THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

MAY 24, 1989

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

"University Hospital prices may again jump almost 10 percent", Minnesota Daily, April 27, 1989

"1989-90 Employee Compensation Plan", April 28, 1989: Internal memo from Robert Dickler to hospital employees.

"'U' search committee starts over", Star Tribune, May 4, 1989

"Medicine moving at rapid pace", St. Paul Pioneer Press Dispatch, May 4, 1989

"Conference to focus on Holocaust euthanasia", St. Paul Pioneer Press Dispatch, May 15, 1989

"The Case for Wider Use of Testing for HIV Infection", New England Journal of Medicine, May 11, 1989

Minnesota Association of Public Teaching Hospitals 1988 Annual Report

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
May 24, 1989
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of the April 26, 1989 Meeting Minutes	Approval
II.	Chairman's Report - Mr. Robert Nickoloff	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Special Presentation: "The University in 1989 -- Diagnosis and Prescription" - President Nils Hasselmo	Information
V.	Committee Reports	
	A. Planning and Development Committee - Mr. Robert Latz	
	1. Quarterly Purchasing Report	Endorsement
	2. Major Capital Expenditure	Information
	3. Quarterly Capital Expenditure Report	Information
	B. Joint Conference Committee Report - Ms. Phyllis Ellis	
	1. Industry Relationships	Information
	2. Disaster Committee	Information
	3. Medical Staff Hospital Council Report	Information

C. Finance Committee Report

- Mr. Jerry Meilahn

1. April 30, 1989 Financial Statements	Information
2. 1989-90 Operating Budget	Endorsement
3. 1989-90 Capital Budget	Information

VI. Other Business

VII. Adjournment

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

APRIL 26, 1989

CALL TO ORDER:

Chairman Robert Nickoloff called the April 26, 1989 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias David Brown, M.D. Paula Clayton, M.D. Robert Dickler Gordon Donhowe Phyllis Ellis George Heenan Kris Johnson Robert Latz David Link James Moller, M.D. Robert Nickoloff Cherie Perlmutter
Not Present:	Erwin Goldfine Jerry Meilahn Barbara O'Grady

APPROVAL OF MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the February 22, 1989 meeting as submitted.

CHAIRMAN'S REPORT:

Chairman Robert Nickoloff noted the appointment of Dr. James Moller as Chairman of Sub-Board of Pediatric Cardiology of the American Board of Pediatrics. Chairman Nickoloff also announced that Kris Johnson had assumed the position of Vice President and General Manager of the Peripheral Vascular Division at Medtronic.

DIRECTOR'S REPORT:

Mr. Robert Dickler apprised the Board of Ms. Barbara Tebbitt's appointment as the Trustee at Large for the Minnesota Hospital Association.

Teamsters, AFSCME and Minnesota Nurses Association (M.N.A.) contract negotiations are all underway. While the University Hospital nurses are not represented by the M.N.A., Mr. Dickler noted, our compensation plan is modeled after the contract settlement.

The Hospitals' average daily census through March is 437; 390 was budgeted. These positive census levels are, Mr. Dickler continued, attributed to an increased length of stay rather than the financially preferable trend of increased admissions.

Two hospital systems in the community are selecting new Chief Executive Officers, Fairview and Healtheast. Mr. Dickler reported that Healtheast is also evaluating their organizational and financial status.

Dr. David Brown announced the selection of Dr. Roberto Heros as Professor and Head of the Department of Neurosurgery. Dr. Heros is currently at Massachusetts General Hospital. His appointment will be confirmed by the Board of Regents in May.

Lastly, Mr. Dickler reported that Ms. Kay Fuecker had accepted a new position at the Board of Regents office.

LEGISLATIVE UPDATE

Mr. Ted Yank apprised the Board of Governors of several bills currently under review by the State Legislature. Provisions for funding insurance coverage for the uninsured have not been made, but the concept will apparently remain under study. The Infections and Pathological Waste Act is expected to place new restrictions on handling infectious wastes and to require that organizations develop comprehensive waste management plans. Consideration is also being given to a bill that would require hospitals to notify emergency medical technicians of the presence of a blood-borne pathogen in a patient that had been transported. A bill had been put forth lending definition to the term "fetal viability". If passed, that more-stringent definition would have implications for managing later-term abortions. A modification to the Patient's Bill of Rights has been proposed. That modification would enhance efforts made by hospitals to reach family members of patients admitted in a non-communicative state. Lastly, two medical assistance-related bills would reestablish the base year cost data upon which payments are made and would allow hospitals to bill the Department of Human Services for outpatient clinic service fees.

HOME HEALTH CARE SERVICES, 1974-1989

Ms. Bev Dorsey, Associate Director for Ambulatory Care Services, presented an overview of the development of home health care services at UMHC and reviewed

current services. UMHC has operated the Home Health Care Program since 1974. Services are provided to home-bound patients who live within a 30-minute one-way drive from the University and are under the care of a University physician.

A full range of services are provided under the direction of Dr. Mark Nesbit, Medical Director. 60% of patients served are in one of these categories: cancer patients, patients needing wound care, and cystic fibrosis patients. Demand for respiratory care services has grown in recent months as have demands for home nutritional support and weekend or holiday care. Approximately 10,000 visits will be made this year.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Ms. Kris Johnson apprised the Board of Radiology's intent to acquire two mobile C-arm Radiographic/Fluoroscopic Units at an approximate cost of $136,000 per unit. In accordance with the Board of Governors Major Capital Expenditure Policy, acquisitions costing $100,000-$600,000 are presented to the Board for informational purposes.

JOINT CONFERENCE COMMITTEE REPORT

Mr. George Heenan reviewed the 1989 Joint Conference Committee work plan. Three categories of agenda items will be addressed by the Committee. Regular or ongoing activities such as medical staff appointments will continue. Eight special issues were also identified. Examples of special issues included industry relationships and the role of the Hospital in recruiting, evaluating and retaining physicians. Lastly, the Committee will continue to review Hospital-wide quality assurance monitoring and evaluation activities.

Two reports of the Credentials Committee were reviewed and discussed. Those reports were dated Feburary 9 and April 3, 1989. The members of the Board of Governors discussed the depth with which they review the Credentials reports. Most felt the level of delegation to the Credentials Committee and the Medical Staff Hospital Council for this review function to be appropriate.

With one dissenting vote, the Board of Governors seconded and passed a motion to approve the Credentials Committee reports as submitted.

Mr. Heenan explained that Medicare conditions of participation mandate that home care agencies have a governing body which assumes oversight responsibility for the agency. The Joint Commission recommends a similar oversight function. At the recommendation of the Joint Conference Committee, the Board of Governors will replace an existing internal oversight group as the Home Health Care Services governing board. The Board of Governors seconded and passed a motion to approve the full set of Home Health Care Services policies and procedures.

Lastly, Mr. Heenan overviewed new and revised policies that govern the Kidney Dialysis Unit. The Kidney Dialysis policies are reviewed annually in an effort to fulfill the conditions of participation in Medicare's End Stage Renal Disease Program.

FINANCE COMMITTEE REPORT

Mr. Cliff Fearing reviewed the Hospital's utilization statistics and financial position for the period from July 1, 1988-March 31, 1989. Admissions year to date are 2.0% over budget. Patient days year to date are 12.2% over budget. The average length of stay was budgeted at 7.7 days and has averaged 8.5 days year to date. The average daily census year to date has been 437; a census of 390 was budgeted. Clinic visits year to date total 200,852, 2.6% over budget.

The Hospital's statement of operations shows revenues over expenses by 42,452, an unfavorable variance of 1,331,478. That statement included a recently added 1.6M Blue Cross adjustment.

Messrs. Dickler and Fearing reviewed the major assumptions employed in developing the 1989-90 operating budget. The financial implications of those assumptions were laid out using two different rate increases, 7.5% and 9.5%. A 7.5% rate increase would produce a budgeted cash flow position of $959,000. A 9.5% rate increase would render a positive cash flow of $2,749,000.

Inpatient census for 1989-90 has been budgeted at 18,860 admissions, 158,100 days and an average daily census of 433. 278,200 outpatient visits are budgeted. Both rate increase scenarios presume significant reductions in the accounts receivable, supplies and expenses, and salaries and fringe benefits. Discussions about these expense reductions, Mr. Dickler noted, had taken place with the Clinical Chiefs and hospital department heads.

The Board of Governors seconded and passed a motion to approve a 9.5% rate increase for 1989-90, with 7.5% of the increase to be implemented on July 1, 1989. Specific approval from the Board of Governors for the incremental 2% increase will be sought. Approval for the entire budget will be sought on May 24, 1989.

1988-89 third quarter bad debts were reviewed. 1,502 accounts are proposed for write-off. Those accounts represented $923,257.76 in write-offs, or 1.8% of gross charges. A more general discussion of bad debt ensued. Following the discussion, the Board of Governors passed a motion asking that a charity care policy be developed that recommends dollar limits on anticipated exposure by individual case, an evaluation of bad debt referral sources, and a process by which exceptions to the policy are granted. Mr. Dickler will recommend this policy to the Board of Governors within 90 days.

ADJOURNMENT:

There being no further business, the April 26, 1989 meeting of the Board of Governors was adjourned at 4:30 P.M.

Respectfully submitted,

Nancy C. Janda
Associate Hospital Director
Secretary to the Board of Governors

DR. NILS HASSELMO

PRESENT POSITION

1989 - present	President, University of Minnesota Minneapolis, Minnesota 55455

EDUCATIONAL BACKGROUND

1956	Fil.mag. - Uppsala University Uppsala, Sweden
1957	B.A. - Augustana College Rock Island, IL
1962	Fil.lic, Uppsala University Uppsala, Sweden
1961	Ph.D., Harvard University Cambridge, MA

CAREER EXPERIENCE

1983 - 1988	Senior Vice President for Academic Affairs and Provost University of Arizona, Tucson, AZ
1965 - 1983	UNIVERSITY OF MINNESOTA - Minneapolis, MN Vice President, Administration and Planning Associate Dean and Executive Officer, College of Liberal Arts Chairman, Department of Scandinavian Languages and Literature Director, Center for Northwest European Language and Area Studies Associate Professor and Professor, Scandinavian Languages and Literature Visiting at the University of Umea, Umea, Sweden - Thord-Grey Lecturer Visiting at Harvard University, Cambridge, MA - Lecturer
1964 - 1965	UNIVERSITY OF WISCONSIN - Madison, WI Visiting Assistant Professor - Scandinavian Studies
1961 - 1963	AUGUSTANA COLLEGE - Rock Island, IL Assistant Professor, Swedish Director, Swedish Summer School
1959-1961	HARVARD UNIVERSITY - Cambridge, MA Teaching Fellow
1954 - 1958	UPPSALA UNIVERSITY - Uppsala, Sweden Teacher, English (as a foreign language)

MINUTES
Planning and Development Committee
May 8, 1989

CALL TO ORDER
In the absence of Ms. B Kristine Johnson, Chair, and Mr. Leonard Bienais, Mr. Robert Dickler called the May 8, 1989 meeting of the Planning and Development Committee to order at 1:00pm in room 8-106 in the University Hospital.

Attendance:	Present	Robert Dickler Robert Latz William Jacott, M.D. Peter Lynch, M.D.
	Absent	B. Kristine Johnson, Chair Leonard Bienias Clint Hewitt Geoff Kaufmann Ted Thompson, M.D.
	Staff	Fred Bertschinger Al Dees Cliff Fearing Greg Hart Nancy Janda John LaBree, M.D. Mark Koenig Bruce Work, M.D. Helene Wald

APPROVAL OF MINUTES
The minutes of the March 16, 1989 meeting were approved as distributed.

OAK STREET PROPERTY
Mr. Hart reviewed recent efforts to secure the acquisition of the Oak Street property and reported no further action would be taken at this time. He reported that both the asking price and the negotiating price far exceeded the appraised value. He stated the 4 buildings on the property would need to be razed and a parking lot development was not a cost effective alternative. Mr. Latz asked if an option to purchase had been considered. Mr. Dickler answered that the property is probably only viable at this time if it is used as rental property and that for a variety of reasons the hospital did not consider this a viable option.

1989-90 CAPITAL BUDGET
Mr. Hart presented the proposed 1989-90 capital budget for information purposes. The $8,300,000 annual equipment and replacement budget consists of $6,723,000 for equipment purchases and $1,577,000 for equipment installation and remodeling.

Anticipated projects over $600,000 in addition to the annual budget include the purchase of a Lithotripter with the dual capability to treat both kidney and gall stones; the phased replacements of a C.T. scanner and a linear accelerator; a computer upgrade; the introduction of Interventional Radiology services (Neuroradiology upgrade), which will constitute a unique service in this region; and upgrading of the existing Heart Cath/CV Radiology units. Mr. Hart reported that the Masonic III project is now an approved rather than anticipated project and will be so reflected in future reporting. Board approval for the $8,300,000 capital budget will be requested at the June meeting.

1988/89 CAPITAL BUDGET STATUS REPORT

Mr. Hart reviewed the 1988/89 capital expenditure report. In the first nine months $3,374,772 has been spent which is lower than what was budgeted ($4,275,000) for recurring equipment and remodeling.

OBSTETRICS AND GYNECOLOGY

Mr. Dickler presented an update on the Phase II Renewal Project for Obstetrics. He noted that the renewal project had earlier included a proposal for an obstetrical unit split between Unit J and 4th floor Mayo. Further study by the planning review committee, assisted by a national consulting firm, now shows that consolidation of the OB program on 4th floor Mayo is more economically and programmatically sound. The project will be moved forward on this basis. An unresolved issue at the present time is whether the program will be developed to accommodate 1000 deliveries per year or phased to accommodate 600 deliveries annually with expansion capabilities to 1000 per year.

QUARTERLY PURCHASING REPORT

Mr. Koenig reviewed two vendor appeals, stating that the positions on these appeals were endorsed, the committee reviewed the report, endorsed it and forwarded the same to the Board for approval.

FORMAT FOR THE QUARTERLY PURCHASING REPORT

Mr. Koenig reviewed a revised format proposed for the quarterly purchasing report. The modified format incorporates graphs and presents summarized data. Increases in threshold reporting levels for "Purchase Orders to Other than Low Bidders" and "Sole Source" were proposed. Set Aside Awards would be summarized by quarter and the list of specific vendors eliminated. The quarterly summary of University Hospital Consortium Activity would be replaced by an annual report on the comparative pricing of consortium and non-consortium products. Mr. Dickler directed Mr. Koenig to verify that these changes would be in compliance with University practice. The proposed changes will be discussed further at the next meeting.

DEVELOPMENT OFFICE QUARTERLY REPORT
Mr. Dickler asked Mr. Bertschinger to defer his report to the next meeting.

MAJOR CAPITAL EXPENDITURES
Mr. Dees gave notice to the Board of an intent to renew the lease on the oldest of the three CT Scanners for a period of up to twelve months.

UMCA REPORT
Dr. Lynch reported that UMCA is out of it's management contract for home alimentation. Recruitment for a chief operating officer and medical director has been delayed until the role of UMCA is better defined. Dr. Lynch also reported a notable increase in referral activity and stated that UMCA has been able to rewrite some contracts for better returns to physicians. UMCA is also considering a pilot to use the current IDX system for billing in other departments.

ADJOURNMENT
Mr. Dickler adjourned the Planning and Development Committee at 2:20 p.m.

Respectfully submitted,

Helene Wald
Administrator, Planning and Marketing and Hospital Outreach

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 17, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Quarterly Purchasing Report

What follows is the Hospital's quarterly purchasing report for the period of January - March 1989.

In this month's agenda package we have included the report in the customary format as well as a modified format which we believe presents the data in a more meaningful and condensed manner.

We will be seeking endorsement of the quarterly report and comments on the new format.

Please call me if you have any questions regarding any portion of the report.

/th

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF JANUARY - MARCH 1989

I. PURCHASE ORDER ANALYSIS

RANGE	NUMBER OF P.O.'s	DOLLAR VALUE
$ 0 - $ 499	6332	$1,030,929.65
$ 500 - $1,999	2247	$2,317,411.14
$ 2,000 - $4,999	635	$1,946,848.24
$ 5,000 - $9,999	249	$1,721,013.11
$10,000 - OVER	324	$8,002,885.32
SUBTOTAL	9787	$15,019,087.46

II. CONFIRMING ORDERS

$ 0 - $ 99	123	$5,807.22
$ 00 - $ 499	171	$41,808.38
$ 500 - $ 999	48	$28,445.90
$1,000 - $1,999	38	$56,112.77
$2,000 - OVER	47	$245,454.75
SUBTOTAL	427	$377,629.02
TOTAL	10,214	$15,396,716.48

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)

III. PURCHASE AWARDS TO OTHER THAN LOW BIDDER ($5,000 OR MORE)

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Protective Eyewear	Warner Industrial Prod. $ 5,274.72	Baxter Scientific $ 5,530.00	Materials
		Glasses were too heavy and uncomfortable.		
		North Star Medical $ 1,368.00	Baxter Scientific $ 5,530.00	Materials
		Glasses did not provide adequate protection.		
2.	Test Kit	Abbott Labs $ 9,375.00	Genetic Systems $ 10,108.80	Labs
		CAP HIV - 1 survey results show that the kit offered has an unacceptable false positive rate, and the incubation time for the product is too long.		
3.	Dialyzers	Terumo $ 16,200.00	Baxter/Travenol $ 21,600.00	Materials
		The membrane of the dialyzer is manufactured with cuprammonium rayon which causes reactions in many patients.		
4.	Protein and Plasma	Baxter Scientific $ 16,920.00	American Bioproducts $ 26,250.00	Labs
		The product offered makes it difficult to quantitate Factor VIII levels of less than 10% for the diagnosis of hemophilia.		
5.	Assay Kits	Amersham $ 5,740.00	Incstar $ 5,827.50	Labs
		The use of the product bid would result in a change in patient test values.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
6.	Towel Clip	SMS $ 10,865.40	Medix $ 11,863.80	Materials
		Ratchet on the instrument is weak.		
		Lobdell $ 11,848.20	Medix $ 11,863.80	Materials
		Instrument is difficult to close.		
7.	Pasco Panels	Baxter Scientific $ 9,089.60/$ 12,160.00	Curtin Matheson $ 16,226.80	Labs
		Products lack several antimicrobials.		
8.	Surgical Microscope	North Central Instruments $ 76,000.00	Midwest Surgical $ 76,990.00	OR
		Alternate scope has a cooling fan which blows over the sterile field, it is difficult to access bulbs to change them, and footpedal is not waterproof.		
9.	Isolation Gown,Disp.	Baxter $ 32,871.60	Medline $ 43,911.60	Materials
		Gown is not fluid resistant and tears easily when unfolding.		
		Teknamed $ 36,225.00	Medline $ 43,911.60	Materials
		Gown is too small and constraining.		
		Intermedical Group $ 41,400.00	Medline $ 43,911.60	Materials
		Gown is too small and has an offensive odor.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
10.	Tubing Pack	Central Medical $ 5,892.00	Master Medical $ 8,388.00	Cardio-Respiratory
		Product did not contain enough tubing to supplement the pump packs used during open heart surgery.		
11.	Hard Shell Venous Reservoir	Baxter Bentley $ 6,500.00	Bard $ 8,500.00	Cardio-Respiratory
		Product lacks a 1/2" venous inlet for return line connection.		
12.	Tray, Urine Meter w/ Foley Cath	Medline $ 22,416.00	Bard $ 24,000.00	Materials
		No seal exists between catheter and tubing, increasing the potential for infection.		
		PMP $ 15,168.00	Bard $ 24,000.00	Materials
		No seal exists between catheter and tubing increasing the potential for infection; gloves cannot be removed from tray without contaminating kit contents; and urimeter measurements are not clear.		
13.	Embolectomy Catheters	Seaburg Medical $ 10,062.00	Baxter V. Mueller $ 14,322.00	Materials
		Catheter was very difficult to thread into vessel, balloon does not deflate properly and syringe size is not as specified.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
14.	Water Phantom Dosimetry	Theratronics $ 62,150.00	Medical Physics $ 97,422.10	Ther. Radiology
		System controller is not designed for X-Y plotter, it does not track preselected isodose curves, cannot use independent electrometers. Additionally, water phantom tank is too small, remote control is not provided, and software package does not allow diagonal scans or locate central axis from scanned beam.		
15.	Office Furniture Guest Arm Chairs	Offisource $ 4,4940.00	Daytons $ 5,219.00	Facilities
		Alternate chair is made of beech instead of maple, and has an inferior seat construction.		

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IV. SOLE SOURCE

VENDOR	CONTRACT/ P.O. #	VALUE	DEPT.	PRODUCT
Douglas Electronics	H093659	$2,900.00	Bio.Med.	CAD/CAM Software
Olympus	H090350	$6,700.00	Cardio.	Xenon Light Source
Kolling Co.	H093667	$21,900.00	Cardio.	Monitor & Interfaces
Stein Gates	H092895	$34,140.00	Cardio.	Jet Ventilators
Baxter	H092828	$2,100.00	Cardio.	Cardiotomy Reservoirs
Dale Medical	H092684	$15,000.00	Cardio.	Pulse Oximeter
Ernest & Whinney	H091789	$25,000.00	Finance	Claims Mgmt. Software
Unisys	H092841	$3,800.00	I.S.D.	Software Education & Support
Unisys Corp.	H091991	$10,750.00	I.S.D.	Alumni Development Software
Joseph & Cogan Assoc.	H092382	$28,900.00	I.S.D.	PATHVU Software
Western Business	H090347	$2,300.00	Labs	Laser Bar Code Reader
Kodak	H099535	OPEN	Labs	Slides
Marquette Electronics	89-332	OPEN	Labs	Electrode
Knowledge Data	H092680	$29,185.00	Labs	Instrument Interfaces
* Integrated Med. Sys.	H092890	$241,115.00	Marketing	Partners-In-Change Software
U.S. West Comm.	H091243	$38,841.69	Marketing	Direct Advertising
Synanon	H091238	$9,200.00	Marketing	Magnetic Tags
* Metro Traffic	H088925	$224,400.00	Marketing	Media Advertising
Tele Engineering	H090425	$20,250.00	M. & O.	Telelift Delivery Cars
Honeywell/BSD	H091471	$9,001.68	M. & O.	Honeywell System Components
Lintex	H376992	$27,250.00	M.S./Linen	Surgeon Gowns
Lintex	H377048	$6,794.00	M.S./Linen	Specialty Robes
* Candela/Comdisco	H099529	$96,444.00	Outpatient	Dye Laser (3 yr. lease agreement)
Baxter/V. Mueller	H375354	$3,112.35	O.R.	Instruments
Karl Storz	H091782	$2,580.00	O.R.	Arthroscope
American Medical Sys.	89-357	OPEN	O.R.	Urological Implants
* Candela	H099534	$249,900.84	O.R.	Lasertripter (3 year lease agreement)
Sebring & Assoc.	H376948	$2,595.00	O.R.	Needles & Membrane Scratchers
Great Lakes Orthpedic	89-750	OPEN	O.R.	Ortho. Implants
Metro Healthcare	H377498	$20,131.60	O.R.	Table Positioning Pad
Stryker	H092898	$19,390.00	O.R.	Sagittal Saw
3M	H379348	$2,497.00	O.R.	Ortho. Staples
Dacomed	H092899	$6,950.00	O.R.	Rigiscan
Hodapp Surgical	89-382	OPEN	O.R.	Neuro. Implants
Ruggles	H375355	$4,165.00	O.R.	Angled Currettes
Ocular Instruments	H376949	$3,675.00	O.R.	Lens Ring System

IV. SOLE SOURCE (cont'd)

Medsurg Products	H093087	$8,500.00	O.R.	Ophthalmoscope
Karlin Technology	H093663	$4,590.00	O.R.	Frame Retractor
Grieshaber	H092685	$16,660.00	O.R.	Instruments
Zinnati Surgical	H380410	$2,530.00	O.R.	Instruments
* Olympus	H090808	$56,610.00	O.R.	Angioscope
DVI	H376757	$7,050.00	O.R./Amb.	Bone Conductor Implant
G.E.	H091474	$30,000.00	Radiology	Coronary Filter Cones
DVI	H375251	$9,000.00	Radiology	Atherocath
Microvasive	H090412	$6,000.00	Radiology	Catheters
Schneider	H093669	$2,285.00	Radiology	Catheters
DVI	H376770	$4,980.00	Radiology	Atherocath
* Advanced Tech Labs	H091470	$87,050.00	Radiology	Ultrasound Upgrade & Probe
DVI	H091797	$6,030.00	Radiology	Catheters
Biochem International	H381284	$2,775.00	Radiology	Respiration Monitor
TOTAL		$1,415,028.16		

V. SET ASIDE AWARDS

A. AWARDED BIDS

CATEGORY	VENDOR	AWARDED AMOUNT
Anti-Embolism Stock-ings (contract)	Halcon	$28,196.60
Carpeting	Context Ltd.	$10,177.08
Furniture	PM Johnson	$20,374.20
Ortho Hard Goods (contract)	Quality Medical	$12,747.68
	TOTAL	$71,495.56

B. DEPARTMENTAL PURCHASES

JANUARY

	P.O. NUMBER	VENDOR	DOLLAR VALUE
1.	H085548	Trophy Craft	$126.75
2.	H090002	Quality Medical	$49.95
3.	H375233	Chrom Tech	$212.50
4.	H375368	Northern Balance	$399.00
5.	H091224	Quality Medical	$638.26
6.	H085549	Trophy Craft	$65.35
7.	H092301	Quality Medical	$319.29
8.	H376096	Medic	$608.25
9.	H085550	Trophy Craft	$101.05
10.	H092435	Quality Medical	$322.35
11.	H376583	Chrom Tech	$297.00
12.	H092551	Trophy Craft	$249.15
13.	H376843	Budget Paper	$49.90
14.	H375098	Art Materials	$81.00
15.	H375121	Art Materials	$426.60
16.	H375459	Art Materials	$36.00
17.	H375673	Art Materials	$27.00
18.	H376614	Art Materials	$365.40
19.	H374495	Halcon	$2,674.75
20.	H374839	Halcon	$255.60
21.	H375204	Halcon	$762.00
22.	H375342	Halcon	$228.60
23.	H375332	Halcon	$1,490.40

V. SET ASIDE (cont'd)

24.	H375469	Halcon	$952.38
25.	H375455	Halcon	$190.50
26.	H375573	Halcon	$114.30
27.	H375793	Halcon	$3,292.00
28.	H375819	Halcon	$1,269.84
29.	H376181	Halcon	$609.60
30.	H376514	Halcon	$2,674.75
31.	H375218	Quality Medical	$85.56
32.	H375330	Quality Medical	$79.00
33.	H374704	Kelly Computer Supply	$95.52
34.	H374843	Falcon Heights Medical	$469.44
35.	H374941	Halcon	$2,856.60
36.	H376850	Halcon	$419.10
37.	H376662	H.A. Roberts	$72.00
38.	H089153	PM Johnson	$20,374.20
39.	H091993	Context, Ltd.	$10,177.08
		JANUARY TOTAL	$53,518.02

FEBRUARY

1.	H377204	Quality Medical	$34.00
2.	H377513	Chrom Tech	$92.50
3.	H092315	Quality Medical	$759.64
4.	H092552	Trophy Craft	$145.80
5.	H377805	Chrom Tech	$325.00
6.	H377735	Chrom Tech	$918.00
7.	H377928	P.M. Johnson	$104.75
8.	H150294	Audio Visual Wholesalers	$163.00
9.	H092756	Quality Medical	$49.95
10.	H092323	Quality Medical	$179.40
11.	H376850	Halcon	$419.10
12.	H377269	Halcon	$762.00
13.	H377484	Halcon	$114.30
14.	H377583	Halcon	$85.20
15.	H377692	Halcon	$2,856.60
16.	H377869	Halcon	$170.40
17.	H378233	Halcon	$1,490.40
18.	H378159	Halcon	$190.50
19.	H377994	Halcon	$127.80
20.	H378305	Halcon	$2,880.50
21.	H378555	Halcon	$228.60
22.	H378772	Halcon	$38.10

V. SET ASIDE (cont'd)

23.	H378893	Halcon	$3,086.25
24.	H377861	Quality Medical	$225.00
25.	H377880	Quality Medical	$79.00
26.	H378981	Quality Medical	$59.25
27.	H376813	Falcon Heights Medical	$44.64
28.	H378662	Falcon Heights Medical	$66.96
29.	H377763	Art Materials	$568.80
30.	H378228	Art Materials	$402.60
31.	H378616	Audio Visual Wholesalers	$378.30
32.	H379003	Chrom Tech	$802.70
33.	H379120	Gisela's Interiors	$721.00
34.	H378513	Halcon	$609.60
35.	H378688	Medical & Legal Visuals	$24.00
36.	H379235	Medic	$675.35
37.	H092482	Quality Medical	$381.50
38.	H378481	Quality Medical	$225.00
39.	H378499	Quality Medical	$85.56
40.	H092553	Trophy Craft	$136.95
41.	H092554	Trophy Craft	$36.00
42.	H092829	P.M. Johnson	$236.80
43.	H377498	Metro Healthworld	$2,031.60
44.	H377332	Halcon	$2,674.75
		FEBRUARY TOTAL	$25,687.15

MARCH

1.	H093666	Context, Ltd.	$1,999.14
2.	H380887	Chrom Tech	$350.00
3.	H150550	Ability Plus	$175.00
4.	H380293	Art Materials	$348.00
5.	H380697	Art Materials	$56.55
6.	H379362	Chrom Tech	$978.55
7.	H380892	Chrom Tech	$147.34
8.	H381493	Chrom Tech	$100.00
9.	H379995	Halcon	$533.40
10.	H380129	Halcon	$2,732.40
11.	H380232	Halcon	$356.40
12.	H380316	Halcon	$170.40
13.	H380317	Halcon	$1,269.84
14.	H380432	Halcon	$2,674.75
15.	H379999	Falcon Heights Medical	$469.44
16.	H379319	Medic	$218.10

V. SET ASIDE (cont'd)

17.	H380556	Medic	$190.90
18.	H381200	Medic	$705.60
19.	H379987	Quality Medical	$525.00
20.	H380011	Quality Medical	$85.56
21.	H380127	Quality Medical	$59.25
22.	H093858	Quality Medical	$845.90
23.	H093934	Quality Medical	$49.95
24.	H092557	Trophy Craft	$86.70
25.	H092558	Trophy Craft	$101.40
26.	H090789	Quality Medical	$179.35
27.	H379737	Art Materials	$84.90
28.	H092555	Trophy Craft	$211.05
29.	H380045	Allanson Business	$173.50
30.	H380100	Quality Medi[illegible]	$170.00
31.	H380187	Medic	$227.50
32.	H090797	Quality Medical	$373.60
33.	H380383	Chron[illegible] Tech	$346.40
34.	H380438	Context, Ltd.	[illegible]1,391.03
35.	H092556	Trophy Craft	$104.55
36.	H090799	Quality Medical	$173.40
37.	H093853	Quality Medical	$376.[illegible]
38.	H380505	Art [illegible]terials	$36[illegible]
39.	H381359	Art Materials	$426.60
40.	H381351	Art Materials	$[illegible]
41.	H379664	Quality Med[illegible]al	$22[illegible]
42.	H379173	Falcon Heights Medical	$387.36
43.	H379530	Halcon	$800.10
44.	H379485	Halcon	$2,880.50
45.	H380532	Halcon	$1,356.25
46.	H380719	Halcon	$190.50
47.	H390609	Halcon	$1,490.40
48.	H381030	Halcon	$38.10
49.	H381131	Halcon	$2,674.75
50.	H381382	Halcon	$914.40
51.	H379733	H.A. Roberts	$1,112.40
		MARCH TOTAL	$31,609.59

C. QUARTERLY GRAND TOTAL

January Purchases	$53,518.02
February Purchases	$25,687.15
March Purchases	$31,609.59
GRAND TOTAL	$110,814.76

VI. VENDOR APPEALS

1. VENDOR NAME/DOLLAR AMOUNT: Medtox/Open Contract
   NATURE OF PURCHASE: Lab Testing
   INTENDED VENDOR/DOLLAR AMOUNT: National Psychology/Open Contract

   REASON FOR APPEAL:

   Vendor contended that notification of unacceptability of their product was not received until after the time for appeal had expired. As letter was postmarked with ample time for vendor to receive, UMHC responded that we were not responsible for the late delivery and therefore, considered the bid closed.

   STATUS: Contract awarded to National Psychology.

2. VENDOR NAME/DOLLAR AMOUNT: Organon Teknika/$ 2,600.00
   NATURE OF PURCHASE: Lab Kits
   INTENDED VENDOR/DOLLAR AMOUNT: Amersham/$ 3,224.00
   REASON FOR APPEAL:

   Organon Teknika maintained that test results were within Hospital standards. After investigation by Labs, this was found to be true. However, the establishment of new quality control and reference ranges would be costly, and the Lab has no extra techs to spare for this task. When new staff is hired in the Spring, Labs will consider this product. This was agreeable to Organon Teknika.

   STATUS: Contract awarded to Amersham.

3. VENDOR NAME/DOLLAR AMOUNT: Narco Medical/$ 42,257.01
   NATURE OF PURCHASE: Patient Care Rental Equipment (2 lines only)
   INTENDED VENDOR/DOLLAR AMOUNT: UHS/$ 51,755.49
   REASON FOR APPEAL:

   Vendor did not offer reprocessing, per specifications, on original bid. Narco claimed that 2 lines of equipment (monitors) were not being reprocessed at UMHC, and therefore they should receive the rental award. UMHC responded by stating that it was house-wide policy to reprocess all monitors and as they did not offer reprocessing, they would not receive the award. Narco then responded by stating they would now be willing to reprocess the monitors. This is considered an alteration to the original bid and contrary to bidding policies and procedures.

   STATUS: Bid is considered closed. Award made to UHS.

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

NATURE OF PURCHASE:	Stretcher
CONSORTIUM VENDOR NAME:	Hausted
PURCHASE ORDER #:	H093322
VALUE OF PURCHASE:	$ 3,524.82
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	$ 994.18

NATURE OF PURCHASE:	Memory Array Card
CONSORTIUM VENDOR NAME:	Hewlett Packard
PURCHASE ORDER #:	H092377
VALUE OF PURCHASE:	$ 2,441.56
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	$ 96.44

NATURE OF PURCHASE:	Healon Syringes
CONSORTIUM VENDOR NAME:	Pharmacia Labs
PURCHASE ORDER #:	N/A
VALUE OF PURCHASE:	$ 1,500.00
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	$ 180.00

NATURE OF PURCHASE:	Forms
CONSORTIUM VENDOR NAME:	Standard Register
PURCHASE ORDER #:	Various
VALUE OF PURCHASE:	$41,626.52
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	N/A

NATURE OF PURCHASE:	Surgical Dressings Contract
CONSORTIUM VENDOR NAME:	Johnson & Johnson
PURCHASE ORDER #:	N/A
VALUE OF PURCHASE:	N/A
VALUE OF NEXT LOWEST COST:	N/A
SAVINGS:	$1,671.00 (December) $ 656.00 (January) $ 406.00 (February)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY (cont'd)

NATURE OF PURCHASE:	I.V Solutions/Sets
CONSORTIUM VENDOR NAME:	Baxter
PURCHASE ORDER #:	N/A
VALUE OF PURCHASE:	N/A
VALUE OF NEXT LOWEST COST:	N/A
SAVINGS:	$48,339.02 (Quarterly Rebate)

Total Savings This Quarter:	**$52,292.64**
Total Savings This Fiscal Year:	**$589,689.48**

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF JANUARY - MARCH 1988

I. PURCHASE ORDER ACTIVITY

II. AWARDS TO OTHER THAN APPARENT LOW BIDDER

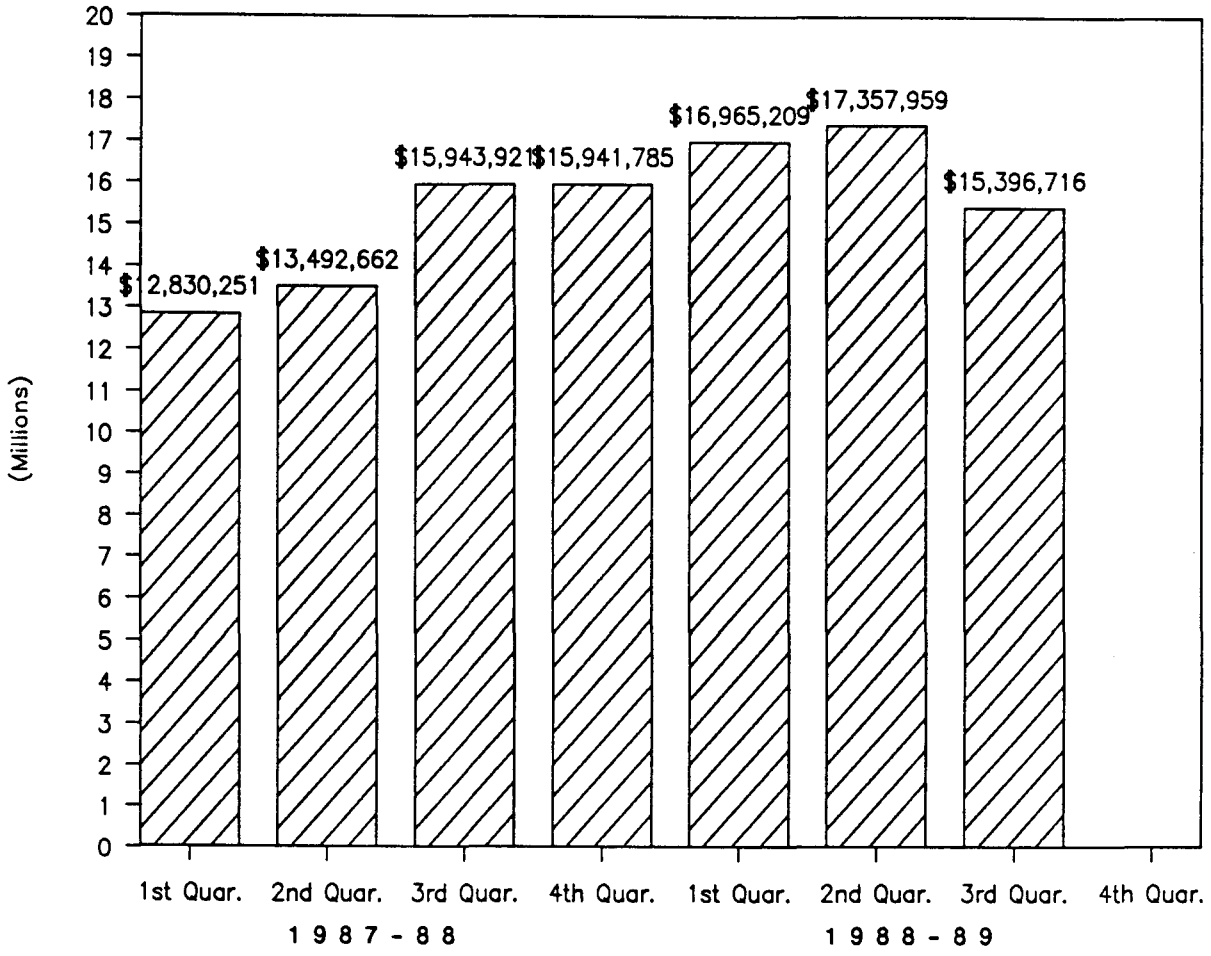
III. SOLE SOURCE ACTIVITY

IV. SET ASIDE ACTIVITY

V. VENDOR APPEALS

DRAFT

PURCHASE ORDER ACTIVITY



THIRD QUARTER, FISCAL YEAR 1988-89, ACTIVITY:

	NUMBER	VALUE
PURCHASE ORDERS	9787	$15,019,087.46
CONFIRMING ORDERS	427	$377,629.02
TOTAL THIS QUARTER	10,214	$15,396,716.48

DRAFT

III. PURCHASE AWARDS TO OTHER THAN LOW BIDDER ($25,000 OR MORE)

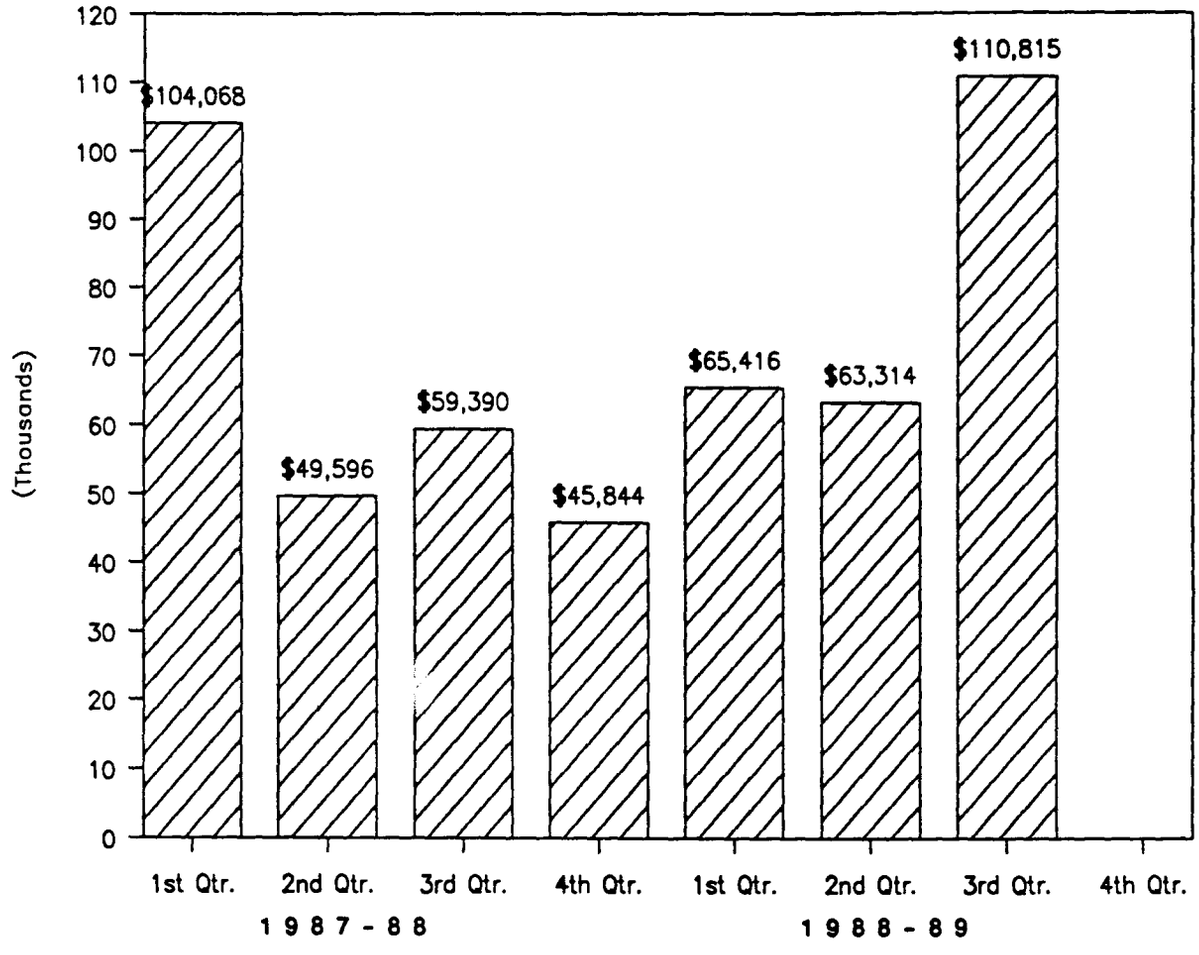
	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Protein and Plasma	Baxter Scientific $ 16,920.00	American Bioproducts $ 26,250.00	Labs
		The product offered makes it difficult to quantitate Factor VIII levels of less than 10% for the diagnosis of hemophilia.		
2.	Surgical Microscope	North Central Inst. $ 76,000.00	Midwest Surgical $ 76,990.00	OR
		Alternate scope has a cooling fan which blows over the sterile field, it is difficult to access bulbs to change them, and footpedal is not waterproof.		
3.	Isolation Gown, Disp.	Baxter $ 32,871.60	Medline $ 43,911.60	Materials
		Gown is not fluid resistant and tears easily when unfolding.		
		Teknamed $ 36,225.00	Medline $ 43,911.60	Materials
		Gown is too small and constraining.		
		Intermedical Group $ 41,400.00	Medline $ 43,911.60	Materials
		Gown is too small and has an offensive odor.		
4.	Water Phantom Dosimetry	Theratronics $ 62,150.00	Medical Physics $ 97,422.10	Ther. Radiology
		System controller is not designed for X-Y plotter, it does not track preselected isodose curves, cannot use independent electrometers. Additionally, water phantom tank is too small, remote control is not supplied, and software package does not allow diagonal scans or location of central axis from scanned beam.		

DRAFT

SOLE SOURCE - $10,000 and Over

VENDOR	CONTRACT/ P.O. #	VALUE	DEPT.	PRODUCT
Kolling Co.	H093667	$21,900.00	Cardio.	Monitor & Interfaces
Stein Gates	H092895	$34,140.00	Cardio.	Jet Ventilators
Dale Medical	H092684	$15,000.00	Cardio.	Pulse Oximeter
Ernest & Whinney	H091789	$25,000.00	Finance	Claims Mgmt. Software
Unisys Corp.	H091991	$10,750.00	I.S.D.	Alumni Development Software
Joseph & Cogan Assoc.	H092382	$28,900.00	I.S.D.	PATHVU Software
Knowledge Data	H092680	$29,185.00	Labs	Instrument Interfaces
Integrated Med. Sys.	H092890	$241,115.00	Marketing	Partners-In-Change Software
U.S. West Comm.	H091243	$38,841.69	Marketing	Direct Advertising
Metro Traffic	H088925	$224,400.00	Marketing	Media Advertising
Tele Engineering	H090425	$20,250.00	M. & O.	Telelift Delivery Cars
Lintex	H376992	$27,250.00	M.S./Linen	Surgeon Gowns
Candela/Comdisco	H099529	$96,444.00	Outpatient	Dye Laser (3 yr. lease agreement)
Candela	H099534	$249,900.84	O.R.	Lasertripter (3 year lease agreement)
Stryker	H092898	$19,390.00	O.R.	Sagittal Saw
Grieshaber	H092685	$16,660.00	O.R.	Instruments
Olympus	H090808	$56,610.00	O.R.	Angioscope
G.E.	H091474	$30,000.00	Radiology	Coronary Filter Cones
Advanced Tech Labs	H091470	$87,050.00	Radiology	Ultrasound Upgrade & Probe
TOTAL		$1,272,786.53		

SET ASIDE ACTIVITY



JANUARY PURCHASES	$53,518.02
FEBRUARY PURCHASES	$25,687.15
MARCH PURCHASES	$31,609.59
TOTAL THIS QUARTER	$110,814.76
VALUE OF CONTRACT AWARDS TO DATE, FISCAL YEAR 1988-89:	$98,606.56

DRAFT

IV. VENDOR APPEALS

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NATURE OF PURCHASE: Lab Testing
INTENDED VENDOR/DOLLAR AMOUNT: National Psychology/Open Contract

REASON FOR APPEAL:

Vendor contended that notification of unacceptability of their product was not received until after the time for appeal had expired. As letter was postmarked with ample time for vendor to receive, UMHC responded that we were not responsible for the late delivery and therefore, considered the bid closed.

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STATUS: Bid is considered closed. Award made to UHS.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Capital Expenditure

Attached is a major capital expenditure report for an item whose acquisition costs falls in the $100,000 - $600,000 range required for Board reporting. This is presented for information consistent with Board of Governors' policy.

We look forward to discussing this item with you at the Board of Governors meeting on May 24, 1989.

GH:th

Attachment

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review:	May 8, 1989
Finance Committee Review:	May 24, 1989
Board of Governors Review:	May 24, 1989

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: CT Scanner

PURCHASE PRICE: $211,632 (1 year lease at $17,636 per month)

DESCRIPTION:

UMHC installed the oldest of its three CT Scanners in 1984. Based on the results of an analysis of financing alternatives, the unit was acquired through a five year, operating lease at a total cost of $1,382,563.20 ($23,042.72 per month). The lease is due to expire on May 31, 1989.

The total volume of CT proceccdures continues to increase annually necessitating operation of three scanners. The projected volume for the current year is 10,360, up 18% from 1985-86 when the decision to purchase a third scanner was made.

The leased unit is no longer state-of-the-art for many procedures and needs to be replaced. However, priority of other equipment needs and the desire to further evaluate the CT machines available in the marketplace has moved planning and budgeting for a replacement into the 1989-90 fiscal year. Therefore, the management staff has decided to extend the current operating lease for an additional one year period.

The cost of the extended lease is included in the fiscal 1989-90 budget projections.

Submitted By: Al Dees
Title: Assoc. Dir.

Approved By:
Title: Senior Associate Director

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18,1989

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Quarterly Capital Expenditure Report

Consistent with Board of Governors' policy, attached please find a report on capital expenditure for the July, 1988 - March, 1989 time period. As you can see from the report, our capital expenditures year-to-date are running below budget and below historical seasonalized spending patterns.

This report is for your information; no action is required.

/th

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
CAPITAL EXPENDITURES
7-1-88 THRU 3-31-89

	ANNUAL BUDGET AND ROLLFORWARD			SEASONILIZED BUDGET			ACTUAL EXPENDITURES		
RECURRING EQUIP & REMODEL:	BUDGET	ROLL FORWARD FROM 6-30-88	TOTAL	9-MONTH BUDGET	9-MONTH ROLLFORWARD	TOTAL	88-89 ACTUAL	87-88 ROLL FORWARD	TOTAL
EQUIPMENT PURCHASES									
88-89 Budget	$6,718,513		$6,718,513	$3,500,000		$3,500,000	$3,097,640		$3,097,640
Rollforward		$2,847,693	$2,847,693		$1,600,000	$1,600,000		$945,698	$945,698
	$6,718,513	$2,847,693	$9,566,206	$3,500,000	$1,600,000	$5,100,000	$3,097,640	$945,698	$4,043,338
REMODELING PROJECTS	$1,272,650		$1,272,650	$775,000		$775,000	$277,132	$187,729	$464,861
	$7,991,163	$2,847,693	$10,838,856	$4,275,000	$1,600,000	$5,875,000	$3,374,772	$1,133,427	$4,508,199
PRINCIPLE PAYMENTS									
CT SCANNER	$179,800					$133,600			$133,600
COMPUTER EQUIP	$665,795					$530,397			$530,397
LITHOTRIPTOR	$288,405					$214,316			$214,316
	$1,134,000					$878,313			$878,313
TOTAL:	$9,125,163					$6,753,313			$5,386,512
BOND PAYMENTS:	$2,815,000								$2,815,000

CAPITAL PROJECTS:

	AUTHORIZED BUDGET	EXPENDITURES 1988-89	TOTAL EXPEND. TO DATE
MRI II	$3,600,000	$363,459	$363,459
DERMATOLOGY	$612,410	$209,557	$270,451
MAYO 4 SURG	$1,029,350	$193,296	$193,296
CUHCC	$1,350,000	$331,373	$331,373
MASONIC HOSP	$600,000	$11,187	$11,187
COMPUTER UPGRADE	$850,000	--	--
NEURORADIOLOGY UPGRADE	$909,000	--	--
TOTAL	$8,950,760	$1,108,872	$1,169,766
MISC. CAPITAL EXPEND		$75,483	
		$1,184,355	

MINUTES
Joint Conference Committee
Board of Governors
May 10, 1989

CALL TO ORDER:

In the absence of Chairman Heenan, David Link called the May, 1989 meeting of the Joint Conference Committee to order at 4:37 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Amos Deinard, M.D.
Phyllis Ellis
David Link
James Moller, M.D.
Bruce Work, M.D.

Absent:
Li[illegible] Arendt, M.D.
Ro[illegible]t Dickler
Geo[illegible] Heenan

Staff:
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Charles Andres, M.D.
James G. White, M.D.

APPROVAL OF MINUTES:

The minutes of the April 12, 1989 meeting were approved as submitted.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work indicated that the primary topic of conversation at recent Clinical Chiefs' meetings has been the implications for clinical services of current UHMC budget and cost containment efforts. He noted that there had also been discussion as to how the clinical services would cope with additional workload in the event of a community nursing strike. Dr. Work also announced that Dr. Robert Maxwell had been nominated for Chief of Staff and that Dr. Patricia Ferrieri had been nominated to be Vice Chief of Staff.

RELATIONSHIPS WITH INDUSTRY

Dr. James White provided an overview of the activities of the Industry University Relationships Review Committee (IURRC). He noted that industry is becoming an increasingly important source of grant funding for research on a national level as federal dollars to support research shrink. Industry dollars can be particularly valuable for young researchers who do not have an established track record.

He noted that the role of the IURRC is to review the grant contracts between researchers and industry to assure that a) there is no conflict of interest present in the relationship, and b) that the academic freedom of the researcher is not severely restricted by any contractual relationship. He stressed that the pool of researchers at the University are a valuable state resource that should be used to help develop the state's economy, but should not become a subsidized tool only for industry.

Discussion ensued relative to the nature and processes involved in University-Industry research relationships.

DISASTER COMMITTEE REPORT

Mary Ellen Wells, Assistant Director, introduced Dr. Charles Andres, Chairman of the UMHC Disaster Committee. Dr. Andres described the Emergency Medical System (EMS) at the University, state and national levels and UMHC's role as an integral part of the overall system. UMHC's involvement is coordinated through the Disaster Committee. He made particular note that we maintain our preparedness for emergency situations that will happen at some point and described a number of disaster drills which UMHC participates in on at least a biannual basis.

Discussion ensued regarding various aspects of UMHC's expected participation in a number of emergency scenarios.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT:

Dr. James Moller noted that the Council had passed a new policy which addresses the problem of incomplete surgical documentation. The new policy puts a physician on probationary status if 5% of that physician's operative reports are not completed within three days of the procedure on a quarterly basis. If the physician cannot rectify the situation in one quarter, the physician will loose the ability to schedule operating room time. If after two quarters the physician is still not in compliance, all privileges will be suspended. Discussion ensued.

Dr. Moller also noted that there was a new law that would require physicians to report other physicians under certain circumstances to the State Board of Medical Examiners (SBME). Physicians who do not report such behavior to the SBME could be held liable for not reporting and be subject to loss of their license. He noted that this creates a number of very difficult dilemmas for physicians

Discussion ensued and Dr. Moller indicated that the Impaired Physician Task Force would gear up to examine the law and its implications for UMHC staff.

OTHER BUSINESS

Answering a question from David Link, Greg Hart informed the group that extensive follow up activity was being conducted to the utilization review discussions at the Clinical Cheifs April 14th retreat.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:20 P.M.

Respectfully Submitted

Theodore J. Yank

DISCLOSURE OF FINANCIAL ARRANGEMENTS WITH INDUSTRY

University of Minnesota

1. PREAMBLE

The University of Minnesota actively encourages and participates in interaction with private companies as an important component of its research, education, and public service missions. Research agreements between the University and private companies provide a valuable source of funds, equipment, and topics for University research. Consulting arrangements and other contacts between faculty and private companies advance the faculty's ability to provide a high quality research and educational experience for students and enhance employment opportunities for students. Licensing by the University to private companies, consulting services by faculty for private companies, assistance by faculty in new company starts, and other forms of technology transfer are critical to meeting society's needs. The University, therefore, clearly has a responsibility to foster the free flow of ideas and individuals between the University and the private sector.

The commitment of the University to this responsibility is reflected by its policies and guidelines relating to interaction with industry. The Patent and Technology Transfer Policy, Policy on Outside Consulting, and Guidelines on Interaction with Industry all recognize the value of various types of relationships with the private sector and provide the means to advance these relationships. These policies and guidelines are supported by the integrity of the faculty and by the adherence of the faculty to principles of good scholarly and professional practice. In view of the increased interaction between the University and the private sector there is a need for a vehicle to safeguard the University's independence, credibility, and primary missions, and the integrity of those University staff members involved in such interactions. Accordingly, this statement of principles is intended to facilitate and encourage interaction with the private sector by ensuring an environment in which University personnel are permitted the maximum freedom to enter into and continue various types of relationships outside of the University, while at the same time furthering the principal missions of the University and maintaining high standards of professional and ethical conduct.

2. OTHER APPLICABLE POLICIES AND LAWS

This policy complements the provisions of other applicable policy, regulation, and laws, including the Policy on Outside Consulting, the Patent and Technology Transfer Policy, the statement "On Preventing Conflicts of Interest in Government-Sponsored Research at Universities," Guidelines on Interaction with Industry, the Tenure Code, and applicable state and federal law. This policy is intended to help implement and expand upon these other related requirements. It should be noted that this policy does not apply to Medical School consultation practices that are in accord with the Regents' Policy on Private Consultation Practice.

3. GENERAL PRINCIPLES

With the acceptance of appointment or employment, an individual makes a commitment to the University and accords the University his or her primary professional loyalty according to the terms of appointment or employment. Every person is expected to arrange outside obligations, financial interests, and activities so as not to conflict or interfere with this overriding commitment to the University. At the same time, no one benefits from undue interference with the legitimate external activities of individuals who fulfill their primary full-time duties—teaching at the University, conducting scholarly research under its sponsorship, and meeting the other obligations to students and colleagues. Indeed, the involvement of individuals in outside professional activities, both public and private, often serves not only the participants but the University as a whole. It has been, and continues to be, assumed that all individuals will be alert to the possible effects of outside activities on the objectivity of their decisions, their obligations to the University, and the University's responsibility to others.

The areas of potential conflict may be divided into two broad categories. The first relates to conventional conflicts of interest—situations in which individuals may have the opportunity to influence the University's decisions in ways that could lead to personal gain or give improper advantage to their associates. The second is concerned with conflicts of commitment—situations in which an individual's external activities, often valuable in themselves, interfere or appear to interfere with their paramount obligations to students, colleagues, and the University. Researchers and scholars are given great freedom in scheduling their activities with the understanding that their external activities will enhance the quality of their direct contributions to the University.

Currently, universities customarily use the term "industry" in the generic sense, to encompass their relations with all facets of the private sector. Throughout this policy, therefore, the term "industry" is not used in any restrictive sense, but rather applies generally to all private enterprise. This policy is intended to apply solely to sponsored research, technology transfer, and other written agreements as provided for in Section 5.f.

4. DEFINITIONS

a) PERSONNEL shall mean all persons appointed, employed and/or compensated by the University, including faculty, visiting faculty and researchers, professional and administrative staff, civil service employees, research and teaching assistants, residents, fellows, and trainees.

b) COMPANY shall mean any corporation, partnership, proprietorship, firm, association, or other legal entities worldwide, excluding government entities in the United States.

c) INTEREST shall mean any of the following interests in the aggregate held in a COMPANY, but not in a mutual fund whose investment policies are beyond the control of the individual, by PERSONNEL and/or PERSONNEL's spouse and/or dependent children:

(i) an investment comprising equity or options to purchase equity with a total current [illegible] greater than $1,000.00 or representing [illegible] the total COMPANY equity; and/or

(ii) personal payments (excluding consulting fees), gifts, and other benefits, including personal loans and services, received from a COMPANY by PERSONNEL within the previous twelve months with a total current value of more than $1,000.00 and/or

(iii) a consulting arrangement with a COMPANY or other agreement to provide services to a COMPANY which is or should be disclosed in accordance with the Policy on Outside Consulting;

(iv) status as a director, scientific director or member of the scientific board of advisors, officer, partner, trustee, or employee (other than a consultant) of a COMPANY.

d) SPONSORED RESEARCH shall mean any research sponsored by a COMPANY at the University which is governed by an agreement, written or oral, in which there is ongoing expectation or interest by the COMPANY in information developed under the research, the results of the research and/or property rights in the product of the research.

5. OPERATING PRINCIPLES

a) General. PERSONNEL may form relationships with COMPANIES, including acquiring an INTEREST in a COMPANY, provided that such relationships satisfy this policy and any other applicable policies and laws. The University encourages all PERSONNEL to form relationships with COMPANIES which further its education, research, and public service missions. For example, effective transfer of University technology may require that the PERSONNEL who originally developed the technology have a consulting agreement with or otherwise assist the COMPANY in acquiring rights in the technology. Under such circumstances, equity in the COMPANY may be an appropriate means to compensate the PERSONNEL. The COMPANY may also desire to fund further University research concerning the technology to be conducted by those PERSONNEL. These combination relationships and other relationships are permissible, and may indeed be very desirable to meeting University objectives, provided that the disclosure requirements in this policy are satisfied. Disclosure will allow the opportunity for review to ensure that the performance of PERSONNEL's duties is not compromised.

b) Actual Conflicts. PERSONNEL shall not enter into or allow conflicts of interest or conflicts of commitment to the University, as those terms are annunciated in the General Principles. Determination whether an actual conflict exists shall be made by the appropriate vice president, or chancellor, if a coordinate campus is involved. If PERSONNEL wish to initiate or continue such a conflicting relationship with a COMPANY and remain associated with the University, they shall seek a suitable leave of absence, reduction of appointment, or other arrangements with the University.

c) SPONSORED RESEARCH Proposals. PERSONNEL with an INTEREST in a COMPANY and who propose SPONSORED RESEARCH to be funded by that COMPANY shall disclose the existence of the INTEREST. To the extent allowed by law, such disclosure shall be considered private until the project is awarded. The disclosure shall be public information after the project is awarded.

d) SPONSORED RESEARCH Participation. PERSONNEL with an INTEREST in a COMPANY and who participate in SPONSORED RESEARCH funded by that COMPANY shall disclose the existence of the INTEREST. Such disclosure shall be considered public information.

e) Technology Transfer. PERSONNEL with an INTEREST in a COMPANY shall disclose the existence of that INTEREST in the instance that the University is considering the transfer of rights, by license or otherwise, in technology developed by PERSONNEL to the COMPANY. To the extent allowed by law, disclosure shall be considered private.

f) Other Written Agreements. In addition to restrictions in applicable law, PERSONNEL with an INTEREST in a COMPANY shall not propose, negotiate, or approve on behalf of the University a contract or other commitment concerning that COMPANY without full disclosure of the INTEREST. The disclosure shall be considered public information. This paragraph applies to all written agreements including, but not limited to, lease agreements, and orders and requests for goods, services, or personnel from COMPANIES (including equipment, consulting services, and legal services). This provision does not cover research grants and contracts and relationships otherwise covered by Section 5.c., 5.d. or 5.e. above.

g) Public Statements. PERSONNEL with an INTEREST in a COMPANY are expected to refrain from making public statements (statements for use by the press and/or to individuals with an interest in the stock of the COMPANY) regarding SPONSORED RESEARCH prior to publication of the results in recognized scientific literature or presentations at recognized scientific meetings. Whenever possible, the University shall include a clause reflecting this principle in each industry sponsored grant, contract, or agreement.

6. IMPLEMENTATION

a) Compliance with this policy requires a three step determination:

(i) Does an INTEREST exist?
The existence of an INTEREST is determined by applying Section 4.c. to the situation.

(ii) When an INTEREST exists, must it be disclosed?
This is determined by applying Sections 5.c., 5.d., 5.e. and 5.f. to the situation.

(iii) When an INTEREST exists, must approval of a vice president, or chancellor, if a coordinate campus is involved, be obtained?
This is determined by applying Section 6.b.to the situation or, when a BA Form 23, Application for External Research or Training Support, is not involved, by the appropriate department head or dean after consultation with PERSONNEL involved.

b) Disclosure under Sections 5.c. and 5.d. shall be made in the manner prescribed by BA Form 23. These dis-

closures will be made as part of the proposal process and shall be updated as PERSONNEL are added to the project or as INTEREST of PERSONNEL changes during the term of the project. After acknowledgment by the appropriate department head and dean, the BA Form 23 and accompanying proposal shall be sent to the Office of Research and Technology Transfer Administration. The Office of Research and Technology Transfer Administration will forward the BA Form 23 to the appropriate vice president, or chancellor, if a coordinate campus is involved, for approval when required.

It is required by University policy that all SPONSORED RESEARCH be covered by a BA Form 23. However, disclosures made during the term of the project and disclosures not made on a BA Form 23 shall be in the form of a memo to the appropriate department head and dean for their acknowledgment. The memo shall then be sent to the Office of Research and Technology Transfer Administration for consideration and for forwarding to the appropriate vice president, or chancellor, if a coordinate campus is involved, when approval is required.

The memo shall define the nature of the contract or other agreement and the COMPANY involved. Where possible, appropriate documentation from the COMPANY shall be attached. This memo shall be submitted in a timely manner so as to permit consideration by appropriate administration officials prior to consummation of the relationship.

c) Approval of the appropriate academic vice president, or chancellor, if a coordinate campus is involved must be obtained prior to submission of the SPONSORED RESEARCH proposal to the COMPANY or participation in SPONSORED RESEARCH, and approval of the Vice President for Finance and Operations must be obtained prior to the transfer of rights in technology developed by PERSONNEL to the COMPANY, when PERSONNEL have an INTEREST in the COMPANY that is:

(i) an investment comprising equity or options to purchase equity with a total current value of more than $25,000.00 or representing more than 5% of the total COMPANY equity; and/or

(ii) personal payments (excluding consulting fees), gifts, and other benefits, including personal loans and services, received from a COMPANY to PERSONNEL within the previous twelve months with a total current value of more than $2,000.00; and/or

(iii) a consulting arrangement with a COMPANY or other agreement to provide ser a COMPANY which is or should be disclosed in accordance with the Policy on Outside Consultin with annual compensation of more tha $10,000.00; and/or

(iv) status as a director, scientific director or membe of the scientific board of advisors, officer, partner, trustee, or employee (other than a consultan of a COMPANY.

Faculty may wish to seek the above approval in appr priate cases where an INTEREST exists but does n meet the above definitions. Approval shall be grante or denied within two weeks of submission to th president, or chancellor, if a coordinate campus i volved.

Factors that will be taken into account by the appropr ate vice president, or chancellor, if a coordinate can pus is involved determining approval include:

(i) THE PROMINENCE AND SIGNIFICANC GIVEN THE UNIVERSITY AFFILIATIO Where the name and/or authority of the Unive sity (as opposed to that of the researcher) is mo clearly being invoked, the University should i tutionally examine research af mo carefully.

(ii THE EFFECT OF THE OUTCOME ROJECT ON EXPECTED BEHA THERS. Where endor oject policy will result in people in significant numbe using a product or investing money or otherwi changing their lives, the University must bear sponsibility to maintain objective evaluatior Where these first two factors combine to sugg the University or a segment thereof, is acting an independent evaluative laboratory, Universi responsibility is at a maximum.

(iii) DEGREE OF INVOLVEMENT AND DA GER OF OVER-COMMITMENT TO DETF MENT OF UNIVERSITY MISSIONS. T University has the duty to scrutinize requests the light of its own missions. High quality search should be encouraged. The extent of volvement of PERSONNEL in a project sho not conflict with University activities.

d) Disclosure under Section 5.e. shall be made in t form of a memo to the Assistant Vice President for F search and Technology Transfer Administration. Tl memo shall be submitted timely manner so as permit consideration by appropriate administration ficials prior to consummation of the relationship.

e) Disclosure under Section 5.f. shall be made by memo to PERSONNEL with no INTEREST in the COMPANY who have final authority over negotiations and approval. The memo shall define the nature of the contract or other agreement and the COMPANY involved. Where possible, appropriate documentation from the COMPANY shall be attached. This memo shall be submitted in a timely manner so as to permit consideration by appropriate administration officials prior to consummation of the relationship.

f) The University will maintain a standing committee to deal with issues concerning this policy. This committee shall have the following principal functions:

(i) to assist in the implementation of this policy;

(ii) to answer questions concerning this policy (the identity of PERSONNEL asking questions and the specific facts of questions shall be kept private to the extent allowed by law);

(iii) to review and comment on any disciplinary action to be taken under this policy;

(iv) upon the request of affected faculty, to review a decision by an administration official that an INTEREST constitutes an actual conflict of interest. The results of this review shall be forwarded to the appropriate vice president, or chancellor, if a coordinate campus is involved, and President of the University for final action; and

(v) to periodically review this policy, including the set financial thresholds established herein.

This committee shall be comprised of:

1 member of the Senate Research Committee
1 member of either the Senate Faculty Affairs or Judicial Committees
1 member of the Patent and Technology Transfer Council
1 member of the Medical School
1 member of the Institute of Technology
1 member representing the other colleges
1 member representing the coordinate campuses
1 ex officio member of the Office of Research and Technology Transfer Administration
1 ex officio member of the University Attorney's Office.

Members from standing committees, the Patent and Technology Transfer Council, and ex-officio members, shall be appointed by the committees, Council, and offices, respectively, which they represent. The members from the Medical School and the Institute of Technology shall be appointed by their respective deans. The member representing the other colleges shall be appointed by the Vice President for Academic Affairs in consultation with the deans of the other colleges. The member representing the coordinate campuses shall be appointed by consultation among the chancellors of the coordinate campuses.

g) Appropriate disciplinary action (for faculty, under the Tenure Code) may be taken by the University against PERSONNEL who violate this policy.

Questions regarding this policy should be directed to:

John Thuente, Director
Patents and Licensing 624-2816

Judy Volinkaty
Patents and Licensing 624-3317

GENERAL DESCRIPTION OF THE UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS EMERGENCY PREPAREDNESS PLAN

The general concept behind the development of the University of Minnesota Hospitals' Emergency Preparedness Plan, is to maintain an emergency response level which is appropriate to the situation and simple to implement. In order to accomplish this goal, an emergency preparedness plan has been set forth which will respond to any emergency situation, whether generated internally or externally.

Because of the wide variety of possible emergency situations, the University Hospitals' response philosophy is to assemble a group of informed decision makers to direct the Hospitals' activities during an emergency situation. To facilitate this decision making, and to assist in dealing with the emergency, various response activities are described in this manual as well as some basic guidelines which the decision making group, hereinafter referred to as the Emergency Management Staff (E.M.S.) will utilize.

In general, the University of Minnesota Hospitals and Clinics Emergency Preparedness Plan is composed of a few basic employee and staff responses to an emergency situation, combined with direction and decision making on the part of the Emergency Management Staff. The Director of Protection Services shall be responsible for insuring that the Hospitals' emergency preparedness is at a desirable level.

The Emergency Management Staff shall function under the auspices of the Disaster Committee and the Fire Sub-Committee. All activities relating to emergency situations of an internal nature not dealing with patient care or patient supervision, shall be under the jurisdiction of the Fire Sub-Committee. The Disaster Committee has the responsibility for the development and updating of the overall Hospital Disaster Plan, with special attention being given to externally generated emergency situations and internal emergencies involving patient care or supervision. All policies, procedures, and reports are to be channeled to the appropriate committee by the Director of Protection Services, who is to provide any necessary support to both the Fire and Disaster Committees.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
April 26, 1989

MINUTES

ATTENDANCE:

Present:	Carol Campbell Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Elwin Fraley, M.D. Vic Vikmanis
Not Present:	Erwin L. Goldfine Jerry Meilahn Barbara O'Grady
Staff:	Al Dees Greg Hart Teri Holberg Nancy Janda Nels Larson Dan Rode Barbara Tebbitt

CALL TO ORDER:

The Finance Committee was called to order by Mr. Robert M. Dickler on April 26, 1989 at 12:16 p.m.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the April 10, 1989 meeting as written.

JULY 1, 1989 THROUGH MARCH 31, 1989 FINANCIALS:

Mr. Clifford Fearing reported that ancillary activity levels continued to increase even though inpatient admissions for March were 2% under budget. Patient days were 1414 days over budget and the average length of stay was 8.5 days, which was budgeted at 7.7 days. Average daily census for March was 437. The first twenty-one days of April were reported to be running

slightly ahead of budget with an average daily census of 451. Outpatient visits were 1% over budget. A substantial turnaround was reported in the February to March net revenue. The net revenue position for March was $679,000, where February had a loss of $489,000. Ancillary revenue was reported to be 10.9% over budget and the receivables had declined from 107 days to 101 days.

Lastly, Mr. Fearing reported the $21,765,000 remaining from the construction fund was transferred from the Trustees to the Hospital. The transfer will enable UMHC to earn a higher rate of interest of 9.5% on those funds.

1989-90 BUDGET:

Mr. Fearing presented to the Committee the 1989-90 Budget for information only. The 1989-90 Budget will be brought before the Committee in May, 1989 for endorsement.

Mr. Fearing stated what was brought before the Committee at this time had three major changes in the assumptions that were made in the proposal at the April 10th joint meeting. The changes were: 1) a decline in receivable levels by $2,000,000, 2) a reduction in general supply and expenditure by $2,000,000 and, 3) a reduction in FTEs from 4100 to 4080, reducing costs by $2,500,000.

With these assumptions a 1989-90 budget was developed with a 7.5% rate increase, creating a cash flow of $959,000, and a 9.5% rate increase which would have a cash flow of $2,700,000. Because it remains unclear how the Medicare regulations and compensation packages will impact the budget, two rate increases were provided with the idea of proposing a rate increase of 9.5% with an implementation effective 7/1/89 of 7.5%. This would provide the flexibility to increase rates throughout the year up to 9.5% without the need to have the formal 60 day notice for rate review.

Mr. Fearing, therefore, submitted to the Committee, for endorsement, a rate increase of 9.5% with an implementation of 7.5% on July 1, 1989.

The Board of Governors Finance Committee seconded and passed the motion of a 9.5% rate increase with the immediate implementation effective July 1, 1989 of a 7.5% rate increase.

Buying Down of Hospital Debt - Update

Mr. Fearing updated the Committee on the buying down of the Hospital's debt. Medicare had proposed adjustments which would have disallowed all the interest expense on the Unit J building. Their reasoning was twofold: 1) they felt UMHC had over borrowed on the 1982 Bond issue by approximately $21,000,000 and, 2) the total reserves were not dedicated to a specific project. Mr. Fearing reported after consulting with UMHC's Medicare attorney it was decided not to pursue the reimbursement of the $21,000,000. As a result of this decision Medicare has agreed not to offset the interest income on this debt which would created a double offset.

With regard to the second issue, Mr. Fearing stated there are indications Medicare will not pursue the reserve issue any further. UMHC met with Medicare and presented to them documentation showing the renewal project was in fact a two phase project. Phase one being the Unit J building and phase two the extensive remodeling of the Mayo building. Medicare has not made a final decision as of yet, but it appears they may be changing their position.

Mr. Fearing reported that with the uncertainty of the reserve issue and with the transferring of the $21,765,000 at an interest rate of 9.5% from the Trustee to UMHC, it is felt it is not time to buy down the debt. Further evaluation of the buying down on the debt will be made after Medicare has decided on the reserve issue.

MAJOR CAPITAL EXPENDITURE:

Mr. Al Dees reviewed, for information purposes, a major capital expenditure report in the $100,000 - $600,000 range. The major capital expenditure would be for two mobile C-arm radiolographic/fluoroscopic units, which was included in the capital budget for this year. The operating room will receive one of these machines because of an increase in demand, and the other will go to endoscopy suite where the number of procedures have increased enough to justify having a machine in there at all times. At the present time the endoscopy suite is sharing a machine in with the forth floor procedure room.

THIRD QUARTER, 1988-89 BAD DEBTS:

Mr. Dan Rode reported the bad debts for the third quarter totaled $923,257.76 represented by 1,502 accounts. Recoveries amount to $4,810.44, leaving a net charge-off of $918,447.32. This amount represents 1.18% of gross charges and compares to a budgeted level of 1.05%.

The Finance Committee seconded and passed a motion to endorse the Third Quarter 1988-89 Bad Debt report as submitted.

There being no further discussion, the April 26, 1989 meeting was adjourned at 1:25 p.m.

Respectfully submitted,

Teri Holberg

Teri Holberg
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 24, 1989

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period July 1, 1988 through April 30, 1989

The Hospital's operations through the month of April continue to reflect both inpatient admissions and outpatient visit activity that are above budgeted levels although the month of April saw a decline in inpatient census levels. Both ancillary and routine revenue are above budgeted levels for the month of April and year-to-date.

INPATIENT CENSUS: For the month of April, inpatient admissions totaled 1,538, which was 45 below budgeted admissions of 1,583. Our overall average length of stay for the month was 8.5 days. Patient days for April totaled 13,366 and were 1,191 days over budget. The decrease in admission levels from budget was primarily in the areas of Gynecology and Ophthalmology. It was partially offset by an increase in Medicine.

To recap our year-to-date inpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Admissions	15,853	15,411	15,643	232	1.5
Patient Days	127,043	118,975	133,204	14,229	12.0
Avg Length of Stay	8.0	7.7	8.5	0.8	10.4
Avg Daily Census	416.5	391.4	438.2	46.8	12.0
Percent Occupancy	71.9	67.8	75.5	7.7	11.4

OUTPATIENT CENSUS: Clinic visits for the month of April totaled 22,215 which was 1,239, or 5.3%, under budgeted visits of 23,454. Areas in which actual visits were under budget included Otolaryngology, Surgery, OB/GYN, Medicine and Ophthalmology. The decreases were partially offset by increases in Diabetes Center, Orthopedics, Masonic Day Hospital and Family Practice. Community University Health Care Center (CUHCC) visits for the month of April totaled 4,246, which was 278, or 7.0%, over budgeted visits of 3,968 while Home Health visits of 976 for the month were 187, or 23.7%, above budgeted visits of 789.

To recap our year-to-date outpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Clinic Visits	217,056	219,185	223,067	3,882	1.8
CUHCC Visits	40,046	41,270	38,966	(2,304)	(5.6)
HHA Visits	7,838	7,996	10,059	2,063	25.8

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses over revenue by $1,033,700, an unfavorable variance of $1,990,932.

Patient care charges through April totaled $258,587,465, which was 11.4% over budget. Routine revenue was 15.2% over budget and reflects our year-to-date favorable patient day variance.

Ancillary revenue was $17,341,352 above budget (10.1%) and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $ 8,917 per admission compared to the budgeted average of $7,982 per admission. Outpatient revenue per clinic visit has averaged $225 compared to the budgeted average of $226.

Operating expenditures through April totaled $226,262,536 and were $11,339,932(5.3%) over budgeted levels of $214,922,604. The overall unfavorable variance relates primarily to the increased demand for patient services, and is reflected in higher personnel costs and patient care supplies (drugs, blood, and medical supplies and services).

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of April 30, 1989, totaled $93,068,254 and represented 102.6 days of revenue outstanding. The overall increase in our patient receivables in April of 1.2 days occurred primarily in Minnesota Medical Assistance and Medical Assistance - Other States.

CONCLUSION: The Hospital's overall operating position for the month of April is negative, for the second time this fiscal year. Losses for the month were centered around increased salary costs and deductions from charges. We will continue to investigate these variances and will report on them at the May 24, 1989 meeting.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1988 TO APRIL 30, 1989

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$232,172,387	$258,587,465	$26,415,078	11.4%
Deductions from Charges	40,154,261	59,046,042	$18,891,781	47.0%
Other Operating Revenue	7,186,765	7,891,864	$705,099	9.8%
Total Operating Revenue	199,204,891	207,433,287	8,228,396	4.1%
Total Expenditures	214,922,604	226,262,536	11,339,932	5.3%
Net Operating Revenue	(15,717,713)	(18,829,249)	(3,111,536)	-19.8%
Non-Operating Revenue and Expenses	17,848,874	19,457,440	1,608,566	9.0%
Revenue Over/Under Expense	$2,131,161	$628,191	($1,502,970)	
Prior Year BC/BS Adjustment		(1,619,440)		
Adjusted Revenue Over/(Under) Expense		(991,249)		

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Admissions	15,411	15,643	232	1.5%
Patient Days	118,975	133,204	14,229	12.0%
Average Daily Census	391.4	438.2	46.8	12.0%
Average Length of Stay	7.7	8.5	0.8	10.4%
Percentage Occupancy	67.8	75.5	7.7	11.4%
Outpatient Clinic Visits	219,185	223,067	3,882	1.8%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18, 1989

TO: Members of the Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: 1989-90 Operating Budget

The 1989-90 Operating Budget was presented to the Finance Committee on April 10th and 26th, and also to the Board of Governors for information on April 26, 1989. On April 26, 1989 the Board of Governors approved a 9.5% rate increase for 1989-90 with 7.5% of the increase to be implemented on July 1, 1989. The remaining 2% will be implemented, if necessary, when final compensation plans and regulatory payment levels are known. Implementation of any part of the additional 2% increase will be approved by the Board of Governors.

At this time we are requesting your endorsement of the remaining components of the 1989-90 Operating Budget to be brought to the Board of Regents for information at their June 1989 meeting and action in July 1989.

Attached for your review is the Summary Statement of Operations and Cash Flow for the current and budget years. We look forward to discussing this with you on May 24, 1989.

/th

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS AND SUMMARIZED OPERATING CASH FLOW
1988/89 ANNUAL BUDGET, CURRENT YEAR PROJECTION, 1989/90 BUDGET

	ANNUAL BUDGET	CURRENT YEAR PROJECTION	1989/90 BUDGET @ 1.075	1989/90 BUDGET @ 1.095
Gross Patient Charges	$281,419,000	$308,963,000	$340,467,000	$346,[illegible],000
Deductions from Charges	48,671,000	69,452,000	79,853,000	83,513,000
Other Operating Revenue	8,684,000	9,409,000	10,47[illegible],000	[illegible]476,000
Total Operating Revenue	$241,432,000	$248,920,000	$271,091,000	$273,664,000
Expenditures				
Salaries	$106,821,000	$114,595,000	$123,859,000	$123,859,000
Fringe Benefits	24,605,000	24,288,000	27,976,000	27,976,000
Contract Compensation	11,091,000	10,830,000	11,644,000	11,644,000
Medical Supplies, Drugs, Blood	47,713,000	53,743,000	58,337,000	58,337,000
Campus Administration Expense	256,000	256,000	282,000	282,000
Depreciation	17,918,000	[illegible]25,000	18,283,000	18,283,000
General Supplies & Expense	50,072,000	[illegible],687,000	52,747,000	52,747,000
Total Expenditures	$258,476,000	$274,024,000	$293,128,000	$293,[illegible],000
Net Revenue from Operations	($17,044,000)	($25,104,000)	($22,037,000)	($19,464,000)
Total Non-Operating Revenue				
Appropriations	$14,725,000	$14,883,000	$15,579,000	[illegible],579,000
Accrued Interest on Appropriations	0	126,000	0	0
Interest Income on Reserves	5,258,000	7,260,000	6,906,000	6,906,000
Shared Services	101,000	168,000	181,000	[illegible]000
Investment Income on Trustee Held Assets	1,094,000	1,008,000	873,000	[illegible]00
Other Investment Income	0	130,000	130,000	000
Total Non-Operating Revenues	$21,178,000	$23,575,000	$23,669,000	$23,[illegible]
Revenue Over/-Under Expenses	$4,134,000	($1,529,000)	$1,632,000	$4,205,000
Add Non-Cash Outlays:				
Depreciation	17,918,000	17,625,000	18,283,000	18,283,000
University Support	300,000	156,000	182,000	182,000
Net Increase to Working Capital	863,000	2,272,000	2,539,000	2,539,000
Total Funds Provided	23,215,000	18,524,000	22,636,000	25,209,000
Funds Applied				
Increase in Accounts Receivable	5,891,000	4,307,000	3,051,000	3,834,000
Capital Expenditures:				
Principal Payment on Fixed-Rate Bonds	2,815,000	2,815,000	2,215,000	2,215,000
Principal Payment on Equipment	1,014,000	1,014,000	840,000	840,000
Recurring Equipment and Renovation	8,000,000	7,591[illegible]	[illegible]76,000	7,876,000
Parking Ramp Sinking Fund	76,000	[illegible]	[illegible],000	76,000
Interest Income Committed to Capital Plan	5,258,000	5,258,000	5,[illegible]0,000	5,550,000
Funding for Unit J	0	0	2,069,000	2,069,000
Total Funds Applied	23,054,000	21,061,000	21,677,000	[illegible]2,460,000
Total Cash Available from Operations	$161,000	($2,537,000)	$959,000	$2,749,000

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

May 18, 1989

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: 1989-90 Capital Budget

Enclosed please find the proposed 1989-90 capital budget. Our operating budgets assumed cash flow for equipment and remodeling of $8,300,000.

As the attached summary indicates, we are recommending an equipment and remodeling budget next year of $8,300,000. Of this amount, $6,723,000 is for equipment purchases, the remainder is for equipment installation and remodeling. A departmental breakdown of the equipment budget is 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. 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 ten-year capital expenditure plan. This ten-year plan does not require Board approval, but is informational in nature. The ten-year plan includes projects which have been identified as part of the Board approved Mayo remodeling plan (Renewal Project -Phase II). Please note major expenditures for Renewal Project II are included on the second page of the ten-year plan.

We will request Board approval for the recommended $8,300,000 capital budget at your June meeting. This month's presentation is for information only. Major capital expenditures 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

1989 - 1990 Capital Budget Summary

Equipment Purchases	$6,723,000.00
Equipment Installation	$115,250.00
Remodeling	$1,461,750.00
Total	$8,300,000.00

DEPARTMENT	AMOUNT*
Admissions	$2,873
Ambulatory Care	$262,037
Biomedical Eng.	$22,770
Bone Marrow Transplant	$369
Cardio-Respiratory	$556,540
C.C.T.V.	$44,040
Communications	$20,861
Environmental Svcs.	$67,770
Fin. Accounting	$41,623
Hospital Facilities	$7,104
Human Resources	$39,610
Infection Control	$4,550
Information Services	$855,820
Laboratories	$987,643
Labs - Neurology	$28,000
Maint. & Operations	$11,423
Materials Services	$155,635
Medical Records	$99,090
Nursing Services	$138,303
Nutrition	$43,514
Operating Rooms	$675,840
Patient Accounting	$9,200
Patient Relations	$1,231
Pharmacy	$8,370
PM and R	$34,594
Protection Svcs.	$6,600
Psychiatry	$3,203
Quality Assurance	$10,739
Radiology	$1,387,167
Therapeutic Radiology	$525,000
Anticipated Future Requests	$671,481
GRAND TOTAL	$6,723,000

* Departmental allocations may vary as refinement to this budget occurs.

1989 - 1990 Capital Budget Summary

Items Between $100,000 and $600,000

Diagnostic Radiology	Radiographic/Tomagraphic Peds	$168,000.
	Gamma Camera	$210,000.
Hospital Laboratories	Pathfinder Mega	$118,000.
Information Services	Applications Software and Related Hardware (possible systems to be purchased include; Purchasing, Automated [illegible]me Card, Patient Care Documentation, Casemix Management, IMS Expansion, Outpatient Registration Scheduling and Billing)	[illegible]7,552.
[illegible]nerapeutic Radiology	Stereotactic Radio Surgery	$50[illegible]0.
Grand Total		$1,673,552.

ANNUAL CAPITAL REQUIREMENTS

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
APPROVED PROJECTS												
Dermatology Clinic.....(C)	0	630,000	0	0	0	0	0	0	0	0	0	630,000
A-15 Computer/Disc Drives.....(A)	3,800,000	0	0	0	0	0	0	0	0	0	0	3,800,000
MRI - II.....(C)	0	2,600,000	1,000,000	0	0	0	0	0	0	0	0	3,600,000
CUHCC.....(C)	0	331,373	1,018,627	0	0	0	0	0	0	0	0	1,350,000
Masonic III.....(C)	0	200,000	400,000	0	0	0	0	0	0	0	0	600,000
Approved Projects Subtotal.....	3,800,000	3,761,373	2,418,627	0	0	0	0	0	0	0	0	9,980,000
ANTICIPATED PROJECTS												
Lithotripter II.....	0	0	1,100,000	0	0	0	0	0	0	0	0	1,100,000
Lithotripter I Upgrade.....	0	0	0	0	1,216,000	0	0	0	0	0	0	1,216,000
Replace CT Scanners.....	0	0	992,000	0	1,094,000	0	1,206,000	0	0	0	0	3,292,000
Replace Linear Accel.....	0	0	1,700,000	0	1,300,000	0	1,500,000	0	0	0	0	4,500,000
Replace MRI-I.....	0	0	0	0	0	3,063,000	0	0	0	0	0	3,063,000
Computer Upgrade.....	0	650,000	1,700,000	4,150,000	1,500,000	1,500,000	1,500,000	5,500,000	1,500,000	1,500,000	1,500,000	21,000,000
Neuroradiology Upgrade.....	0	0	1,809,000	0	0	0	0	0	0	0	0	1,809,000
Anticipated New Technology.....	0	0	0	1,400,000	0	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	22,400,000
Heart Cath/CV Radiology.....	0	0	800,000	2,500,000	3,000,000	0	0	0	0	0	0	6,300,000
Property - Oak and Fulton.....	0	0	0	0	0	0	0	0	0	0	0	0
Anticipated Projects Subtotal.....	0	650,000	8,101,000	8,050,000	8,110,000	8,063,000	7,706,000	9,000,000	5,000,000	5,000,000	5,000,000	64,680,000
ANNUAL EQUIPMENT AND REMODELING PROJECTS												
Annual Equipment Replacement.....(B)	4,407,000	6,500,000	6,723,000	6,925,500	7,209,000	7,411,500	7,654,500	8,545,500	8,950,500	9,598,500	10,368,000	84,293,000
Annual Remodeling.....(B)	1,141,000	1,500,000	1,577,000	1,624,500	1,691,000	1,738,500	1,795,500	2,004,500	2,099,500	2,251,500	2,432,000	19,855,000
Equipment Rollforward.....(D)	0	2,850,000	0	0	0	0	0	0	0	0	0	2,850,000
Annual Equip and Remod Subtotal.....	5,548,000	10,850,000	8,300,000	8,550,000	8,900,000	9,150,000	9,450,000	10,550,000	11,050,000	11,850,000	12,800,000	106,998,000
ANNUAL PRINCIPAL PAYMENTS												
Unit J Principal Payments.....(B)	2,706,000	2,815,000	2,215,000	2,345,000	2,490,000	2,650,000	2,830,000	3,015,000	3,230,000	3,455,000	3,705,000	31,456,000
VRDB Principal Payments.....	0	0	0	0	0	0	0	0	1,681,000	1,681,000	1,681,000	5,043,000
Existing Other Principal Payments.....(B)	1,169,000	1,478,000	916,000	598,000	148,000	76,000	0	0	0	0	0	4,385,000
Annual Principal Payments Subtotal.....	3,875,000	4,293,000	3,131,000	2,943,000	2,638,000	2,726,000	2,830,000	3,015,000	4,911,000	5,136,000	5,386,000	40,884,000
Annual Capital Requirement Subtotal.....	13,223,000	19,554,373	21,950,627	19,543,000	19,648,000	19,939,000	19,986,000	22,565,000	20,961,000	21,986,000	23,186,000	222,542,000

(A) Funded from Trustee Account as of June 30th, 1988 of $3,880,000
(B) Funded as part of 1987-88 budget totalling $9,423,000
(C) Funded from Reserves as of June 30th, 1988, funding included in Beginning Reserve Balance
(D) 2.2 million funded as of June 30th, 1988, funding included in Beginning Reserve Balance

BUILDING REPLACEMENT/MODERNIZATION

RENEWAL PROJECT PHASE II	Bldg	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Surgical Path.....(A)	Mayo	0	700,000	330,000	0	0	0	0	0	0	0	0	1,030,000
Mayo Clinical Program Remodeling Project.....	Mayo	0	0	1,575,000	5,512,500	5,325,075	0	0	0	0	0	0	12,412,575
Unit J Expansion Project.....	J	0	200,000	2,600,000	8,224,423	10,260,173	1,469,778	0	0	0	0	0	22,754,373
Building Upgrade.....	Mayo	0	0	2,125,000	4,910,000	4,977,788	0	0	0	0	0	0	12,012,788
Other Mayo Programs.....	Mayo	0	0	840,000	1,102,500	2,554,727	4,187,911	2,424,935	2,680,191	0	0	0	13,790,265
Total Project.....		0	900,000	7,470,000	19,749,423	23,117,762	5,657,689	2,424,935	2,680,191	0	0	0	62,000,000
Annual Capital Requirement Subtotal.....		13,223,000	19,554,373	21,950,627	19,543,000	19,648,000	19,939,000	19,986,000	22,565,000	20,961,000	21,986,000	23,186,000	222,542,000
Total.....		13,223,000	20,454,373	29,420,627	39,292,423	42,765,762	25,596,689	22,410,935	25,245,191	20,961,000	21,986,000	23,186,000	284,542,000

(A) Funded from Reserves as of June 30th, 1988, funding included in Beginning Reserve Balance

Minnesota Daily
April 27, 1989

University Hospital prices may again jump almost 10 percent

By Delores Lutz
Staff Reporter

University Hospital's prices could jump more than 9 percent next year — for the second year in a row — under a plan approved Wednesday by the hospital's Board of Governors.

But officials plan to implement a 7.5 percent increase July 1, with another 2 percent to be added only if necessary.

"We're looking for flexibility if certain things happen," said Clifford Fearing, the hospital's senior associate director for finance.

The uncertainties involved in preparing the 1989-90 budget include various anticipated changes in Medicare reimbursement, labor costs, and patient demand for services.

Administrators expect attrition, not lay-offs, to decrease the hospital staff by the equivalent of 83 full-time jobs. The hospital currently has the equivalent of 4,153 full-time positions.

University Hospital's budget will be presented for board approval in May. The price increase had to be approved this week, however, because state regulations require hospitals to announce price changes 60 days before implementation.

Last year, University Hospital prices jumped 9.8 percent, breaking a three-year string of 2.9 percent increases. In 1987, hospital prices in the metropolitan area rose by an average of almost 5 percent, according to the Council of Hospital Corporations, a trade association representing 25 Twin Cities hospitals.

The 7.5 percent price increase would bring the hospital's total patient charges to an estimated $340,467,000 next year, according to hospital administrators.

The budget assumes that officials can cut costs by more than $6 million.

At this point, hospital officials expect to increase nurses' salaries by 12 percent; other employees would receive a 6 percent incre

Although registered nurses at University Hospital are not un ized, their salaries usually comparable to those of their p at Twin Cities hospitals with M nesota Nurses Association tracts. The MNA contract co up for renewal this spring.

University Hospital offici project 18,860 hospital admiss next year, a drop from the 19 they expect to have by the en this fiscal year.

Health care providers across country are keeping an "eye Washington, D.C., where M care reimbursement changes will take effect in October being debated.

But educated guesses about precise changes vary alm hourly, making it difficult to dict the future of the vol health care industry, Rob Dickler, the hospital's genera rector, told the board.

"Putting together a budget more challenging this year budget process is normally," he

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

April 28, 1989

TO: All Employees, UMHC

FROM: Robert Dickler RD
General Director

SUBJECT: 1989-90 Employee Compensation Plans

You may have read a potentially misleading reference in The Minnesota Daily on April 27th which deserves clarification. The Daily article indicated that nursing staff would be receiving 12% salary increases next year, and other employees would be receiving 6% increases. This reference was part of a larger article on the Hospital's budget presentation to the Board of Governors on April 26th.

We wish to communicate to you the fact that the employee compensation plans for 1989-90 have **not** yet been finalized. This will not occur until the end of May, and even then all elements of next year's pay plan may not be known.

The process for determining the pay plan involves marketplace assessments, assessments of the effects of union contract settlements, and numerous other considerations, such as pay equity, changes in shift differentials, fringe benefit cost increases, etc. A simple figure of 12%, 6%, or any other figure can thus be misleading and would typically include the cost of all of these elements. We would not want our employees to conclude from the Daily article that these are final figures which will apply to all employees. They are not final and the actual pay change which will occur for any single employee will be different than these figures.

As noted earlier, we will be communicating as much of the planned compensation increases as possible to you when they are better known, hopefully at the end of May. AFSCME and Teamster employees pay increases will, of course, be determined through the contract negotiations, currently in place. Nursing staff salary levels will, as has been the case in the past, generally reflect the marketplace. University pay plans for staff in University-dominated classes, (clerical, data processing, etc.) will be finalized once the legislative allocation is better known. Other Hospital employee pay plans will be determined over the coming weeks.

In the meantime, please feel free to contact your department head or Elisabeth White or Patti Dion at 6-5550 if you have any remaining questions.

/th

Thursday/May 4/1989/Star Tribune

'U' search committee starts over

By Gordon Slovut
Staff Writer

The University of Minnesota's search for a new chief of oncology (cancer study) will start over with four women on the search committee and orders to recruit women and minority group candidates.

University President Nils Hasselmo said in letters to the Equal Opportunity for Women Committee and to the Faculty Advisory Committee on Women that the search has been seriously flawed and that the original search committee should have interviewed Dr. Clara Bloomfield, the university's leading leukemia researcher.

"It is clear that (she) was a candidate," he said.

The search committee had said she was not a candidate because she did not formally apply. Committee members said they had urged her to do so.

Bloomfield, who has been sought by other institutions, has notified the university that she is quitting to become chief of medicine at the Roswell Park Memorial Institute in Buffalo, N.Y., one of the country's leading cancer centers. Bloomfield said last night that she will move to Buffalo in midsummer.

Bloomfield, who was at Ohio State University in Columbus to lecture yesterday, said she was pleased by Hasselmo's statement that the selection process was flawed. She has said she had been told she didn't have a chance of getting the position at Minnesota despite the backing of Dr. B.J. Kennedy, who wants to retire as chief of oncology, and others in that division.

So for the third time in a year, Dr. Thomas Ferris, chairman of the Department of Medicine, has appointed a committee to search out the best candidates.

This spring Ferris disbanded the first committee, created in mid-1988, after controversy over the failure to recruit female candidates. Bloomfield said the search was not fair and open.

Ferris appointed the second search committee last month, dropping one member, adding two and reappointing six.

The second committee has been disbanded and a new nine-member one appointed, including none of the seven people who served on the first committee. Ferris appointed Dr. Jack Oppenheimer, professor of medicine and director of endocrinology, as chairman. Oppenheimer was one of the two added to the second committee and was its chairman.

Cherie Perlmutter, acting university vice president for health sciences, said Bloomfield, 46, could change her mind about Buffalo and decide to be a candidate.

Hasselmo said in his letters that the new committee will meet this month with Patricia Mullen, director of equal opportunity and affirmative action, to determine how to get women and minority group candidates.

He said recruiting will end in September, when the process of interviewing candidates will begin.

He said the original search committee had "faulty and incomplete records, an inadequate pool of female and minority candidates, and questions related to the candidacy of a well-qualified woman faculty member."

St. Paul Pioneer Press Dispatch
Thursday, May 4, 1989

Medicine moving at rapid pace

By Walter Parker
Staff Writer

Had Rip Van Winkle been a doctor in the 1980s instead of a bum in the 1770s, he would have only needed to sleep five years — not 200 — to awaken to a radically transformed world.

The explosive pace of change in medicine is evident from a report on specialty medical procedures in Twin Cities hospitals released this week by the Health Planning Board of the Metropolitan Council.

Well over 10,000 people a year in the metro area now undergo magnetic resonance imaging, a sophisticated diagnostic technique that wasn't even available five years ago. And it costs anywhere from $500 to $1,500 per procedure.

Helicopter ambulances were another gleam in someone's eye in 1984. But in 1988, two hotly competing services in the Twin Cities transported 1,379 patients.

Open-heart surgery, an earlier generation's "medical miracle," continued to boom, despite the predictions of some that it would be eclipsed by competition from new, cheaper and less invasive techniques. There were 3,394 adult open-heart surgeries in 1987, 16.7 percent more than in 1983.

The number of cardiac catheterizations, a technique used for both diagnosing and treating heart disease without resorting to surgery, more than doubled from 1983 through 1987, to 12,913 procedures.

Specialty after specialty seems to have been rearranged by the onrush of technology, said Paul Riddle, assistant director of the health planning board.

"We live in a high-tech society, so you're going to have to expect medicine and health care to be high-tech too," Riddle said.

In most instances, the changes represent progress, he said. But Riddle said the report raises questions about whether the highly competitive medical business is putting the new technologies where they will do the public the most good.

"We're a little concerned that the big hospital corporations will all try to be everything," he said.

On the other hand, Riddle said, there are limits to this approach, because hospitals are subject to antitrust laws that outlaw collusion. They also must worry about high-tech specialty clinics springing up and competing for patients.

Several doctors interviewed agreed.

Dr. Leonard Levitan, a diagnostic radiologist with the St. Paul Radiology group, said that magnetic resonance imaging has proved invaluable in diagnosing and treating knee disorders. The use of magnetic resonance, which was introduced in 1985 as a tool for diagnosing head and central nervous system problems, has expanded rapidly.

"I read a case today where it demonstrated two ligament tears and a fracture of the knee bone so subtle it couldn't be seen on X-ray," he said.

Dr. Victor Tschida, president of St. Paul Heart Clinic, said the introduction of new clot-dissolving drugs and improved catheters have created a "bias toward action" in the treatment of heart attack victims, where previously doctors were limited to monitoring the extent of damage.

He said as doctors are better able to detect and treat underlying coronary disease before a heart attack, they will be doing more open-heart surgery and more procedures to clear clogged arteries.

Lithotripsy, a procedure in which the patient's kidney stones are bombarded with ultrasound waves that crush the stones, has grown as well, according to the health board's figures. The development of lithotripter machines has all but eliminated once-common stone-removal surgery, said Dr. Paul Gleich, head of the urology section at St. Paul-Ramsey Medical Center.

"This is one of the most impressive revolutions I've seen in medicine," he said. Doctors began using the machines in the Twin Cities about three years ago. Patients are often treated without having an overnight stay in the hospital, at a total cost of about $5,000 to $6,000, compared with $10,000 for surgery and hospital stay, he said.

HOSPITAL SPECIALTY SERVICES

	1983	1985	1987	1988
Adult open-heart surgery				
West Metro	2,311	2,272	2,884	
East Metro	597	377	510	
Adult heart catheterization				
West Metro	5,416	7,803	10,978	
East Metro	988	1,460	1,935	

Organ transplants	1985	1986	1987	1988
Heart	15	51	65	52
Kidney	243	254	238	237
Bone marrow	102	131	157	180
Liver	26	31	34	33
Kidney stone lithotripsies	169	527	879	1,151
Helicopter ambulance runs		841	1,158	1,379
Magnetic resonance imaging				
West Metro	1,768	6,654	10,671	
East Metro	0	1	70	

Some 1988 figures were not available.

Source: Health Planning Board of Metropolitan Council

Conference to focus on Holocaust euthanasia

St Paul Pioneer Press Dispatch

Monday May 15 1989

By Walter Parker
Staff Writer

Fifty years after Nazi officials approved a formal order for euthanasia that resulted in the deaths of 75,000 patients in mental institutions, scholars from around the world will be meeting in Minneapolis this week to debate the impact of this tragedy on medical ethics today.

"The question we want to address is: How did doctors and other reputable health care professionals get involved with a euthanasia murder program?" said Arthur Caplan, director of the University of Minnesota's Center for Biomedical Ethics.

The center is sponsoring a conference entitled "The Meaning of the Holocaust for Bioethics" from Wednesday through Friday at the Radisson University Hotel. The meeting is expected to attract widespread attention and is tentatively scheduled to be the subject of ABC-TV's "Nightline" program Wednesday.

"This isn't just about concentration camps, it's about the road to them," said Caplan.

In September 1939, he said, Nazi officials designated nine psychiatrists and 39 other mental health professionals to examine 280,000 questionnaires filled out by mental hospital patients in Germany and German-controlled territory.

Eventually, Caplan said, 75,000 of the patients were culled and put to death. The decision-makers apparently put people with hereditary diseases, including alcoholism, at the top of the death list as part of an overall effort at eugenics, or genetic "purification." Others singled out included the mentally retarded, handicapped children, schizophrenics and "demented elderly," who today would probably be called Alzheimer's disease patients.

"There's been a tendency to dismiss the scientists and doctors involved in the Holocaust as third-rate or fringe members of the German medical and scientific professions," Caplan said. "But recent scholarship shows that view is just plain wrong."

Among the 29 speakers and panelists at the conference are Robert Proctor of the New School for Social Research in New York and Benno Muller-Hill of the Institute of Genetics at the University of Cologne in West Germany.

Both have recently published books arguing that the leaders of German medicine and science laid the foundation for euthanasia against the mentally ill and later for genocide against Jews, Slavs, Gypsies and homosexuals, he said.

Caplan predicted intense debate over the relevance today of the Nazis' history. He said at least one of the visiting scholars believes the Nazis' approach has modern parallels in contemporary practices, such as use of fetal tissue for transplant, and passive euthanasia for the terminally ill.

"It's a provocative problem: Are we at risk of going down some of paths and roads the German scientists found themselves going down?" he said.

Another topic on the agenda is whether scientists should make use of data from cruel Nazi medical experiments on concentration camp inmates. The question was first raised a year ago by Robert Pozos, a physiologist and hypothermia expert, who had uncovered obscure Nazi reports of experiments on limits of human toleration of cold.

Pozos, then chairman of the physiology department at the University of Minnesota-Duluth, is now vice president for minority affairs at the University of Washington.

on the lung, such as causing a change in the pulmonary blood flow or the secretion of mucus, that may also contribute to the pathophysiology of asthma. From our study it is not possible to determine whether the loss of nerves that are immunoreactive to VIP is a primary abnormality in asthma or is secondary to the disease process. Further studies need to be conducted to elucidate the role of nerves containing VIP in asthma.

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SPECIAL ARTICLE

THE CASE FOR WIDER USE OF TESTING FOR HIV INFECTION

FRANK S. RHAME, M.D., AND DENNIS G. MAKI, M.D.

EIGHT years into the most serious pandemic of infectious disease in modern history, we possess the technology and resources to test for evidence of human immunodeficiency virus (HIV) infection accurately and economically. Yet there has been great reluctance on the part of the federal government and medical leaders to advocate extensive use of HIV testing as a public health measure. We believe that a very strong case can be made for wider HIV testing.

Most discussions of HIV testing reach a conclusion on whether testing should be encouraged, at least in populations in which the prevalence of infection with the virus is high. Although Weiss and Thier in their recent *Journal* editorial[1] found no basis for testing beyond screening before blood and tissue donation, most national bodies have favored the broader use of HIV testing. The Committee for the Oversight of AIDS Activities of the Institute of Medicine favored "expanded voluntary testing combined with counseling of all those whose behavior may have put them at risk for exposure to HIV."[2] Likewise, the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended that "people who fall into any of the [high-risk] categories should seek testing and counseling services from their physician or public health agency, regardless of the presence or absence of symptoms."[3] Even more strongly, the Centers for Disease Control (CDC) has endorsed routine testing of persons who may have a sexually transmitted disease, intravenous drug abusers, and others who consider themselves at risk of HIV infection.[4] The Canadian National Advisory Committee on AIDS has also recommended voluntary HIV testing in persons whose histories put them at risk.[5] In endorsing HIV testing, none of these groups has presented a rationale beyond the reduction of transmission of HIV. We offer here additional public health reasons for much wider use of HIV testing, and we argue further that persons infected with HIV can gain important, direct health benefits from learning of their infection as early as possible.

We advocate only voluntary testing, by which we mean that the test must be discussed with the person before testing, and that testing may be refused. Moreover, all HIV testing must be accompanied by stringent institutional and societal safeguards of confidentiality and privacy.[6]

In November 1987, the Public Health Service estimated that there were between 945,000 and 1,400,000 persons infected with HIV in this country.[7] Even to-

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day, most of them do not know that they are infected, although HIV testing has been available for four years. Since September 1985, it has been necessary to report all cases of HIV infection in Minnesota. (This has brought, incidentally, no known harm to those whose infection has been reported.) As of April 1, 1989, there have been 1100 reported cases of HIV infection in addition to 504 reported cases of acquired immunodeficiency syndrome (AIDS). The Minnesota Department of Health estimates that there are between 10,000 and 30,000 Minnesotans infected with HIV (Osterholm MT: personal communication, December 5, 1988). If one uses the low end of this range and allows for substantial underreporting of diagnosed HIV infections, less than 20 percent of Minnesotans infected with HIV know of their infection. The situation in Wisconsin is quite similar: 318 cases of residents with AIDS and an additional 1065 cases of HIV infection have been reported; and an estimated 7000 to 11,000 residents of Wisconsin are thought to have HIV infection (Davis JP: personal communication, April 10, 1989). Nationally, the percentage of persons infected with HIV who know of their infection is probably smaller, because the level of acceptance of HIV testing in the upper Midwest is thought to be relatively high and the prevalence of HIV infection is relatively low. The continuing detection of HIV infection among blood donors (0.043 percent of first-time donors through 1987),[7] applicants for military service (0.15 percent),[8] and Job Corps applicants (0.33 percent)[7] is strong evidence that many — and probably most — Americans infected with HIV are not aware of it, although nearly all infected persons will ultimately report histories that put them at risk of HIV infection. Thus, current efforts to make persons infected with HIV aware of their infection are failing. We argue here that widespread voluntary HIV testing based within the health care system must be promoted nationally to bring us nearer the goal of informing all persons infected with HIV about their condition.

Before focusing on the testing of apparently healthy, asymptomatic persons, we should address two related issues. First, our views on the testing of asymptomatic persons do not apply to the testing of those with symptoms compatible with illness caused by HIV, for whom few would argue with the clinical value of an HIV test. Second, there are several specific clinical situations in which persons without HIV-related symptoms should be tested routinely. The CDC has explicitly recommended that an HIV test be performed in all persons with syphilis[9] or active tuberculosis,[10] because the presence of HIV infection alters the suggested therapy and follow-up. It is, we believe, a logical extension of the CDC recommendation to advocate testing for HIV infection in all tuberculin-positive persons. Although the current policy of smallpox vaccination in U.S. military forces can be questioned,[11] it seems wise to recommend an HIV test before vaccination.[12] Finally, the CDC has also implicitly recommended testing before vaccination in persons in whom bacille Calmette–Guérin vaccine is indicated[13] and — when health care personnel have been exposed to a patient's blood through injury such as a needle stick — explicitly recommended testing the patient for HIV infection.[14]

Benefits for Persons Infected with HIV

We believe that detecting the infection as early as possible can provide substantial, direct health benefits to all persons infected with HIV. Tuberculin skin testing should be performed before a loss of delayed cutaneous hypersensitivity occurs. Although only about 2 percent of all U.S. patients with AIDS contract tuberculosis,[15] those with dormant foci of *Mycobacterium tuberculosis* have a very high risk of active disease.[16] Since a large fraction of the people infected with HIV will contract AIDS, all those with current positive tuberculin tests or reliable histories of positive tuberculin tests should receive preventive therapy with isoniazid, unless there are major contraindications. This therapy should be instituted as early as possible because active tuberculosis may be the first illness caused by HIV and because the presence of other illnesses associated with HIV infection or the administration of other therapies may complicate the administration of isoniazid. Influenza vaccine and pneumococcal polysaccharide vaccine are recommended for all people infected with HIV.[17,18] The recommendation for pneumococcal immunization explicitly states that the vaccine be given as early in the course of HIV disease as possible, to maximize the antibody response. Since patients with AIDS are at an increased risk of sepsis and pneumonia caused by *Haemophilus influenzae* type b[19,20] as well as *Streptococcus pneumoniae*, a similar case can be made for immunization against *H. influenzae*.

The early detection of asymptomatic HIV infection provides an even more important health benefit to those who — because they are unaware of their infection, are incompletely educated about hazardous signs and symptoms, or deny the possibility of contracting HIV-related disease — fail to seek medical attention promptly when symptomatic HIV illness appears. Clinicians experienced with AIDS know well the frustration of encountering persons infected with HIV who have very low numbers of CD4+ T cells and who are seeking medical attention only after months of gradual worsening of HIV-induced symptoms or with advanced opportunistic infection. Clearly, many would have benefited from earlier institution of therapy with zidovudine or a therapy specific to opportunistic infection. Many persons who may be infected with HIV do not fully recognize that HIV infection is a treatable condition. The capacity for denial is sufficiently strong that a far more active approach to HIV testing should be taken than we now have, for timely intervention in a larger number of cases.

Evidence is accumulating that, after initial infection, CD4+ T-cell counts first fall, then remain relatively stable, and finally begin to decrease more rapid-

ly. This last phase is a harbinger of opportunistic infection.[21,22] If the absolute value and the slope of the CD4+ T-cell count are independent predictors of illness induced by HIV, serial monitoring is needed for the best assessment of the severity of HIV disease. We believe infected persons should be seen at least quarterly so that therapy with zidovudine and prophylaxis against *Pneumocystis carinii* pneumonia can begin at the earliest appropriate time. Patients should probably be seen even more frequently until the physician is confident that they will recognize and promptly report subtle symptoms induced by HIV.

If evidence establishes that therapy is indicated for asymptomatic HIV infection, testing will benefit patients in yet another way. Protocol 019 of the National Institutes of Health AIDS Clinical Trials Group, a placebo-controlled trial of zidovudine for asymptomatic HIV infection, could end at any time with a recommendation that all persons infected with HIV should receive zidovudine. We would then confront two problems: the orderly identification of HIV infection in the large number of people at risk for HIV who would come forward immediately, and the timely identification of those who deny to themselves their histories of risk factors for HIV.

Benefits to the Public Health

We believe that a recommendation to undergo HIV testing as part of routine health care would also have important benefits to society. General acceptance of HIV testing would reduce the reluctance to be tested of persons who know they are at increased risk. Taking the test would heighten the sense of vulnerability that is a necessary part of decisions to adopt more healthful behavior.[23] Although there are many sexually transmitted disorders that should convince all persons to avoid unprotected coitus, the fear of HIV infection may foster most powerfully the changes in sexual behavior our society must make. Taking the test would enhance appreciation of the fact that AIDS is a problem that society at large must face. It would help undercut the pernicious we–they mentality that feeds the social stigmatization associated with AIDS and HIV infection.

There has been widespread discussion of the public health benefit of HIV testing — primarily as an adjunct to counseling — as part of the efforts to reduce the transmission of HIV. In their editorial, Weiss and Thier describe this rationale, without detailed analysis, as "unproved."[1] We agree that the available studies are not conclusive, but in the populations studied, HIV testing appears to have reduced unsafe sexual behavior in those infected with HIV.[24-26] The effect of testing on those who are found not to be infected with HIV is admittedly less clear, but it too appears favorable. If one presumes that most people do not want to hurt others and that the gravity of HIV infection is becoming more widely recognized, the beneficial effects of testing should grow with time. In any case, these studies are only indirectly relevant to the context we discuss, because they were limited to homosexual men who volunteered for HIV-related studies, attended counseling and testing centers, or otherwise came forward voluntarily. Such persons had already broken through some of the denial that acts as a barrier to changing their behavior. Our greatest concern is to reach the great number of persons infected with HIV who are not availing themselves of any current options in testing and who are not confronting their risk of HIV infection.

As evidence that identifying persons infected with HIV through more widespread testing would reduce risk through more intensive counseling, we offer the findings of a study in blood donors[27] and our experience with patients with hemophilia. Williams et al.[27] found substantial reductions in unsafe activities — reductions considerably greater than those likely in society as a whole — during the year after blood donors were notified of their infection. Patients with hemophilia are even more relevant to the context we discuss — the widespread testing of persons in the general population receiving health care. Most patients with hemophilia are already under close medical supervision, and because their physicians recognize that their patients are at increased risk of infection with HIV most patients have been encouraged to undergo testing. There is ample evidence that in spite of general educational messages about their very substantial risk of HIV, many patients with hemophilia engage in unprotected sex.[28-30] Although we know of no systematically collected data on the point, we are convinced that many patients with hemophilia do not begin to pay attention to the risk of sexual transmission of HIV until they are tested. Furthermore, we have found that intensive, repeated counseling, ideally involving the patients' regular sexual partners, is often required to reduce unsafe sexual practices among those whose tests are positive to their current levels, which are still unsatisfactory. Finally, we believe that persons infected with HIV who are tested through the health care system serve as the best starting points for programs to notify sexual partners.

An additional and often overlooked public health benefit of HIV testing is the identification of candidates for research studies of zidovudine and experimental therapies. There has been insufficient recognition of the critical need for research subjects among persons who are potentially infected with HIV. For instance, the AIDS Clinical Trials Group's protocol 019, which is of enormous importance to the million or more asymptomatic persons infected with HIV in this country, will have taken almost two years to complete enrollment. It is preferable to conduct Phase I and II trials of potential agents against HIV in patients who are not taking other antiviral agents, but a large majority of patients with symptoms take zidovudine. The need for asymptomatic people infected with HIV to participate in the initial studies of

promising therapeutic agents is urgent. We are in a desperate race against time to develop therapies for those who are now infected with HIV. All persons infected with HIV who want to help fight AIDS should be strongly urged to participate in experimental studies.

Another reason for expanding HIV testing is the potential benefit of zidovudine therapy after exposure to HIV. Eleven cases of occupational transmission of HIV with documented seroconversion have been reported among health care personnel in the United States.[31-33] Additional cases of such transmission have been reported from outside this country[31,34] or without documented seroconversion.[31] Many more such cases have undoubtedly occurred but have not yet been recognized, have not been published because they could not be reliably attributed to exposure on the job, or have not been reported because no formal system of surveillance for occupational transmission exists. Two published reports of experiments with animal models have described the beneficial effects of zidovudine after exposure to a retrovirus. In mice exposed to Rauscher murine leukemia virus, infection was prevented when zidovudine administration lasting 20 days was begun within four hours of exposure, but not when treatment was begun seven days after exposure.[35] In weanling kittens inoculated with feline leukemia virus, zidovudine administration for 42 days prevented viremia when treatment was begun one hour after inoculation, but not when begun seven days after inoculation; treatment that began three and seven days after exposure afforded intermediate degrees of protection.[36] The applicability of these studies to persons exposed to HIV is limited, but we believe that hospitals should offer personnel who have been exposed to the blood or other high-risk bodily fluids of a patient infected with HIV the option of zidovudine prophylaxis paid for by the hospital. However, the potential benefits of postexposure treatment with zidovudine are not sufficient to warrant it in personnel exposed to a patient at low risk whose status for infection with HIV is still being evaluated. If prophylaxis with zidovudine is accepted, it should be initiated as soon after exposure as possible, ideally within an hour, but the assessment of a patient for possible HIV infection in so short a time is logistically very difficult. This is an additional argument in favor of the routine, voluntary screening for HIV in newly hospitalized patients.

Another current issue bears on the testing of hospitalized patients for HIV. The CDC and the Department of Labor have recommended the adoption of "universal precautions" — precautions in the care of all patients, not just those known to be infected with hepatitis B or HIV.[14] Efforts to encourage the careful handling of specimens from untested patients are certainly laudable, because some infectious materials will inevitably be unrecognized as such. But the adoption of universal precautions is sometimes used as an argument against HIV testing, and some hospitals have removed warning designations for patients known to be infectious and their specimens. This approach has been advocated without careful study of whether health care workers are in practice as vigorous in exercising precautions when the patient has no known infection as they are when the patient is known to be infectious. The concept of universal precautions clearly deviates from that of targeted precautions concerning patients with known infection, which has been the approach for the past 20 years to preventing cross-infection and transmission with virtually all other contagious diseases.[37] Universal precautions might provide less protection than routine HIV screening and targeted precautions in hospitals with a low prevalence of HIV and hepatitis B among their patients or in situations — such as certain types of surgery — in which very heavy exposure to blood and a high incidence of percutaneous injury occur.[38] We believe that the effectiveness of universal precautions should be evaluated scientifically. The outcome of such studies may provide a basis for the institution of routine screening of hospitalized patients in at least some contexts.

Benefit versus Harm

Having established that there are personal as well as public health benefits in increasing the percentage of persons infected with HIV who know of their infection, we are still left with difficult issues. Would an extensive HIV testing program based within the health care system have paradoxical effects on public health? Does the diagnosis of an asymptomatic HIV infection constitute a *net* benefit to the infected person?

HIV testing based within the health care system could paradoxically have adverse effects on public health in two ways. It is often asserted that aggressive testing programs could drive underground, or away from the health care system, those who fear or know that they are infected with HIV. We believe those likely to respond in this way are already underground, and every person retains the right to refuse testing. Aggressive testing programs could also lead to the rejection of all efforts at testing, even at centers for counseling and testing. We believe, however, that raising the issue with all patients increases the probability that those who refuse the test in a hospital or office will use such centers.

The disruption caused by a false positive test is uniformly advanced as an argument against the wider use of testing. However, screening with sequential enzyme immunoassays followed by confirmation with Western blot testing according to current, more stringent criteria should produce a false positive test only rarely.[39,40] It must be acknowledged that the studies cited were done in high-quality laboratories and may suffer from spectrum bias.[41] Falsely reactive enzyme immunoassay results might be more common in ill persons[42] than in healthy blood donors or military recruits.

Nonetheless, false positive tests — i.e., screening with enzyme immunoassay followed by Western blot confirmation — occur so infrequently that no large North American population (with the possible exception of blood donors, who are already being tested) is so free of HIV infection that the predictive value of a positive result would be appreciably reduced. The published reports of false positive results of Western blot testing according to modern interpretive criteria[43,44] are subject to criticism: the findings were not derived from population-based studies; they are subject to referral bias[41]; we do not know how representative their specimens are; and their positive results may have been detected on specimens whose enzyme immunoassay screening was nonreactive.

The practical problem in serologic testing for HIV is the indeterminate Western blot test. According to screening of Minnesota blood donors between 1985 and 1988, just under 1 in 1000 uninfected persons will have a repeatedly reactive enzyme immunoassay and an indeterminate Western blot.[42] The specificity of testing for HIV is improving. Current screening of Minnesota blood donors shows that about 1 in 1000 has a repeatedly reactive enzyme immunoassay, and of these, 12 percent have indeterminate Western blots (Jackson JB: personal communication, February 27, 1989). Culture of blood for HIV, now available by mail from laboratories with 98 percent rates of recovery of HIV from asymptomatic persons infected with HIV,[45] can help resolve indeterminate Western blot tests. Polymerase chain-reaction testing will probably further enhance this capability.

How then can persons infected with HIV be harmed by learning of their infection? Most go through a period of intense emotional distress after diagnosis. This period, however, seldom lasts more than several weeks. Since the reality of HIV infection will ultimately make itself known to most or all persons infected with HIV, to put off learning of an HIV infection postpones but does not eliminate the period of anguish. And in any case, the potential anguish should be weighed against the aggregate anxiety of those who know they are at risk yet remain untested. It is tempting to try to shield anyone from harsh and unfair realities, but this somewhat paternalistic temptation runs counter to the prevailing trend toward a patient's right to know, a trend that has arisen in this generation. Part of the physician's responsibility is to be the bearer of bad news.

It could be argued that counseling and testing centers are better able to mitigate the initial distress associated with the diagnosis of an HIV infection. A substantial fraction of HIV testing, however, already occurs in physicians' offices and hospitals,[46] and counseling by a physician with whom one already has an established relationship should be advantageous. Moreover, an extensive program of HIV testing based within the health care system would stimulate physicians to acquire the requisite skills. It has been argued that HIV testing serves the tested best when it is performed in settings that offer anonymity. Although many who would be tested prefer anonymity, it is nonetheless an elusive goal for most persons who find themselves infected with HIV, even while they remain asymptomatic. It is psychologically burdensome to withhold the information from all friends and loved ones. In addition, virtually all counseling and testing centers advise persons infected with HIV to obtain a physician. We believe that persons who do not contact a physician immediately are more apt to delay seeking medical care if HIV-related symptoms occur. Recommendations to inform dentists and other health care workers about one's HIV infection are uniform.

Finally, it can be argued that the benefits to those infected with HIV are outweighed by the potential for discrimination. Most discrimination related to HIV — in the workplace, in housing, in schools, and in society — is irrational, notwithstanding substantial public sentiment[47] to the contrary. Some types of discrimination, although unfair, are understandable in economic terms. An employer motivated by economic considerations will tend not to hire, promote, or specially train infected persons because they are more likely to use sick-leave and health-insurance benefits. Similarly, an insurer will prefer not to offer health insurance to persons with HIV. Because discrimination will subvert the good that wider HIV testing can produce, we must vigorously fight it. Physicians should also fight for society's acceptance of homosexuality[48] and for improved funding for drug abuse treatment and related research. We have a special responsibility to advance these positions because of their importance in the fight against AIDS. In essence, we are arguing that HIV infection should be treated as much as possible like any other infectious disease. We should fight the unfair consequences that interfere with this goal.

Routine Screening within the Health Care System

We have concluded that HIV testing provides a net benefit both to the public health and to persons infected with HIV. We now turn to the issue of implementing broader testing. We believe that the nation's physicians and other health care providers should assume a much more active role in promoting HIV testing. Before presenting our argument we digress to assert two important underlying premises. We believe that a thorough sexual and drug-use history must be part of any routine health assessment. Patients should find physicians they trust, and they should be candid about these aspects of their history. These premises should be supported by advocates for gay and bisexual persons and substance abusers.

How could routine recommendation of HIV testing affect interaction between patient and physician? We believe it would provide a focus for and enhance efficiency of taking a history of risk for HIV. It would act

as a probe to make the history more accurate — a good outcome if our earlier premises are correct. The interaction would begin with the physician saying in effect, "I recommend an HIV test to all my patients because some people who have risked exposure to HIV don't realize it, and many persons whose activities put them at risk find it difficult to disclose them." A brief risk history would follow.

The patients' responses would fall into three groups. The largest group would deny any risk history and would not object to being tested. Brief counseling would be given before the test. Those with absolutely no risk history would make a small financial sacrifice on behalf of those who are infected with HIV. Among those who have a risk history but deny it would be most of the people infected with HIV who would benefit from expanded testing.

A second group of patients would acknowledge risk histories. Of these, some would have done so whether a test had been recommended or not. In others, the reluctance to be tested can be used to elicit a more accurate history. All these patients should receive lengthy counseling. Some will and some will not permit testing. For those tested and found to be seronegative, counseling after the test must include information about the possibility of false negative tests.

The smallest group of patients would decline an HIV test without acknowledging activities putting them at risk. The physician's judgment would dictate the appropriate level of counseling. If broader HIV testing becomes the norm, the presence of a negative test in a patient's medical record will no longer be suggestive of a risk history for HIV. Those who refuse testing are more likely to be infected with HIV.[49] Whether they acknowledge a risk history or not, they should be encouraged strongly to seek public health facilities that offer anonymous testing.

We believe it no longer tenable to do less than strongly recommend an HIV test to all patients who acknowledge any sexual contact with homosexual men, any needle sharing, or multiple unsafe heterosexual contacts. Physicians should vigorously elicit such histories. Testing should also be recommended to those who received unscreened blood transfusions after 1977 (many of whom are unaware that they received them),[50] those with a history of any sexually transmitted disease (including acute hepatitis B), and those with lymphopenia, unexplained elevation of hepatic enzymes, or positive status for hepatitis B markers. Testing should also be encouraged for those who have been exposed sexually to any person who has tested positive for HIV or any untested person in the above categories.

We also strongly favor universal prenatal testing for HIV. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists currently recommend counseling and HIV testing of pregnant women who are "at increased risk of HIV infection."[51,52] This selectivity is inconsistent with the U.S. and Canadian decision to extend hepatitis B testing to all pregnant women because risk histories are often inaccurate.[53,54] Comparison with universal prenatal screening for rubella, which has been advocated since 1984,[55] is instructive. In the five years since 1984, there have been 21 cases of congenital rubella in the nation.[56] Since thousands of babies infected with HIV are born annually,[57] universal prenatal screening will prevent many more than five cases of neonatal HIV infection a year through decisions to have abortions or to limit the number of future pregnancies. If routine screening of pregnant women is accepted nationwide, its extension to the general population is logically only a small step.

Is it economical to recommend HIV testing to all adults who enter the health care system? Elderly women with negative risk histories are extremely unlikely to be infected with HIV. Perhaps our recommendation should be abridged to include only adults under 60 or in some parts of the country only men under 60. The problem of course is that if testing is justifiable in any segment of an apparently uninvolved population, the boundary between that segment and the rest of the population will inevitably be arbitrary. We urge serious consideration of recommending the test to populations with no apparent risk histories for HIV, especially if the prevalence of infection exceeds some very low threshold. We are recommending HIV testing vigorously to all U.S. adults under the age of 60 regardless of their reported risk history.

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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JUNE 28, 1989

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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
June 28, 1989
2:30 P.M.
555 Diehl Hall

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III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Special Presentation: "The University Hospital Consortium" - Mr. Robert J. Baker	Information
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	2. Development Office Quarterly Report	Information
	3. Renewal Project Phase II: Clinical Department Office Space	Information
	B. Joint Conference Committee - Mr. George Heenan	
	1. Medical Staff-Hospital Council Report Credentials Committee Recommendations	Approval
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C. Finance Committee

- Mr. Jerry Meilahn

1. May 31, 1989 Financial Statements — Information

2. 1989-90 Compensation Plan — Approval

VI. Other Business

VII. Adjournment

MINUTES

Board of Governors
The University of Minnesota Hospital and Clinic

May 24, 1989

Call to Order

Chairman Robert Nickoloff called the May 24, 1989 meeting of the Board of Governors to order at 2:35 p.m. in 555 Diehl Hall.

Attendance

Present:
David Brown, M.D.
Robert Dickler
Phyllis Ellis
Erwin Goldfine
George Heenan
Robert Latz
David Link
Peter Lynch, M.D.
for Paula Clayton, M.D.
Jerry Meilahn
James Moller, M.D.
Robert Nickoloff
Barbara O'Grady
Cherie Perlmutter

Not Present:
Leonard Bienias
Gordon Donhowe
Kris Johnson

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the April 26, 1989 meeting as submitted.

Chairman's Report

Chairman Robert Nickoloff announced the dates of the 1989 Board of Governors retreat. The retreat will be held on October 2-3, 1989 at Riverwood Conference Center in Monticello.

Mr. Nickoloff also reviewed the names of four newly-appointed Regents including Jean B. Keffeler, Alan C. Page, Mary J. Page, and Darrin M. Rosher.

Lastly, Mr. Nickoloff noted an honor bestowed upon Mr. Erwin Goldfine. Goldfine Hall on the campus of University of Minnesota-Duluth will be dedicated on June 2, 1989.

Director's Report

The May Hospital census, Mr. Dickler reported, dropped off slightly. The drop was attributable primarily to a decreased length of stay.

Mr. Dickler reported that the Minnesota Nurses Association and the community hospitals successfully negotiatd a two-year contract. The implications for our compensation plan are currently being evaluated. Mr. Dickler noted that the Minnesota Daily ran an April 27, 1989 article which estimated salary increases for hospital employees. An April 28, 1989 memo from Mr. Dickler to all UMHC employees clarified the parameters of the tentative compensation plan.

The Center for Biomedical Ethics sponsored a conference entitled "The Meaning of the Holocaust for Bioethics", May 17-19, 1989. Mr. Dickler reported the day and time of the television broadcast of conference highlights.

Lastly, Mr. Dickler reviewed efforts by the State Labor Management Committee to replace the current state healthcare indemnity carrier with a preferred provider network. Given that University and Hospital employees participate in the state-wide benefits program, the inclusion of The University of Minnesota Hospital and Clinic as a provider in the chosen network is considered essential.

Planning and Development Committee Report

The Board of Governors seconded and passed a motion to approve the January-March, 1989 Quarterly Purchasing Report. A newly-formatted report was also reviewed for informational purposes.

Mr. Robert Latz and Mr. Greg Hart explained the Hospital's intent to extend the lease on a CT scanner that was installed in 1984. In accordance with the Board of Governors Policy on Capital Expenditures purchases or leases valued between $100,000-$600,000 are presented to the Board of Governors for informational purposes. The current lease will expire on May 31, 1989. Extension of the lease for one year will cost $211,632.

Joint Conference Committee Report

Ms. Phyllis Ellis described the activities of the Industry University Relationships Review Committee. The Committee is chaired by Dr. James White, Associate Dean of the School of Medicine. Dr. White explained the role of the

Review Committee to the Joint Conference Committee as one that reviews grant contracts between researchers and industry to ensure that the academic freedom of the physician is not unduly confined by the contract and that the relationship does not present conflicts of interest.

The Joint Conference Committee had also reviewed the roles and responsibilites of the Disaster Committee. Dr. Chuck Andres, Chairman of the Disaster Committee, had described actions taken by the Committee to ensure the Hospital is prepared for disasters that would necessitate comprehensive emergency responses from our institution.

Lastly, Ms. Ellis and Dr. Moller overviewed a new hospital policy intended to address the problem of incomplete operative reports. The new policy puts a physician on probationary status if 5% of that physician's operative reports during a given quarter are not completed within three days of the procedure.

Dr. Moller also discussed stringent new reporting requirements for physicians or other health professionals who have first-hand knowledge of the impairment of a professional's ability to perform.

Finance Committee Report

Mr. Jerry Meilahn and Mr. Cliff Fearing reviewed the April 30, 1989 financial statements. Operations year to date through the month of April reflect admissions and outpatient visit levels that are above budget. The month of April, however, was not a favorable month. Admissions during April were .8% under budget; the length of stay was 8.5 days. Outpatient activity during the month was 5.3% under budget. Payroll expenditures and receivables stayed up, despite decreasing activity levels. The Hospital's overall operating position for the month of April is negative for the second time this fiscal year. Fiscal year to date, revenues exceed expenses by 628,191; 1,502,970 less than anticipated. Mr. Fearing also explained a $1,619,440 Blue Cross prior year adjustment in some detail.

The 1989-90 operating budget had been presented to the Finance Committee on April 10 and 26th and to the Board of Governors on April 26, 1989. Mr. Fearing reiterated the proposal to implement a 7.5% price increase on July 1, 1989. A request to implement an additional 2% price increase will be made, if necessary, when final compensation plans and regulatory payment levels are known.

The Board of Governors seconded and passed a motion to endorse the 1989-90 operating budget as presented.

Mr. Greg Hart reviewed the proposed 1989-90 Capital Budget in detail. The budget recommends equipment and remodeling totaling $8,300,000. $6,723,000 of that amount is earmarked for equipment purchases. A list of expenditures between $100,000-$600,000 was highlighted as was a ten year capital expenditure plan which anticipates major projects and building modernization requirements.

The recommended $8,300,000 capital budget will be presented for approval on June 28, 1989.

Special Presentation: President Nils Hasselmo

President Nils Hasselmo began by describing the outcomes of the legislative session. The University was granted just under $95 million, in addition to the base appropriation. Legislative discussions generally affirmed the direction implicit in the University's decade-long planning process; a planning process directed toward enhancing the quality of educational offerings. Decisive quality improvements will be sought; enrollment goals will be managed as appropriate to those quality improvements. During the legislative session, faculty salaries and the quality of undergraduate education were emphasized as priorities.

President Hasselmo intends, in coming months, to concentrate his efforts on improving accountability and communication between University leaders and the legislature. The University's financial management system is being overhauled. The necessary level of reserves for the University, the President noted, is also being studied.

In conclusion, the President observed that the balance between quality education and general access to education is likely to be discussed for some time.

Adjournment

There being no further business, the May 24, 1989 meeting of the Board of Governors adjourned at 4:30 p.m.

Respectfully submitted,

Nancy Janda

Nancy C. Janda
Associate Hospital Director
Secretary to the Board of Governors

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 22, 1989

TO: Members of the Board of Governors

FROM: Nancy Janda
Associate Hospital Director
Secretary to the Board of Governors

We are honored to have Mr. Robert J. Baker as our enrichment speaker this month. Mr. Baker is the President of the University Hospital Consortium, Inc. His resume includes seven noteworthy years from 1970-1977. Those years were spent as a member of the administrative staff at the University of Minnesota Hospital and Clinic.

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

NCJ:jm

Robert J. Baker
President
University Hospital Consortium, Inc.
One Mid America Plaza, Suite 700
Oakbrook Terrace, IL 60181
(312) 954-4707

PERSONAL

Marital Status: Married, Two Children
Height: 6'2"
Weight: 210 lbs.
Age: 45

EXPERIENCE

1986-Present — President and Chief Executive Officer, University Hospital Consortium, Inc., and its subsidiary organizations, which provides national services to 41 university hospitals. Responsible for operationalizing the programs of the consortium. Major programs include capital; pharmaceuticals; supply and solutions purchasing programs; professional liability coverage through a pool and a captive insurance company; new technology assessment; and development and management services. Initial responsibilities include establishing the national office in Chicago and recruiting professional staff.

1977-1986 — Director, University of Nebraska Hospital and Clinic. Responsible for the fulfillment of the mission, goals and objectives of the hospital. Major accomplishments include the establishment of the hospital Board of Governors; restructuring and establishing new bylaws and organization for the hospital medical staff; restructuring and improving the financial capability and stability of the hospital; improving the managerial responsiveness of the organization; establishing a joint venture HMO; an active marketing plan; and a geographically distributed suburban ambulatory care program.

1977 — Senior Associate Director, University of Minnesota Hospitals. Responsible for long-range program planning; hospital governance; consortium development; legal affairs; public information; house staff affairs; external relations; hospital outreach and fund raising; liaison with clinical chiefs, and office of vice president for health affairs; assisting in the development of a consortium of four public teaching hospitals; developing and conducting a process of long-range program planning with board, central administration, medical and management staff, and Metropolitan Health Board; participating in physical facility planning for hospital replacement.

1974-1976 Associate Director of Operations, University of Minnesota Hospitals. Responsible for management of hospital departments and administrative liaison to the medical staff organization; providing direction to administrative staff involved in hospital operations, nursing and operations analysis; medical staff involvement including rewriting and implementing medical staff bylaws, reallocating hospital beds and expanding utilization review and audit activities to meet external requirements; participated in establishing a hospital Board of Governors and a shared services program.

1973-1974 Associate Director, University of Minnesota Hospitals. Responsible for radiology; therapeutic radiology; personnel; operations analysis; admissions; medical records; outpatient department; emergency department; respiratory therapy; social service; masonic hospital; administrative liaison to the clinical chiefs and medical staff executive committee; representing hospital on health sciences, medical staff and hospital committees. Project assignments included union negotiations and establishing a hospital resource monitoring system.

1970-1973 Assistant Director, University of Minnesota Hospitals. Responsible for outpatient department; radiology; therapeutic radiology; emergency department; materials management; central sterile supply; patient relations and masonic hospital; representing hospital on health sciences, medical staff and hospital committees; establishing a new respiratory therapy department and a new personnel department autonomous from central university personnel; hospital lead person on first union contract negotiations with the American Federation of State, County and Municipal employees. Implementation of off-site supply storehouse and perpetual inventory control system; participation in design and construction of a new emergency department and functional design of a new ambulatory care building.

1968-1970 Administrator, of the 50 bed U.S.P.H.S. Indian Hospital, Sells, Arizona, and two outlying full-time outpatient health centers. Responsible for hospital management, medical and professional staff affairs; worked closely with the Indian community, local Indian Health Board and regional office of the Indian Health Service.

Summer and Part-Time	Administrative Trainee, U.S.P.H.S. Indian Hospital Keams Canyon, Arizona. Summer, 1967.
	Administrative Intern, Providence Hospital, Detroit, Michigan. Spring, 1964.
EDUCATION 1966-1968	University of Chicago, Chicago, Illinois M.B.A., 1968. Concentration in Hospital Administration.
1962-1966	Kalamazoo College, Kalamazoo, Michigan B.A., 1966. Liberal arts majoring in economics.
MILITARY SERVICE 1968-1970	U.S. Public Health Service Commissioned Corporal.
AWARDS, FELLOWSHIPS AND RECOGNITIONS	Who's Who Among Students in American Universities and Colleges, 1966
	Carl A. Erickson Fellowship, 1966
	Mary H. Bachmeyer Award for Student Most Likely to Succeed in Hospital Administration, University of Chicago, 1968
	Outstanding Young Men of America, 1974
	Who's Who in America, 1984
MEMBERSHIPS	American College of Hospital Administrators
	Nebraska Hospital Association
	Omaha-Council Bluffs Hospital Association
	Association of American Medical Colleges
	Council of Teaching Hospitals
	University of Chicago, Hospital Administration Alumni Association
	American Red Cross

EXTERNAL ACTIVITIES

Nebraska Hospital Association
Board of Directors, 1982-1983

Omaha & Council Bluffs Hospital Association
Board of Directors, 1978-1986
President, 1982-1983

American Red Cross
Board of Directors, 1978-1986
Chapter Chairman, 1983-1984

Consortium for the Study of University Hospitals
Board of Directors, 1980-1984
Secretary, 1981-1982
Vice President, 1983-1984

University Hospital Consortium
Vice President, 1984
President, 1985-1986

University Hospital Consortium Services Corp.
President, 1985-1986

University of Nebraska Medical Center
Program in Health Services Administration
Instructor, 1977-1985

Church of the Cross - Presbyterian
Clerk of Session, 1983
Personnel Committee Chairman, 1984-1985
Pastoral Search Committee, 1986

Association of American Medical Colleges
AAMC Assembly, 1981-1986

Council of Teaching Hospitals
Administrative Board, 1985-1986

Midlands Area Health Advisory Committee, 1983-1986

American Hospital Association
House of Delegates, 1984-1986
Section of Metropolitan Hospitals, 1984-1986
Capital Incorporation Task Force, 1984-1986
Chairman, 1984-1986
Regional Advisory Board, 1984-1986

MINUTES
Planning and Development Committee
June 5, 1989

CALL TO ORDER
Ms. B. Kristine Johnson, Chair, called the June 5, 1989 meeting of the Planning and Development Committee to order at 1:00 p.m. in room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Robert Dickler Clint Hewitt Geoff Kaufmann Robert Latz William Jacott, M.D. Ted Thompson, M.D.
	Absent	Leonard Bienias Peter Lynch, M.D.
	Staff	Fred Bertschinger Cliff Fearing Greg Hart Nancy Janda John LaBree, M.D.

APPROVAL OF MINUTES
The minutes of the May 8, 1989 meeting were approved as distributed.

RENEWAL PROJECT PHASE II, CLINICAL DEPARTMENT OFFICE SPACE
Mr. Dickler provided a history of the phase II renewal project in terms of the allocation of clinical department space. He said that there were a number of scenarios, recruitment issues, and long-standing commitments involved in the project since its inception. Since the initial plan, a new planning process has evolved that does not require relocation of several office configurations. Within this proposal any space currently occupied as office space would not receive remodeling funds. Estimates of costs to provide basic space remodeling are $30/square foot for minimal remodeling and $75/square foot for substantial remodeling. $1.58 million has been earmarked for remodeling space for clinical departments plus necessary environmental upgrades.

It has been agreed that the Dean is the responsible party for determining if any changes will be made to the existing plan and will make the decisions for spending the funds available. If a Medical School department wants more space it will be taken out of the space allocated to the Medical School; if more funds are needed, the Departments and Medical School will be responsible.

The present plan has the approval of the Dean, the Chiefs, and the Vice President.

After a number of questions were fielded, Mr. Dickler told the group that the document would be presented at the next Planning and Development meeting for endorsement.

1989-90 CAPITAL BUDGET

Mr. Hart presented the proposed 1989-90 capital budget for endorsement. The $8,300,000 annual equipment and replacement budget consists of $6,723,000 for equipment purchases, $115,250 for equipment installation, and $1,461,750 for remodeling.

The capital budget as presented was unanimously endorsed by the committee.

QUARTERLY DEVELOPMENT OFFICE UPDATE

Mr. Bertschinger reviewed the contributions received by the Development office in FY 1989 to date. He stated that the annual solicitation of employees, faculty and staff will be held in the near future and that they are doing telemarketing with good success. Mr. Bertschinger reported that his office is putting together a grant request to the Kresge Foundation.

UMCA REPORT

Dr. Lynch was not present at the meeting; however, his report was included in the material mailed to each member.

ADJOURNMENT

Ms. Johnson adjourned the Planning and Development Committee at 2:15 p.m.

Respectfully submitted,

Ann Frohrip
Principal Secretary
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 1, 1989

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: 1989-90 Capital Budget

Enclosed please find the proposed 1989-90 capital budget. Our operating budgets assumed cash flow for equipment and remodeling of $8,300,000.

As the attached summary indicates, we are recommending an equipment and remodeling budget next year of $8,300,000. Of this amount, $6,723,000 is for equipment purchases, the remainder is for equipment installation and remodeling. A departmental breakdown of the equipment budget is 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. We will be presenting brief reports to the Board on the $100,000 - $600,000 purchases during the upcoming year.

The last attachment presents a ten-year capital expenditure plan. This ten-year plan does not require Board approval, but is informational in nature. The ten-year plan includes projects which have been identified as part of the Board approved Mayo remodeling plan (Renewal Project - Phase II). Please note major expenditures for Renewal Project II are included on the second page of the ten-year plan.

We are requesting Committee and Board approval for the recommended total $8,300,000 capital budget at the June meetings. We will be reporting actual capital expenditures compared to budget on a quarterly basis during the fiscal year, consistent with Board policy. Major capital expenditures 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

1989 - 1990 Capital Budget Summary

Equipment Purchases	$6,723,000.00
Equipment Installation	$115,250.00
Remodeling	$1,461,750.00
Total	$8,300,000.00

DEPARTMENT	AMOUNT*
Admissions	$2,873
Ambulatory Care	$262,037
Biomedical Eng.	$22,770
Bone Marrow Transplant	$369
Cardio-Respiratory	$556,540
C.C.T.V.	$44,040
Communications	$20,861
Environmental Svcs.	$67,770
Fin. Accounting	$41,623
Hospital Facilities	$7,104
Human Resources	$39,610
Infection Control	$4,550
Information Services	$855,820
Laboratories	$987,643
Labs - Neurology	$28,000
Maint. & Operations	$11,423
Materials Services	$155,635
Medical Records	$99,090
Nursing Services	$138,303
Nutrition	$43,514
Operating Rooms	$675,840
Patient Accounting	$9,200
Patient Relations	$1,231
Pharmacy	$8,370
PM and R	$34,594
Protection Svcs.	$6,600
Psychiatry	$3,203
Quality Assurance	$10,739
Radiology	$1,387,167
Therapeutic Radiology	$525,000
Anticipated Future Requests	$671,481
GRAND TOTAL	$6,723,000

* Departmental allocations may vary as refinement to this budget occurs.

1989 - 1990 Capital Budget Summary

Items Between $100,000 and $600,000

Diagnostic Radiology	Radiographic/Tomagraphic Peds	$168,000.
	Gamma Camera	$210,000.
Hospital Laboratories	Pathfinder Mega	$118,000.
Information Services	Applications Software and Related Hardware (Possible systems to be purchased include; Purchasing, Automated Time Card, Patient Care Documentation, Casemix Management, IMS Expansion, Outpatient Registration Scheduling and Billing)	$677,552.
erapeutic Radiology	Stereotactic Radio Surgery	$500,000.
Grand Total		$1,673,552.

ANNUAL CAPITAL REQUIREMENTS

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
APPROVED PROJECTS												
Dermatology Clinic.....(C)	0	630,000	0	0	0	0	0	0	0	0	0	630,000
A-15 Computer/Disc Drives.....(A)	3,800,000	0	0	0	0	0	0	0	0	0	0	3,800,000
MRI - II.....(C)	0	2,600,000	1,000,000	0	0	0	0	0	0	0	0	3,600,000
CUNCC.....(C)	0	331,373	1,018,627	0	0	0	0	0	0	0	0	1,350,000
Masonic III.....(C)	0	200,000	400,000	0	0	0	0	0	0	0	0	600,000
Approved Projects Subtotal.....	3,800,000	3,761,373	2,418,627	0	0	0	0	0	0	0	0	9,980,000
ANTICIPATED PROJECTS												
Lithotripter II.....	0	0	1,100,000	0	0	0	0	0	0	0	0	1,100,000
Lithotripter I Upgrade.....	0	0	0	0	1,216,000	0	0	0	0	0	0	1,216,000
Replace CT Scanners.....	0	0	992,000	0	1,094,000	0	1,206,000	0	0	0	0	3,292,000
Replace Linear Accel.....	0	0	1,700,000	0	1,300,000	0	1,500,000	0	0	0	0	4,500,000
Replace MRI-I.....	0	0	0	0	0	3,063,000	0	0	0	0	0	3,063,000
Computer Upgrade.....	0	650,000	1,700,000	4,150,000	1,500,000	1,500,000	1,500,000	5,500,000	1,500,000	1,500,000	1,500,000	21,000,000
Neuroradiology Upgrade.....	0	0	1,809,000	0	0	0	0	0	0	0	0	1,809,000
Anticipated New Technology.....	0	0	0	1,400,000	0	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	3,500,000	22,400,000
Heart Cath/CV Radiology.....	0	0	800,000	2,500,000	3,000,000	0	0	0	0	0	0	6,300,000
Property - Oak and Fulton.....	0	0	0	0	0	0	0	0	0	0	0	0
Anticipated Projects Subtotal.....	0	650,000	8,101,000	8,050,000	8,110,000	8,063,000	7,706,000	9,000,000	5,000,000	5,000,000	5,000,000	64,680,000
ANNUAL EQUIPMENT AND REMODELING PROJECTS												
Annual Equipment Replacement.....(B)	4,407,000	6,500,000	6,723,000	6,925,500	7,209,000	7,411,500	7,654,500	8,545,500	8,950,500	9,598,500	10,368,000	84,293,000
Annual Remodeling.....(B)	1,141,000	1,500,000	1,577,000	1,624,500	1,691,000	1,738,500	1,795,500	2,004,500	2,099,500	2,251,500	2,432,000	19,855,000
Equipment Rollforward.....(D)	0	2,850,000	0	0	0	0	0	0	0	0	0	2,850,000
Annual Equip and Remod Subtotal.....	5,548,000	10,850,000	8,300,000	8,550,000	8,900,000	9,150,000	9,450,000	10,550,000	11,050,000	11,850,000	12,800,000	106,998,000
ANNUAL PRINCIPAL PAYMENTS												
Unit J Principal Payments.....(B)	2,706,000	2,815,000	2,215,000	2,345,000	2,490,000	2,650,000	2,830,000	3,015,000	3,230,000	3,455,000	3,705,000	31,456,000
VRDB Principal Payments.....	0	0	0	0	0	0	0	0	1,681,000	1,681,000	1,681,000	5,043,000
Existing Other Principal Payments.....(B)	1,169,000	1,478,000	916,000	598,000	148,000	76,000	0	0	0	0	0	4,385,000
Annual Principal Payments Subtotal.....	3,875,000	4,293,000	3,131,000	2,943,000	2,638,000	2,726,000	2,830,000	3,015,000	4,911,000	5,136,000	5,386,000	40,884,000
Annual Capital Requirement Subtotal.....	13,223,000	19,554,373	21,950,627	19,543,000	19,648,000	19,939,000	19,986,000	22,565,000	20,961,000	21,986,000	23,186,000	222,542,000

(A) Funded from Trustee Account as of June 30th, 1988 of $3,880,000
(B) Funded as part of 1987-88 budget totalling $9,423,000
(C) Funded from Reserves as of June 30th, 1988, funding included in Beginning Reserve Balance
(D) 2.2 million funded as of June 30th, 1988, funding included in Beginning Reserve Balance

BUILDING REPLACEMENT/MODERNIZATION

RENEWAL PROJECT PHASE II	Bldg	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Surgical Path.....(A)	Mayo	0	700,000	330,000	0	0	0	0	0	0	0	0	1,030,000
Mayo Clinical Program Remodeling Project.....	Mayo	0	0	1,575,000	5,512,500	5,325,075	0	0	0	0	0	0	12,412,575
Unit J Expansion Project.....	J	0	200,000	2,600,000	8,224,423	10,260,173	1,469,778	0	0	0	0	0	22,754,373
Building Upgrade.....	Mayo	0	0	2,125,000	4,910,000	4,977,788	0	0	0	0	0	0	12,012,788
Other Mayo Programs.....	Mayo	0	0	840,000	1,102,500	2,554,727	4,187,911	2,424,935	2,680,191	0	0	0	13,790,265
Total Project.....		0	900,000	7,470,000	19,749,423	23,117,762	5,657,689	2,424,935	2,680,191	0	0	0	62,000,000
Annual Capital Requirement Subtotal.....		13,223,000	19,554,373	21,950,627	19,543,000	19,648,000	19,939,000	19,986,000	22,565,000	20,961,000	21,986,000	23,186,000	222,542,000
Total.....		13,223,000	20,454,373	29,420,627	39,292,423	42,765,762	25,596,689	22,410,935	25,245,191	20,961,000	21,986,000	23,186,000	284,542,000

(A) Funded from Reserves as of June 30th, 1988, funding included in Beginning Reserve Balance

UNIVERSITY OF M ESOTA
TWIN CITIES

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

Date: May 31, 1989

To: Planning and Development Committee

From: Fred Bertschinger

Subject: Development Office Quarterly Report

Attached for your information are summary reports of activities and donations received during the third quarter of FY 1989 (Jan.-Mar. 1989).

If you have any questions about this report, please call me at 626-6008.

Contributions Received
UMHC Development Office
FY 1989

	I 7-9/88	II 10-12/88	III 1-3/89	IV 4-6/89	Totals
Patients Fund	$ 6,502	$ 3,530	$ 4,273		$ 14,305
Transplant Ass. Fund	3,433	1,951	3,040		8,424
Variety Club Pldg	105,091	279	6,498		111,868
Other Funds	20,599	62,419	64,979		147,997
Totals to Funds	$135,625	$68,179	$78,790		$282,594

Goal = $880,000

Tribute Gifts	55	147	198	400
Gifts in Kind	0	0	$1,217	$1,217
Irrevocable	2	0	0	2
re Gifts	$275,000	0	0	$275,000
Revocable	4	0	1	5
Future Gifts	0	0	0	0

Activities and Events
UMHC Development Officer
FY 1989

1988

July 1 — Annual Campaign solicitations by mail for UMHC employees, medical staff, and Board of Governors continues from June. Contributions support the Patients Fund and the Transplant Assistance Fund.

July 10-15 — Educational Institutes at University of Wisconsin, sponsored by the National Association for Hospital Development (NAHD) attended by Fred Bertschinger.

September 5 — Commodores Chorus Recognition Luncheon.

September 17 — Donor Recognition Luncheon hosted by Bob and Sue Dickler.

October 2-6 — NAHD Educational Conference and Accreditation exam in Dallas, Texas. Fred Bertschinger has received "certified" status by NAHD.

November 27 — Operating Room Nurses Holiday Party to benefit the Transplant Assistance Fund.

1989

January 15 — WCCO-AM, "Breakfast of Champions" live sports show from the Bierman Indoor Football Practice Facility.

January 17 — First mailing of FORESIGHT newsletter of personal financial planning to donors and friends.

April 19 — Communication Workers of America Local 7200 selected the Transplant Assistance Fund as their annual benefit project.

April 26 — U of M Development Office, TEAMS, telemarketing efforts begin following direct mail trial to one-half of former donors to benefit the Patients Fund and Transplant Assistance Fund.

May 10 — Third Annual Sigma Chi Derby Days to benefit the Child/Family Life program.

May 13 — Delta Chi "Duluth Trek" bicycle ride to benefit the Child/Family Life program.

May 17 — Donor recognition and cultivation event, including a tour of UMHC and attendance at the U of M Alumni Association Annual meeting with guest speaker Walter Cronkite.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 22, 1989

TO: Members of the Board of Governors

FROM: Robert Dickler
Hospital Director

RE: Renewal Project Phase II:
Clinical Department Office Space

Over the past six months, discussions have been pursued to resolve clinical department office space issues related to the second phase of the Renewal Project. These efforts have manifested the enclosed plan. Both an executive summary and complete proposal are enclosed for your consideration.

This proposal has been reviewed and endorsed by the Dean's office, Office of the Vice President for Health Sciences and Council of Chiefs of Clinical Services. While some issues continue to be identified by individual departments, it is our belief that these issues can reasonably be resolved within the financing and square footage parameters identified in the plan.

For ease of reproduction, color coding has been eliminated from the attached floor plans. That color coding differentiated areas scheduled for light remodeling from those where we anticipate heavier remodeling. In the Psychiatry floor plan, color coding had been used to differentiate existing space from new space. Color coded originals will be available for your review at the Board of Governors meeting.

We look forward to discussing this proposal with you. Please feel free to contact me if you have any questions.

RD:jm

Executive Summary

UMHC Renewal Project Phase II

Associated Clinical Departmental and General Space Issues

Introduction

This document is intended to summarize the key outcomes and recommendations relative to the recent extensive discussions on the subject of clinical departmental office space and space reallocation. The full history and complexity of this subject is described in detail in the Discussion Paper. Sections include history, departmental locations, funding for renovation, Hospital/Medical School space allocations, and future policy.

History

Most of the issues currently under review arise out of planning for Mayo renovation which occurred in the mid-1980s. At that time, office space for Psychiatry, Urology, Neurosurgery, Anesthesiology, Obstetrics, Neonatology and Surgical Pathology was addressed. Space was allocated for Neuro-epilepsy shortly thereafter. The then-planned move of Psychiatry from the sixth floor of Mayo to the fifth floor of Mayo was a major element of the overall plan. As that element changed, with inpatient Psychiatry planned in the Unit J addition, critical assumptions related to Mayo renovation and departmental office space were altered. That change, coupled with several points of ambiguity historically, have created the need for re-examination of plans from space allocation , location, and financing perspectives. While this re-examination has addressed the immediate needs of those departments involved in Mayo renovation, it has also raised issues of longer-term policy.

Departmental Locations

The locations for each of the clinical departmental offices involved in Renewal Project II, following the re-examination referenced above, are as follows:

1. Psychiatry, Anesthesiology, Neurosurgery, and Neuro-epilepsy would retain their existing office configurations on Mayo 6 and Mayo 5. Additional space to meet the current office program requests would be provided contiguous to the existing departmental spaces for Psychiatry, Anesthesiology, and Neurosurgery. Neuro-epilepsy is not programmed for additional space.

2. Psychiatry day hospital and outpatient facilities would also be located on Mayo 6, to facilitate interactions between these functions and the departmental offices.

3. NICU offices would be located on Mayo 4 as previously planned, contiguous to OB and the Unit J link.

4. OB office space would be developed contiguous to the OB Unit on Mayo 4 in a configuration consistent with final OB inpatient planning.

5. Radiology clerical, office and associated space would be located on Mayo 2 as previously planned.

6. Urology offices would be moved to Mayo 4, contiguous to the planned Cysto suite. A location closer to Unit J on Mayo 4 will be used in order to minimize remodeling costs and improve traffic flow.

7. The remodeling for Surgical Pathology offices on Mayo 4 will continue as planned. In addition, a small increment of space on Mayo 4 will be added to accommodate Neuro-pathology.

Funding for Renovation

8. University Hospital will provide the Medical School with $1,586,000 to accomplish the renovation for departmental office space.

9. In addition to the above, the Hospital will fund central air conditioning for the office spaces as necessary.

10. Funding in 8 and 9 above, to the extent possible, will be provided within the existing Renewal Project budget.

11. The above figure is based on an estimated remodeling cost per square foot of 0-$75. Variances from those remodeling cost levels, plus costs of interior finish upgrades above basic levels and furnishings, will be funded from Medical School and/or departmental sources. Further, the Medical School will be responsible for requests for reallocation of space or funds among the clinical departments.

Hospital/Medical School Space Allocations

12. The source of clinical departmental office space expansion from the 1985 plan to the current plan will be the vacated Hospital space allocated to the Medical School in 1985.

13. As a result of these numerous changes, the Medical School will receive 5300 NSF on Mayo 6 when vacated and 5,104 NSF elsewhere above and beyond clinical department office space.

14. In addition to (13) above, the Medical School will be assigned 10,400 NSF of currently unplanned Mayo/Rehab space and the Hospital, likewise, will retain 10,400 NSF of currently unplanned space.

15. The northwest corner of Mayo 5 will be used to meet the 5,104 NSF and 10,400 NSF allocations to the Medical School.

16. Other than the space allocated to the Medical School per #14 above, the 5300 NSF on Mayo 6, and the spaces allocated for departmental expansion, the Hospital will retain all other vacated Mayo/Rehab space, including that space temporarily assigned to various Medical School departments, to meet its programmatic requirements.

Future Policy

17. The above recommendations should not be viewed as setting precedent for future clinical departmental office space funding. The proposal reflects only the unique circumstances and considerations discussed in this document.

18. The Hospital, Medical School, Council of Chiefs of Clinical Services and Vice President for Health Sciences concur that comprehensive guidelines will be developed to avoid any further ambiguity regarding the provision of space, construction/remodeling, and maintenance of all clinical department office space. It is further recommended that the office space needs of clinical departments (Hospital and non-Hospital based) be a shared responsibility with the Medical School and clinical departments having the primary responsibilty. These guidelines will be developed jointly prior to May 1, 1989. It is understood that funding for any projects in addition to those specified herein will need to be delayed pending approval of the guidelines.

19. In relationship to #18 above the Hospital has indicated a willingness to provide full or partial funding for clinical departments (both Hospital and non-Hospital based) in circumstances such as relocation for Hospital activities, administrative offices, and special activity. All commitments must be in compliance with the Board of Governors capital expenditure guidelines.

Conclusion

The above 19 points, taken in totality, address the major issues related to clinical departmental office space location and renovation. In addition it finalizes planned reallocation of space from the Hospital to the Medical School. Further specifics are referenced in the full Discussion Paper and associated appendices, and more specific references therein should serve as the source of interpretation of the key points outlined in the Executive Summary.

Discussion Paper

UMHC Renewal Project Phase II

Associated Clinical Department and General Space Issues

January 1989

I. INTRODUCTION:

For several years a series of issues have been identified which are related to the University Hospital Renewal Project. With the formulation of an approved plan for the second phase of the Renewal Project, intensive discussions have occurred over the past several months to resolve these issues.

These issues fall into three inter-related areas of consideration: (1) the provision of space and associated funding for clinical department offices that have been, or are currently, related to the Renewal Project plan; (2) confirmation and/or modification of the commitments made in 1985 for reallocation of vacated Hospital space to the Medical School; and, (3) identification and potential reallocation of additional vacated Hospital space beyond the 1985 commitment. The intent of this discussion paper is to provide background for, and discussion of, each of these areas and to propose a comprehensive solution for all of these issues.

II. BACKGROUND

A. Clinical Departmental Office Space

While the issues and debates relating to clinical department office space have a long history, and are inherently related to the overall space constraints facing the institution, an appropriate point in time to focus on the specific circumstances confronting the Hospital and Medical School is the planning process which was undertaken for the second phase of the Renewal Project in the mid-1980s. At that time, it was envisioned that several clinical department office areas would need to be relocated due to the displacement of these functions for the development of clinical facilities and for reallocation of the sixth floor of the Mayo complex to the Medical School. Clinical department office space affected by these circumstances included Anesthesia, Neurosurgery, Urology, Psychiatry, and Surgical Pathology. In addition, planning at that time envisioned the potential need for new office configurations for the NICU faculty, OB faculty as a component of the new OB unit, PM&R faculty offices

integral to the rehabilitation and therapy patient care units, and Radiology needs not accommodated in Unit J.

At the time that these clinical departmental office space office configurations were incorporated in Renewal Project planning, the general position adopted by the Hospital was that when departmental areas needed to be relocated for Hospital needs the Hospital would assume responsibility for replacement at an equal level of quality and magnitude of space. In most of these instances, this commitment was articulated in writing and, in accord with the plans identified at that time, there were specific references to the level of Hospital financial responsibility - if any - which might be necessary for both relocated departmental space or other departmental areas. In other instances incomplete written communication or only verbal discussions occurred regarding financial responsibility for these office areas.

With the adoption of the current plan for the second phase of the Renewal Project, the necessity of relocating many of these departmental areas has been eliminated or reduced. This is because the current plan relocates Psychiatry inpatient facilities to Unit J eliminating the necessity of dislocating departmental space on floor 5 of Mayo.

The Hospital has articulated a position that since there is not a requirement to relocate many of these departmental areas that the new plan displaces these old agreements. This position has been disputed aggressively by many departmental and Medical School officials since their planning has assumed incorporation of these departmental requirements in the Renewal Project. In addition, it is articulated that historic planning provided for close proximity of offices and clinical space when this was considered to be appropriate, and other planning activities since 1985 has assumed that these departmental space needs would be accommodated by the Hospital. The departments and Medical School further argue that since it was assumed that these needs would be accommodated, neither the School nor departments have developed financial plans or resources for these office needs.

For example, the 1985 plan envisioned that the Psychiatry offices would relocate to areas on the fifth floor of Mayo already configured for departmental offices, i.e. - Anesthesiology and Neurosurgery. This relocation provided, in essence, an upgrade for Psychiatry since these facilities are already air-conditioned. While the 1985 plan stipulated that no Hospital funds would be needed beyond dome room upgrades

for Psychiatry offices, it also committed to air-conditioning Psychiatry facilities. Later renditions of the 1985 plan identified a need to continue to utilize some of the Psychiatry office space on the sixth floor and the current plan provides flexibility regarding Psychiatry facilities in Mayo. Those same 1985 plans required relocation of Neurosurgery, Anesthesiology, Neuro-epilepsy, and Urology to accommodate Psychiatry.

The foregoing background is further complicated by the historic Hospital position regarding responsibility for clinical department office space and events which have transpired since these plans were formulated. In relationship to the historic Hospital position, while no specific policy has existed it is clear that the Hospital has assumed only limited responsibility for clinical department space requirements. The responsibility the Hospital has assumed relates primarily to office space for Hospital based clinical departments (Radiology, Therapeutic Radiology, and Lab Medicine & Pathology); singular or small office configurations for faculty performing administrative functions for the Hospital; replacement of space displaced for other purposes; and occasional exceptions associated with recruitment or issue resolution. The Hospital has also provided loans to the Medical School and/or clinical departments for some clinical department space activity. This historic position would provide a rationale for Hospital funding of some of these areas.

In relationship to events which have transpired since the original plans were formulated in 1985, these plans have to some degree - often in an unclear fashion - been incorporated into recruitment efforts completed or currently in process for chairpersons of clinical departments. In addition, circumstances have changed which have led to redefinitions of space requirements for many of these departments.

B. Mayo Sixth Floor

In the 1985 Renewal Project Phase II plan, it was determined that the Hospital could reduce its space requirements in Mayo with the opening of Unit J and the remodeling of existing facilities. One of the areas relinquished was the sixth floor of the Mayo complex (37,000 NSF). All of this space, less 5,000 NSF retained by the Hospital for mechanical space, was allocated by the Health Sciences to the School of Medicine.

The viability of this plan is now in question depending on the outcome of the clinical department office space issues. Because the current Renewal Project plan does

not require relocation of Psychiatry to the fifth floor, whether the sixth floor space commitment to the Medical School can, or should, be fulfilled on the sixth floor or elsewhere needs to be resolved.

C. Other Space

At the time that the current plan for the second phase of the Renewal Project was formulated, it was determined that with the addition of a finished floor on Unit J as much as 20-24,000 additional NSF of existing Hospital space would not be required by the Hospital for the Renewal Project. The exact magnitude of space and its location cannot be determined until both master zoning and detailed planning can be completed. The Hospital also noted that this square footage may diminish as planning occurs due to the inefficiencies in space utilization inherent in reducing remodeling costs through re-use of existing space configurations. Re-use of existing space may require the use of more space than is technically required to fulfill program plans. This reallocation is also impacted by the magnitude and location of departmental space.

III. DISCUSSION AND PROPOSAL

The space issues related to the second phase of the Renewal Project are obviously complex and multi-faceted. To a large extent the ability to resolve the issues related to reallocated space are dependent upon a solution to clinical department office space. It is also necessary to have some sense of the solution to these clinical department office space issues to finalize overall planning for Phase II of the Renewal Project.

The key questions which require resolution in relationship to clinical department space are both the magnitude of space and sources of funding for necessary remodeling. In an attempt to resolve this issue the Hospital has developed an approach to clinical department space allocations and funding which attempts to equitably resolve the issue through the Hospital and Medical School sharing the implications of space requirements and the Hospital providing a base level of funding for remodeling with the School and departments assuming responsibility for levels of interior finish, furnishing and remodeling beyond those necessary for basic and acceptable office configurations.

Prior to detailing this approach, and its impact on each of the three major issue areas, it is necessary to articulate that this proposal should not be interpreted as precedent setting in relationship to the Hospital, Medical School and departments respective responsibilities for clinical department space in the future. Rather, it is a stand-alone proposal to resolve a set of multi-faceted issues which over time have become so complicated that it is literally impossible to adequately sort out all of the

ramifications, commitments and implications. Furthermore, it is assumed that as an integral component of this proposal a policy regarding future Hospital responsibility in relationship to clinical departmental space will be adopted by the Hospital and concurred with by the Medical School, clinical departments and Vice President for Health Sciences.

A. Clinical Department Office Space

Clinical department areas incorporated into these considerations include all or part of the office configurations for NICU, Obstetrics, Psychiatry, Urology, Anesthesia, Neurosurgery, Radiology and Neuro-epilepsy. In addition, a component of the Surgical Pathology program not incorporated in the current plans is also included. These departments, in aggregate for the space affected by the 1985 Phase II Renewal Project, occupied 25,162 NSF and developed program plans for 27,712 NSF. No specific plans existed in 1985 for Neuro-epilepsy and the Surgical Pathology expansion and square footage is not incorporated for these activities in the 27,712 NSF figure. Detailed figures are provided in Attachment I.

Over the past three years these program plans have been revised and updated for some departments so that current program plans indicate a potential need, based upon departmental requests, for 36,738 NSF including Neuro-epilepsy and the Surgical Pathology expansion. These figures are also detailed in Attachment I.

The 1985 plans envisioned the development of this square footage as part of the Renewal Project at a level of remodeling which would provide normative office configurations at a base level of interior finish (basic floor finishes, painted walls, basic drapes). Those plans also assumed that furnishings would be relocated from existing office areas or provided by the departments. The plans also assumed air conditioning in areas which did not have adequate environmental control because of window units or no air conditioning.

The 1985 plans for Psychiatry, Urology, NICU and OB also incorporated proximity of departmental offices to the inpatient and outpatient facilities included in the Renewal Project. Such proximity was felt to be desirable for both departmental and patient care programs.

Given the foregoing, a clinical department space plan has been developed which incorporates the basic tenets of the 1985 plan, but recognizes that total relocation of many of these departmental areas is no longer necessary. More specifically:

1. The current plan would retain the existing office configurations for Psychiatry, Anesthesiology, Neurosurgery and Neuro-epilepsy. Additional space required in accord with the current program request would be provided contiguous to these existing departmental areas. (NOTE: Current plans indicate that Neuro-epilepsy does not require additional space).

2. For Psychiatry the day hospital and outpatient facilities would be developed contiguous to existing and expanded departmental space on the sixth floor of Mayo.

3. NICU office space would be developed in accord with the 1985 plan, i.e., on the fourth floor of Mayo contiguous to the OB unit and the Unit J overpass.

4. OB office space would be developed in accord with the 1985 plan, i.e., contiguous to the OB unit on the fourth floor of Mayo.

5. Radiology office space would be developed in accord with the 1985 plan, i.e, on the second floor of Mayo in the old Radiology area.

6. Urology office space would be developed partially in accord with the 1985 plan - i.e., on the fourth floor of Mayo contiguous to clinical facilities. A new location has been identified, however, to minimize remodeling costs and improve traffic patterns.

7. The incremental expansion for Surgical Pathology beyond currently approved plans would be contiguous to the planned location on the fourth floor of Mayo.

This plan further envisions that the incremental expansion of space from the 1985 plan to the current plan would be allocated from the space committed to the Medical School in 1985. Thus, the Medical School would assume responsibility for office program expansion beyond the requirements identified in the 1985 plan.

Finally, the plan envisions that the Hospital would provide funding for remodeling in accord with the spirit of the 1985 plan. This funding plan assumes that any space that is currently utilized as clinical department space is satisfactory and no remodeling funds will be provided with two exceptions: air conditioning, where necessary, and funds to provide basic remodeling of dome rooms currently allocated to Neurosurgery and Anesthesiology. Funding would be provided for

incremental space or new space developed for clinical departments. A review of these areas indicates that 9,202 NSF of this space will require minor remodeling (few wall changes, painting, removal of fixtures, etc.) and 9,809 NSF requires moderate remodeling (some basic configuration changes). In aggregate this remodeling is estimated to require funding of $1,586,000. This estimate is based upon $35/sq. ft. for minor remodeling; $75/sq. ft. for moderate remodeling; and factors for public space, architect fees, and some additional non-building costs. $35 and $75/sq. ft. for remodeling costs includes provision for inflation as well as some contingencies.

This estimate does not include the cost of necessary air conditioning, more substantive changes in configuration, upgraded interior finishes, or furnishing. The plan as developed assumes all of these costs - to the degree they are incurred - will be funded by the Medical School or departments with the exception of air conditioning of the necessary areas of Mayo sixth floor, which will be funded by the Hospital. Ongoing maintenance of all departmental office space will be the responsibility of the Medical School and University.

B. & C. Sixth Floor Mayo Space and Other Space

The foregoing plan obviously has significant impact on the allocation of Mayo sixth floor to the Medical School. Of the 32,000 NSF originally assumed to be available for redistribution, Psychiatry departmental offices, clinic space and day hospital will require 26,700 NSF leaving 5,300 NSF available for redistribution. Because space on the sixth floor of Mayo, for a variety of reasons, is very inefficient the 26,700 NSF originally committed has a 60% efficiency factor applied to it. Thus, 16,020 NSF elsewhere in Mayo or other facilities, along with 5,300 NSF on Mayo 6, needs to be allocated to meet the original 1895 commitment to the Medical School.

As noted earlier, it is currently estimated that up to 24,000 NSF of additional space may be available for redistribution based upon the current Renewal Project Phase II plan. This figure has been effected by recent decisions relating to the relocation of the PM&R Department, which committed 3,200 NSF of this 24,000 NSF estimate. Thus, up to 20,800 NSF may be available for redistribution.

To facilitate planning for both the Hospital and other Health Sciences units, it is proposed that this 20,800

NSF be allocated equally to the Hospital and Medical School. The retention of 10,400 NSF by the Hospital would be potentially utilized for a variety of purposes. First, it would be utilized to reduce remodeling costs where additional space allocations to Hospital programs can have a substantial impact on these costs. Second, it would be utilized to partially deal with Hospital space issues not incorporated into the second phase of the Renewal Project. These include ambulatory care, finance departmental space, hospital-based bone marrow office expansion and other needs which have been identified as space deficient. Also included within these potential needs are new activities such as child care facilities.

These total adjustments and changes require an aggregate of 26,420 NSF to be allocated to the Medical School in addition to the 5,300 NSF remaining on Mayo sixth floor. This 26,420 NSF is reduced by the incremental space required for the expansion of clinical department offices of 11,000 NSF which results in a final figure for allocation of 15,404 NSF to be relinquished to the Medical School in addition to the remaining sixth floor space. The foregoing calculations are detailed in Attachment IV.

To accommodate this space allocation, it is proposed that a significant component of the northwest corner of the Mayo complex on the 5th floor be allocated to the Medical School. The potential space which would be included in this allocation is identified in Attachment V.

It should be noted that this plan has attempted to identify areas for clinical departmental space which require the least possible level of remodeling from current configurations - thus, the change in location for Urology and Psychiatry offices from the 1985 plan. In addition, to minimize remodeling it envisions utilizing 38,628 NSF to fulfill the 36,738 NSF program (see Attachment I). Attachment II identifies the location of these clinical department spaces and color codes the level of anticipated remodeling. Attachment III summarizes and totals the necessary remodeling.

V. CONCLUSIONS AND RECOMMENDATIONS

The foregoing proposal is intended to provide a comprehensive solution to the clinical departmental space issues, as well as historical and current reallocations of space. Based upon this plan, it is recommended that:

A. Up to an aggregate of 38,628 NSF of existing and new sq. footage be allocated to resolve the departmental office space requirements of Psychiatry, Urology, Anesthesiology, Neurosurgery, Radiology, OB, NICU, Neuro-epilepsy, and Surgical Pathology. It is further recommended that this space be allocated in the areas identified in Attachment II.

B. An aggregate of up to $1,586,000 of the approved Renewal Project budget be allocated by the Hospital for clinical department office space remodeling. The utilization of these funds is restricted to actual remodeling costs and associated fees and may not be utilized for furnishing or major upgrades of interior finishes. In addition, it is recommended that air conditioning be funded, to the extent necessary, through the existing Hospital Renewal Project budget. Based upon the information available, the space and funds identified should - in aggregate - be adequate to meet the departmental requirements.

Because the impact of incremental space for clinical department offices effects the total space available for Medical School activities, and clinical department offices are ultimately the Medical School's responsibility, the actual final plans for these areas should fall under the purview of the Medical School. Likewise, while the aggregate funding should be adequate, the Medical School should have the prerogative of reallocating funds between specific aspects of the project and to add other funding from non-Hospital sources if it is deemed appropriate. If the full magnitude of funds are not needed for the purposes stated, these should revert to the Hospital. It is, therefore, further recommended :

C. That responsibility for further planning of the clinical departmental space specified in this document be the responsibility of the Medical School,including the prerogative to reduce space allocations and reallocate funds between project components. Any funding beyond the $1,533,000 specified will be the responsibility of the Medical School and/or clinical departments and any unspent funds for the project and the purposes identified will revert to the Hospital. All planning will be coordinated with the Hospital and the Medical School will use the Renewal Project Phase II consultants (architect and consultant fees at normative levels are included in the budget allocation provided by the Hospital). Ongoing responsibility for maintenance and upkeep of clinical department office space affected by the project is the responsibility of the Medical School and University.

As noted in recommendation B it is recommended that funding for clinical department space come from the existing Renewal Project Phase II budget. Current estimates indicate that sufficient flexibility exists to accommodate these requirements. It should be recognized, however, that further planning may require reconsideration of, and an increase to, the project budget by the Board at a later date. Necessary approval processes for renovation of Medical School space included in the Renewal Project will also need to be clarified.

The foregoing parameters for clinical department office space, as well as the factors discussed in regard to the sixth floor of Mayo and other space reallocations, permits the overall issue of space reallocation to also be resolved. It is, therefore, recommended that:

D. A total of 15,504 NSF on the fifth floor of the Mayo complex (northwest corner) and 5,300 NSF on the sixth floor of Mayo be allocated from the Hospital to the Medical School.

This reallocation from the Hospital to the School replaces the 1985 reallocation of Mayo sixth floor to the Medical School through the Vice President for Health Sciences, and is inclusive of additional space which can be reallocated as a result of the Renewal Project Phase II plan.

These allocations are net of additional space required for clinical department office space above and beyond the NSF determined in 1985. If further planning results in a reduction of space required for clinical department offices incorporated in these recommendations, this space remains under the purview of the Medical School. No Hospital funding beyond that specified for clinical department office space is associated with these space transfers.

Finally, as noted earlier, this recommendation should not be viewed as establishing Hospital responsibility in the future for clinical department space. To the contrary, this proposal reflects unique considerations and circumstances. To assure that the level of ambiguity and confusion which surrounded these issues is minimized in the future, it is, therefore, further recommended that:

E. The Hospital, Medical School, Council of Chiefs of Clinical Services and Vice President for Health Sciences concur that comprehensive guidelines must be developed to avoid any further ambiguity regarding the provision of space, construction/remodeling, and maintenance of all clinical department office space. It is further recommended that the office space needs of clinical departments (hospital and non-hospital based) be a

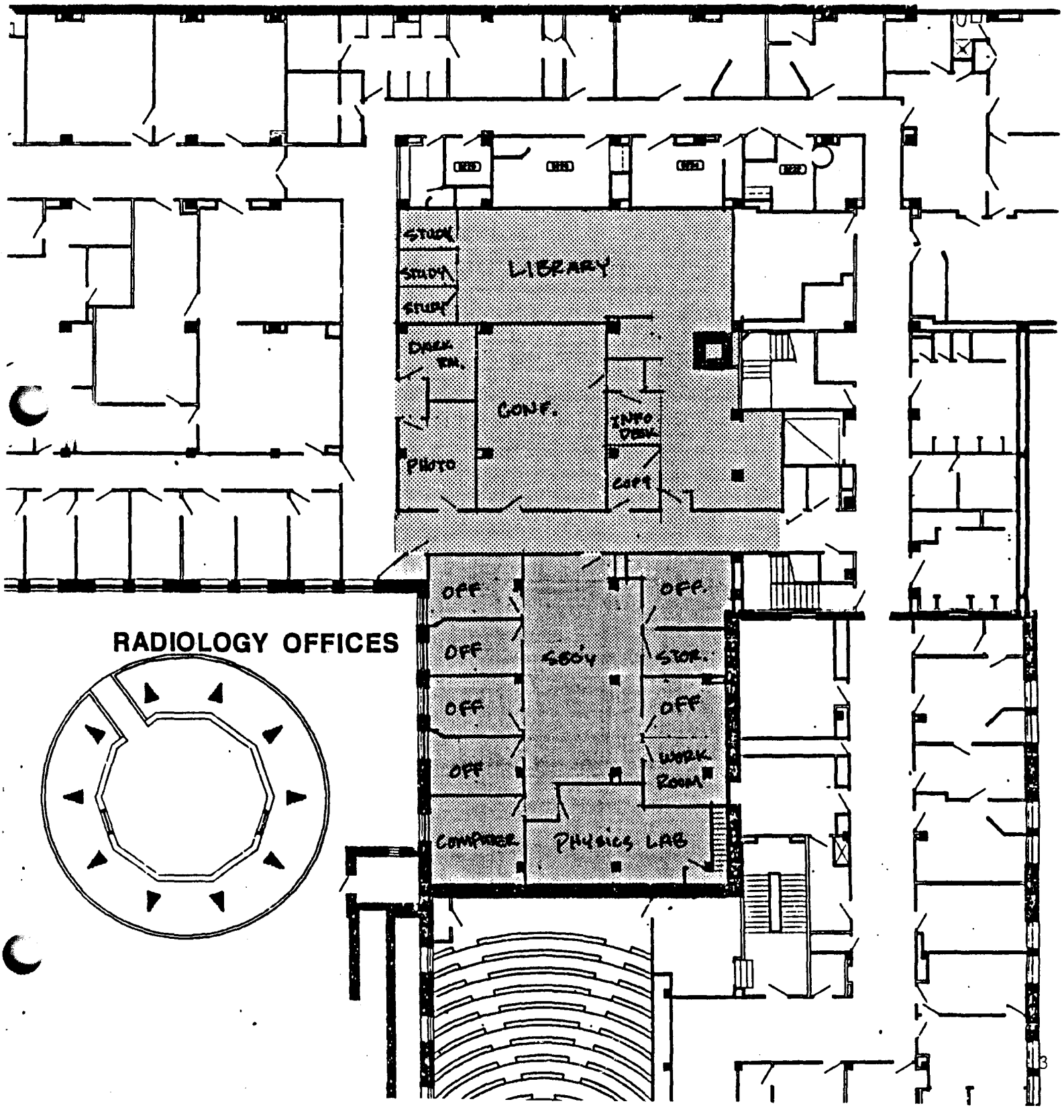
responsibility shared to some extent by all the foregoing parties but that the Medical School and clinical departments have the major responsibility for funding clinical department office space. These guidelines will be developed jointly prior to May 1, 1989. It is understood that funding for any projects in addition to those specified herein will need to be delayed pending approval of the guidelines.

It should be noted that in the spirit of this shared responsibility the Hospital has indicated a willingness to provide full or partial funding in a variety of circumstances including relocation of clinical department office space for Hospital funtions, faculty serving in Hospital administrative roles for a significant percentage of their effort (i.e. 35% or more), faculty fulfilling an administrative functions where all parties agree location within Hospital areas is necessary, and a variety of special circumstances such as recruitment, new programs, etc. These, and other guidelines, which may be adopted for Hospital funding would be applicable to all clinical departments and controlled by UMHC Board of Governor captial guidelines.

The foregoing recommendations should provide appropriate resolution of existing problems, appropriate future guidelines, and help expedite Renewal Project Phase II planning and construction.

ATTACHMENT I

	Approx. Existing Prior to 1985	1985 Program Request	Net Change	Current Program Request	Actual Office Plan	Actual vs 1985 Program
NICU	340	1100	+ 760	1100	1100	0
OB/Gyn	690	690	0	1300	1372	682
Psychiatry	10900	12555	+1655	16400	16500	3945
Urology	2401	2890	+ 489	3800	4228	1338
Anesthesia	3454	3300	- 154	4820	5493	2193
Neurosurgery	2770	2570	- 200	3000	3339	769
Radiology	4607	4607	0	4607	4607	0
Subtotal	25162	27712	2550	35027	36639	8927
Neuro Epilepsy	0	0	0	1400	1678	1678
Surg Path Expansion	0	0	0	311	311	311
Total	25162	27712	2550	36738	38628	10916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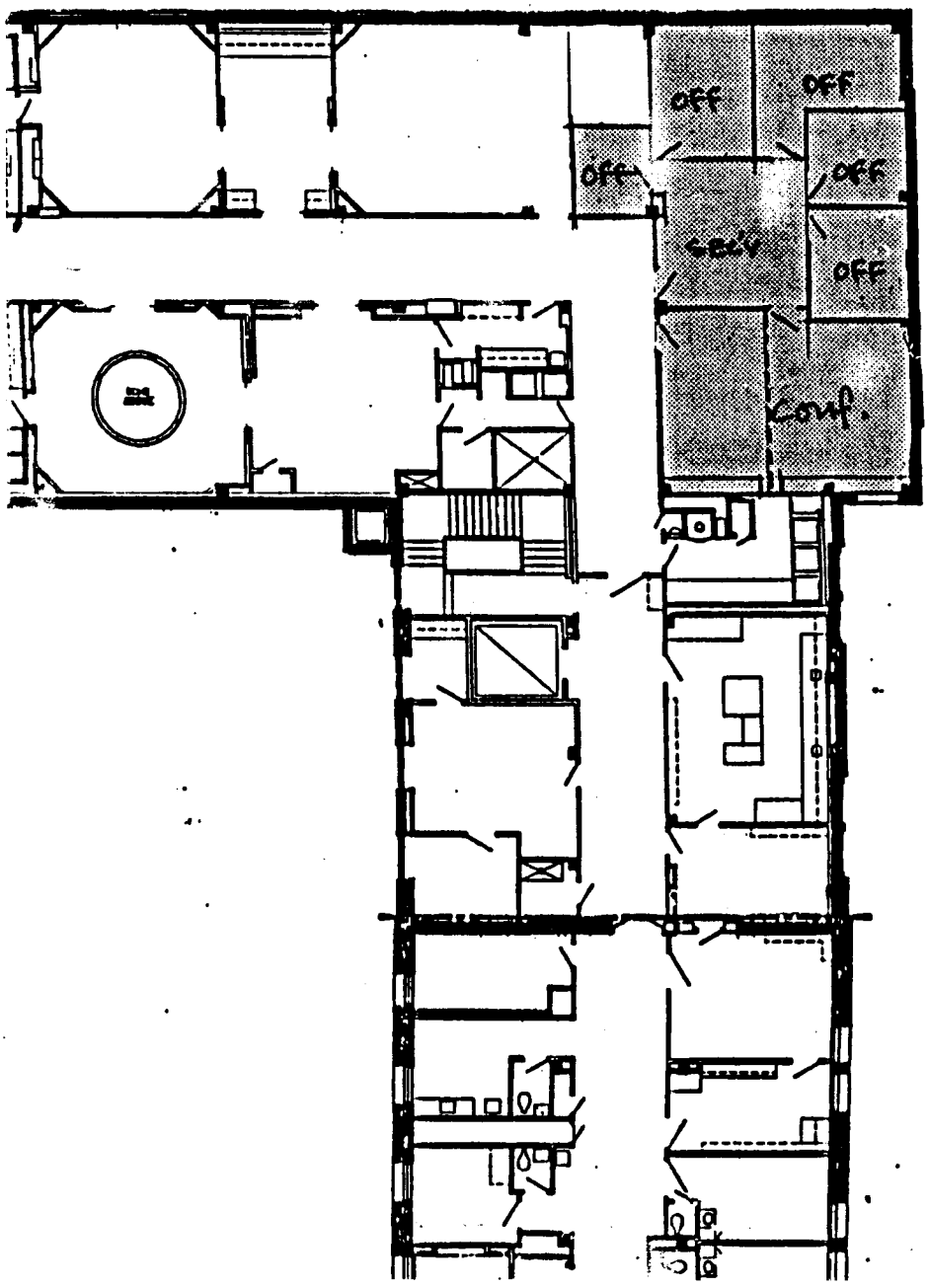
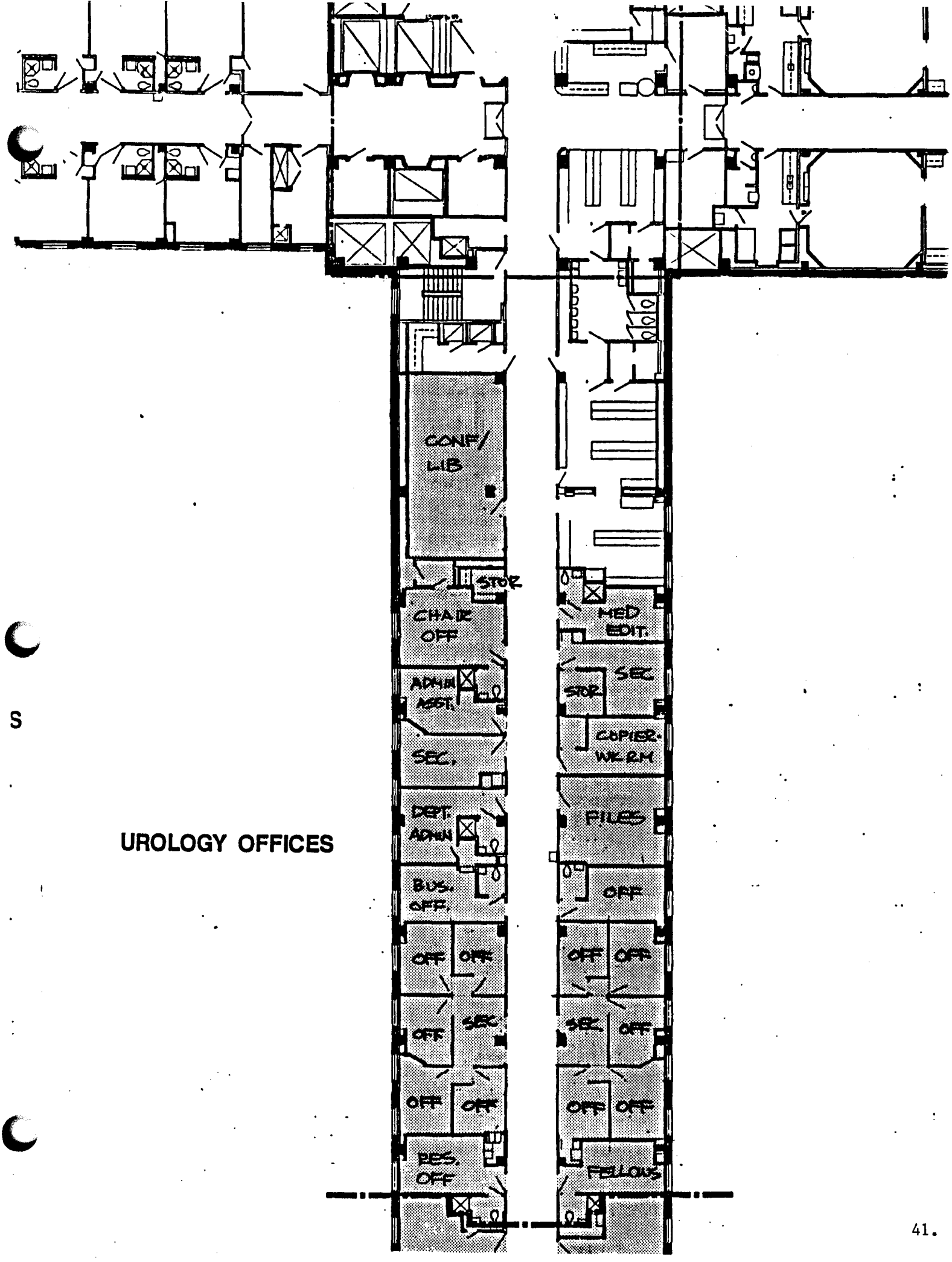
RADIOLOGY OFFICES

OB/GYN OFFICES



This office location is tentative. Final office configuration and location is subject to additional planning.



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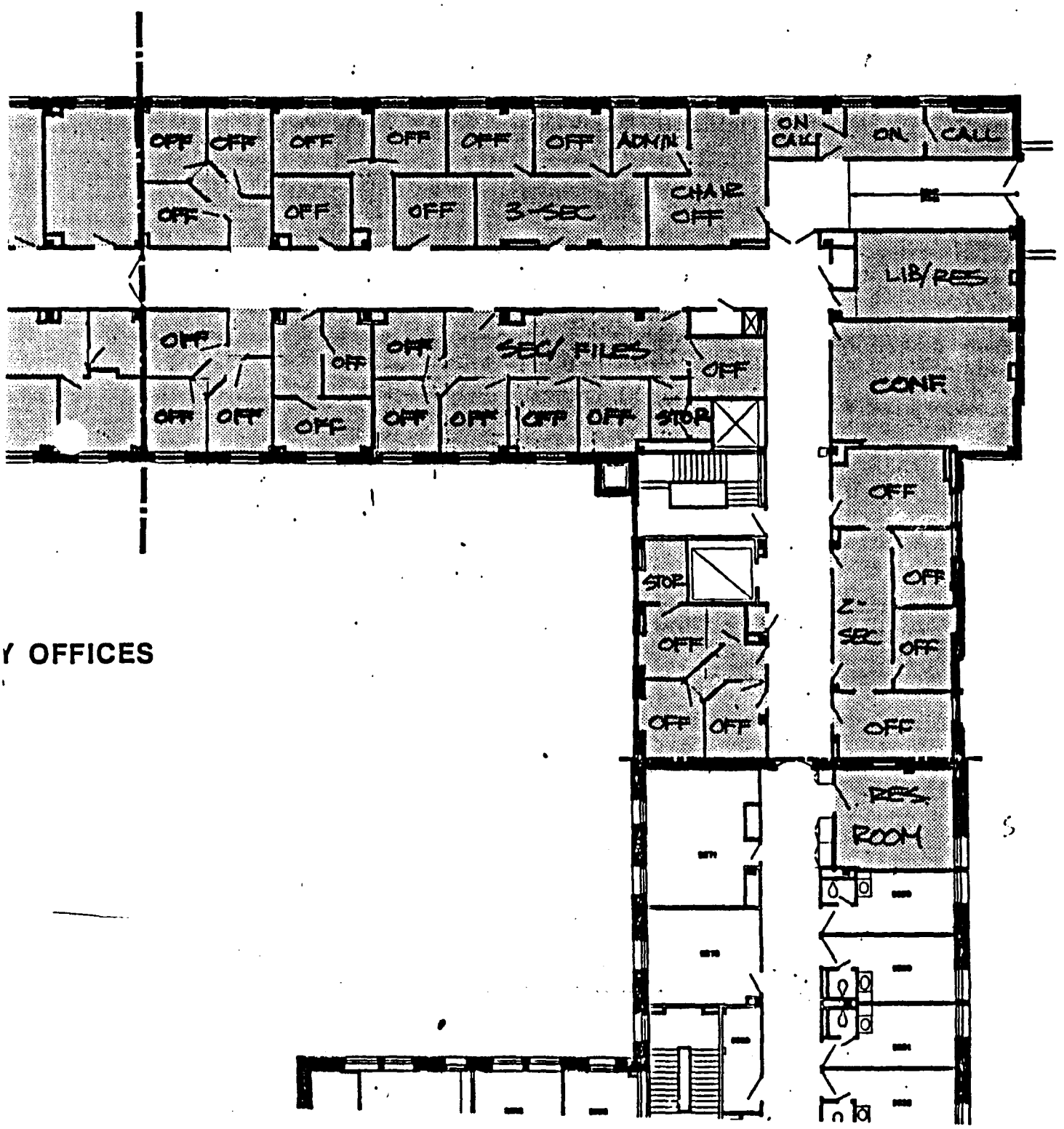

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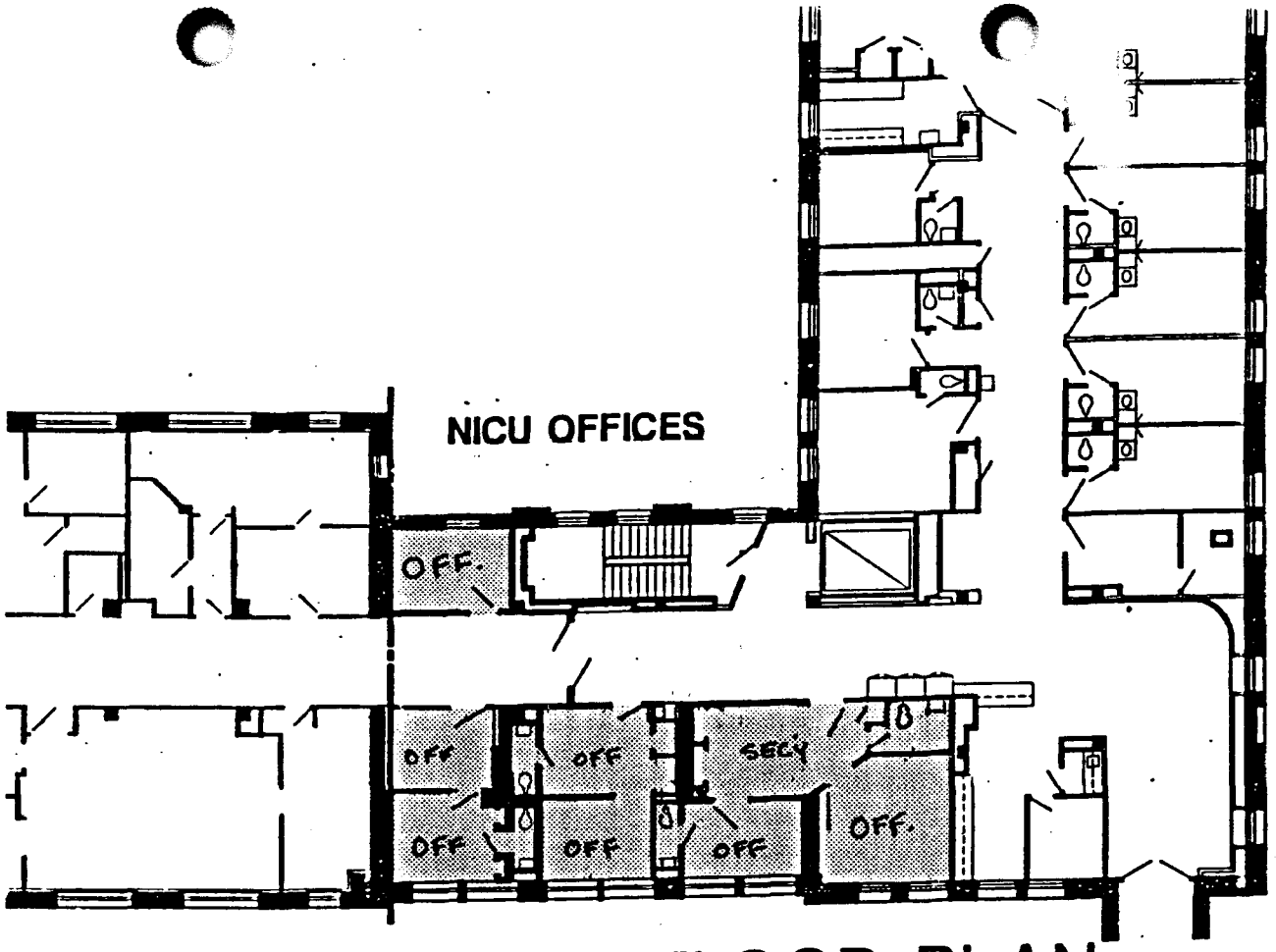
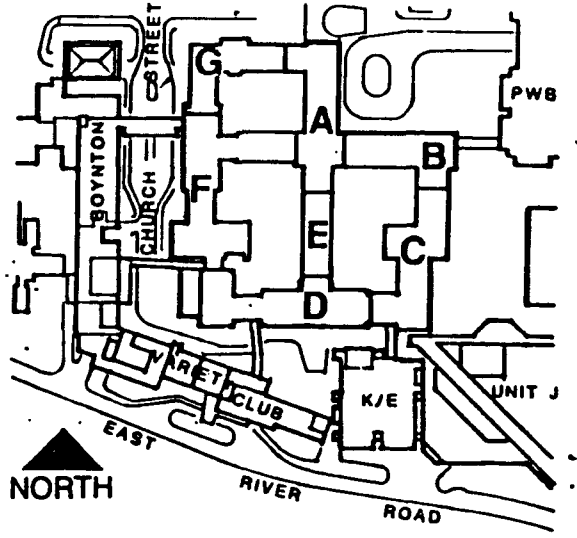


4th FLOOR PLAN

SCALE 1/16" = 1:0 9-26-88

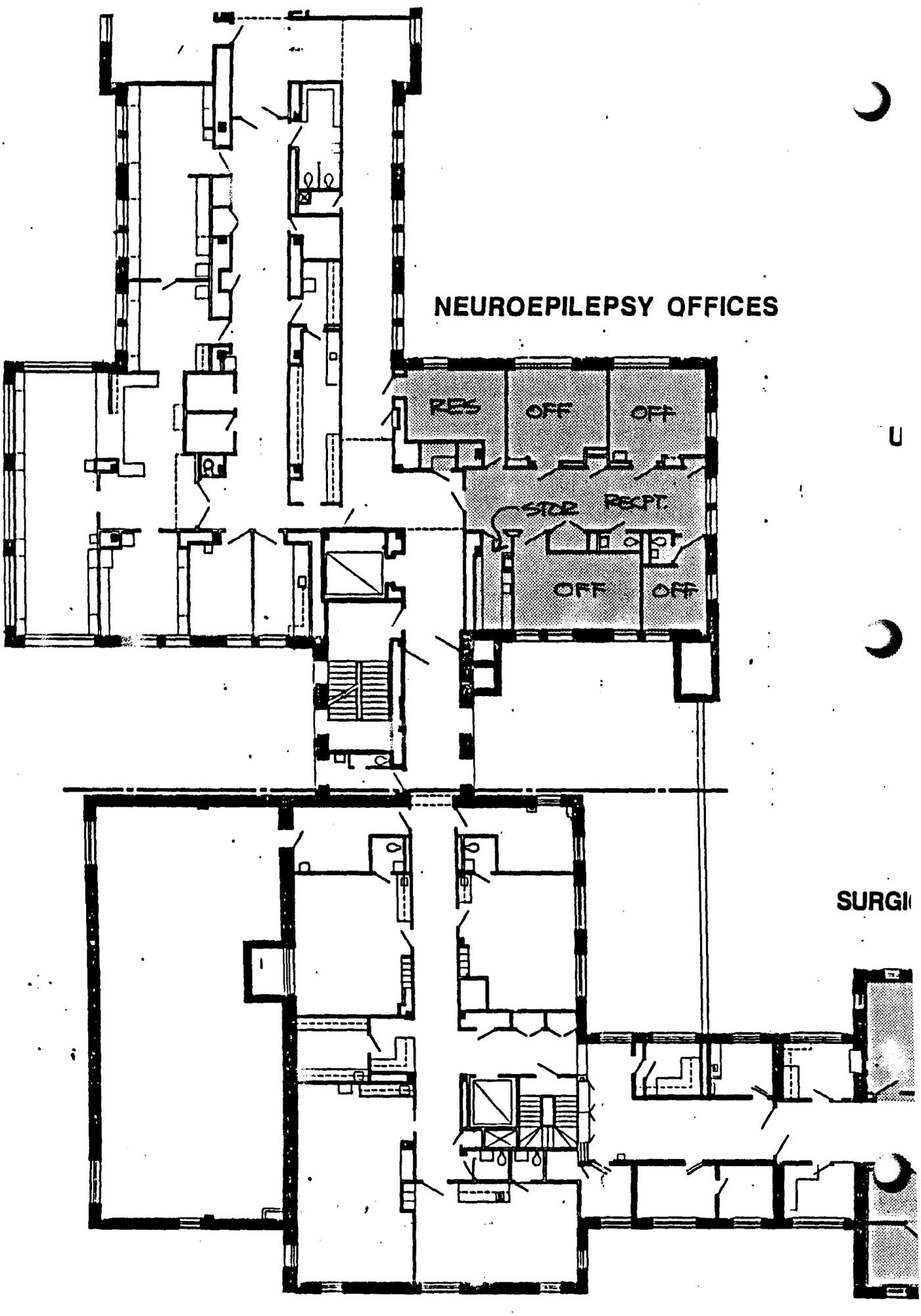
University of Minnesota
Hospital and Clinic
Minneapolis, Minnesota

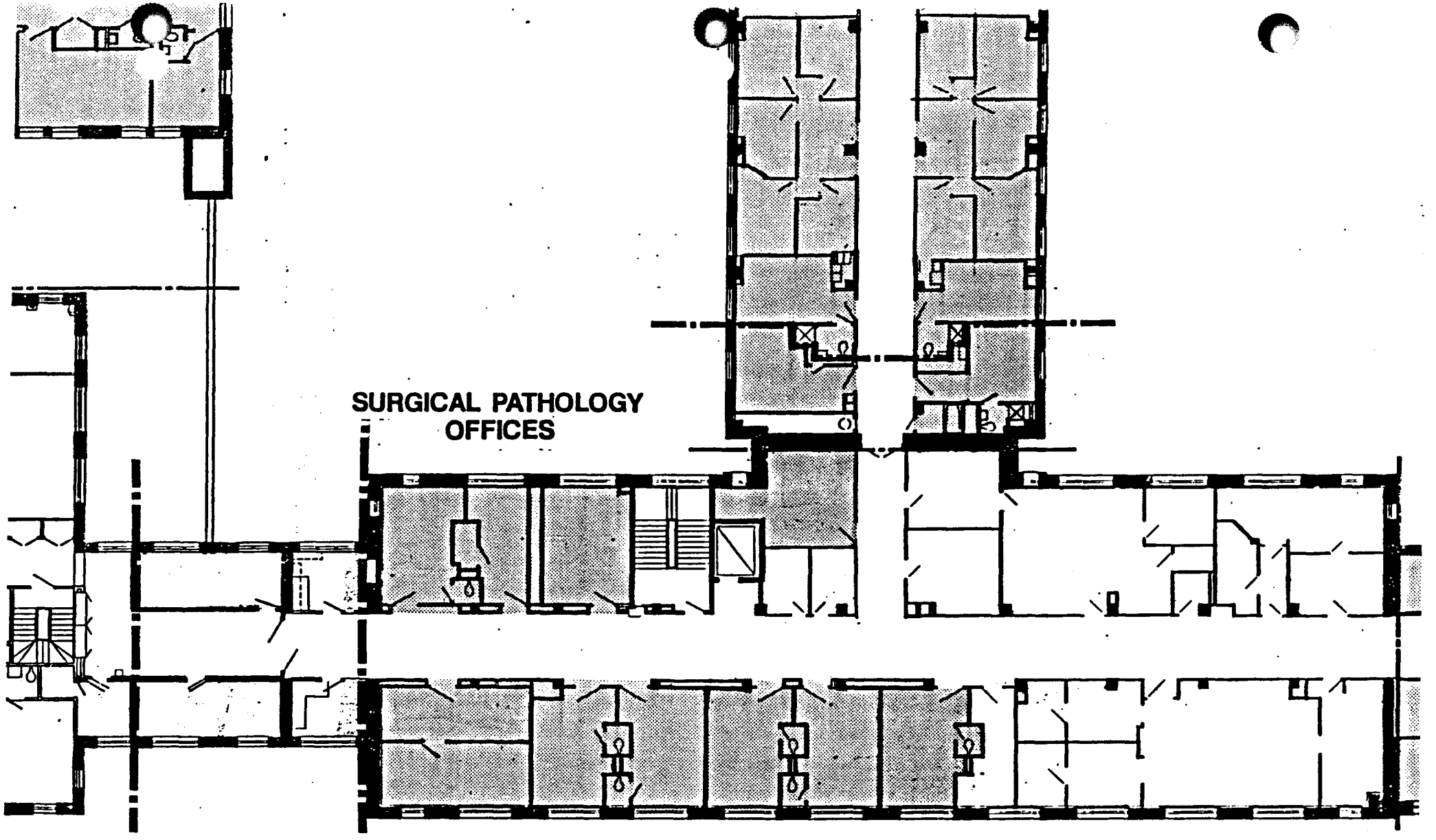


KEY PLAN

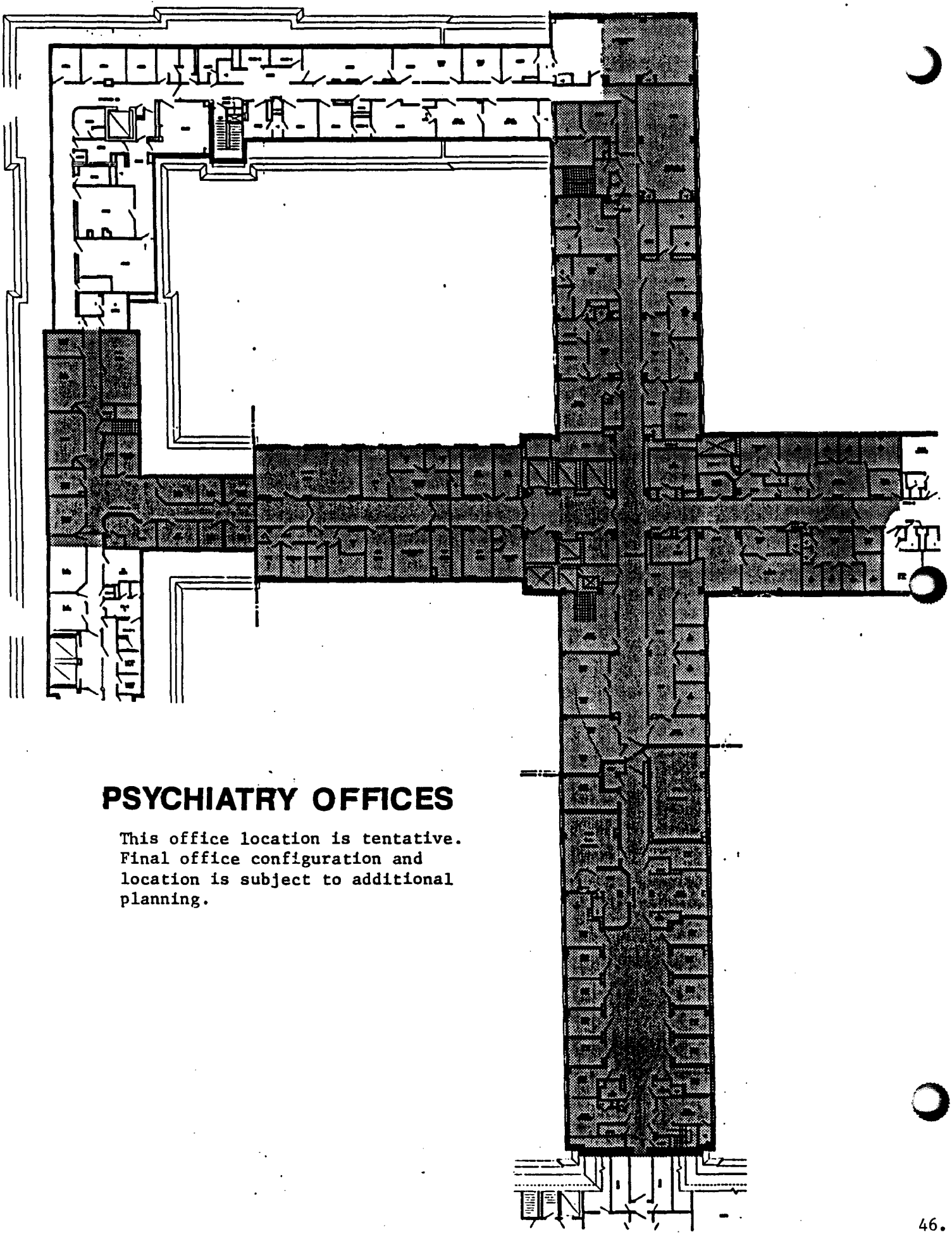
UNIVERSITY HOSPITALS RENOVATION PROJECT

MAYO HOSPITAL


NEUROEPILEPSY OFFICES
RES
OFF
OFF
SEC.
RECPT.
OFF
OFF

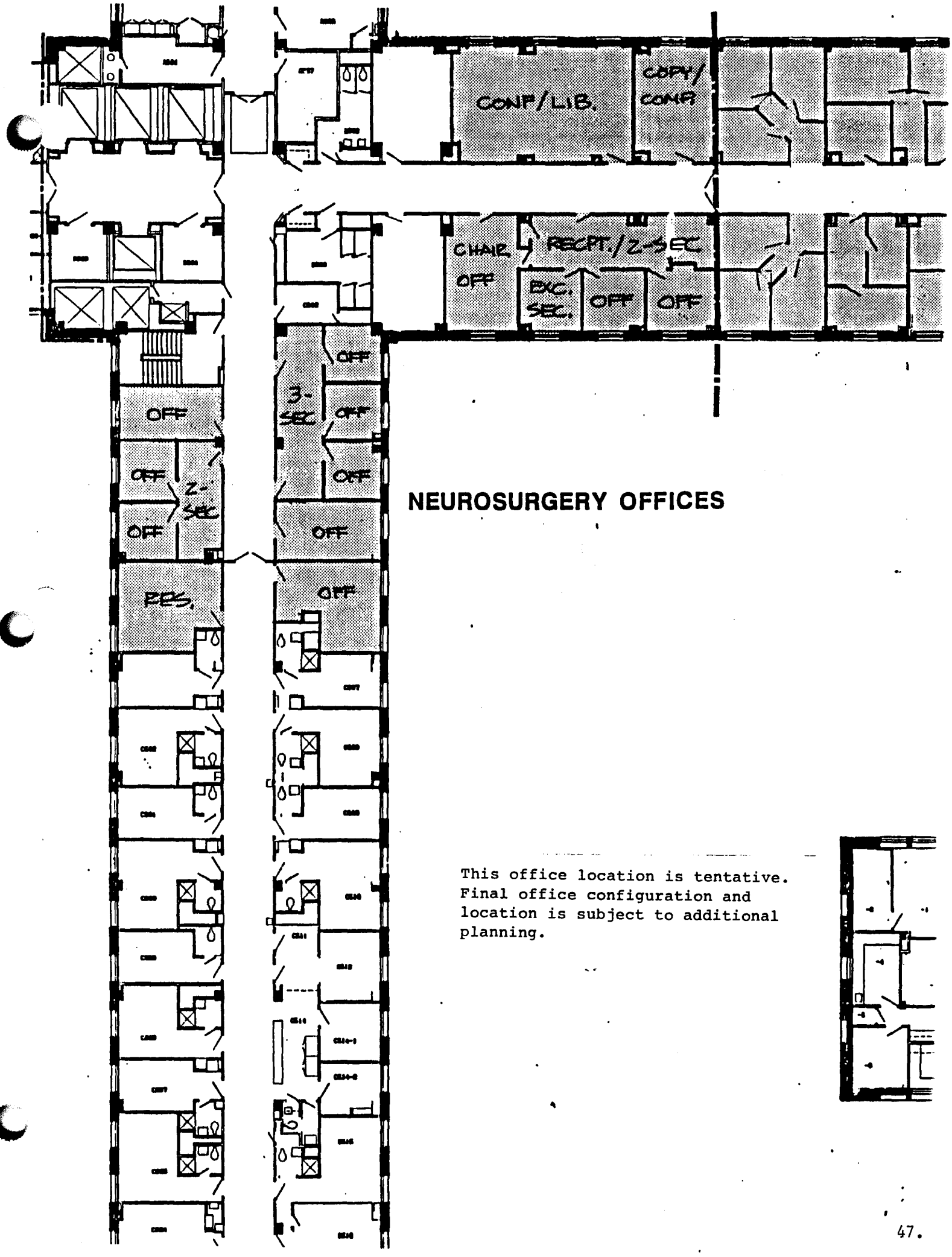


SURGICAL PATHOLOGY EXPANSION



PSYCHIATRY OFFICES

This office location is tentative. Final office configuration and location is subject to additional planning.



NEUROSURGERY OFFICES

This office location is tentative. Final office configuration and location is subject to additional planning.

ATTACHMENT III

RENOVATION COSTS BASED ON CURRENT PROGRAM

DEPARTMENT	PROGRAM NSF	PLANNED NSF	RENOVATION COSTS -0- NSF	-0- $	MIN NSF	MIN $	MOD NSF	MOD $	TOTAL NSF	TOTAL $
NICU	1,100	1,100	-	-	1,100	48,125	-	-	1,100	48,125
OB/GYN	1,300	1,372	-	-	-	-	1,372	128,625	1,372	128.625
PSYCHIATRY	16,400	16,500	11,200	-0-	5,300	231,875	-	-	5,300	231,875
UROLOGY	3,800	4,228	1,618	-0-	1,140	49,875	1,470	137,812	2,610	187,687
ANESTHESIA	4,820	5,493	2,693	-0-	751	32,856	2,049	223,295	2,800	*256,151
NEUROSURGERY	3,000	3.339	2,428	-0-	911	39,856	-	-	911	39,856
NEURDEPILEPSY	1,400	1,678	1,678	-0-	-	-	-	-	-	-
RADIOLOGY	4,607	4,607	-	-	-	-	4,607	431,906	4,607	431,906
SURG PATH EXPANSION	311	311	-	-	-	-	311	****55,000	311	55,000
TOTALS	35,738	38,628	19,617	-0-	9,202	402,587	9,809	976,638	19,011	***1,379,225

*INCLUDES $31,200 TO INFILL THE EXISTING MAYO O.R. OBSERVATION

1,379,225x1.5=1,586,000

***CONSTRUCTION COSTS ONLY

****INCLUDES $40,000 FOR MECHANICAL SERVICE FOR RELOCATED LAB

37,000	Approximate ...able NSF Mayo Level 6
- 5,000	Available for future mechanical space
32,000	Space originally assumed to be available for redistribution to other Health Sciences users

Proposed Future Occupancy of Mayo Level 6

16,400	Psychiatry offices
5,800	Psychiatry Day Hospital program
4,500	Psychiatry Clinic
26,700	Proposed future NSF programmed on Mayo Level 6

Proposed New Commitment Regarding Redistribution of Hospital Space

32,000	Original commitment on Level 6
26,700	Proposed future programs on Level 6
5,300	Remains available for redistribution on floor 6

32,000	Original construction on Level 6
5,300	Available NSF on Level 6 for redistribution
26,700	Remaining commitment of Hospital space
x.6	Inefficiency factor for poor configuration/elevation of floor 6
16,020	Proposed new commitment assuming good quality space

==========

Hospital Space Available for Hospital/Non-Hospital Functions Post UHRP Phase II Planning

24,000	UHRP phase II unassigned space
-2,000	Boynton Bridge, Library, files
-1,200	Hospital relocation of Mayo 8
20,800	Remains available
- 2	Assume Hospital and non-Hospital functions have equal justification for space
10,400	Committed to non-Hospital functions

==========

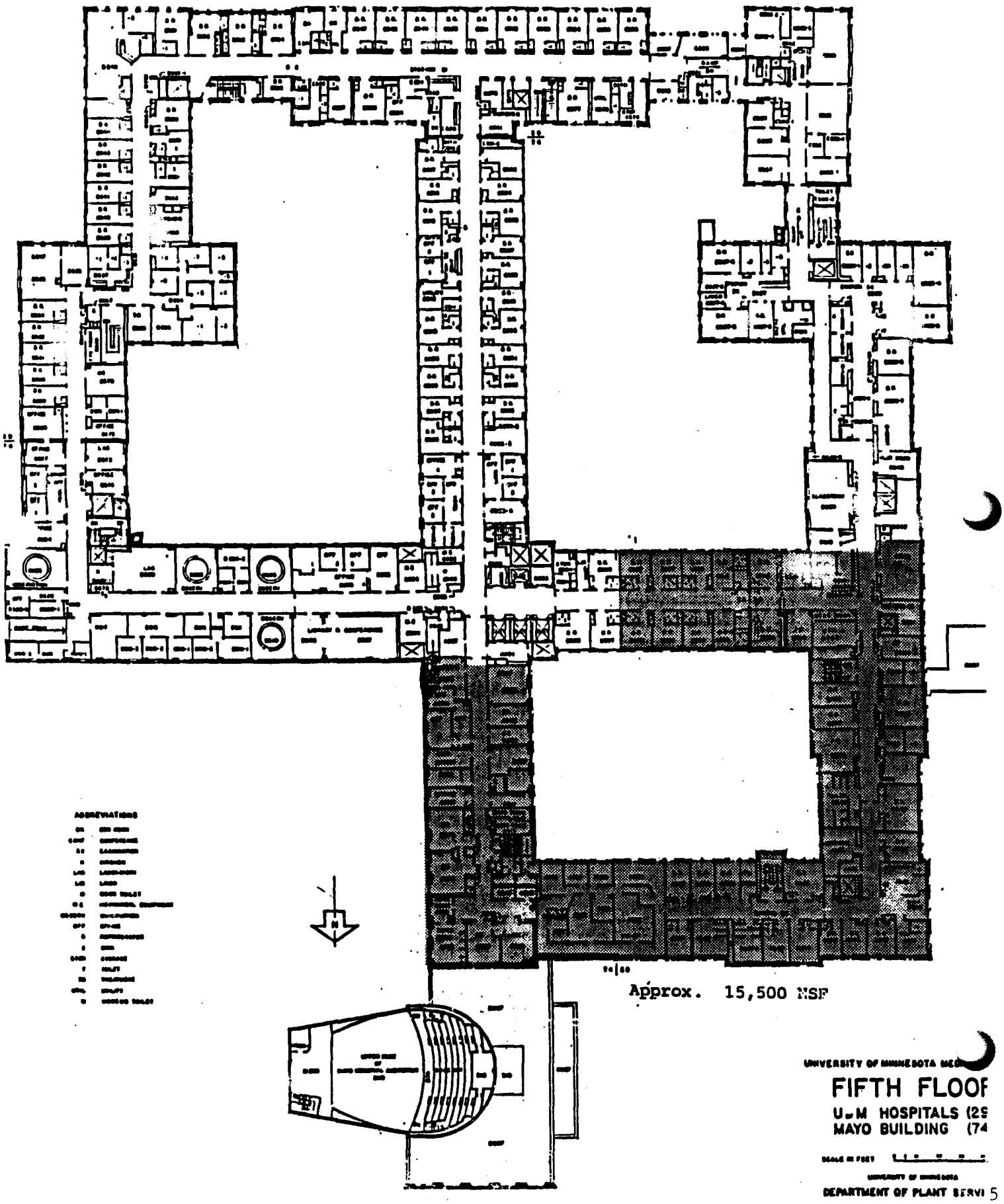
Proposed Commitment of Hospital Space to Medical School

16,020	Remaining commitment from floor 6
10,400	Remaining commitment from UHRP phase II planning
26,420	Proposed new commitment (excluding 7800 NSF on Mayo 6)

Assumed Redistribution of Space

26,420	Proposed new commitment
-10,916	Faculty office requirements expansion since 1985
15,504	Remaining commitment (excluding 5,300 NSF on floor 6)

Attachment V



MINUTES
Joint Conference Committee
Board of Governors
June 14, 1989

CALL TO ORDER:

Chairman Heenan called the June 14, 1989 meeting of the Joint Conference Committee to order at 4:37 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:	Phyllis Ellis David Link George Heenan James Moller, M.D.
Absent:	Liza Arendt, M.D. Robert Dickler Amos Deinard, M.D. Bruce Work, M.D.
Staff:	Jan Halverson Greg Hart Nancy Janda Ted Yank
Guest:	David Brown, M.D. Sue Jensen

APPROVAL OF MINUTES:

The minutes of the May 10, 1989 meeting were approved as submitted.

Medical Staff - Hospital Council Report

Dr. Moller presented the recommendation of the Credentials Committee on the reappointment of Unit I eligible physicians for 1989 through 1991, including recommendations for terminations of medical staff appointments, regular staff appointments, additions/deletions of clinical privileges, change in staff categories, leave of absences, provisional appointments, resignations and loss of medical staff appointments.

After some questions, the committee unanimously endorsed the recommendations.

Medical School Planning and Priorities

Dean David Brown discussed his vision for the future of the Medical School. He stressed that he could only give the committee a limited perspective in the time allotted, but encouraged all of the committee members to read the Medical School's Master Plan that was created to address strategic issues for the

Commitment to Focus initiative. Dr. Brown indicated that this document clearly and in great detail outlines the direction of the Medical School.

Dr. Brown noted that the Medical School is developing a center of excellence in the neurosciences, where he and his colleagues believed there is tremendous potential for research to have an enormous impact on diseases ranging from developmental disorders to psychiatric illnesses such as depression. The focus of neurosciences efforts will be to understand the underlying organic mechanisms of normal and abnormal neurological functions and will involve many Medical School departments notably Neurology, Neurosurgery, Anesthesiology and Psychiatry.

Dr. Brown indicated that an additional area where the Medical School will focus attention is in the Development of Comprehensive Cancer Center that organizes multidisciplinal cancer research and treatment protocols. This type oe center will involve many departments and have huge institutional impact.

Discussion ensued regarding how the UMHC and the Medical School can work together to accommodate the Medical Schools direction.

Chief of Staff and Vice Chief of Staff Appointments

Dr. James Moller requested the Committee's approval of Dr. Robert Maxwell and Dr. Patricia Ferrieri as the new Chief and Vice-Chief of the Medical Staff. Both Dr. Maxwell and Ferrieri had been elected by the medical staff to fill these roles. The committee unanimously approved both and thanked Dr. Moller for his dedicated service and wise counsel during his tenure as the Chief of Staff.

Clinical Chiefs Appointments

Dr. Moller and Greg Hart presented recommendations for the appointments of the Chiefs of the Clinical Services. They noted that three new Chiefs had been recruited, but are not yet on board to replace the current or acting chief. Those being Dr. Richard Price in Neurology, Dr. Robert Jaros in Neurosurgery, and Dr. Richard Palahniuk in Anesthesiology. Searches are also underway for new Chiefs for the departments of Otolaryngology and Laboratory Medicine and Pathology. It was noted that Dr. Elgine Mainous of Hospital Dentistry had just recently submitted his resignation and a search would be organized for a replacement.

After some discussion, the committee unanimously endorsed the recommendations.

Quality Assurance Quarterly Report

Ms. Susan Jensen, Director of Quality Assurance, presented the quarterly quality assurance report that provides indicators of overall departmental compliance with QA activities. She noted that most departments were making significant progress, but that some departments still have some work to do.

Discussion ensued relative to the use of quality assurance data in the overall credentialing process for individual physicians. It was also noted that all

departments must be in significant compliance by the September meeting or there will be a need for the individual Clinical Chiefs to address the committee.

Chairman Heenan also noted that he would like to see a specific progress report for the Department of Psychiatry or would like to have a representative of the department at the next meeting.

Joint Commission on Accreditation of Healthcare Organizations Update

Ms. Nancy Janda described the feedback that UMHC has received from the Joint Commission on the June, 1988 written progress report and the January 10, 1989 focus site visit. She reported that the Joint Commission's response to both were not completely favorable.

Ms. Janda noted that the first reply, relative to the contingency for non-RN nurses circulating in the OR, would soon be resolved since the JCAHO has modified its standards and UMHC will be supplying the additional documentation to clarify our response. However, the second contingency, that of the Medical Record Summary List, seemed to be a more difficult problem. Mr. Hart explained that there are serious questions among the medical staff, many other academic medical centers and even the JCAHO site surveyor relative to the applicability of this type of summary list when an academic hospital is providing subspecialty care.

It was also noted that the major ambulatory care contingency - that of the ambulatory care quality assurance program - had been satisfactorily resolved and thus removed.

Discussion ensued regarding courses of action that UMHC could take in concert with trade organizations to constructively influence the JCAHO to develop more appropriate standards for academic institutions.

Other Business

No other business was conducted.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:28 P.M.

Respectfully Submitted:

Theodore J. Yank

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 16, 1989

TO: Board of Governors

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

SUBJECT: Credentials Committee Report and Recommendations

The Medical Staff-Hospital and the Joint Conference Committee have reviewed and endorsed the attached Credentials Committee Report and Recommendations. Included in this report is the reappointment of medical staff in Unit I eligible for reappointment for 1989-1991.

I am forwarding these recommendations to you for your approval on June 28, 1989.

JHM/cf
Attachment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
ANESTHESIOLOGY		
ANDERSON, WILLIAM W.	Attending Staff	
BELANI, KUMAR G.	Attending Staff	
BERLAUK, JON F.	Attending Staff	
CUMMING, JAMES F.	Attending Staff	
ESTRIN, JORGE	Attending Staff	
GAUTHIER, ROBERT L.	Attending Staff	
GILMOUR, IAN J.	Attending Staff	
JACKSON, JOHN M.	Attending Staff	
KOEHNTOP, DOUGLAS	Attending Staff	
LARSEN, RUSSELL	Attending Staff	
LIAO, JI-CHIA	Attending Staff	
LO, JOSEPHINE N.	Attending Staff	
SWEENEY, MICHAEL F.	Attending Staff	Pediatrics

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
DERMATOLOGY		
BART, BRUCE J.	Clinical Staff	
BAYRD, GARRETT T.	Clinical Staff	
BENDER, MITCHELL E.	Clinical Staff	
DAHL, MARK V.	Attending Staff	
FENYK, JOHN	Clinical Staff	
GENTRY, WILLIAM	Attending Staff	
HORDINSKY, MARIA D.	Attending Staff	
KALISH, RICHARD S.	Attending Staff	
KAYE, VALDA N.	Attending Staff	
LYNCH, PETER J.	Attending Staff	
PETERSON, WILLARD C.	Clinical Staff	
PRAWER, STEVEN E.	Clinical Staff	
VANCE, J.CORWIN	Attending Staff	
ZELICKSON, ALVIN S.	Clinical Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
FAMILY PRACTICE & COMMUNITY HEALTH		
ALLEN, SHARON SMITH	Clinical Staff	
CIRIACY, EDWARD	Attending Staff	
CONNOLLY, JOSEPH P.	Attending Staff	
DALY, MICHAEL L.	Attending Staff	
FONTAINE, PATRICIA C	Attending Staff	
GEPNER, GREGORY J.	Clinical Staff	
HALVORSEN, JOHN G.	Attending Staff	
JACOTT, WILLIAM EARL	Attending Staff	
KEENAN, JOSPEH M.	Attending Staff	
KELLY, JOHN T.	Attending Staff	
KROGH, CHRISTOPHER L	Attending Staff	
LINDBLOM, MAURICE L.	Attending Staff	
MCCONNELL, JOHN W.	Attending Staff	
RICHARDSON, NANCY C.	Clinical Staff	
SATTERFIELD, SHARON	Attending Staff	
SEIM, HAROLD C.	Attending Staff	
SOLBERG, LEIF I.	Clinical Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
HOSPITAL DENTISTRY		
BAKER, JAMES	Clinical Staff	
BEVIS, RICHARD R.	Attending Staff	
CLAY, DAVID	Clinical Staff	
COLE, SANDRA J.	Attending Staff	
DERR, ROBERT E.	Clinical Staff	
ELDEEB, MOHAMED EN	Attending Staff	
FORD, RICHARD T	Clinical Staff	
FRICTON, JAMES R.	Attending Staff	
GATTO, DANIEL J.	Attending Staff	
GOODKIND, RICHARD J	Clinical Staff	
GORLIN, ROBERT J.	Attending Staff	
GRAYDEN, JOSEPH M.	Attending Staff	
HERZBERG, MARK C.	Attending Staff	
HINRICHS, JAMES E.	Clinical Staff	
HOLTE, NORMAN O.	Emeritus Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
HOSPITAL DENTISTRY		
JASPERS, MARK	Attending Staff	
JENSEN, JAMES R.	Attending Staff	
LABELLE, RONALD E.	Clinical Staff	
LARSON, THOMAS D.	Clinical Staff	
LEHNERT, MICHAEL W.	Attending Staff	
LEONARD, MYER S.	Clinical Staff	
MAINOUS, ELGENE G.	Attending Staff	
MARKER, JOHN C.	Clinical Staff	
MARSHALL, JUDITH L.	Clinical Staff	
OLIVER, RICHARD C.	Attending Staff	
PIHLSTROM, BRUCE L.	Attending Staff	
SCHULTE, HERBERT W.	Attending Staff	
SCHULTZ, CHESTER J.	Clinical Staff	
SELF, KARL D.	Attending Staff	
SIMMONS, MARK S.	Clinical Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
HOSPITAL DENTISTRY		
STICKEL, FRANKLIN R	Clinical Staff	
TILL, MICHAEL J.	Attending Staff	
VICKERS, ROBERT	Attending Staff	
WALKER, PAUL O.	Attending Staff	
WILKINSON, CHARLES	Clinical Staff	
WITKOP, CARL J.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
ANDRES, CHARLES W.	Attending Staff	
AZAR, SILVIA H.	Attending Staff	
BACHE, ROBERT J.	Attending Staff	
BANTLE, JOHN	Attending Staff	
BARBOSA, JOSE	Attending Staff	
BENDITT, DAVID	Attending Staff	
BITTERMAN, PETER B.	Attending Staff	
BLOOMER, JOSEPH R.	Attending Staff	
BLOOMFIELD, CLARA	Attending Staff	
BLUMENTHAL, MALCOLM	Clinical Staff	
BOND, JOHN H.	Clinical Staff	
COHN, JAY N.	Attending Staff	
CONFER, DENNIS L.	Attending Staff	
DANIELS, BARBARA S.	Attending Staff	
DUANE, STEVEN F	Clinical Staff	
DUANE, WILLIAM C.	Clinical Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
EGGERT, RONALD C.	Clinical Staff	
FERRIS, THOMAS F.	Attending Staff	
FULLER, BENJAMIN	Clinical Staff	
GAULT, N. L.	Attending Staff	
GILBERSTADT, MARK L	Attending Staff	
GLICKSTEIN, SCOTT L.	Clinical Staff	
GOETZ, FREDERICK C.	Attending Staff	
GOODMAN, JESSE L.	Attending Staff	
GOSE, JEANNE E.	Clinical Staff	
HAMMERSCHMIDT, DALE	Attending Staff	
HEBBEL, ROBERT P.	Attending Staff	
HENKE, CRAIG A.	Attending Staff	
HERTZ, MARSHALL I.	Attending Staff	
HITT, JOHN A.	Attending Staff	
HOMANS, DAVID C.	Attending Staff	
HOSTETTER, THOMAS H	Attending Staff	
HOWE, ROBERT	Attending Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
HUNNINGHAKE, DONALD	Attending Staff	
HURD, DAVID	Attending Staff	
JACOB, HARRY S.	Attending Staff	
JONES, JOHN P.	Attending Staff	
JORDAN, M.COLIN	Attending Staff	
KELLY, JOSEPH R.	Clinical Staff	
KENNEDY, B.J.	Attending Staff	
KIANG, DAVID T.	Attending Staff	
KING, RICHARD	Attending Staff	
KINLAW, WILLIAM B.	Attending Staff	
KUBO, SPENCER H.	Attending Staff	
LABREE, JOHN W.	Attending Staff	
LASSER, ROBERT B.	Clinical Staff	
LAXSON, DAVID D.	Attending Staff	
LERNER, IRVING	Clinical Staff	
LEVITT, JOHN I.	Clinical Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
LEWIS, F.BRUCE	Clinical Staff	
LIMAS, CONSTANTINOS	Attending Staff	
LUIKART, SHARON D.	Attending Staff	
MANSKE, CONNIE L.	Attending Staff	
MARIASH, CARY N.	Attending Staff	
MCCOLLISTER, ROBERT	Attending Staff	
MCGLAVE, PHILIP	Attending Staff	
MCKENNA, JAMES L.	Clinical Staff	
MEIER, PETER	Clinical Staff	
MERYHEW, NANCY L.	Attending Staff	
MESSNER, RONALD P.	Attending Staff	
MILLER, WESLEY	Attending Staff	
MOORE, RANDALL S.	Attending Staff	
MULVAHILL, AMY S.	Attending Staff	
MURRAY, M.J.	Attending Staff	
NATH, KARL A.	Attending Staff	
OLIVARI, MARIA-TERESA	Attending Staff	
OPPENHEIMER, JACK H.	Attending Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
PALLER, MARK S	Attending Staff	
PETERSON, BRUCE	Attending Staff	
PFOHL, RICHARD A.	Clinical Staff	
PLIMPTON, DAVID	Clinical Staff	
RAINES, JOHN R.	Clinical Staff	
RANK, JEFFREY M.	Attending Staff	
RAUSCH, DOUGLAS J.	Attending Staff	
RHAME, FRANK S.	Attending Staff	Laboratory Med & Path
ROBERTSON, R. PAUL	Attending Staff	
SABATH, LEON D.	Attending Staff	
SHAW, MICHAEL J.	Attending Staff	
SKUBITZ, KEITH M	Attending Staff	
SLUNGAARD, ARNE	Attending Staff	
SNYDER, LINDA S.	Attending Staff	
SOLTIS, RONALD D.	Attending Staff	
SVEUM, RICHARD J.	Clinical Staff	

.....continued

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
TOBIAN, LOUIS	Attending Staff	
TOMBERS, JOSEPH M.	Clinical Staff	
TRENCE, DACE L	Clinical Staff	
TUNA, NAIP	Attending Staff	
VENNES, JACK A.	Clinical Staff	
VERCELLOTTI, GREGORY	Attending Staff	
WANG, YANG	Attending Staff	
WANGSNESS, JOHN A	Clinical Staff	
WATSON, KATHLEEN V.	Attending Staff	
WEISDORF, DANIEL J.	Attending Staff	
WHITE, CARL W.	Attending Staff	
WILSON, ROBERT F.	Attending Staff	
WINCHELL, PAUL C.	Emeritus Staff	
WINKELMANN, JOHN C.	Attending Staff	
WOOLLEY, ANTHONY C.	Attending Staff	
ZIMMER, STEVAN D.	Attending Staff	
ZOSCHKE, DAVID C.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
NEUROLOGY		
BIRNBAUM, GARY	Attending Staff	
FIOL, MIGUEL E.	Clinical Staff	
GATES, JOHN R.	Attending Staff	
GUMNIT, ROBERT J.	Attending Staff	
KENNEDY, WILLIAM R.	Attending Staff	
KLASSEN, ARTHUR C.	Attending Staff	
KNOPMAN, DAVID	Attending Staff	
LEE, MYOUNG C.	Attending Staff	
LEPPIK, ILO E.	Attending Staff	
[1] LOCKMAN, LAWRENCE A.	Attending Staff	Pediatrics
MORIARTY, JAMES A.	Attending Staff	
RESCH, JOSEPH A.	Emeritus Staff	
RITTER, FRANK J.	Attending Staff	
ROELOFS, ROBERT I.	Attending Staff	
SHER, PHYLLIS K	Attending Staff	Pediatrics

.....continued

[1] Clinical Chief has not responded for joint appointment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
NEUROLOGY		
SMITH, STEPHEN A.	Clinical Staff	
[1] SWAIMAN, KENNETH F.	Attending Staff	Pediatrics
TORRES, FERNANDO	Attending Staff	

[1] Clinical Chief has not responded for joint appointment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
NEUROSURGERY		
CHOU, SHELLEY N.	Attending Staff	
ERICKSON, DONALD	Attending Staff	
FRENCH, LYLE A.	Emeritus Staff	
HAINES, STEPHEN J.	Attending Staff	
MAXWELL, ROBERT E.	Attending Staff	
ROCKSWOLD, GAYLAN L.	Clinical Staff	
SELJESKOG, EDWARD L.	Attending Staff	
WISIOL, ERICH S.	Clinical Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
OBSTETRICS & GYNECOLOGY		
ADCOCK, LEON	Attending Staff	
CAMPBELL, BRUCE F.	Attending Staff	
CARSON, LINDA F.	Attending Staff	
CRUIKSHANK, STEPHEN	Clinical Staff	
FARB, HARRY F.	Clinical Staff	
FARR, JOHN D.	Clinical Staff	
FEHR, PETER E.	Clinical Staff	
JOSEPH, MARILYN S.	Attending Staff	
LEVINE, HOWARD M.	Clinical Staff	
NORDLAND, ROBERT	Clinical Staff	
PHIPPS, WILLIAM R.	Attending Staff	
PREM, KONALD A.	Attending Staff	
SLOSSER, GAIUS J.	Clinical Staff	
STEGEMAN, CHARLES A.	Clinical Staff	
TAGATZ, GEORGE E.	Attending Staff	
TWIGGS, LEO B.	Attending Staff	
WILLIAMS, PRESTON P.	Attending Staff	
WORK, BRUCE A.	Attending Staff	

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment
to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
OPHTHALMOLOGY		
BROWN, J. DAVID	Clinical Staff	
CAMERON, J. DOUGLAS	Attending Staff	
CANTRILL, HERBERT L.	~~Attending~~ Clinical Staff	
DOUGHMAN, DONALD	Attending Staff	
HOLLAND, EDWARD J.	Attending Staff	
KNOBLOCH, WILLIAM H.	Attending Staff	
LETSON, ROBERT D	Attending Staff	
LINDSTROM, RICHARD L	~~Attending~~ Clinical Staff	
NELSON, JOHN DANIEL	Attending Staff	
RAMSAY, ROBERT C.	Clinical Staff	
RUBENFELD, MARIAN R.	Clinical Staff	
SUMMERS, CAROLE GAIL	Attending Staff	
TANI, GEORGE T.	Clinical Staff	
WIRTSCHAFTER, JONATHAN	Attending Staff	Neurology

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

July 1, 1989 - June 30, 1991

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
UROLOGY		
ERCOLE, CESAR J.J.	Attending Staff	
FRALEY, ELWIN E.	Attending Staff	
GONZALEZ, RICARDO	Attending Staff	
HAIKEL, GEORGE A.	Clinical Staff	
HOPPMANN, HAROLD J.	Clinical Staff	
HULBERT, JOHN C.	Attending Staff	
KAYE, KEITH W.	Clinical Staff	
MAYERSAK, JEROME S.	Clinical Staff	
MCELLISTREM, GERALD	Clinical Staff	
ORTLIP, STEPHEN A	Clinical Staff	
PINTO, MARCOS H.	Clinical Staff	
REDDY, PRATAP K	Attending Staff	
SCHWARTZ, STEVEN	Clinical Staff	
SIDI, ABRAHAM AMI	Attending Staff	
STEIN, NEIL A.	Clinical Staff	
UKE, EROL T.	Clinical Staff	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Delay for Reappointment

SABBITICAL LEAVE OF ABSENCE

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
FAMILY PRACTICE AND COMMUNITY HEALTH		
O'LEARY, JOHN B.	Clinical Staff	
VERBY, JOHN E.	Attending Staff	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Termination
of Medical/Dental Staff Appointments

NO REAPPRAISAL REAPPOINTMENT APPLICATION SUBMITTED

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
BAKER, GARY L.	Clinical Staff	
DUSENBERY, KATHRYN E.	Attending Staff	
FLYNN, PATRICK J.	Clinical Staff	
LAURITZEN, HERBERT	Clinical Staff	
SCHNED, ERIC S.	Clinical Staff	
NEUROLOGY		
RASK, CYNTHIA A.	Attending Staff	
OBSTETRICS AND GYNECOLOGY		
WYNNE, ERNEST C.	Clinical Staff	

****

NO REAPPRAISAL REAPPOINTMENT APPLICATION OR EVIDENCE OF PROFESSIONAL LIABILITY INSURANCE COVERAGE SUBMITTED

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
MEDICINE		
GEBHARD, ROGER L.	Clinical Staff	
TAKAHASHI, MASANAO	Clinical Staff	

****

NO EVIDENCE OF REGENTS ENDORSEMENT IN PROFESSIONAL LIABILITY INSURANCE POLICY

DEPARTMENT	CATEGORY
HOSPITAL DENTISTRY	
CAVANAUGH, GERALD D.	Clinical Staff
SPEIDEL, T. MICHAEL	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Regular Medical/Dental Appointments

DEPARTMENT	CATEGORY	DATE ELIGIBLE
ANESTHESIOLOGY		
BEEBE, DAVID S.	Attending Staff	April 26, 1989
DERMATOLOGY		
SMITH, JANELLEN	Clinical Staff	April 26, 1989
NEUROLOGY		
TALWAR, DINESH	Attending Staff	April 26, 1989
PEDIATRICS		
ANDERSON, PETER M.	Attending Staff	May 16, 1989
ZACH, TERENCE L.	Attending Staff	April 26, 1989
PSYCHIATRY		
BORCHARDT, CARRIE M.	Attending Staff	April 26, 1989
MELLER, WILLIAM H.	Attending Staff	May 16, 1989
SURGERY		
MATAS, ARTHUR J.	Attending Staff	April 26, 1989
SHUMWAY, SARA J.	Attending Staff	May 16, 1989
UROLOGY		
SOUCHERAY, JOHN A.	Clinical Staff	April 26, 1989

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Addition and/or Deletion of Clinical Privileges

DEPARTMENT	CATEGORY
MEDICINE	
HOMANS, DAVID C.	Attending Staff
Add: trans esophageal echocardiography	
WINKELMANN, JOHN C.	Attending Staff
Add: bone marrow transplantation bone marrow harvest - Operating Room	
NEUROSURGERY	
CHOU, SHELLEY	Attending Staff
Delete: Surgical privileges	
OPHTHALMOLOGY	
LETSON, ROBERT D.	Attending Staff
Delete: Photo-coagulation and laser	
SUMMERS, C. GAIL	Attending Staff
Delete: Photo-coagulation and laser	
UROLOGY	
ORTLIP, STEPHEN A.	Clinical Staff
Add: endoscopy of bladder, bladder and uethral dilatation, urethral stenting and endoscopy	
SIDI, ABRAHAM A.	
Add: urethroplasty, ureterolithotomy, ESWL	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Change in Staff Category

DEPARTMENT	PRESENT CATEGORY	RECOMMENDED CATEGORY
FAMILY PRACTICE AND COMMUNITY HEALTH		
CONNOLLY, JOSEPH P.	Attending Staff	Emeritus Staff without privileges
HOSPITAL DENTISTRY		
LEHNERT, MICHAEL W.	Attending Staff	Clinical Staff
MEDICINE		
FULLER, BENJAMIN F.	Clinical Staff	Emeritus Staff without privileges

Recommendation for Leave of Absence

DEPARTMENT	CATETORY
PEDIATRICS	
MILLER, LAURIE C.	Attending Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Provisional Medical/Dental Staff Appointments

DEPARTMENT	CATEGORY
ANESTHESIOLOGY	
ANDERSON, JAMES V.	Attending Staff
MOLINARI, PAUL S.	Attending Staff
LABORATORY MEDICINE & PATHOLOGY	
SWANSON, PAUL E.	Attending Staff
OPHTHALMOLOGY	
RYAN, EDWIN H.	Attending Staff
PEDIATRICS	
POKORA, THOMAS J.	Clinical Staff
SURGERY	
ALDRIDGE, JEFFREY H.	Clinical Staff
CHUTE, EDMUND P.	Attending Staff
UROLOGY	
BERKSETH, ROBERT O.	Clinical Staff

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Resignations from the Medical/Dental Staff

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
HOSPITAL DENTISTRY		
BANDT, CARL L.	Clinical Staff	
HOFFMANN, WILLIAM P.	Clinical Staff	
LABORATORY MEDICINE AND PATHOLOGY		
YUNIS, JORGE J.	Attending Staff	
MEDICINE		
HRUSHESKY, WILLIAM	Attending Staff	
LEVINE, ELLIS	Attending Staff	
LUEPKER, RUSSELL V.	Attending Staff	
OGLE, KATHLEEN M.	Attending Staff	
RICE, FRED A.	Clinical Staff	
VANSELOW, NEAL	Attending Staff	
WILSON, BRUCE C.	Attending Staff	
OBSTETRICS AND GYNECOLOGY		
MALO, JOHN WM.	Clinical Staff	
SURGERY		
JAMIESON, STUART W.	Attending Staff	
KRIETT, JOLENE M.	Attending Staff	

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Resignation from the Faculty of the Medical School/Loss of Medical Staff Appointment

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
EUROLOGY		
ROSENFELD, WILLIAM E.	Attending Staff	

Termination of Faculty Appointment/Loss of Medical Staff Appointment

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
FAMILY PRACTICE AND COMMUNITY HEALTH		
HANSON, STEPHEN L.	Clinical Staff	
HOSPITAL DENTISTRY		
BROWNE, GRAEME A.	Clinical Staff	
ROELOFS, DARLA J.	Clinical Staff	
MEDICINE		
BARAN, KENNETH W.	Attending Staff	
LESSER, JOHN R.	Attending Staff-provisional status	
LOBELL, MICHAEL	Clinical Staff	
SULLIVAN, CHRISTOPHER	Attending Staff	
VANDERHAGEN, LOIS J.	Attending Staff-provisional status	
NEUROLOGY		
METRICK, MICHELE E.	Clinical Staff	

Office of the Chief of 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

DATE: June 8, 1989

TO: Joint Conference Committee
Board of Governors

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

SUBJECT: Appointment of Chief of Staff and Vice-Chief of Staff

My last term of office as Chief of Staff will come to an end on June 30, 1989 as will the term of Dr. Robert Maxwell, Vice-Chief of Staff. The Nominating Committee appointed by the Medical Staff-Hospital Council selected Dr. Robert Maxwell to run for election for the office of Chief of Staff and Dr. Patricia Ferrieri to run for election for the office of Vice-Chief of Staff and the Council approved the recommendations.

The Bylaws of the Medical and Dental Staff, Article V, Part A:, Section 3. Chief of Staff: states (a) Election: The Chief of Staff shall be elected by the voting members of the medical staff by a plurality vote of the staff voting by mail ballot. His or her election shall become effective as soon as approved by the Board. The Chief of Staff shall serve a three-year term and is eligible for a second two-year term but in any event shall serve until a successor has been elected and his or her election approved by the Board. If the office of Chief of Staff becomes vacant, the Vice-Chief of Staff shall serve as acting Chief of Staff for the remainder of the term or until a successor is elected.

Section 4. Vice-Chief of Staff: (a) Election: The Vice-Chief of Staff shall be elected by a plurality vote of the staff voting by mail ballot. His or her election shall become effective as soon as approved by the Board. The Vice-Chief of Staff shall serve a three-year term and is not eligible for re-election but in any event shall serve until a successor has been elected and his or her election approved by the Board.

Elections were held in May and the tabulated results indicate that Dr. Robert Maxwell and Dr. Patricia Ferrieri have won the election by plurality. I hereby request your approval of Dr. Robert Maxwell as Chief of Staff and Dr. Patricia Ferrieri as Vice-Chief of Staff.

Thank you for your consideration of this request.

JHM/cf

CURRICULUM VITAE

Name: Robert Eugene Maxwell, M.D., Ph.D., F.A.C.S.

Home Address: 205 Black Oaks Lane
Wayzata, Minnesota 55391
Telephone: (612) 473-4308

Office Address: Department of Neurosurgery
University of Minnesota Hospitals
Box 142 UMHC
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
Telephone: (612) 624-6666

Birthplace: Lima, Ohio

Birthdate: June 24, 1936

Citizenship: United States

Marital Status: Married

Date: September 13, 1958

Wife: Jana Maxwell

Children: David
Laura
James
Carter

Education:

Secondary School:	
Lima South High School	1951-1954
Undergraduate School:	
The Ohio State University	1954-1958
Medical School:	
The Ohio State University College of Medicine	1958-1962
Graduate School:	
University of Minnesota Graduate School, Neurosurgery	1969-1974

Internship:
Johns Hopkins University Hospitals 1962-1963

Residency:
Johns Hopkins University Hospitals 1963-1964
General Surgery
University of Minnesota Hospitals 1966-1971
Neurological Surgery

Degrees:

Doctor of Philosophy
University of Minnesota August, 1974
Graduate School
Major: Neurosurgery
Minor: Anatomy

Doctor of Medicine
The Ohio State University June, 1962
College of Medicine

Bachelor of Science
The Ohio State University August, 1958
Major: Biology
Minor: Chemistry

Honors:

Alpha Epsilon Delta (pre-med honorary) 1956

Nu Sigma Nu Outstanding Medical Student Award, The Ohio State University 1959

Alpha Omega Alpha (medical honorary) 1961

Doctor of Medicine (cum laude) 1962

Doctoral Thesis:

Maxwell RE: "Experimental brain edema and its response to a glucocorticoid hormone." A thesis submitted to the faculty of the Graduate School of the University of Minnesota in partial fulfillment of the requirements for the Degree of Doctor of Philosophy. 1974

Board Certification:

American Board of Neurological Surgery October, 1974

Medical Licensure:

Ohio, 1962
Maryland, 1963
Minnesota, 1970
South Dakota, 1983

Military Service:

Walter Reed Army Institute of Research 1964-1966
Washington, D.C.

Current Hospital Staff Positions:

Associate Professor of Neurosurgery
Department of Neurosurgery
University of Minnesota

Chief, Section of Neurosurgery
Department of Surgery
Minneapolis Veterans Administration Hospital

Vice Chief of Staff
University of Minnesota Hospital and Clinic
Minneapolis, Minnesota

Current Offices in National and State Societies:

Secretary-Treasurer
Society of University Neurosurgeons

Secretary-Treasurer
Minnesota Neurosurgical Society

Board of Directors
American Society for Stereotactic
and Functional Neurosurgery

Board of Directors
American Society for Stereotactic
and Functional Neurosurgery

Organizations and Societies:

Peyton Neurosurgical Society	1971
Hennepin County Medical Society	1973
Minnesota State Medical Association	1973
American Medical Association	1973
Minnesota Neurosurgical Society	1973
Congress of Neurological Surgeons	1973
Minnesota Society of Neurological Sciences	1974
American Association of Neurological Surgeons	1975
American College of Surgeons	1976
American Epilepsy Society	1981
Society of University Neurosurgeons	1982
American Society for Stereotactic and Functional Neurosurgery	1983
World Society for Stereotactic and Functional Neurosurgery	1983

Committees and Offices:

National and State:

Society of University Neurosurgeons	
Future Sites Selection Committee - Chairman	1985-1987
Secretary-Treasurer	1988-Present
American Association of Neurological Surgeons	
Joint Committee on Education	1988-Present
Graduate Education Subcommittee	1988-Present
Subcommittee Review Articles for Journal of Neurosurgery - Chairman	1988-Present
Congress of Neurological Surgeons	
By-Laws Committee	1973-1974
Host Committee	1983-1984
Member Joint Section on Tumors	1985-Present

American Society for Stereotactic and Functional Neurosurgery Board of Directors	1989-Present
Minnesota Neurosurgical Society Secretary-Treasurer	1985-Present
Minnesota Association of Public Teaching Hospitals Board of Directors	1986-Present
Minnesota Foundation for Health Care Evaluation Board of Directors	1985-Present
American Medical Association Diagnostic and Therapeutic Technology Assessment Reference Panel	1983-Present
Minnesota State Medical Association Resource Group on Driver License Review	1985-Present

University of Minnesota Hospitals and Clinics:

Emergency Department Committee	1978-1983
Invasive Pressure Monitoring Clinical Advisory Task Force	1978-1983
Child Care Task Force	1979-1983
Utilization Review and Medical Records Committee	1980-1984
Cardiorespiratory Advisory Committee	1980-Present

Patient Monitoring Subcommittee	1980-1983
Medical Staff Hospital Council	1981-1985 1986-Present
Joint Conference Committee of Board of Governors	1982-1985
Tissue and Procedure Review Committee	1982-Present
Chairman	1984-Present
Patient Incident Review Committee Chairman	1987-Present
Credentials Committee	1983-Present
Search Committee for Medical Director of Emergency Department	1983
Quality Assurance Steering Committee	1984-Present
Medical Staff Budget Advisory Committee	1983-1985
University of Minnesota Hospitals and Clinics Mission Task Force	1985
Nominating Committee for Medical Staff Hospital Council	1985
Vice Chief of Staff	1986-Present

University of Minnesota Medical School:

Course Director, Neurosurgery (5-510)	1972-Present
Chairman of Phase D Neurosciences Track Committee	1974-1984

Phase D Surgical Specialties Track Committee	1974-1984
Neurology Chairmanship Search Committee	1981-1982
Subcommittee on Graduate Medical Education, University of Minnesota Self-Study Analysis	1982
Didactic/Selective Course Committee	1983-1987
Outpatient/Didactic Teaching and Steering Committee	1987-1988
Clinical Medicine IV Teaching and Steering Committee	1988-Present
Search Committee for Neuropathologist	1982-1983
Dean's Cancer Task Force	1984-Present
Co-Chairman Search Committee for Chairman, Department of Anesthesiology	1987-Present
Graduate Faculty Doctorate Examining Committees for	
Dr. Ken Murray	1977
Dr. Dan Ahlberg	1977, 1978
Dr. William Druckemiller	1977, 1978
Dr. Robert Clubb	1978
Dr. Robert Harris	1978
Dr. Fernando Diaz	1978
Dr. Richard Moser	1979
Dr. Alexa Canady	1981
Dr. John Godersky	1982
Dr. Mahmoud Nagib	1982
Dr. Terry Hood	1983
Dr. Gary Rea	1984

Graduate Student Advisee:

Robert Clubb, M.D., Ph.D. 1976-1978

Visiting Professorships:

National Institute of Health
Bethesda, Maryland
March, 1985

University of Maryland School
of Medicine
Baltimore, Maryland
January, 1988

The University of Texas Health
Science Center
San Antonio, Texas
The George William Church Lecturer
June 9, 1989

Sources of Research Funding:

Ultrastructure of Evolution of Cerebral
Edema USPHS 07341 - Co-investigator
Ns5626-03 $111,161 1968-1972

The Use of Barbiturates in Experimental
Head Injury MMF-MRF5-76 - Co-investigator
$3,800 1976-1977

Comprehensive Study of Central Nervous
System Trauma - Principal Investigator
NIH-N01-NS7-2369 $130,000 1977-1979

Identification and Treatment of Patients
with Intractable Epilepsy by Corpus
Callosotomy.
NINCDS Comprehensive Epilepsy Program Grant
1-P50NS163018 - Co-investigator
$202,920 1980-1984
$228,534 1985-1989

CURRICULUM VITAE

PATRICIA FERRIERI, M.D.

Born: Pittsburgh, Pennsylvania, Oct. 23, 1939

Education:

Vassar College; A.B. 1961
Poughkeepsie, New York

University of Pittsburgh; M.D. 1965
Pittsburgh, Pennsylvania

Professional Training and Academic Positions:

Intern, Pediatrics University of Minnesota Minneapolis, Minnesota	1965-66
Resident, Pediatrics Assistant Chief Resident University of Minnesota Minneapolis, Minnesota	1966-68 1967-68
Medical Fellow Pediatric Infectious Diseases University of Minnesota Minneapolis, Minnesota	1968-71
Assistant Professor Department of Pediatrics University of Minnesota Minneapolis, Minnesota	1971-74
Associate Professor Department of Pediatrics University of Minnesota Minneapolis, Minnesota	1974-79
Professor Department of Pediatrics University of Minnesota Minneapolis, Minnesota	1979-
Professor Department of Laboratory Medicine and Pathology University of Minnesota Minneapolis, Minnesota	1982-
Director Clinical Microbiology Laboratory University of Minnesota Hospital Minneapolis, Minnesota	1982-

Professional Honors:

Career Investigator Fellowship of American Heart Association, July 1968-June 1970
Departmental Post-Doctoral Trainee (NICHHD), July 1970-June 1971

National Society Memberships:

Diplomate, National Board of Medical Examiners, July 1966
Diplomate, American Board of Pediatrics, December 1970
American Association for the Advancement of Science
American Society for Microbiology
Northwestern Pediatric Society
American Federation for Clinical Research
Society for Pediatric Research, 1974
Midwest Society for Pediatric Research, 1974
Central Society for Clinical Research, 1976
Lancefield Society, 1976
Infectious Diseases Society of America, 1977
American Association of Immunologists, 1978
American Association of Pathologists, 1982
Academy of Clinical Laboratory Physicians and Scientists, 1983
Pediatric Infectious Diseases Society

Local Organizations:

Minnesota Chapter of the National Foundation for Infectious Diseases; Officer, 1984 -

Editorial Boards:

Pediatric Research, 1978-1984
Journal of Clinical Microbiology, 1981-1984; 1984-1986; 1987-
American Journal of Diseases of Children, 1987-

Federal Appointments:

NIH - Bacteriology and Mycology Study Section, 1981-1985; Chairman 1984-1985
FDA - Vaccines and Related Biologic Products Advisory Committee, 1987-

American Society for Microbiology Activities:

Chairperson Elect Division B, 1985-1986
Chairperson, Division B (Microbial Pathogenesis), 1986-1987

Research Grant Support:

NIH: Investigator-initiated support has been granted since 1971, approximately two grants simultaneously
Currently: "Host Responses To Group B Streptococci"
RO1 AI-13926; this has been renewed competitively three times, successfully.
Period: 7/1/88 - 6/30/92 Years 11-14 $533,000
Thrasher Foundation: "Identification and Prevention of Streptococcal Infections and Rheumatic Fever and Rheumatic Heart Disease in High Risk Populations" $115,489
Period: 7/1/87-6/30/90; Dr. Ferrieri, Co-Principal Investigator

Committee Memberships:

Department:
Educational Policy Committee, Department of Pediatrics, 1972-
Scientific Program Committee, Department of Pediatrics, 1973/74,75/76
Pediatric Residency Committee, 1982-
Pediatric Internship Selection Committee, 1972-1982
Pediatric Residency Selection Committee, 1972-1975
Chairman, Pediatric Residency Selection Committee, 1976-1977
Member, Board of Directors, Pediatric Specialists, 1975-1979
Member, K-E Planning Committee, 1975-1979
Member, Pediatric Ward Utilization Committee, 1977-
Member, Pediatric Promotions Committee, 1979-
Member, Laboratory Medicine and Pathology Promotions Committee, 1985-1989; Chairperson 1987-1989
Tenure Track Review Committee, Laboratory Medicine & Pathology, 1986-1987
Laboratory Medicine and Pathology Residency Committee, 1987-

Medical School:
Medical School Committee for Minority Students, 1973-1975; 1979-1980
Phase B ENT Committee, 1972-1977
Member, Dean's Committee - Study Committee Regarding Obstetrics, 1974
Scholastic Standing Committee of the Medical School, 1974-1977
Course Director, Pediatric Infectious Diseases Elective, Peds 5-535
Microbiology course - clinical correlation lectures
Medical School Promotions Committee, 1980-1983
Microbiology Search Committee, 1980-1983
University Senate, 1981-1984; 1985-
Committee on Committees, 1988-

Hospital:
Hospital Infection Committee, University of Minnesota Hospital, 1972-
Subcommittee on Skin Washing, Sterilization, and Disinfectants, 1972-
Chairman, Subcommittee on Nursery and Infant Wards, 1972-
Member, Advisory Board, Childbearing-Childrearing Center
Pediatric Planning Task Force, 1977
Obstetrics Unit Task Force, 1979
Member, Medical Staff-Hospital Council, 1980-1987

Post-M.D. Teaching:

Consultant, Infectious Diseases, University Hospitals plus ad hoc activities here and at other affiliated hospitals

Teach students, residents and fellows in training in Infectious Diseases or Microbiology

Lectures Delivered (on Infectious Diseases and Bacteriology to the following groups):
Newborn Intensive Care Unit House Staff Clinical Microbiology Staff of Hospital
Minnesota Department of Health Seminars
Intercity Infectious Disease Group
Minnesota Interlaboratory Microbiological Association
Grand Rounds, University and Affiliated Hospitals

Infectious Disease Trainees:

Primary advisor for:

Robert Bortolussi, M.D., 1975-1978
Present Position: Associate Professor
Microbiology; Infectious Disease Research Unit
I.W. Killam Hospital for Children
Dalhousie University, Halifax, Nova Scotia

Robert J. Ancona, M.D., 1977-1979
Present Position: Assistant Professor
Department of Pediatrics, Baltimore City Hospital
Baltimore, Maryland

Janet R. Gilsdorf, M.D., 1979-1982
Present Position: Assistant Professor
Department of Pediatrics
University of Michigan, Ann Arbor, Michigan

Nathaniel R. Payne, M.D., 1982-1985
Present Position: Staff Neonatologist
Children's Health Center of Minneapolis
Minneapolis, Minnesota

Scott A. Halperin, M.D., 1982-1985
Present Position: Assistant Professor
Microbiology, Infectious Disease Research Unit
I.W. Killam Hospital for Children, Dalhousie University
Halifax, Nova Scotia

Secondary or joint advisor for:

Joseph Brown, III, M.D., 1970-1973
Present Position: Associate Chairman
Department of Pediatrics
Texas Tech University, El Paso, Texas

Auea E. Flores, Ph.D., 1979-1981
Present Position: Research Associate
Department of Pediatrics
University of Minnesota, Minneapolis, MN

National and International Activities:

Review articles and submit critiques for:
New England Journal of Medicine; Infection and Immunity; Pediatric Research; Antimicrobial Agents and Chemotherapy; Obstetrics and Gynecology; Pediatrics; Journal of Clinical Microbiology; American Journal of Diseases of Children; Journal of Infectious Diseases, etc.

Member, Site Visit Team from NIAID to review applications for program project grants

Review grant applications for National Institute of Allergy and Infectious Diseases

Chairman or co-chairman of infectious disease meetings for ICAAC, ASM, SPR national meetings

Invited speaker for various educational programs, nationally, internationally, e.g. Canadian Congress of Laboratory Medicine, Hamilton, Ontario, June 1977

Participant, International Streptococcal Symposium:

1972 Amsterdam, The Netherlands
1975 Prague, Czechoslovakia
1978 Oxford, England
1981 Lund, Sweden
1984 Mt. Fuji, Japan; Chaired Session
1987 Cologne, West Germany; Chaired Session

Visiting Professor:

Al-Azar University, Cairo, Egypt, February 3-16, 1979
Dalhousie University, Halifax, Nova Scotia, June 20-22, 1979
Hygiene Institute, Cologne, West Germany, April 2-5, 1980
National Institute of Hygiene, Warsaw, Poland, April 8-16, 1980
Tripler Army Medical Center, Honolulu, Hawaii, February 19-25, 1981
University of Vancouver, British Columbia, March, 1984
Guangdong Cardiovascular Institute, Guangzhou, China, April 9-11, 1986
Institute of Experimental Medicine, Leningrad, Russia, September 30-October 9, 1988

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 16, 1989

TO: Members of the Board of Governors

FROM: Robert Dickler, General Director
James Moller, M.D., Chief of Staff

SUBJECT: Annual Appointments 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 service 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 service 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 reappointment 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 appointment of the following Clinical Chiefs for 1989-90:

Name	Department
George Adams, M.D.	Otolaryngology
Essam Awad, M.D.	Physical Medicine & Rehab.
Richard Brunning, M.D.	Lab Medicine & Pathology
Shelley Chou, M.D.	Neurosurgery
Edward Ciriacy, M.D.	Family Practice
Paula Clayton, M.D.	Psychiatry
Donald Doughman, M.D.	Ophthalmology
Thomas Ferris, M.D.	Medicine
Elwin Fraley, M.D.	Urology
Arthur Klassen, M.D.	Neurology
Russell Larsen, M.D.	Anesthesiology
Seymour Levitt, M.D.	Therapeutic Radiology
Peter Lynch, M.D.	Dermatology
Alfred Michael, M.D.	Pediatrics
John Najarian, M.D.	Surgery
Roby Thompson, M.D.	Orthopaedic Surgery
William Thompson, M.D.	Radiology
Bruce Work, M.D.	Obstetrics & Gynecology

Dr. Elgene Mainous is serving in his initial three year term as Chief of Hospital Dentistry, thus reappointment is not required this year.

We anticipate that several changes to the above list will be recommended to the Board of Governors during the year as medical staff appointments for individuals recently recruited are received and as searches currently under way are completed.

Thank you.

/kj

The University of Minnesota Hospital and Clinic

QUALITY ASSURANCE PROGRAM EVALUATIONS AND FOLLOW-UP

June 7, 1989

Background Information

Following the March meeting of the Joint Conference Committee, meetings were held with the Clinical Departments identified as non-compliant with the quality monitoring process to re-evaluate their monitoring programs and their commitment to improving those programs. The results of these meetings were very positive and a summary of the items discussed appears below. Given the current contingency from the Joint Commission in this area, it is essential that Departments increase their compliance levels very soon in order to demonstrate a full 12 months of compliance with the standards before the next survey in late 1990.

Overall, each department needs to accomplish varying degrees of improvement in the following areas:

1) Further development of meaningful indicators, including thresholds to determine when further evaluation is necessary.

2) Review of monitoring reports for trends and patterns on a quarterly basis in addition to the monthly case by case reviews of morbidity and mortality. Case reviews are currently well done by most services.

3) More complete documentation of case reviews and the monitoring reports in the monthly minutes, especially in relation to recommendations, conclusions, actions, and follow-up resulting from discussion at the meeting. Copies of the minutes should be routinely forwarded to Quality Assurance Services.

Neurology

1) Trends and patterns associated with morbidity, mortality, and other quality assurance indicators will be discussed at the monthly Adult Neurology Quality Assurance meeting.

2) Peds Neurology will be evaluated separately and Quality Assurance staff will meet with Dr. Swaiman.

3) Several indicators will be added to the Adult Neurology monitor: hospital acquired infections, adverse drug reactions during hospitalization, documentation of consent of DNR/DNI patients.

Obstetrics

1) Dr. Work will discuss the need for indicators with the division directors.

2) Quality Assurance Services staff will participate in the further development of the indicators and provide data on a quarterly basis.

3) Monthly divisional meetings will include morbidity and mortality review as well as review of the quality monitors on a quarterly basis.

Surgery

1) Dr. David Dunn will be the department's QA liaison. Quality Assurance staff will assist him to further refine the current indicators him for all divisions except Cardiovascular Surgery.

2) Surgery Department infection control data will be incorporated into the quarterly monitors.

3) The Surgery Department secretary will begin attending the weekly Complications Conferences and Quality Assurance Staff will work with her to format the minutes. The quality monitoring reports will be reviewed for trends and patterns on a quarterly basis at this meeting.

4) A follow-up meeting will be held with Dr. Najarian in 2-3 months to appraise him of progress with the QA Program.

Medicine

1) A divisional approach to quality monitoring was endorsed by Dr. Ferris.

2) Dr. Ferris will inform the Divisional Directors that Quality Assurance staff will be contacting them to discuss and refine current QA indicators.

3) A Divisional Director may assign the QA responsibility to another individual within the division.

Ophthalmology

1) Dr. Doughman will appoint Dr. Letson as the QA representative for the department following discussion with him.

2) Revised indicators will initially concentrate on inpatients on the anterior segment service, with additional indicators to be developed for other services later in 1989. Dr. Doughman will consider assigning the identification of complications to the Chief Resident.

3) A secretary will be assigned to record minutes on a monthly basis and QA Services Staff will work with this individual to format the minutes.

4) The flow of QA information will be diagrammed for the department.

5) QA Services will meet with the individual in charge of developing the Department's research database to determine what information might be linked to the QA monitors.

Family Practice

1) The need for outcome indicators was discussed and several will be added to the monitoring process.

2) Marjorie Wilson will work with QA Services staff to format the meeting minutes and copies will be sent to Quality Assurance on a monthly basis.

Psychiatry

1) Meeting not yet held.

The University of Minnesota Hospital and Clinic

MONITORING AND EVALUATING THE QUALITY AND APPROPRIATENESS OF CARE

ASSESSMENT OF THE CLINICAL DEPARTMENTS' COMPLIANCE

DEPARTMENT	MONITORING					MONTHLY MEETINGS		
	Indicators	Thresholds for Evaluation	Conclusions	Actions	Follow-up	Frequency	Findings from Major Care Aspects Discussed	Minutes with Conclusions and Actions
ANESTHESIOLOGY	1		3	3	3	1	2	2
Summary of Indicators:	Intraoperative Complications; Post-anesthetic Complications; Long Stays in PAR; Transfers to ICU; Deaths							
DENTISTRY	1	-	3	4	4	2	3	3
Summary of Indicators:	Post-Op Infections; Device/Graft Malfunctions; Return to OR for Bleeding; Return to ER; Unplanned Admission; Anesthesia							
DERMATOLOGY	2	-	2	2	3	3	4	4
Summary of Indicators:	Complications; Patient Complaints; Response Time to Requests for Inpatient Consults							
FAMILY PRACTICE	3	-	4	4	4	2	3	3
Summary of Indicators:	Readmissions; Others not implemented							
MEDICINE	3	-	5	5	5	1	4	4
Summary of Indicators:	Complications; Adverse Drug Reactions; Deaths; Patient Complaints							
White (Cardiology)	2	-	4	4	4	4	4	4
Masonic (Oncology)								
Red (Hematology)								
Blue (GI/Endoscopy)								

DEPARTMENT	MONITORING					MONTHLY MEETINGS		
	Indicators	Thresholds for Evaluation	Conclusions	Actions	Follow-up	Frequency	Findings from Major Care Aspects Discussed	Minutes with Conclusions and Actions
Green (Renal/Dialysis)								
Yellow A (Pulmonary)								
Purple (BMT) [See special care units]								
Other Medicine								
NEUROLOGY	3	-	3	4	4	1	3	3
Summary of Indicators: Deaths; Complications; Incident Reports; Patient Complaints								
NEUROSURGERY	2	-	2	2	2	1	2	2
Summary of Indicators: Deaths; Complications such as Post-op Infections, CNS Deficit, Post-op Cerebral Spinal Fluid Leak								
NUCLEAR MEDICINE	1	-	4	4	4	4	4	4
Summary of Indicators: Complications; Scheduling Difficulties; Incompleteness of Exams; Patient Complaints; Indications for Procedures								
OBSTETRICS/ GYNECOLOGY	1	-	4	4	4	1	3	2
Gyn-Oncology								
Summary of Indicators: Complications; Incident Reports; Patient Complaints								

DEPARTMENT	MONITORING					MONTHLY MEETINGS		
	Indicators	Thresholds for Evaluation	Conclusions	Actions	Follow-up	Frequency	Findings from Major Care Aspects Discussed	Minutes with Conclusions and Actions
Gynecology								
Obstetrics								
Summary of Indicators: Deaths; Low Apgars; Infant Injury; Complications of Delivery								
OPHTHALMOLOGY	3	-	5	5	5	1	5	5
Summary of Indicators: Coroneal Transplant Complications; Retinal Reattachement Complications; Patient Complaints								
ORTHOPAEDICS	1	-	3	4	4	1	3	3
Summary of Indicators: Post-op Complications; Malfunction of Orthopedic Devices; Incident Reports								
OTOLARYNGOLOGY	1	-	2	2	2	1	3	3
Summary of Indicators: Post-op Complications; Incident Reports; Evaluation of Stapedectomies and Tympanoplasties								
PEDIATRICS	4	-	5	5	5	1	4	4
Summary of Indicators: In development.								
Peds Cardiology								
Peds Dialysis/Renal								
Peds Pulmonary								
Peds Other								

DEPARTMENT	MONITORING					MONTHLY MEETINGS		
	Indicators	Thresholds for Evaluation	Conclusions	Actions	Follow-up	Frequency	Findings from Major Care Aspects Discussed	Minutes with Conclusions and Actions
PSYCHIATRY	3	-	3	3	3	4	4	4
Summary of Indicators: Documentation of Assessment Data; Psych Evaluation; Treatment Plan and Progress; No clinical indicators.								
RADIOLOGY	2	2	2	2	2	2	2	3
Summary of Indicators: Complications; Indications for Procedures								
REHABILITATION	2	-	1	2	2	1	2	1
Summary of Indicators: Gross Motor Function for Peds pts; Follow-up Urine Cultures; X-Rays before Heat Therapy; Clinical Pertinence of Record; Incident Reports								
SPECIAL CARE UNITS								
Medical ICU	1	-	3	3	3	1	3	2
Surgical ICU	1	-	3	3	3	1	3	2
Newborn ICU	1	-	2	2	2	1	1	1
Pediatric ICU	1	-	2	2	2	1	1	1
Bone Marrow Tx								

DEPARTMENT	MONITORING					MONTHLY MEETINGS		
	Indicators	Thresholds for Evaluation	Conclusions	Actions	Follow-up	Frequency	Findings from Major Care Aspects Discussed	Minutes with Conclusions and Actions
SURGERY	1	-	4	4	4	1	3	3
Summary of Indicators: Deaths; Post-op Complications; Incident Reports								
Transplant								
Cardiovascular	2	-	4	4	4	4	4	4
General Surgery								
THERAPEUTIC RADIOLOGY	1	-	2	2	2	1	3	3
Summary of Indicators: Late Effects and Complications of Radiation; Incident Reports								
UROLOGY	1	-	3	3	3	3	3	3
Summary of Indicators: Deaths; Post-op Complications; Pelvic, Rectal & Review of Systems Done								

SCORING (See detailed scoring definitions on attached pages)

1 - Substantial Compliance
2 - Significant Compliance
3 - Partial Compliance
4 - Minimal Compliance
5 - Non-Compliance

File: [Sys]<VINCEWP>Compliance Last Updated: 06/07/89

COLUMN DEFINITIONS
MONITORING AND EVALUATING THE QUALITY AND APPROPRIATENESS OF CARE
ASSESSMENT OF THE CLINICAL DEPARTMENTS COMPLIANCE

Column Heading	Definition
Indicators	A defined, measurable dimension of the quality or appropriateness of an important aspect of care or service. Indicators specify the patient care activities, events, occurrences or outcomes to be monitored and evaluated to determine if patient care conforms to current standards of acceptable practice. Data is collected for each indicator.
Thresholds for Evaluation	A pre-established level or point in data that will trigger intensive evaluation to determine whether an opportunity to improve care exists.
Conclusions	A specific determination of whether the data identifies a problem or opportunity to improve care.
Actions	A summary of the recommendations made or actions to be taken to resolve concerns identified by the indicator. Who or what is expected to change should be identified; who is responsible for implementing action; what action is appropriate and when change is expected to occur.
Follow-Up	A determination of when the indicator will be reviewed again to determine if the concerns/problems were resolved by the recommendations and actions taken.
Frequency of Monthly Meetings	Score 1 There are 11 or 12 monthly meetings each year; preceding months information is reviewed after any lapse. Score 2 There are 10 monthly meetings each year. Score 3 There are 9 monthly meetings each year. Score 4 There are 4 to 8 monthly meetings each year.. Score 5 There are 3 or fewer meetings each year.

Findings from Major Care Aspects Discussed	Score 1	All major aspects of quality assurance findings are presented over the course of one year; the minutes reflect active discussion.
	Score 2	Most major aspects of quality assurance findings are presented in the course of one year; the minutes generally reflect active discussion.
	Score 3	Some major aspects are presented; there is little evidence of active discussion by those in attendance.
	Score 4	Few major aspects are presented; the usual procedure is perfunctory acceptance or approval of reports from committees.
	Score 5	Meeting agendas consist almost entirely of business items with little or no reference to quality assurance issues.
Minutes with Conclusions and Actions	Score 1	The minutes contain a record of conclusions, recommendations, and actions taken after discussions of quality assurance issues. (Patients or practitioners singled out by the monitoring and evaluation process need not be identified.) There are regular reviews of previous recommendations or actions to determine their effectiveness.
	Score 2	Most minutes contain a record of conclusions, recommendations, and actions taken and evidence of follow-up activities.

Score 3	The minutes rarely contain a record of conclusions, recommendations, and actions taken, but the surveyor(s) can determine that actions are taken (eg. a policy has been changed regarding an important aspect of patient care). OR Some minutes contain a record of conclusions, recommend-ations, and actions taken.
Score 4	The minutes only occasionally contain a record of conclusions, recommendations, and actions taken.
Score 5	The minutes rarely or never contain a record of conclusions, recommendations, and actions taken.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

DATE: June 21, 1989

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Associate Director

RE: Joint Commission on Accreditation of Healthcare Organizations

You may recall The University of Minnesota Hospital and Clinic was last surveyed by the Joint Commission on November 13-16, 1987. Our findings from that site visit included twenty priority recommendations or, in the Joint Commission's words, contingencies.

Corrective actions have been taken on all of the contingencies. The results of those corrective actions were reported to the Joint Commission in three ways:

1. June 4, 1988 written progress report.

2. December 4, 1988 written progress report.

3. January 10, 1989 focus site visit.

We have received feedback from the Joint Commission on the June, 1988 written progress report and the January 10, 1989 focus site visit. The Joint Commission's response to both was less than favorable; their responses are attached.

I will look forward to discussing these responses with you on June 28, 1989.

NCJ:jm

Joint Commission
on Accreditation of Healthcare Organizations

March 10, 1989

Robert Dickler
Hospital Director
The University of Minnesota
Hospital And Clinic
Harvard St At East River Rd
Minneapolis, MN 55455

Dear Mr. Dickler:

We are writing to acknowledge your further efforts towards compliance with the standards of the Joint Commission. However, based upon the written progress report which you submitted, we believe that further monitoring of your progress will assist you in more fully achieving the intent of the standards. Accordingly, the contingency on your accreditation status has not been removed. This contingency is specified in the attached report.

If substantial compliance is not evidenced in the area addressed by this contingency in the time frame indicated, your accreditation status could be adversely affected.

We direct your attention to the fact that any other reports or focused survey visits concerning other contingencies related to your accreditation award must also be satisfied in order to maintain your accreditation.

In accordance with Joint Commission policy, this action is confidential. Any release of the contents of this report is at your discretion.

We encourage your continued attention to this contingency.

Sincerely,

John E. Milton
Director
Hospital Accreditation Program

cc: James H. Moller, MD, President Of the Medical Staff
Robert Latz, Chairman Of the Governing Body

875 North Michigan Avenue
Chicago Illinois 60611
312/642-6061

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
MINNEAPOLIS, MINNESOTA

DATE OF REPORT RECEIPT
JUNE 8, 1988

ACCREDITATION DECISION: As a result of the written progress report received on the above date, your organization has been awarded continued accreditation contingent upon compliance in the areas detailed in the attached report preceded by the symbol (C). The findings of this report indicate that your organization has not yet satisfied the requirements of this contingency.

The results of this written progress report do not affect any other contingency requirement that may exist on your current accreditation status.

In the event that your organization does not make sufficient progress in the areas not in compliance noted below, your accreditation status may be withdrawn.

CONTINGENCY: A written progress report will be required within approximately three (3) months from the date of the attached letter, March 10, 1989. This report should address only the recommendations on the following pages preceded by the symbol (C) and relating to the following topic:

1. Nursing Direction and Staffing

The written progress report should be completed and sent to:

Progress Report Coordinator
Hospital Accreditation Program
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

SUPPLEMENTAL RECOMMENDATIONS

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE ACCREDITATION MANUAL FOR HOSPITALS, 1988. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

NURSING SERVICES

(C) 1. Only qualified registered nurses are assigned to head nurse/supervisor and circulating nurse positions in the surgical and obstetrical suites. (NR.4.5)

DEFICIENCIES IN COMPLIANCE WITH STANDARD (NR.4.5) WERE PREVIOUSLY REPORTED.

THE HOSPITAL SUBMITTED A NARRATIVE DESCRIPTION OF THE PRESENT STAFFING POLICY FOR THE OPERATING ROOM SUITE. HOWEVER, NO DOCUMENTATION OF THE ACTUAL WORKED STAFFING SCHEDULE WAS INCLUDED IN THE REPORT.

Joint Commission

May 19, 1989

Gregory Hart
Interim Director
University Of Minnesota
Hospital And Clinic
Harvard Street at East River Road
Minneapolis, MN 55455

Dear Mr. Hart:

We are writing to acknowledge your further efforts towards compliance with the standards of the Joint Commission. However, based upon the findings of your recent focused survey, we believe that further monitoring of your progress will assist you in more fully achieving the intent of the standards. Accordingly, the contingency on your accreditation status has not been removed. This contingency is specified in the attached report.

If substantial compliance is not evidenced in the area addressed by this contingency in the time frame indicated, your accreditation status could be adversely affected.

We direct your attention to the fact that any other reports or focused survey visits concerning other contingencies related to your accreditation award must also be satisfied in order to maintain your accreditation.

In accordance with Joint Commission policy, this action is confidential. Any release of the contents of this report is at your discretion.

We encourage your continued attention to this contingency.

Sincerely,

Lance O. Hoxie
Director
Accreditation Program for
Ambulatory Health Care

cc: James H. Moller, MD, Chief Of Staff
Robert Latz, Chairman Of the Governing Body

875 North Michigan Avenue
Chicago, Illinois 60611
312-642-6061

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
MINNEAPOLIS, MINNESOTA

DATE OF FOCUSED SURVEY
JANUARY 10, 1989

SURVEYOR
DALE S. BENSON, MD

ACCREDITATION DECISION: As a result of the focused survey conducted on the above date, your organization has been awarded continued accreditation contingent upon compliance in the areas detailed in the attached report preceded by the symbol (C). The findings of this survey indicate that your organization has not yet satisfied the requirements of this contingency.

The results of this focused survey do not affect any other contingency requirement that may exist on your current accreditation status.

In the event that your organization does not make sufficient progress in the areas not in compliance noted below, your accreditation status may be withdrawn.

CLEARED CONTINGENCY TOPICS: The following topics, reviewed as a part of this contingency response, have been found in substantial compliance:

1. Monitoring and Evaluation of Patient Care

CONTINGENCY: A written progress report will be required within approximately six (6) months from the date of the attached letter, May 19, 1989. This report should address only the recommendations on the following pages preceded by the symbol (C) and relating to the following topic:

1. Medical Record Summary List

This written progress report should consist of an analysis of the use of summary lists in a representative sample of approximately 100 medical records for patients seen since the date of your organization's survey. An acceptable report would indicate that significant surgical procedures, past and current diagnoses or problems, and currently and recently used medications are documented on summary lists in at least 90 percent of the medical records.

The written progress report should be completed and sent to:

Progress Report Coordinator
Accreditation Program for Ambulatory Health Care
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

SUPPLEMENTAL RECOMMENDATIONS

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE ACCREDITATION MANUAL FOR HOSPITALS, 1989. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

HOSPITAL-SPONSORED AMBULATORY CARE SERVICES

(C) 1. A summary list of significant past surgical procedures, past and current diagnoses or problems, and currently and recently used medications is legibly recorded in the same location in each patient record. (HO.5.3)

DEFICIENCIES IN COMPLIANCE WITH STANDARD (H8.5.3) WERE PREVIOUSLY REPORTED.

IT WAS NOTED THAT THE USE OF SUMMARY LISTS DISTINCT AND SEPARATE FROM A MEDICATION LIST COMMENCED IN OCTOBER, 1988, AND LESS THAN 25% OF THE 50 MEDICAL RECORDS REVIEWED CONTAINED AN APPROPRIATELY COMPLETED SUMMARY LIST. IT WAS NOTED THAT A MEDICATION SHEET HAS BEEN USED SINCE 1985, AND APPROXIMATELY 60% TO 70% OF THE MEDICAL RECORDS REVIEWED CONTAINED AN APPROPRIATELY COMPLETED MEDICATION LIST. A WRITTEN PROGRESS REPORT IS REQUIRED TO BE SUBMITTED IN SIX (6) MONTHS. THIS REPORT SHOULD INCLUDE EVIDENCE THAT THE FOLLOWING INFORMATION IS DOCUMENTED ON SUMMARY LISTS IN A REPRESENTATIVE SAMPLE OF APPROXIMATELY 100 MEDICAL RECORDS OF AMBULATORY PATIENTS SEEN SINCE NOTIFICATION OF THIS CONTINGENCY: SIGNIFICANT PAST SURGICAL PROCEDURES, PAST AND CURRENT DIAGNOSES OR PROBLEMS, AND CURRENTLY AND RECENTLY USED MEDICATIONS. WE URGE YOU TO CONTINUE MONITORING COMPLIANCE WITH THE SUMMARY LIST STANDARD(S) UNTIL AT LEAST 90% COMPLIANCE IS ACHIEVED AND CONSISTENTLY MAINTAINED.

/ 05/11/89
AHC000010498*87*1

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
May 24, 1989

MINUTES

ATTENDANCE:

Present:	Carol Campbell Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Elwin Fraley, M.D. Erwin L. Goldfine Jerry Meilahn Barbara O'Grady
Not Present:	Vic Vikmanis
Staff:	Al Dees Greg Hart Teri Holberg Nancy Janda Nels Larson Helen Pitt Dan Rode

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on May 24, 1989 at 12:18 p.m.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the February 22, 1989 and April 26, 1989 meetings as written.

JULY 1, 1989 THROUGH APRIL 30, 1989 FINANCIALS:

Mr. Clifford P. Fearing reported that UMHC had experienced a decline in the inpatient census for the month of April. Inpatient admissions for April totaled 1538, which was 2.8% under budget. The average length of stay was

at 8.5 Days, or .8 days over budget, and patient days for April were reported to be 9.3% over budget. As of April, year-to-date admissions were 1.5% over budget and patient days were 12% over budget. The average daily census for April was 438 days or 11% over budget. The first 22 days of May showed a decline in average daily census of 20 days and a decline in average length of stay to 8.2 days. Outpatient admissions were reported to be 5.3% under budget for the major clinics for the first time this year. CUHCC and Home Health visits continued to be over budget. Ancillary revenue was reported to be 10.1% over budget, and the accounts receivable were reported to have increased 1.2 days in April.

Lastly, Mr. Fearing reported the Hospital had a year-to-date positive revenue over expense of $628,000. This amount was exclusive of the $1,600,000 audit adjustment on the prior year Blue Cross receivables. Had the adjustment been calculated in for the month of April, the Hospital would have had a net loss of $991,000. Mr. Fearing reported he had spoken with the auditors from Peat Marwick. They indicated to him a prior period adjustment will be made to last year's financial statement for that $1,600,000. As a result of this, this year will stand on its own and the revenue over expense for the month of April will be $628,000.

Mr. Robert Dickler informed the Committee that a hiring freeze had recently been imposed on the Hospital. He stated the reasons for this decision were twofold: 1) in the months of April the Hospital lost approximately $1,000,000 and was $2,000,000 behind budget, and 2) a decline in the average daily census. Mr. Dickler stated no hiring will be made at this time without the signing off by one of the Senior Associate Directors. The hiring freeze is in addition to the reduction in FTEs that was planned in the 1989-90 Budget.

1989-90 OPERATING BUDGET:

Mr. Clifford Fearing submitted to the Financial Committee, for endorsement, the 1989-90 Operating Budget. The 1989-90 Budget would have a rate increase of 9.5% with an implementation of 7.5% on July 1, 1989. After it becomes known how changes in Federal regulations will impact the budget and if it is believed necessary, with prior Board approval the remaining 2% would be implemented. The 9.5% rate increase would produce a net cash flow of $2,700,000, where the 7.5% rate increase would produce a $959,000 net cash flow. Mr. Fearing informed the Committee the 1989-90 Budget will go before the Board of Regents at their June meeting for information and to be presented to their July meeting for action.

The Board of Governors Finance Committee second and passed the motion to approve the 1989-90 Operating Budget.

1989-90 CAPITAL BUDGET:

Mr. Greg Hart presented to the Committee the 1989-90 Capital Budget and the Hospital's ten-year capital expenditure plan for information only. The 1989-90 Capital Budget will be brought before the Committee in June for endorsement. The ten-year capital expenditure plan does not require Board approval.

Ten-year Capital Expenditure Plan

Mr. Hart stated that in order to fund the ten year capital plan the Hospital will need to generate through the next ten years $284,542,000 either from existing reserves or from cash flows generated from operations. Mr. Hart stated the $284,000,000 comprised of approved projects (ex., Dermatology Clinic, MRI II, Masonic III, CUHCC), anticipated projects (ex., lithotripter II, replace CT scanner, computer upgrade) annual equipment and remodeling, principal payments on existing debt, and the second phase of the renewal project.

Mr. Hart reported the CUHCC project has been delayed because the architectural estimate exceeded the $1.5 M that was budgeted for the project. Non-hospital sources of funds are now being investigated in order to complete the project. The Committee will be kept fully informed of the status of this project.

Capital Budget

Mr. Hart presented to the Committee the 1989-90 Capital Budget of $8,300,000. The $8,300,000 would come from current year operating cash flow. Of the $8,300,000, $6,700,000 would be for the purchasing of equipment, $115,000 for equipment installation, and $1,400,000 for remodeling. Because of the financial uncertainty in the coming year, Mr. Hart stated even though the Board will have approved the $8,300,000, the departments will not be authorized to spend all of the funds given to them at one time. The departments will be authorized to spend 25% of their allotted amount per quarter. Review of the Hosptial's financial situation will periodically be taken and, if it is felt necessary, the remaining amount of unspent capital funds, at the time of the review will be designated to other areas of the Hospital.

QUARTERLY CAPITAL EXPENDITURE REPORT:

Mr. Hart presented to the Committee the Quarterly Capital Expenditure Report for information only.

Mr. Hart reported the capital expenditure year-to-date was $4,500,000. Comparing that amount to the seasonalized budget, the Hospital has underspent the capital budget by $1,300,000. Mr. Hart informed the Committee that within the next two months the items that have been budgeted but not purchased will be reviewed and one of two things will occur. At that time it will be decided if the item will be rollforward to the the next year, or it was no longer necessary to purchase and the funds will go back into the reserves.

MAJOR CAPITAL EXPENDITURES:

Mr. Al Dees reviewed, for information purposes, a major capital expenditure report in the $100,000 - $600,000 range. The major capital expenditure would be for a one year continuation of the lease on a CT Scanner. Mr. Dees stated that because of priority of other equipment needs and the

desire to further evaluate CT machines in the marketplace, it was decided to to extend the lease on the existing CT machine rather than purchase a new one at this time.

MRI FINANCING:

Mr. Fearing reported to the Committee, for information, the refinancing of the second MRI. It was been brought before the Committee at an earlier date to purchase a second MRI for $2,192,000. After the recommendation was made the Hospital was approached by Comdisco, a medical equipment resale company. Comdisco's assistance in purchasing the MRI would guarantee an up front salvage value of $348,000 to the Hospital. This would bring the purchase price for the Hospital to $1,988,000. The depreciation and interest rate return from Medicare and Medicaid would be approximately $540,000 over the life of the item. Therefore, the net cost of the MRI through Comdisco would be $1,430,000, which would be at a minimum $60,000-70,000 less than what the Hospital had originally intended on spending.

There being no further discussion, the May 24, 1989 meeting was adjourned at 1:25 p.m.

Respectfully submitted,

Teri Holberg

Teri Holberg
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 28, 1989

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1988 through May 31, 1989**

The Hospital's operations through the month of May continue to reflect both inpatient admissions and outpatient visit activity that are above budgeted levels although the month of May saw a slight decline in inpatient census levels. Both ancillary and routine revenue are above budgeted levels for the month of May and year-to-date.

INPATIENT CENSUS: For the month of May, inpatient admissions totaled 1,619, which was 12 below budgeted admissions of 1,631. Our overall average length of stay for the month was 8.0 days. Patient days for May totaled 12,908 and were 342 days over budget. The decrease in admission levels from budget was primarily in the areas of Cardiovascular Surgery, Gynecology, and Ophthalmology.

To recap our year-to-date inpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Admissions	17,551	17,042	17,262	220	1.3
Patient Days	141,041	131,541	146,080	14,539	11.1
Avg Length of Stay	8.0	7.7	8.4	0.7	9.1
Avg Daily Census	419.8	392.7	436.1	43.4	11.1
Percent Occupancy	72.5	68.1	74.9	6.8	10.0

OUTPATIENT CENSUS: Clinic visits for the month of May totaled 24,683 which was 1,850, or 8.1%, over budgeted visits of 22,833. Areas in which actual visits were over budget included Diabetes Center, Dermatology, Orthopedics, Masonic Day Hospital and Family Practice. The increases were offset by decreases in OB/GYN, Medicine and Ophthalmology. Community University Health Care Center (CUHCC) visits for the month of May totaled 4,531, which was 166, or 3.8%, over budgeted visits of 4,365, while Home Health visits of 1,097 for the month were 282, or 34.6%, above budgeted visits of 815.

To recap our year-to-date outpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Clinic Visits	240,322	242,018	247,750	5,732	2.4
CUHCC Visits	44,118	45,635	43,850	(1,785)	(3.9)
HHA Visits	8,643	8,811	11,156	2,345	26.6

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses exceeding revenues by $1,400,714, an unfavorable variance of $4,168,434.

Patient care charges through May totaled $284,017,131, which was 10.7% over budget. Routine revenue was 14.2% over budget and reflects our year-to-date favorable patient day variance.

Ancillary revenue was $17,969,433 above budget (9.4%) and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $8,870 per admission compared to the budgeted average of $7,982 per admission. Outpatient revenue per clinic visit has averaged $224 compared to the budgeted average of $225.

Operating expenditures through May totaled $248,267,553 and were $11,275,880 (4.8%) over budgeted levels of $236,991,673. The overall unfavorable variance relates primarily to the increased demand for patient services, and is reflected in higher personnel costs and patient care supplies (blood and medical supplies and services).

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of May 31, 1989, totaled $88,940,078 and represented 99.4 days of revenue outstanding. The overall decrease in our patient receivables in May of 3.3 days occurred primarily in Commercial Insurance and Medicare.

CONCLUSION: The Hospital's overall operating position for the month of May is negative. This is the second consecutive month we have reported an operating loss, much of it due to significant increases in deductions from charges. We have seen an improvement in our operating expense position and continue to monitor and adjust our level of activity as appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1988 TO MAY 31, 1989

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$256,649,683	$284,017,131	$27,367,448	10.7%
Deductions from Charges	44,387,613	65,652,112	21,264,499	47.9%
Other Operating Revenue	7,931,585	8,715,455	783,870	9.9%
Total Operating Revenue	220,193,655	227,080,474	6,886,819	3.1%
Total Expenditures	236,991,673	248,267,553	11,275,880	4.8%
Net Operating Revenue	(16,798,018)	(21,187,079)	(4,389,061)	-26.1%
Non-Operating Revenue and Expenses	19,565,739	21,405,805	1,840,066	9.4%
Revenue Over/Under Expense	2,767,721	218,726	(2,548,995)	
Prior Year BC/BS Adjustment		(1,619,440)	(1,619,440)	
Adjusted Revenue Over/Under Expense	$2,767,721	($1,400,714)	($4,168,435)	

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Admissions	17,042	17,262	220	1.3%
Patient Days	131,541	146,080	14,539	11.1%
Average Daily Census	392.7	436.1	43.4	11.1%
Average Length of Stay	7.7	8.4	0.7	9.1%
Percentage Occupancy	68.1	74.9	6.8	10.0%
Outpatient Clinic Visits	242,018	247,750	5,732	2.4%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

June 19, 1989

TO: Members, Finance Committee
Members, Board of Governors

FROM: Robert Dickler RD
General Director

SUBJECT: 1989-90 Employee Compensation Plan

We are requesting Board of Governors approval of the 1989-90 employee compensation plan this month, consistent with the Board approved Hospital Personnel Policies. As we have discussed in the past several months, this has been a somewhat difficult year to project in terms of employee compensation, given the community nursing negotiations, changing supply and demand relationships for a number of health professional classifications, and the still outstanding union negotiations with the AFSCME and Teamster bargaining units within the University.

The budget which the Board of Governors approved last month made certain assumptions about increases in employee compensation for next fiscal year. The recommendations we are presenting are within the salary expenditure levels projected in the 1989-90 budget.

As you are aware, the Board of Governors' approval of employee compensation matters relates to "Hospital-dominated classes" (primarily health professional, technical, and supervisory classifications), while the compensation plans for Hospital employees in "University-dominated classes" (e.g. secretarial staff, data processing staff) are determined by the University.

Compensation plans for employees in bargaining units represented by unions (AFSCME and Teamsters) are, of course, determined through the collective bargaining process. Union negotiations are underway with both bargaining units. Although the union contracts expire on June 30th, it is unlikely that the economic portion of the negotiations will be concluded until mid July or sometime thereafter. We will provide the Board of Governors with additional information on the tentative economic outcome of the union negotiations as such information becomes available.

The Finance Committee and Board of Governors discussed pay equity (comparable worth) earlier this year. The original Board approved four year pay equity plan concludes in June of this year. Consistent with the Board's earlier discussion, pay equity continues as an element of the compensation plan for 1989-90. This will keep us on the same schedule as the University for completion of pay equity in 1990-91.

With the above background information, the following recommendations for the 1989-90 compensation plan for non-student, non-unionized employees in Hospital-dominated classes are presented, with a recommended effective date of July 1, 1989:

1. A 4% general increase consisting of a 2% change in salary ranges and a 2% progression increase, i.e., movement through the salary range. For employee classes whose progression increases have traditionally been on a "step" basis to match the community (e.g., radiologic technologists), the "step" plan will continue to be used, rather than the above 2% progression increase. The total cost of these increases is $981,738.

2. Pay equity increases for classes eligible for such adjustments, continuing the previously approved plan, representing a $168,700 commitment.

3. Increases for registered nurse-related classes consistent with the recent community nursing contract settlement. These increases involve changes in salary ranges, progression increases, and increases in other areas of compensation such as shift differential and charge pay. Baccalaureate level nurses at UMHC will received $25 per month more than those in the community as part of this recommendation. Pay equity for nursing staff is achieved within this overall compensation package. The total cost of these increases is $4,611,202.

4. Additional marketplace increases, primarily for health professionals, where marketplace data or recruitment/retention issues evidence the need for such adjustments. These increases will be accomplished within the overall budget. The Hospital's financial position during the year, as well as market conditions, will be a consideration relative to actual implementation of these increases.

The University has not yet finalized its compensation plan for Civil Service employees. Compensation increases for Hospital employees in University-dominated classes will be set by the University when the Civil Service pay plan is finalized.

As noted earlier, we will report back to the Board relative to the status and outcomes of union negotiations. If we believe adjustments to the above plan are needed based upon union contract settlements, we will make recommendations to the Board accordingly.

We are recommending Board of Governors approval of the four components of the pay plan as outlined above. We look forward to answering any questions you may have at next week's meetings.

/th