said Sue Thomas Hegyvary, dean of the School of Nursing at the University of Washington, Seattle.

But outrageous as the proposal sounds, it must be taken seriously, Hegyvary told about 50 nursing educators Thursday at a conference at the Radisson University Hotel.

"It's a very real threat. There's a lot of money behind it already," she said.

In Wisconsin, some proponents have gone so far as to suggest that these registered care technologists be recruited from the welfare rolls, Hegyvary said.

The two-day conference, spon-

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sored by the University's School of Nursing, focuses on using marketing techniques in recruiting students.

Part of the problem, educators acknowledge, is that women now have attractive career opportunities in other fields, such as business, medicine and law.

Another factor is demographic change: The declining birth rates of a generation ago mean that there are fewer people in the college age group.

Minnesota educators organized the national conference because they are proud of their own recent breakthroughs in recruiting techniques, according to Eleanor Sullivan, associate dean of the nursing school.

Eighty-five percent of the hospitals in the country are short of nurses, Hegyvary said. According to one estimate, by 1990 the country will be short 390,000 nurses with bachelor's degrees, she said.

Meanwhile, the economic pressures on hospitals and physicians are mounting. "Hospitals are not going to stand by and do nothing while beds are closed and patients can't get in. Every institution fights for survival," Hegyvary said. "And if physicians can't get patients admitted to the hospital, that cuts into the physician's income."

All of that probably will inspire lobbying in several state legislatures for laws licensing registered care technologists, she said. Nurses must prepare to fight the proposal at the local level, she advised.

Registered nurses graduate from two-year associate degree programs at community colleges, three-year diploma programs in hospitals or four-year baccalaureate programs in colleges and universities.

But the proposed registered care technologists actually would have less training than now is required for licensed practical nurses, Hegyvary said. By law, LPNs are prohibited from performing certain tasks, such as administering drugs.

Hegyvary's message was sobering to Susan Lanphier, an associate professor of nursing at Alverno College in Milwaukee, Wis., a private school with 300 nursing students.

"At first I laughed, then I got scared," Lanphier said. "The AMA has a lot of power and money, and there's a lot at stake here."

The Minnesota Daily

Tuesday, June 14, 1988

Board appoints three regents' professors

The University Board of Regents appointed professors Ellen Berscheid, Paul Gassman and B.J. Kennedy regents' professors at a Friday board meeting.

"It is certainly an honor for me to be a regents' professor, and I certainly hope I can fulfill the expectations of the board," said Kennedy, a Department of Medicine professor with a special interest in problems associated with aging.

Berscheid, a psychology professor, has earned international recognition for research on social psychology and interpersonal attraction, according to a search committee recommendation.

Gassman, a chemistry professor, has made several contributions in the area of organic chemistry and has a "world-famous" University laboratory, the committee said.

Kennedy, Berscheid and Gassman will replace retiring regents' professors Leonid Hurwicz, John Turner and Herbert Wright.

The University established the rank of regents' professor in 1968. In addition to the title, each of the 20 professors receives a $10,000 annual salary increase.

"This is, we like to think, the highest academic distinguishment for our faculty," said Regent Chairman David Lebedoff. "They honor us for adding the name 'regents' to their title."

— **Susan Sevareid**

Lilly says UM regents not blameless

Associated Press

David Lilly, former University of Minnesota vice president for finance, says the university's regents cannot absolve themselves of blame for financial scandals that rocked the state's largest higher-education institution earlier this year.

Lilly

"When they say they didn't know what was going on, it's not like I didn't give them every opportunity to ask," Lilly said in an interview with the Minneapolis-based Star Tribune.

"My family wanted me to speak out earlier, and I wouldn't do it. I didn't think it was adding anything. You work 10 years at the university and all of a sudden you get into a big contest, you destroy a lot of things that you did. I was tempted, though. But it's all over now and I'm saying what I want to say. I'm retired."

Lilly, 71, said he has felt misunderstood by the public and maligned by the media since his departure. He moved up a planned June retirement to March after revelations about a little-known reserve fund and cost overruns in the renovation of Eastcliff, the university president's mansion.

Lilly had estimated that renovating then-President Kenneth Keller's official residence would cost no more than $650,000, but the project was expanded and the cost mushroomed to $1.5 million.

"My big mistake was I assumed that we had informal approval (from regents) for all of the things we did. It's clear now that I should have brought the whole thing to the board and asked for a public vote. ... I took their silence for understanding."

Lilly, who joined the university in 1978 as head of the School of Management, was named vice president for finance in December 1983.

In February, Lilly underwent surgery for heart problems and decided at that point to retire in June. Lilly moved up his departure by three months after Keller resigned over the Eastcliff controversy, and no permanent replacement has been named.

Lilly said he is convinced his work improved the university's financial health.

While regents and legislators have said they didn't know about a controversial central reserve fund

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Lilly

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until a legislative audit, Lilly said the information was available to the regents' Audit Committee and to any state official who would have studied university financial records.

"I never came to grips with the fact that I was dealing with material that was very familiar to me and very unfamiliar to the regents. I don't know what I would have done differently," he said.

"I think I would have set up seminars. It's a ticklish situation, to say to the people you're working for, 'I don't think you know enough about this.'"

Last week, Lilly appeared before a special commission appointed by Gov. Rudy Perpich to study the university. He presented a summary showing that university investments, including endowments and other fund balances, increased in value from $415 million in June 1983 to $841 million in January 1988.

He said reserves were included in those totals and in investment reports presented on a quarterly and annual basis.

St. Paul Pioneer Dispatch
June 16, 1988