THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JANUARY 24, 1990

TABLE OF CONTENTS

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

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
JANUARY 24, 1990
2:30 P.M.
555 DIEHL HALL

AGENDA

I.	Approval of the December 20, 1989 Minutes	Approval
II.	Chairman's Report	Information
	-Mr. Robert Nickoloff	
III.	Hospital Director's Report	Information
	-Mr. Robert Dickler	
IV.	Special Presentation: Dr. James Q. Swift	Information
	-Clinical Chief of Dentistry Services Assistant Professor and Director of Graduate Students in Oral and Maxillofacial Surgery	
V.	Committee Reports	
	A. Joint Conference Committee	
	-Mr. George Heenan	
	1. The Joint Conference Committee did not meet	
	B. Planning and Development	
	-Ms. B. Kristine Johnson	
	1. CUHCC Facility Project	Endorsement
	2. CT Scanner	Information
	3. ICU Information System	Information
	4. CHC Waste Disposal Project	Information

C. Finance Committee

-Mr. Jerry Meilahn

1. December 31, 1989 Financial Statements	Information
2. Hospital Admissions Policies	Information
3. Second Quarter, 1989-90 Bad Debts	Endorsement

D. Bylaws Committee Report

- Ms. B. Kristine Johnson	Endorsement

VI. Other Business

VII. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

December 20, 1989

Call To Order

Mr. Robert Nickoloff called the December 20, 1989 meeting of the Board of Governors to order at 2:45 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
Jerry Meilahn
Robert Maxwell, M.D.
Robert Nickoloff
Cherie Perlmutter

Not Present: Barbara O'Grady

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the November 15, 1989 meeting as submitted.

Special Presentation: Roberto C. Heros, M.D.

Mr. Robert Dickler introduced the Board to Dr. Roberto C. Heros, Professor and Chairman of Neurosurgery. Dr. Heros received his medical education from the University of Tennessee and his post graduate education from Massachusetts General Hospital, Boston. Dr. Heros presented to the Board an overview of the Department of Neurosurgery along with goals and objectives for the department.

Chairman's Report

Mr. Nickoloff notified the Board of an invitation from the Board of Regents to a luncheon on January 11, 1990. The Board is encouraged to attend.

Mr. Nickoloff encouraged the Board to attend the Holiday Party immediately following the Board meeting in the Dale Shepard Room at the Campus Club.

Mr. Nickoloff called attention to an article from Corporate Report, distributed at the meeting, featuring Vice Chair Kris Johnson.

Mr. Nickoloff than called on Mr. George Heenan who presented Mr. David Link, Board of Governors student representative, with a plaque recognizing his participation as a member of the Board of Governors and of the Joint Conference Committee.

Hospital Director's Report

Mr. Dickler informed the Board of the Council of Hospital Corporations discussions with Twin City Hospitals regarding cost effective management of waste disposal. An incinerator built and operated by a consortium of hospitals is being considered.

Mr. Dickler updated the Board in regards to the Renewal Project. An alternative plan to the original "J" vertical expansion and Mayo renovation plan is being discussed.

Mr. Dickler informed the Board that committees are being formed to continue work on the identified areas derived from the Board of Governors Retreat. Results will be brought back to the Board for discussion.

Mr. Dickler reported that the Timberwolves visited patients at the Hospital on December 14, 1989.

Joint Conference Committee Report

Mr. George Heenan reported to the Board that significant progress has been made towards meeting the Joint Commission requirements for quality monitoring in clinical departments. A fourth quarter 1990 Joint Commission visit is anticipated.

Dr. Robert Maxwell presented the recommendations of the Credentials Committee which were endorsed by the Medical Staff-Hospital Council on November 14 and the Joint Conference Committee on December 13. The recommendations of the Credentials Committee were unanimously endorsed as presented.

Dr. Maxwell presented the Joint Conference Committee's recommendation to approve the appointment of Dr. James Q. Swift as Clinical Chief of Dentistry Services. The Board of Governors seconded and passed a motion approving the appointment of Dr. Swift.

Mr. Heenan reported on the patient satisfaction survey which is administered to patients discharged from UMHC. The survey attempts to uncover both patient-specific concerns and system-wide issues. Staff continues to score highly on the survey and 99 percent of the patients indicated they would recommend UMHC to friends and relatives.

Planning and Development Committee Report

Ms. Kris Johnson called on Mr. Greg Hart for the Renewal Project Update. Mr. Hart presented Option C which would require demolition of part of the Mayo Building and a 9-story tower built on that site. Although the physical facility plan is markedly different under this newer option, both options would be funded entirely from University Hospital cash reserves and operating cash flow. The alternative option under consideration generally retains the same programmatic objectives, budgeted expenditure levels and financing plan originally set forth. The Renewal Project will be brought to the Board of Governors in February or March for review and approval.

Mr. Hart called on Ms. Mary Ellen Wells to present the CUHCC Project to the Board. In February of 1988 the Board of Governors approved the purchase of land and building project for replacement of the CUHCC facility. The project was originally approved at a cost not to exceed $1,500,000; 1,350,000 of hospital reserve funding was committed. As the project proceeded, it became apparent that the project had been greatly underestimated. Ms. Wells explained the difference between the previous and current project cost estimates. The new cost of the project is estimated to be $2.35 million. Several options for funding the project are being evaluated. More information will be brought back to the January Board meeting.

Mr. Hart reviewed the capital expenditure report included in the packet. Less than 10 percent of the capital budget was expended in the 1st quarter of the fiscal year.

Finance Committee Report

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the financial report. Mr. Fearing reported the Hospital's Statement of Operations for the first four months of the 1989-90 fiscal year showed revenue over expenses by $4,170,623, a favorable variance of $1,340,436.

Mr. Fearing reported inpatient admissions totaled 1,493, which was 3 below budgeted admissions of 1,496. Overall average length of stay for the month was 8.5 days. Outpatient Clinic visits for the month of November totaled 21,746 which was 168 or 0.8 percent above budgeted visits of 21,578.

Mr. Meilahn presented a recommendation by Deloitte & Touche for UMHC to continue to support UMCA at the 1988-89 level, adjusted for position vacancies for the 1989-90 UMCA fiscal year. The proposed Hospital contribution for the period December 1, 1989 - November 30, 1990 was $136,152. The Board of Governors seconded and passed a motion approving support of UMCA.

Bylaws Committee Report

Ms. Johnson presented a complete set of final recommendations from the Bylaws Committee to the Board. Following some discussion, it was decided to bring the recommendations back to the Board for endorsement at the January 24, 1990 meeting.

Adjournment

There being no further business, the December 20, 1989 meeting of the Board of Governors was adjourned at 4:30 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

CURRICULUM VITAE

James Q. Swift, D.D.S.

BIRTHDATE:	October 12, 1953
BIRTHPLACE:	Manchester, Iowa
RESIDENCE:	4725 Isabel Avenue Minneapolis, Minnesota 55406 (612) 722-8824
OFFICE:	Division of Oral and Maxillofacial Surgery Department of Diagnostic & Surgical Sciences University of Minnesota School of Dentistry 7-174 Moos Health Science Tower 515 Delaware Street S.E. Minneapolis, MN 55455-0329 (612) 624-7937

HIGHER EDUCATION

1981-1985	Certificate: Division of Oral and Maxillofacial Surgery, Department of Surgery, University of Oklahoma College of Medicine, Oklahoma City, OK
1980-1981	Certificate: General Practice Residency, Oklahoma Children's Memorial Hospital, Oklahoma City, OK
1976-1980	D.D.S. Degree: University of Iowa College of Dentistry, Iowa City, IA
1972-1976	BA Degree: Cornell College, Cum Laude, Mt. Vernon, IA.

LICENSING BOARDS

1989	State of Minnesota Dental License #D-10436
1988	State of Florida Dental License #DN0011710
1987	Diplomate, American Board of Oral and Maxillofacial Surgery
1986	State of Oklahoma, General Anesthesia Permit #55
1985	State of Oklahoma Specialty Board, Oral and Maxillofacial Surgery, Licence #84
1980	State of Oklahoma, Dental License #4186
1980	Central Regional Dental Board

CURRENT APPOINTMENTS

1989-Present	Assistant Professor Division of Oral and Maxillofacial Surgery Department of Diagnostic & Surgical Sciences University of Minnesota School of Dentistry Minneapolis, MN
1989-Present	Director Graduate Training Program, Division of Oral and Maxillofacial Surgery Department of Diagnostic & Surgical Sciences University of Minnesota School of Dentistry Minneapolis, MN
1989-Present	Acting Head Division of Oral and Maxillofacial Surgery Department of Diagnostic & Surgical Sciences University of Minnesota School of Dentistry Minneapolis, MN
1989-Present	Clinical Chief, Department of Dentistry University of Minnesota Hospital and Clinic Minneapolis, MN
1989-Present	Consultant Cleft Palate and Maxillofacial Clinic University of Minnesota School of Dentistry Minneapolis, MN

PAST APPOINTMENTS

1988-1989	Consultant, Cleft Palate Clinic, Keyes Speech and Hearing Center, University of Oklahoma, Oklahoma City, OK
1985-1989	Assistant Professor Department of Oral and Maxillofacial Surgery, University of Oklahoma College of Dentistry, Oklahoma City, OK
1985-1989	Clinical Assistant Professor Division of Oral and Maxillofacial Surgery, University of Oklahoma College of Medicine, Oklahoma City, OK
1986-1989	Member, Graduate Faculty University of Oklahoma Health Sciences Center Oklahoma City, OK
1985-1989	Consultant, Oral/Maxillofacial Surgery Veteran's Administration Medical Center, Oklahoma City, OK
1986-1989	Director of Anesthesia and Pain Control University of Oklahoma College of Dentistry, Oklahoma City, OK

1985-1989	Lecturer, General Practice Residency Program Oklahoma Children's Memorial Hospital, Oklahoma City, OK
1984-1985	Chief Resident Division of Oral and Maxillofacial Surgery, Department of Surgery, University of Oklahoma, Oklahoma City, OK

HOSPITAL COMMITTEES

1989-Present	Council of Chiefs of Clinical Services University of Minnesota Hospital and Clinic Minneapolis, MN
1989-Present	Operating Room Committee University of Minnesota Hospital and Clinic Minneapolis, MN

UNIVERSITY COMMITTEES

1989-Present	Advanced Education in Dentistry Advisory Committee University of Minnesota School of Dentistry, Minneaplis, MN
1989-Present	Member, Implant Team University of Minnesota School of Dentistry, Minneapolis, MN
1989	Search Committee, Director of Oral Radiology University of Oklahoma College of Dentistry, Oklahoma City, OK
1988-1989	Search Committee, Associate Dean of Clinical Affairs University of Oklahoma College of Dentistry, Oklahoma City, OK
1987	Search Committee, Dean University of Oklahoma College of Dentistry, Oklahoma City, OK
1987-1989	Appeals Board University of Oklahoma College of Dentistry, Oklahoma City, OK
1985-1989	Research Committee University of Oklahoma College of Dentistry, Oklahoma City, OK
1985-1989	Clinic Policies Committee University of Oklahoma College of Dentistry, Oklahoma City, OK
1985-1989	Continuing Education Committee University of Oklahoma College of Dentistry, Oklahoma City, OK
1985-1989	Periodic Review/Promotions Committee University of Oklahoma College of Dentistry, Oklahoma City, OK

PRESENT HOSPITAL STAFF APPOINTMENTS

1989-Present	Hennepin County Medical Center 701 Park Avenue South, Minneapolis, MN
1989-Present	University of Minnesota Hospitals and Clinics 500 Harvard Street S.E., Minneapolis, MN

PAST HOSPITAL STAFF APPOINTMENTS

1987-1989	Mercy Health Center 4300 W. Memorial Rd., Oklahoma City, OK
1986-1989	Presbyterian Hospital N.E. 13th and Lincoln, Oklahoma City, OK
1985-1989	Oklahoma Memorial Hospital 800 N.E. 13th, Oklahoma City, OK
1985-1989	Oklahoma Children's Memorial Hospital 940 N.E. 13th Street, Oklahoma City, OK
1985-1989	Veteran's Administration Medical Center 921 N.E. 13th Street, Oklahoma City, OK
1985-1989	O'Donoghue Rehabilitation Institute 1122 N.E. 13th Street, Oklahoma City, OK

COMMUNITY SERVICE

1988-1989	Member, Board of Directors, Oklahoma County Chapter, American Red Cross
1988-1989	Member, Strategic Planning Committee, Oklahoma County Chapter, American Red Cross
1988-1989	Faculty Lecture Series, University of Oklahoma College of Dentistry, Oklahoma City, OK
1987-1989	Donated Dental Services Program, Oklahoma Foundation of Dentistry for the Handicapped, Oklahoma City, OK
1987-Present	Health Volunteers Overseas, Oral and Maxillofacial Surgery Division.
1986-1989	Chairman Medical Advisory Committee, American Red Cross Tissue Bank, Oklahoma County Chapter, American Red Cross, Oklahoma City, OK
1986-1989	Member, Tissue Bank Committee, American Red Cross Tissue Bank, Oklahoma County Chapter, American Red Cross, Oklahoma City, OK

PROFESSIONAL ORGANIZATIONS

1989-Present	Minneapolis District Dental Society
1989-Present	Minnesota Dental Association
1987-Present	Fellow, American Association of Oral and Maxillofacial Surgeons
1987-Present	American Cleft Palate Association
1987-Present	American Trauma Society
1987-Present	American Society of Dental Anesthesiologists
1986-Present	Society of Educators of Oral/Maxillofacial Surgery
1985-1989	Oklahoma County Dental Society
1985-1989	Oklahoma Dental Association
1985-Present	American Dental Association
1986-Present	Southwest Society of Oral and Maxillofacial Surgeons
1985-Present	Oklahoma Society of Oral and Maxillofacial Surgeons

CERTIFICATIONS

1988-Present	Arthroscopy American Association of Oral & Maxillofacial Surgeons
1987-Present	Provider Advanced Trauma Life Support American College of Surgeons (In conjunction with AAOMS)
1987-Present	IMZ Implant/Surgical Course University of North Carolina, Research Triangle Park, NC
1986-Present	Instructor Advanced Cardiac Life Support, American Heart Association Oklahoma County Affiliate, Oklahoma City, OK
1986	CO_2 Lasers in Oral/Maxillofacial Surgery Northwestern University, Chicago, IL

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 18, 1990

TO: Members, Board of Governors

FROM: Robert Dickler

REGARDING: Community University Health Care Center (CUHCC)

Last month we presented information to you regarding the CUHCC facility project. We are now requesting your endorsement of the changes in this project.

In February 1988 the Board of Governors approved the continuation of the CUHCC program and the purchase of land and a building project for the replacement of the CUHCC facility. The project was approved at a cost not to exceed $1,500,000, with $1,350,000 of hospital reserve funds committed. The remaining balance of $150,000 was to be funded by the City of Minneapolis.

During the facility design process, it became apparent that the amount budgeted was substantially underestimated. As a result, we have spent the past year carefully scrutinizing the budget and exploring alternatives to minimize any further capital commitment for the Hospital. We have concluded that the project should continue and we have identified a number of sources for the additional funds that would be needed to complete the project. These include using some of the proceeds of the pledge from the Variety Club.

Since the December Board of Governors meeting, we have contacted Health One, the owners of Mt. Sinai, to discuss the possibility of moving CUHCC there. They are still negotiating with the Minneapolis Public Schools and are uncertain whether space will be available. We will continue to explore this option with Health One, but do not want to delay the current plans only to find Mt. Sinai not feasible in a few months. Therefore, if approved, we will continue to design the new facility, but will not sign any contracts without further evaluation of the Mt.Sinai option.

We recommend your endorsement of the project increase to $2,350,000. Since the recommendation involves an increase in the budget in excess of the Regents' threshhold, it will also be presented to the Board of Regents for their approval.

Attached is a summary of the budget dilemma, alternatives that were explored, and the financing plan that we have developed. We look forward to discussing this with you next week. Thank you.

Attachment

Community University Health Care Center
Facility Replacement Project

Project Background

The Community University Health Care Center (CUHCC) is UMHC's neighborhood-based clinic located on 16th Avenue near Franklin in south Minneapolis. It began in 1966 as a five year demonstration project to provide multi-disciplinary pediatric health care to children of low-income families and expanded over the years to include adult medical care and dental and mental health services. Through the unique prepaid program, CUHCC, the Hospital, and the medical staff contribute over $500,000 each year in charity care.

In February, 1988, recognizing the need for a new, larger facility, the UMHC Board of Governors endorsed the purchase of land and the construction of a new facility for CUHCC at a cost of $1,500,000. The City of Minneapolis committed $150,000 to support the project, and the Hospital committed up to $1,350,000 from its reserve funds.

Upon approval, the land at Franklin and Bloomington was purchased, an architect was chosen, and preliminary plans were developed. Based on these plans, a revised construction budget was completed in December 1988. This budget identifies a much larger project cost now totaling $2,350,000, which is $850,000 greater than the approved budget.

Following is an explanation of the original inaccurate estimate, information on the current estimate, alternatives that were explored, potential sources for the funding the outstanding balance, and a recommended plan of action.

Original Project Estimate

The original project estimate for the land and a building located adjacent to the current CUHCC facility was $1,500,000. This estimate was based on information obtained from a consulting architect and later supported by the architect who was chosen to complete the project. However, as the project progressed, a number of unanticipated items surfaced:

1) Many University construction requirements were not included in the architect's estimate so the general, mechanical and electrical requirements were miscalculated. These requirements were examined to see if any reductions could be achieved, and it was determined that they were appropriate. The University has set standards for energy conservation and building life expectancy that are above community standards, yet reasonalbe when considering the ongoing maintenance and operational efficiencies that are achieved. Examples include using dual light switches that allow half of a room's lights to be turned off; roofing material and HVAC equipment that will last 20-25 years instead of 10 years; and wiring cable trays rather than just laying the wires in the ceiling so that future electrical work can be done more efficiently.

2) The City would not allow one of the alleys to be vacated. As a result, the neighboring grocery store would have to be demolished to meet parking requirements.

3) Since many non-building estimates are determined as a percentage of the building estimate, these costs have increased proportionately.

4) Non-building estimates such as telephones, furniture and moveable equipment, and contingencies were greater than originally anticipated.

5) A 5% increase has been included for inflation for the total project.

As the above factors indicate, programmatic changes are not the cause of the higher project cost. The only programmatic change involves a $30,000 patient/staff/community education room.

Attachment I provides a detailed breakdown of the cost implication of these changes through a comparison between the original and revised estimates.

Revised Estimate

When it became apparent that there were discrepancies in the budget, the Hospital asked two independent contractors who have worked with the Unive in the past to provide nonbinding estimates for the project. They worked closely with the architect and with the Hospital Facilities Office to develop their recommendations. The conclusion, after careful study, was that the project would cost $2,350,000.

Alternatives

During the past 10 months, Hospital Administration has explored a number of alternatives to solve the budget dilemma. The first option was to stay within the budgeted amount of $1,500,000. If this option is chosen, the building would need to be scaled down to approximately 9,000 square feet. This is 40-45% less than what the space consultants indicated would be needed to minimally meet program requirements. By comparison, the current CUHCC facility is approximately 10,000 square feet, and space is extremely limited. Therefore, activity levels would need to be reduced by approximately 30% if a building is constructed within the approved budget.

The building size could be reduced by 2,000 square feet and still meet the program's basic, immediate needs. The community room (1,000 s.f.) could be eliminated and an additional 1,000 square feet could be removed by eliminating some office space, a dental operatory, two exam rooms, and waiting areas. This would reduce the project costs by approximately $150,000, however, this would eliminate any potential program development and growth.

Since Mt. Sinai recently closed, and there appears to be space available there, this option was again explored. Health One, the owner of Mt. Sinai, is currently negotiating with the Minneapolis Public Schools and is not prepared to discuss the possibilities yet. We will continue to pursue this option as we plan the new facility so we do not delay the project any further. Also, City officials were contacted, and they are unwilling to make any further commitments.

The preferred alternative, therefore, is to continue with the project, recognizing the increased capital expense, and identify potential alternative funding options so that any additional use of Hospital reserves beyond the $1,350,000 would not be necessary.

Financial Plan

Based on the assumption that the project would need to have full funding identified before the Board of Governors could act favorably on the increased costs, Hospital Administration explored a number of alternatives during the past few months. As a result, a number of sources have been identified, and additional funds totaling $850,000 have been identified and other opportunities continue to be pursued.

The Variety Club of the Northwest has become an enthusiastic supporter of CUHCC over the past two years. They have made a number of contributions toward clinic operations, and the Variety Club Advisory Committee will soon receive a proposal to commit $800,000 (over a four year period) of their overall pledge to the University toward the increased costs of the CUHCC facility. This commitment should be finalized by the end of the year. Additionally, the Honeywell Foundation has committed $50,000.

CUHCC has been designated by the University Foundation as the University's project that can apply for a Kresge Challenge Grant. A recent meeting with Kresge officials was held and their initial reaction to the program is positive. A proposal to Kresge will be submitted with a target goal that will be determined during the next month. Additional contributions are also being sought. Attachment II summarizes the sources of funds available.

Recommendation

Given the Board of Governors' support for CUHCC and its special mission and that funding is in hand to cover the overage, the Hospital should continue the CUHCC facility project at the revised figure of $2,350,000. Further sources of funding will be pursued, and if funds are raised in excess of the identified shortfall, or if the project is completed under the revised budget, the Hospital's use of reserve funds of $1,350,000 would be reduced accordingly.

Attachment I
CUHCC Facility Project Costs
Original vs Revised Estimates

Item	Original Estimate		Revised Estimate	
Land Acquisition		$300,000		$300,000
Building Costs				
General	592,184		751,800	
Mechanical	166,140		331,800	
Electrical	79,740		120,750	
Demolition of CUHCC	40,000		40,000	
Misc and Contingencies	99,157		145,200	
Sub-Total		977,221		1,389,550
Non-Building Costs				
Sitework	40,300[1]		95,000[2]	
Furnishings & Equipment	15,000[1]		179,470[2]	
Consultant's Fee	74,978		104,300	
Demolition of Grocery Store	0		35,000	
Contingencies	28,117		80,200	
Telephone System	8,000		100,000[3]	
Miscellaneous	56,384		66,480	
Sub-Total		222,779		660,450
Total Project Cost		**$1,500,000**		**$2,350,000**

1) This assumed the use of $60,000 in funds made available from the sale of the Grocery store equipment. However, the equipment has not been sold to date.

2) This includes $30,000 for medical record files and $38,000 for 3 dental operatories that were not originally anticipated.

3) It is anticipated that this figure will be reduced. Alternative telephone systems are being explored.

Attachment II
CUHCC Facility Project
Sources of Funding

Sources	Original Estimate	Revised Estimate
Hospital Reserves	$1,350,000	$1,350,000
City of Minneapolis	150,000	150,000
Variety Club Pledge	---	800,000
Honeywell Foundation	---	50,000
Total Sources	**$1,500,000**	**$2,350,000**

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 11, 1990

MEMO

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

RE: CT Scanner Replacement

UMHC acquired the oldest of its three CT Scanners in 1984. To enable the Diagnostic Radiology Department to continue to provide state-of-the-art CT imaging services and to handle the volume of procedures ordered on a timely basis, we are proposing to replace this scanner.

The proposal will be presented to the Planning and Development Committee, the Finance Committee and the Board for information during the January meetings and for approval during February.

GH/ad

attachment

PROPOSAL FOR CT SCANNER REPLACEMENT
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

INTRODUCTION

The University of Minnesota Hospital and Clinic (UMHC) installed the oldest of its three CT scanners in 1984. Based on the results of an analysis of financing alternatives completed at that time, the unit was acquired through a five year, operating lease. In April 1989, the decision was made to extend the lease for an additional one year period. The lease will now expire on April 30, 1990.

PROPOSAL

Acquire a new CT scanner to replace the Siemens DR3 scanner originally leased and installed in 1984.

RATIONALE

A. Providing timely service for the volume of CT scans being ordered requires operation of three, state-of-the-art scanners.

Annual increases in the total volume of CT scans performed have continued during the past three fiscal years:

	NO. PROCEDURES	% CHANGE
1985-86	8783	--
1986-87	9728	10.8%
1987-88	10008	2.9%
1988-89	10435	4.3%

Annualization of the volume from the first five months of the current fiscal year indicates that the total for the year may fall back to the 1987-88 level. If this occurs, it will be the first year since CT was introduced at UMHC that an increase over the prior year is not experienced.

The increased availability and usage of Magnetic Resonance Imaging (MRI) has had a negative impact on the volume of head and spine scans ordered. The volume fell from a peak of 5220 in 1986-87 to 4507 in 1988-89. However, the increase in body CT scans, from 4300 in 1986-87 to 5657 in 1989-90, has more than offset the head and spine decline. In addition, Roberto Heros, M.D. and Richard Price, M.D., chairpersons of Neurosurgery and Neurology, project that the demand for head and spine scans will plateau or increase again during the next several years as they work to increase the caseloads in their departments and as the relative strengths of CT versus MRI scans for certain types of imaging become better defined.

The trends in CT usage at UMHC are similar to those being experienced elsewhere. In August 1988, the journal Diagnostic Imaging contained a

report on the survey of ten community hospitals of 300 to 600 beds and six university hospitals. All reported increases ranging from 3 to 25% from the prior year.

B. The Siemens DR3 scanner does not have the following state-of-the-art features and capabilities:
   1. Bore size large enough to enable utilization for interventional procedures such as biopsies or drainage procedures.

   2. High and low contrast spatial resolution factors which produce higher quality images and enable detection of smaller lesions.

   3. High scanning and image reconstruction speeds which decrease procedure times and provide capability for scanning more patients. UMHC is currently not able to fulfill all demands for same day scanning of clinic patients who live outside the metropolitan area.

   4. 3D image reconstruction to enable usage for measuring volumes of tumor masses.

   5. Very high speed scanning enabling capture of multiple images while the patient holds his/her breath which improves the accuracy of volume measurements of tumor masses.

ESTIMATED COST

CT Scanner	$1,200,000
Installation and Control Room Remodeling	17,000
TOTAL	$1,217,000

FINANCING

Several financing alternatives are available: lease through the vendor or a third party, borrow from the University's equipment loan fund or a commercial vendor, or purchase with UMHC reserve funds. The alternative used will be the one which is determined to be the least costly at the time the acquisition contracts are written.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 17, 1990

TO: Members, Board of Governors

FROM: Robert Dickler

SUBJECT: Council of Hospital Corporations Medical Waste Incinerator Project

In the last few months the Hospital has been investigating the advisability of a Council of Hospital Corporations (CHC) proposal to build and operate a medical waste incinerator. The proposal calls for the formation of a corporation consisting of interested CHC hospitals for the purpose of jointly researching, planning, constructing and operating a medical waste incinerator in or near the Minneapolis/St. Paul metro area.

CHC has retained a consulting firm to research the feasibility of the concept and prepare a business entry plan. The attached Executive Summary broadly outlines the findings to date. If successful, the Hospital would be sharing the expense, commitment, and benefits of this project with the entire University.

At this time we are presenting this proposal to the Committee for information. We will be requesting endorsement of our intention to fully commit to this project at our February meeting.

Regents approval is also required for this project. Attached for your information is notification to CHC of our intent to seek Regents approval. The Hospital/University commitment of funds at this time is limited to 150% of $71,611 or $107,416. Based on CHC's preliminary estimates the anticipated aggregate capital commitment for the University, if the project were to be brought to fruition, is anticipated to be in the range of $600,000 - $625,000.

We will be discussing this issue in greater detail at our meeting. Please feel free to call me prior to that time if you have questions.

/th

Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 18, 1989

Allan N. Johnson, Ph.D., President
Council of Hospital Corporations
Suite 221 North
2550 University Avenue West
St. Paul, Minnesota 55114

Re: Medical Waste Incineration Project

Dear Mr. Johnson:

In accordance with the Infectious Waste Disposal Business Entry Plan, November 1989 and the November 20, 1989 Council of Hospital Corporations Board discussion, the University of Minnesota hereby signifies its intention to request approval from the Board of Regents for authority to participate in the medical waste incineration project. To signify our intention to seek Board authority to participate, the University of Minnesota hereby agrees to a cash assessment not to exceed 150 percent of $71,611.21, the exact cash assessment being dependent upon the percentage of hospitals participating in the project. Pursuant to the representations of the Council of Hospital Corporations, the cash assessment will be refunded unless hospitals representing more than 75 percent of the biological waste volume agree to participate.

The University of Minnesota is governed by the Data Practices Act, Minnesota Statutes Sec. 13.01 et. seq. and its treatment of data related to the medical waste incineration project will be governed by that statute.

The University of Minnesota agrees that it will not make any new commitments to biological waste disposal entities other than this project until a final decision is made with respect to the feasibility of the project and final decisions regarding operational permits.

bcc: Clifford Fearing
Jan Halverson, Esq.
Gregory Hart
Mark Koenig

Sincerely,

Gordon Donhowe
Vice President
Finance and Operations
University of Minnesota

GD/hg

I. EXECUTIVE SUMMARY

A. Project Incentive

General Management Services (GMS) and the associated firm of Richard, Crisman & Opitz, Inc., as part of their consulting work, have been following the developing legislation and regulations pertaining to the handling and disposal of infectious wastes for over two years. It was thus possible to forecast that the financial impact of complying to the pending regulations would force hospitals to shut down their existing on-site incinerators.

Commercial infectious waste disposal capacity is not available to absorb the infectious waste volumes disposed at on-site hospital incinerators, which is the largest portion of the infectious waste being generated.

It was also evident that a commercial infectious waste disposal organization would be able to, and as is indeed occurring currently, charge disposal costs significantly above those previously paid by hospitals.

The cost of obtaining permitting is sufficiently high to discourage others seeking entry into the infectious waste incineration business once the first party has received a permit. Thus future commercial infectious waste disposal pricing would also be affected only nominally by competition.

B. Project Purpose

In view of the above, the Council of Hospital Corporations contracted with GMS to develop a business entry (action) plan having the following objectives:

1. To maintain hospital control of the costs associated with medical waste disposal.

2. To collectively address this pressing environmental, political and public relations problems in the most effective, efficient and publicly safe manner.

3. To retain the flexibility to respond to the disposal needs of physicians on hospital medical staffs, clinics or other hospitals.

C. GOVERNANCE

A review and evaluation of alternatives with the law firm of Dorsey & Whitney led to the conclusion that a separate Board be formed for this subsidiary consisting of 3 members of the CHC Board, three outside board members and the President of the CHC serving as board chairman. The subsidiary board would need to have decisions affecting hospitals not represented on the board ratified by the CHC board.

The Executive Director of the subsidiary would report to the subsidiary board.

D. CORPORATE STRUCTURE

A for-profit CHC subsidiary was determined to be the structure most suited to meet the project goals after evaluation of several alternatives. Among its advantages is that it is simple to create and is flexible as far as the entities which may use the subsidiaries services.

E. INFECTIOUS WASTE VOLUMES GENERATED

The economics are fairly sensitive to the waste volume to be incinerated. Thus, the amount of infectious waste (as defined at the time) generated by each of the 24 participating hospitals was either weighed or was determined from invoiced received from the commercial disposal company. The resulting amount, annualized for 1989 (8,141,200 pounds) was then adjusted to obtain the equivalent volume after all of the participating hospitals have adopted the new definition for infectious waste legislated in Minnesota on July 1, 1989. The resulting "base" volume of 5,814,800 pounds was used for 1989.

The throughput capacity of the plant and its operating costs are based on this base volume for the 24 participating hospitals only, increasing at 3%/year compounded. The maximum capacity of the plant is 11,800,000 pounds/year. This leaves more than adequate capacity for disposal of the infectious wastes for generators other than the participating 24 hospitals before additional capacity, for which space has been provided, needs to be added.

F. CURRENT DISPOSAL COSTS

The actual current infectious waste disposal costs at each hospital, including packaging and sharps disposal costs were extracted from hospital cost accounting records. This inclusive cost average for the 24 participating hospitals is $0.378/pound.

G. COST IMPACT OF REGULATIONS

Disposal cost increases from $37,800/ year to $264,100/year and added capital investments from $297,000 to $712,000 accompanied by a significant public relations burden are projected for 1990/91 depending on the volumes generated, the current disposal method and when existing disposal contracts expire.

H. PLANT INVESTMENT

The investment required for an infectious waste incineration plant sized for a maximum throughput of 11,000,000 pounds /year was estimated from quotations received for the major equipment incorporating the latest (8/25/98) proposed permanent standards

to become effective on January 1, 1992 for infectious waste incinerators. Rosewood Construction provided the estimate for the site preparation and building costs.

The total financing required is estimated to be as follows:

Capital investment	$3,007,800
Working capital	598,000
Start-up costs	441,000
Total	$4,047,200

I. OPERATING COSTS AND PRO FORMAS

The final income statement, cash flow and balance sheet pro formas prepared by Arthur Andersen Company are in Appendix I-1, pages 61-69. The assumptions are in Appendix H-5 & 6, pages 57-59.

The disposal price which the subsidiary charges to its participating hospitals would be set by the Board of the subsidiary. The price which would generate an annual profit of about $100,000 for the operation is $0.31/pound and if the steam generated is sold, which appears to be a good possibility, the price would be $0.29/pound. This is the total disposal price which includes packaging supplies including sharps packaging, transportation and disposal costs. This compares directly to the average cost of $0.378 paid by the 24 participating hospitals, prior to further cost increases.

This price assumes that 6,376,000 pounds of infectious waste would be incinerated for the 24 hospitals in 1992. If only 5.4 million pounds are incinerated the price without steam credit is $0.35/pound and at 4.4 million pounds it is $0.40/pound without steam credit.

This scenario assumes that all of the investment except that for land and building needs to be replaced in years 7 & 8 at current cost inflating at 5%/year compounded ($3,362,645). It is possible that new technology may generate more regulations following those to be effective in 1992 which could require some additional investment. If the investment required exceeds the cash flow generated, some additional borrowing, backed by price increases, may be needed. It is difficult to visualize that such potential regulations would cause such a catastrophic result.

All other costs in the operating statement and pro formas are at constant dollars.

J. SITING, PERMITTING AND ASH DISPOSAL

An initial survey identified 35 potential sites in Minnesota for the disposal operation all but one of which is within a 60 mile radius of the Twin Cities,

K. INCINERATION TECHNOLOGY

Controlled air, two stage incineration in a fixed hearth incinerator followed by a heat recovery unit to produce steam and a wet scrubber to meet and exceed the proposed permanent standards for infectious waste incinerators published on August 25, 1989 will be used. These formed the basis of the quotation received for the incineration equipment and monitoring devices.

The technology is not new, the controls and monitoring devices and operating conditions all having been commercially available and used for many years. The newness is that infectious waste incinerators installed heretofore have never had to use these more sophisticated process, pollution control and monitoring devices to meet prior, uninforced and less comprehensive standards.

Other technologies for decontamination of infectious wastes exist and all have their niche application. Some, such as autoclaving may in future years capture a small portion of the market created by new generators of infectious waste. It is generally agreed, however, that incineration will continue to be the dominant method used to dispose of infectious waste.

L. FINANCING

Outside financing of the entire $4,047,200 is planned. This financing would be backed by a contract from each participating hospital to commit their infectious waste volume to the CHC subsidiary. In addition, each participating hospital would provide a letter of credit for their portion of the loan, based on volume. The loan would be obtained by the CHC subsidiary. No financing would be sought from the local community nor from any other public agency.

The financing would be obtained in two steps. The initial amount to be financed would be the $565,000 required to obtain the permit. Aportion would be financed via letter of credit, the balance using a line of credit. Financing of the remaining $3,482,200 would take place after the permit has been issued.

M. CHECK POINTS

Three check point have been built in as the project develops.

1. After all hospital contracts and their letters of credit have been received. This is anticipated to occur on or before the end of 1989.

2. During the fifth month after project initiation, using quotations and preliminary approvals received to confirm that the project goals and objectives contained in this report are still on track. This could occur during May, 1990.

3. After the permit has been granted and before final arrangements for the financing of the remaining $3,482,200 are undertaken. This could occur in November/ December 1990.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
December 20, 1989

MINUTES

ATTENDANCE:

Present:	Carol Campbell Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Jerry Meilahn
Not Present:	Elwin Fraley, M.D. Barbara O'Grady Vic Vikmanis
Staff:	Greg Hart Teri Holberg Nancy Janda Mark Koenig Nels Larson Shannon Lorbiecki Barbara Tebbitt Mary Ellen Wells

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on December 20, 1989 at 12:05 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the November 15, 1989 meeting as written.

JULY 1, 1989 THROUGH NOVEMBER 30, 1989 FINANCIALS:

Mr. Clifford P. Fearing reported to the Finance Committee for the month of November inpatient admissions totaled 1,493, which was 3 below budget; average length of stay was 8.5 days; patient days totaled 12,465, which were 346 days below budget; and the average daily census was 415. The first fourteen days of December were reported to have an average daily census of 431. Ancillary revenue was reported to be 6.2% under budget and operating expenditures were reported to 5.1% below budget. Mr. Fearing stated the Hospital's year-to-date Statement of Operations showed revenues over expenses by $3,745,578, a favorable variance of $1,319,003. The month of November had expenses in excess of revenues of $425,045.

Lastly, Mr. Fearing stated as of November 30 the balance of accounts receivable totaled $85,877,722 and represented 96.5 days of revenue outstanding.

YEAR END PROJECTIONS:

Mr. Nels Larson reported to the Committee, for information, the first quarter year end projections. These projections were developed from data taken through November, 1989.

Mr. Larson stated admissions will be .3% under budget, clinic visits will be approximately 2% under budget, and average length of stay will be reduced to 8.0 days, which will result in a decrease in patient days by approximately 4%. Total operating revenue is now projected to be 5.7% under budget, and total expenditures 5.6% under budget. These reductions would result in the net revenue from operations to be 4.1% under budget. In non-operating revenue Mr. Larson stated there will be 12.3% more in interest income on reserves than what was budgeted due to delays in renewal project expenditures and other capital equipment purchases.

Lastly, Mr. Larson noted the total revenue over expense is now projected to be $3,105,636, which is $1,473,636 more than what was originally budgeted.

UMCA 1989-90 SUPPORT:

Mr. Fearing presented to the Finance Committee, for approval, the request for continued support to the University of Minnesota Clinical Associates (UMCA). The Hospital's support to UMCA for the period December 1, 1989 to November 30, 1990 would be $136,152. Mr. Fearing reported the support would be used for UMCA Officers, Executive Director, Medical Director, data processing costs, case management services, and space related costs.

The Finance Committee passed a motion to approve Hospital support to UMCA of $136,152 for the period December 1, 1989 to November 30, 1990.

QUARTERLY CAPITAL BUDGET REPORT:

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

Mr. Hart reported the actual capital expenditures year-to-date was $512,199. Comparing that amount to the seasonilized budget, the Hospital had underspent the capital budget by $112,801. Mr. Hart stated for the first quarter of the fiscal year funds were distributed only on exceptional basis. Mr. Hart also stated for the rest of the fiscal year only one third of the capital budget will be released at each quarter.

RENEWAL PROJECT II UPDATE:

Mr. Hart presented to the Committee a status report on the Renewal Project II. Mr. Hart stated an alternative proposal is now being considered which would consist of the demolition of part of the existing Mayo complex and the construction of a new facility "wing" on the southeast corner of Mayo. With this proposal the two floors to Unit J would not be added and a smaller amount of renovation would be done in the Mayo building. Mr. Hart stated the objectives of the original project would not change with the new proposal. New facilities would still be developed for the four clinical departments, psychiatry, obstetrics, physical medicine and rehabilitation, and urology, the alternative proposal would also stay within the Board approved budget of $62,000,000 and would be financed entirely from University Hospital reserves and operating cash flows.

Mr. Hart stated one of the primary reasons to consider this proposal would be that more money is being invested in new facilities rather than remodeling and upgrading systems in older facilities. The major disadvantage would be that it would take 12-18 months longer to place the major clinical programs in their new locations with the new plan compared to the original.

Mr. Hart concluded by stating it was anticipated that a more specific proposal to this alternative project would be presented to the Board of Governors for information in January or February, and requesting approval in February or March.

CUHCC:

Ms. Mary Ellen Wells presented to the Committee, for information, a status report on the Community University Health Care Center (CUHCC) project. Ms. Wells informed the Committee the new CUHCC facility will now cost $2,350,000 rather than the $1,500,000 that was approved by the Board in February, 1988. Ms. Wells stated the reasons for the $850,000 underestimation were:

1. General, mechanical and electrical requirements were miscalculated because many University requirements were not included in the architect's estimate,

2. A neighboring grocery store would have to be demolished because the City would not allow one of the alleys to be vacated for parking purposes,

3. Non-building estimates, ex: telephones, furniture, were greater than originally anticipated,

4. A 5% increase was included for inflation,

5. Non-building estimates are determined as a percentage of the building estimate, those costs have increased proportionately.

Ms. Wells stated many options were considered, for example staying within the budgeted amount of $1,500,000, or reducing the building size by 2,000 square feet, but it was decided to continue with the original plan and pursue outside sources for the additional funding. Ms. Wells reported funds totalling $850,000 have been identified and opportunities continue to be pursued.

It was reported the Variety Club of the Northwest will contribute $800,000 over a four year period, the Honeywell Foundation will contribute $50,000, $25,000 in cash and the remaining in building systems, and CUHCC has been designated by the University Foundation as the University's project that can apply for a Kresge Challenge Grant.

Ms. Wells concluded by stating further sources of funding will be pursued, and if funds are raised in excess of the identified shortfall, or if the project is completed under the revised budget, the Hospital's use of reserve funds of $1,350,000 would be reduced accordingly.

There being no further discussion, the December 20, 1989 meeting was adjourned at 1:45 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

January 24, 1990

TO: Board of Governors

FROM: Clifford P. Fearing

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

The Hospital's operations for the month of December reflect inpatient admissions, patient days and outpatient visit activity below budgeted levels. Ancillary revenue is below budgeted levels for the month, while routine revenue showed a slight increase over budgeted levels.

INPATIENT CENSUS: For the month of December, inpatient admissions totaled 1,434, which was 27 below budgeted admissions of 1,461. Our overall average length of stay for the month was 7.6 days. Patient days for December totaled 11,982 and were 243 days below budget. The decrease in admission levels from budget was primarily in the areas of Medicine, Clinical Research, Ophthalmology, and Urology. The decreases were partially offset by increases in Surgery, Otolaryngology, and Neurosurgery.

To recap our year-to-date inpatient census:

	1988-89 Actual	1989-90 Budget	1989-90 Actual	Variance	% Var
Admissions	9,552	9,342	9,334	(8)	(0.1)
Patient Days	79,968	78,854	75,797	(3,057)	(3.9)
Avg Length of Stay	8.3	8.4	8.0	(0.4)	(4.8)
Avg Daily Census	434.6	428.6	411.9	(16.7)	(3.9)
Percent Occupancy	74.5	73.1	71.0	(2.1)	(2.9)

OUTPATIENT CENSUS: Clinic visits for the month of December totaled 19,646 which was 1,932, or 9.0%, below budgeted visits of 21,578. Visits were significantly below budget in Adult Psych, Dermatology, Urology, Ophthalmology, OB/GYN, and Dentistry. Areas that reported visits considerably above budgeted levels were Radiation Therapy and Otolaryngology. Community University Health Care Center (CUHCC) visits for the month of December totaled 3,980 which was 445, or 12.6%, over budgeted visits of 3,535, while Home Health visits of 975 for the month were 27, or 2.7%, below budgeted visits of 1,002.

To recap our year-to-date outpatient census:

	1988-89 Actual	1989-90 Budget	1989-90 Actual	Variance	% Var
Clinic Visits	134,391	137,137	134,123	(3,014)	(2.2)
CUHCC Visits	23,081	23,071	26,050	2,979	12.9
HHA Visits	5,942	5,948	5,609	(339)	(5.7)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows revenues over expenses by $3,209,290, a favorable variance of $1,154,619.

Patient care charges through December totaled $160,694,993, which was 4.8% under budget. Routine revenue was 2.2% under budget and reflects our unfavorable inpatient census variance.

Ancillary revenue was $7,039,788 below budget (5.8%) and primarily reflected the unfavorable variance in clinic visits. Inpatient ancillary revenue averaged $8,761 per admission compared to the budgeted average of $8,922 per admission. Outpatient revenue per clinic visit averaged $236 compared to the budgeted average of $271.

Operating expenditures through December totaled $137,831,799 and were $6,758,824 (4.7%) below budgeted levels of $144,590,623. The overall favorable variance relates primarily to the decreased demand for patient services, and is reflected across most expense categories.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of December 31, 1989, totaled $87,042,644 and represented 97.3 days of revenue outstanding. The overall increase in our patient receivables in December of .8 days occurred primarily in Blue Cross/Out-of-State, Commercial Insurance, and Medical Assistance - South Dakota.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels for year-to-date December. While we have seen some improvement in our expenditure levels, we are continuing to closely monitor our demand for services and make those operating changes that are necessary and appropriate to bring our expense levels into line with net revenues.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1989 TO DECEMBER 31, 1989

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$168,796,269	$160,694,993	($8,101,276)	-4.8%
Deductions from Charges	39,578,332	37,411,280	(2,167,052)	-5.5%
Other Operating Revenue	4,950,740	5,214,066	263,326	5.3%
Total Operating Revenue	134,168,677	128,497,779	(5,670,898)	-4.2%
Total Expenditures	144,590,623	137,831,799	(6,758,824)	-4.7%
Net Operating Revenue	(10,421,946)	(9,334,020)	1,087,926	10.4%
Non-Operating Revenue and Expenses	12,476,617	12,543,310	66,693	0.5%
Revenue Over/Under Expense	$2,054,671	$3,209,290	$1,154,619	

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Admissions	9,342	9,334	(8)	-0.1%
Patient Days	78,854	75,797	(3,057)	-3.9%
Average Daily Census	428.6	411.9	(16.7)	-3.9%
Average Length of Stay	8.4	8.0	(0.4)	-4.8%
Percentage Occupancy	73.1	71.0	(2.1)	-2.9%
Outpatient Clinic Visits	137,137	134,123	(3,014)	-2.2%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 16, 1990

TO: Members, Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Hospital Admissions Policies

Attached is a copy of the Hospital Admissions Policy which has been approved by the Medical Staff-Hospital Council and Council of Clinical Chiefs. Subsequent to their approval Mr. Robert Latz reviewed the policy and suggested changes in item 8. The changes consisted of the elimination of "acknowledges that it has an obligation to assist" and replaced it with "will assist" (see attached).

This policy is presented to you this month for your information.

/th

Attachment

From existing UMHC Policy 5.14 regarding UMHC's Hill-Burton Community Service and Emergency Service obligations HHS 42 C.F.R. Section 124(G)

BACKGROUND

The Department of Health and Human Services (HHS) requires health care facilities that accept funds under Title VI (Hill-Burton Act) to provide uncompensated services and ensure that services are offered to the public without discrimination.

As of January 1, 1981, UMHC met its uncompensated services requirement. Under Subpart G of 42CRF Part 124, UMHC continues to have a community service obligation.

POLICY

In compliance with 42CRF, Part 124, Section G, The University of Minnesota Hospital and Clinic shall make **emergency services** available to all persons residing in UMHC's service area, which is the state of Minnesota. These services shall be rendered without regard to "race, color, national origin, creed, or any other grounds unrelated to an individual's need for the service or the availability of the needed service in the facility." UMHC shall post the appropriate notices required under Subpart G and shall report on its compliance with its Title VI obligation.

PROCEDURE

1. Under Section 124.603 of Subpart G (42CRF Part 124), UMHC must make emergency services available to all persons residing within our service area, the state of Minnesota. Therefore, all such persons shall be permitted access to the hospital's Emergency Department for **emergency services.** Subpart G does not change other legal or ethical requirements related to the rendering of **emergency services.**

2. Acceptance of such patients for **emergency services** does not require UMHC to render non-emergency services once the patient is stabilized. However, UMHC must accept Minnesota residents who are covered under Medicare or Medicaid/Medical Assistance Programs for all necessary services per the rules and regulations governing these programs.

3. Signs indicating UMHC's obligations under Subpart G shall be posted in the Emergency Department, Admissions Department, and Registration Office/Cashiers area. The wording and placement of these signs shall be the responsibility of the Director of Admissions in consultation with appropriate administration staff in the Emergency Department and the Finance Division.

4. All UMHC departments involved with the rendering of care shall coordinate with the Associate Director of Finance responsible for Hill-Burton obligations to ensure that all reporting required under Subpart G is completed. These departments shall include but not be limited to Admissions, Emergency, Outpatient Clinics, Patient Relations, and Social Work.

5. Any questions regarding the eligibility for admission of a patient for emergency and/or elective services shall be referred to the Director of Admissions or her/his designee.

6. Section G does not require UMHC to accept patients not physically present at UMHC for emergent or elective services. All such requests for services (usually occurring via phone or in writing) shall be referred to the Director of Admissions or her/his designee.

7. **Emergency Services** are defined as the reasonable diagnosis and treatment services necessary to eliminate any immediate threat to a patient's life or well-being and the referral or transfer to the appropriate facility for follow-up or ongoing care.

   UMHC shall treat, on an emergency basis, any patient who presents himself/herself, in person, to UMHC in Minneapolis, MN, for emergency service. Such persons shall receive medical care, as required, until the emergency condition is eliminated. Medical care beyond that point shall be dictated by the medical condition of the patient, the patient's or the patient's guardian's expressed desires and the requirements of the patient's third party payer.

8. Non-Emergency Health Care Services

   UMHC recognizes that in order to continue to support its tripartite mission of patient care, education, and research, proper business practices must be used to ensure the financial support of UMHC. Concurrently UMHC ~~acknowledges that it has an obligation to assist~~ will assist its patients to secure coverage whenever possible. To this end UMHC will work with the patient or patient guarantor to obtain any and all financial support that may be available. To accomplish these objectives UMHC requests the medical staff notify Hospital Admissions or Registration five (5) working days prior to any pending admission or clinic visit to allow for a pre-admission or outpatient visit financial screening. UMHC shall provide non-emergency care to patients who meet the following financial criteria.

   Admission Requirements (non-emergency):

   1. All non United States citizens must have made a deposit, verified a credit line or have insurance coverage equal to the estimated procedure expense, and such deposits credit lines or insurance must be accepted and/or confirmed prior to the day of admission in writing.

   2.a. All out-of-state patients except Medicare patients must make a deposit, verify a credit line and/or have written confirmation of insurance or public assistance coverage equivalent to at least 85% of the estimated procedure expense prior to admission. The remaining 15% must be paid under a payment plan established prior to admission. If a contract or agreement exists between UMHC and the patient's third party payor that prohibits this practice, this provision will not be required.

2.b. The University of Minnesota Hospital and Clinic will accept Medicare coverage as meeting the financial requirements in 2.a.

2.c. For elective admissions The University of Minnesota Hospital and Clinic will not accept Medical Assistance as adequate coverage from states whose medical assistance program do not meet the expected payment levels established from time to time by UMHC. (At the present time UMHC financial criteria is a minimum of 85% of charges.) UMHC will accept emergency out-of-state Medical Assistance patients without regard to coverage limits. However, UMHC will not be responsible for any transportation services for these patients.

3.a All State of Minnesota patients will be provided care without regard to their ability to pay for their care. However, every Minnesota resident will be expected to contribute to the cost of their care at levels consistent with their ability to pay. Deposit requests will be based on ability to pay but not mandatory before admission is approved.

Minnesota Patients With or Pending Medical Assistance, or Other Public Assistance Programs:

3.b. Prior to a non-emergency admission of any Minnesota resident eligible for Medical Assistance, General Assistance Medical Care, Services for Children with Handicaps, or other public assistance programs, the patient must be certified by the county as eligible and all necessary actions associated with eligibility must be completed. Admissions will be deferred until such certifications and/or agreements are completed.

4. The Hospital Director, Senior Associate Directors, Associate Directors, the Director of Admissions, or the administrator on call shall have the authority to waive any or all of the above requirements and will work with the medical staff in making exception decisions.

5. All exceptions or lack of proper procedure will be reported to the Board of Governors when a bad debt does occur.

To facilitate the implementation of these policies, the admissions and registration departments will work with the clinical departments to review coverage and secure deposits where appropriate and defer elective admissions until appropriate coverage has been secured. It will be the responsibility of the clinical department to notify admissions and registration of the pending admission or clinic visit, and all non-emergency or non-urgent admissions or clinic visits should not be scheduled for at least five (5) working days.

It will be the responsibility of admissions and registration to perform the financial review and to defer the admission or clinic visit when appropriate.

A physician who believes an immediate admission or clinic visit is imperative due to the medical condition of the patient may admit the patient or schedule the clinic visit without regard to the financial condition of the patient.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 12, 1990

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - Second Quarter
Fiscal Year 1989-90

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the second quarter of 1989-90 is $546,932.58 represented by 1612 accounts. Bad debt recoveries during the period amounted to $22,995.87 (37 accounts) leaving a net charge-off of $523,936.71.

The net bad debts of $523,936.71 for the quarter were 0.66% of gross charges. This compares to a budgeted level of bad debts of 1.22% ($1,005,553).

A statistical summary is attached along with a detailed description of losses over $2,000.00 and recoveries over $200 for each month of the second quarter.

Total fiscal year bad debts have amounted to $1,007,853.82 represented by 2,850 accounts. Recoveries during the fiscal year amounted to $32,948.18 (93 accounts), leaving a net charge-off of $974,905.64.

The net bad debts of $974,905.64 for the fiscal year were 0.61% of gross charges. This compares to a budgeted level of bad debts of 1.22% ($2,067,423).

Along with the quarter attachments, we have also included a fiscal year statistical summary and a breakdown of bad debts by residence and admitting clinical services.

CPF:slw

Attachments

UMHC Hospital Billing Department

Bad Debt Statistics: October 1989 through December 1989
In two ranges of account size

	Under $2000	# of Accounts	Over $2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Bad Debt (701) Write-Offs	$36,587.45	96	$226,060.22	20	$262,647.67	116
Bad Debt (702) Charity Care	$24,416.70	49	$48,312.61	9	$72,729.31	58
Total	$61,004.15	145	$274,372.83	29	$335,376.98	174
Recoveries	($1,178.53)	6	$0.00	0	($1,178.53)	6
Net Total	$59,825.62	145 *	$274,372.83	29 *	$334,198.45	174 *
Outpatient						
Bad Debt (701) Write-Offs	$134,702.90	1242	$29,093.32	6	$163,796.22	1248
Bad Debt (702) Write-Offs	$28,896.01	185	$18,863.37	5	$47,759.38	190
Total	$163,598.91	1427	$47,956.69	11	$211,555.60	1438
Recoveries	($2,755.80)	30	($19,061.54)	1	($21,817.34)	31
Net Total	$160,843.11	1427 *	$28,895.15	11 *	$189,738.26	1438 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	$171,290.35	1338	$255,153.54	26	$426,443.89	1364
Bad Debt (702) Charity Care	$53,312.71	234	$67,175.98	14	$120,488.69	248
Total	$224,603.06	1572	$322,329.52	40	$546,932.58	1612
Recoveries	($3,934.33)	36	($19,061.54)	1	($22,995.87)	37
Total Net Bad Debt	$220,668.73	1572 *	$303,267.98	40 *	$523,936.71	1612 *
Dollars Budgeted					$1,005,553.00	

NOTE: More than $2,000 amount includes legal settlements totaling $19595.49

* Net total of accounts does not include recoveries.

C:\123\RPT\BD\QTR2-90.WK1 sev

UMHC Hospital Billing Department

Bad Debt Statistics: October 1989 through December 1989
In five ranges of account size

	Less Than $100	# of Accounts	$100 - $999	# of Accounts	$1000 - $1999	# of Accounts	$2000 - $9,999	# of Accounts	$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	$981.11	31	$24,835.66	57	$10,770.68	8	$69,734.35	14	$156,325.87	6	$262,647.67	116
Bad Debt (702) Charity Care	$434.77	10	$15,079.22	33	$8,902.71	6	$22,572.68	7	$25,739.93	2	$72,729.31	58
Total	$1,415.88	41	$39,914.88	90	$19,673.39	14	$92,307.03	21	$182,065.80	8	$335,376.98	174
Recoveries	($74.44)	3	($1,104.09)	3							($1,178.53)	6
Net Total	$1,341.44	41 *	$38,810.79	90 *	$19,673.39	14 *	$92,307.03	21 *	$182,065.80	8 *	$334,198.45	174 *
Outpatient												
Bad Debt (701) Write-Offs	$29,875.62	880	$94,156.05	354	$10,671.23	8	$29,093.32	6	$0.00	0	$163,796.22	1248
Bad Debt (702) Write-Offs	$4,747.36	109	$19,384.88	73	$4,763.77	3	$18,863.37	5	$0.00	0	$47,759.38	190
Total	$34,622.98	989	$113,540.93	427	$15,435.00	11	$47,956.69	11	$0.00	0	$211,555.60	1438
Recoveries	($410.37)	21	($2,345.43)	9					($19,061.54)	1	($21,817.34)	31
Net Total	$34,212.61	989 *	$111,195.50	427 *	$15,435.00	11 *	$47,956.69	11 *	($19,061.54)	0 *	$189,738.26	1438 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	$30,856.73	911	$118,991.71	411	$21,441.91	16	$98,827.67	20	$156,325.87	6	$426,443.89	1364
Bad Debt (702) Charity Care	$5,182.13	119	$34,464.10	106	$13,666.48	9	$41,436.05	12	$25,739.93	2	$120,488.69	248
Total	$36,038.86	1030	$153,455.81	517	$35,108.39	25	$140,263.72	32	$182,065.80	8	$546,932.58	1612
Recoveries	($484.81)	24	($3,449.52)	12	$0.00	0	$0.00	0	($19,061.54)	1	($22,995.87)	37
Total Net Bad Debt	$35,554.05	1030 *	$150,006.29	517 *	$35,108.39	25 *	$140,263.72	32 *	$163,004.26	8 *	$523,936.71	1612 *
Dollars Budgeted											$1,005,553.00	

* Net total of accounts does not include recoveries.

C:\123\RPT\BD\QTR2-90.WK1 sev

UMHC Hospital Billing Department

Bad Debt Statistics: July 1989 through December 1989
In two ranges of account size

	Under $2000	# of Accounts	Over $2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Bad Debt (701) Write-Offs	$67,374.80	175	$335,912.78	37	$403,287.58	212
Bad Debt (702) Charity Care	$48,157.33	93	$139,950.00	25	$188,107.33	118
Total	$115,532.13	268	$475,862.78	62	$591,394.91	330
Recoveries	($1,956.76)	10	($3,031.46)	1	($4,988.22)	11
Net Total	$113,575.37	268 *	$472,831.32	62 *	$586,406.69	330 *
Outpatient						
Bad Debt (701) Write-Offs	$221,949.82	2058	$75,116.70	16	$297,066.52	2074
Bad Debt (702) Write-Offs	$83,106.03	434	$36,286.36	12	$119,392.39	446
Total	$305,055.85	2492	$111,403.06	28	$416,458.91	2520
Recoveries	($6,579.63)	80	($21,380.33)	2	($27,959.96)	82
Net Total	$298,476.22	2492 *	$90,022.73	28 *	$388,498.95	2520 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	$289,324.62	2233	$411,029.48	53	$700,354.10	2286
Bad Debt (702) Charity Care	$131,263.36	527	$176,236.36	37	$307,499.72	564
Total	$420,587.98	2760	$587,265.84	90	$1,007,853.82	2850
Recoveries	($8,536.39)	90	($24,411.79)	3	($32,948.18)	93
Total Net Bad Debt	$412,051.59	2760 *	$562,854.05	90 *	$974,905.64	2850 *
Dollars Budgeted					$2,067,422.00	

NOTE: More than $2,000 amount includes legal settlements totaling $33208.29

* Net total of accounts does not include recoveries.

C:\123\RPT\BD\YTD90-Q2.WK1 sev

UMHC Hospital Billing Department

Bad Debt Statistics: July 1989 through December 1989
In five ranges of account size

	Less Than $100	# of Accounts	$100 - $999	# of Accounts	$1000 - $1999	# of Accounts	$2000 - $9,999	# of Accounts	$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	$1,614.43	50	$48,506.59	113	$17,253.78	12	$129,919.67	28	$205,993.11	9	$403,287.58	212
Bad Debt (702) Charity Care	$1,059.18	23	$26,172.15	56	$20,926.00	14	$77,113.62	22	$62,836.38	3	$188,107.33	118
Total	$2,673.61	73	$74,678.74	169	$38,179.78	26	$207,033.29	50	$268,829.49	12	$591,394.91	330
Recoveries	($98.44)	6	($1,858.32)	4	$0.00	0	($3,031.46)	1	$0.00	0	($4,988.22)	11
Net Total	$2,[illegible]	73 *	$72,820.42	169 *	$38,179.78	26 *	$204,001.83	50 *	$268,829.49	12 *	$586,406.69	330 *
Outpatient												
Bad Debt (701) Write-Offs	$49,038.23	1450	$155,426.87	594	$17,484.72	14	$75,116.70	16	$0.00	0	$297,066.52	2074
Bad Debt (702) Write-Offs	$9,285.36	228	$55,585.23	193	$18,235.44	13	$36,286.36	12	$0.00	0	$119,392.39	446
Total	$58,323.59	1678	$211,012.10	787	$35,720.16	27	$111,403.06	28	$0.00	0	$416,458.91	2520
Recoveries	($1,543.19)	66	($2,958.43)	12	($2,078.01)	2	($2,318.79)	1	($19,061.54)	1	($27,959.96)	82
Net Total	$56,780.40	1678 *	$208,053.67	787 *	$33,642.15	27 *	$109,084.27	28 *	($19,061.54)	0 *	$388,498.95	2520 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	$50,652.66	1500	$203,933.46	707	$34,738.50	26	$205,036.37	44	$205,993.11	9	$700,354.10	2286
Bad Debt (702) Charity Care	$10,344.54	251	$81,757.38	249	$39,161.44	27	$113,399.98	34	$62,836.38	3	$307,499.72	564
Total	$60,997.20	1751	$285,690.84	956	$73,899.94	53	$318,436.35	78	$268,829.49	12	$1,007,853.82	2850
Recoveries	($1,641.63)	72	($4,816.75)	16	($2,078.01)	2	($5,350.25)	2	($19,061.54)	1	($32,948.18)	93
Total Net Bad Debt	$59,355.57	1751 *	$280,874.09	956 *	$71,821.93	53 *	$313,086.10	78 *	$249,767.95	12 *	$974,905.64	2850 *
Dollars Budgeted											$2,067,422.00	

* Net total of accounts does not include recoveries.

C:\123\RPT\BD\YTD90-Q2.WK1 sev

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1990
By Service

Admitting Service	Second Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Anesthesiology				
Clinical Research	154.34	1	171.32	2
Dentistry				
Dermatology				
Family Practice				
OB	13.50	1	13.50	1
NB				
GYN	2,152.34	3	6,108.18	6
GYN-Oncology	36,049.17	16	36,544.95	20
Lab Medicine & Pathology				
Medicine-Blue	701.38	2	6,840.02	7
Green	10,573.72	4	13,456.95	10
Masonic (Onc)	1,416.34	5	16,141.10	17
Purple	63,884.95	3	63,884.95	3
Red A	30,032.99	4	36,558.17	10
Red B			3,964.15	2
Rose A	5,268.86	2	5,566.08	3
Rose B			672.70	2
White A	3,375.25	9	10,189.34	15
White B	1,513.35	4	10,235.55	10
Yellow A	728.67	4	5,609.63	6
Yellow B	9,201.92	4	11,309.14	9
Neurology	428.47	2	7,830.90	11
Neuro-epilepsy				
Neurosurgery	30,531.53	10	34,495.11	14
New Born-General	1,663.88	4	4,202.75	5
Obstetrics-General	18,517.41	6	34,114.53	8
-Midwife	751.71	1	751.71	1
Opthamology	2,832.28	4	6,563.44	7
Orthopaedic Surgery	9,992.93	11	11,579.64	14
Otolaryngology	3,362.04	4	4,227.18	6
Pediatrics-General	48,782.03	21	53,449.95	35
Dermatology				
Neurology	1,787.80	2	44,793.63	6
Neurosurgery				
Opthalmology	2,771.36	1	10,220.30	4

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1990
By Service

Admitting Service	Second Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Orthopaedics			360.00	1
Otolaryngology			343.02	1
Surgery Green	2,138.85	1	6,905.67	5
Surgery Orange				
Surg. Transplant	333.34	1	333.34	1
Urology				
Physical Med. & Rehab.	1,469.96	4	1,469.96	4
Psychiatry-Child	777.13	2	1,523.88	3
-Adult	8,488.06	11	41,347.99	28
Radiology				
Surgery-Blue	4,002.79	7	15,909.69	17
Orange	2,226.52	4	7,799.64	11
Purple	2,467.48	6	11,556.63	12
Red	15,039.61	4	21,276.51	7
White	6,189.66	6	9,390.47	10
Therapeutic Radiology				
Urology	6,978.78	7	28,813.62	13
Unknown	18,258.64	2	32,111.68	7
Outpatient	187,013.16	1,453	380,644.33	2,596
Total	541,872.20	1,636	999,281.30	2,950
Medicare Bad Debt*	(20,998.07)	(32)	(42,237.40)	(117)
Legal Settlements	19,595.49	3	33,208.29	6
Bad Debt Agcy Und $50	58.63	2	285.91	5
Bad Debt - Med NC Chgs	6,404.33	3	17,315.72	6
Grand Total	546,932.58	1,612	1,007,853.82	2,850
Recoveries	(22,995.87)	37	(32,948.18)	93
Net Total	523,936.71	1,612	974,905.64	2,850

* NOTE: Medicare Bad Debts are included in the State Breakdown but are no longer included as a Bad Debt.

C:\123\RPT\BD\SVC-Q290.WK1 sev

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1990
By State

State	Second Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Alabama			643.13	1
Alaska			48.96	1
Arizona	778.11	5	1,318.17	6
Arkansas				
California	298.50	4	5,179.01	32
Colorado	3,410.02	38	4,161.55	47
Connecticut	172.50	2	172.50	2
Delaware				
Dist. of Colombia			74.00	1
Florida	1,592.67	8	1,592.67	8
Georgia			40.60	3
Hawaii				
Idaho	25.66	1	25.66	1
Illinois	2,385.85	33	8,320.06	52
Indiana	1,668.73	14	1,669.17	15
Iowa	6,970.32	11	8,110.14	18
Kansas			156.82	2
Kentucky	2,138.85	1	2,138.85	1
Louisiana			20.00	1
Maine				
Maryland				
Massachusetts	25.00	1	25.00	1
Michigan	509.23	3	1,622.59	12
Minnesota	416,223.95	1,362	725,988.11	2,469
Mississippi				
Missouri	9,479.35	5	9,479.35	5
Montana				
Nebraska				
Nevada	605.13	12	605.13	12
New Hampshire				
New Jersey	475.33	1	475.33	1
New Mexico				
New York	268.36	4	5,991.86	17
North Carolina			340.52	1
North Dakota	39,401.97	34	44,461.21	49
Ohio	898.72	3	1,074.16	5

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1990
By State

State	Second Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Oklahoma	2,652.42	3	7,423.34	4
Oregon	116.30	1	116.30	1
Pennsylvania			4,903.96	3
Puerto Rico	68.30	1	68.30	1
Rhode Island	4.50	1	4.50	1
South Carolina				
South Dakota	14,431.00	28	77,171.57	58
Tennessee	54.00	1	54.00	1
Texas	583.17	7	14,023.41	15
Utah				
Vermont				
Virginia			23.30	1
Washington				
West Virginia				
Wisconsin	22,181.90	51	57,305.71	101
Wyoming				
Out-of-Country	14,452.36	1	14,452.36	1
Total	541,872.20	1,636	999,281.30	2,950
Medicare Bad Debt*	(20,998.07)	(32)	(42,237.40)	(117)
Legal Settlements	19,595.49	3	33,208.29	6
Bad Debt Agcy Und $50	58.63	2	285.91	5
Bad Debt - Med NC Chgs	6,404.33	3	17,315.72	6
Grand Total	546,932.58	1,612	1,007,853.82	2,850
Recoveries	(22,995.87)	37	(32,948.18)	93
Net Total	523,936.71	1,612	974,905.64	2,850

* NOTE: Medicare Bad Debts are included in the State Breakdown but are no longer included as a Bad Debt.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 19, 1990

TO: Members of the Board of Governors

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

RE: Board of Governors Bylaws

The attached document summarizes Board of Governors Bylaw changes that have been recommended by the Bylaws Committee for your endorsement. The document is an exact duplicate of the one included in the December, 1989 Board of Governors agenda packet. Wording recommended for deletion is underlined. Proposed wording additions are in bold faced print.

The Bylaw changes are being presented for your endorsement on January 24, 1990. Final approval for the Bylaw changes rests with the Board of Regents.

NCJ/gs

Draft #6
December 8, 1989

Board of Governors
Bylaws
Considerations for Change

I. Size of Board

Article II, Section 1. Membership. p2

"The University of Minnesota Hospital and Clinic's governing board shall be known as the Board of Governors. The Board shall consist of thirteen (13) voting and three (3) nonvoting members..."

Should the Board of Governors membership be expanded to include additional public members?

Alternative Language Endorsed: The University of Minnesota Hospital and Clinic's governing board shall be known as the Board of Governors. The Board shall consist of thirteen (13) **sixteen (16)** voting and three **(3)** non-voting members.

The Vice President for Health Sciences, the Vice President for Finance and the Dean of the Twin Cities Medical School shall be ex-officio non-voting members. The Chair of the Council of Clinical Chiefs, the Chief of Staff and the Hospital Director shall be ex-officio voting members. The remaining ten (10) **thirteen (13)** members shall be appointed by the Board of Regents. One of these ten (10) **thirteen (13)** shall be a Health Sciences student.

II. Board of Governors Input into Membership Selection

Article II, Section 1. Membership. p2

"...The remaining ten (10) members shall be appointed by the Board of Regents. One of the ten (10) shall be a health sciences student. The others shall be selected for their proven or potential governance skills as evidenced by community leadership, occupation, previous governance experience or otherwise. In selecting members, the Board of Regents also considers it desirable to have broad community representation of women and minority groups..."

Should the Board of Governors have a formal channel for nominating new Board members or for suggesting needed skills?

Alternative Language Endorsed: Article II, Section I. Membership, **Appointment and Reappointment.**

The University of Minnesota Hospital and Clinic's governing board shall be known as the Board of Governors. The Board shall consist of thirteen (13) **sixteen (16)** voting and three **(3)** non-voting members. The Vice President for Health Sciences, the Vice President for Finance and the Dean of the Twin Cities Medical School shall be ex officio non-voting members. The Chair of the Council of Clinical Chiefs, the Chief of Staff and the Hospital Director

shall be ex officio voting members. The remaining ten (10) **thirteen (13)** members shall be appointed **or reappointed** by the Board of Regents **upon the recommendation of the Board of Regents Nominating Committee.**

The Chair of the Board of Governors and the Vice President for Health Sciences shall serve as ex officio non-voting members of the Board of Regents Nominating Committee. One of the ten (10) **thirteen (13)** shall be a Health Sciences student. The others shall be selected for their proven or potential governance skills as evidenced by community leadership, occupation, **and current or** previous governance experience or otherwise. In selecting members, the Board of Regents also considers it desirable to have broad community representation, including geographic distribution and representation of women and minority groups. Paid employees of the University shall not be eligible to serve on the Board except as ex officio members.

III. Duration of Service

Article II, Section 2. Terms of Office. p3

"The regular term of office of each member shall commence as of January 1 of the year of appointment shall be for a period of three years, except for the Health Sciences student whose term shall be for one year...No member except ex officio members shall serve longer than three successive terms..."

Can a public member serve more than one set of three successive terms?

Can a student representative serve more than one year? More than one set of three successive terms?

Alternative Language Endorsed: Section 2. Terms of Office.

The regular term of office of each member shall commence as of January 1 of the year of appointment and shall be for a period of three years, except for the Health Sciences student whose term shall be for one year. Persons appointed to fill vacancies shall serve the unexpired portion of the term of the office that was vacated. The student member shall continue to serve only so long as he or she continues to be a student in good standing enrolled in or on regular vacations from the University of Minnesota.

The Health Sciences student shall serve one term only. Service as a Health Sciences student shall not preclude eligibility for service as a member of the Board of Governors in subsequent years. No members except ex officio members shall serve longer than three successive **two consecutive** terms. Persons who are appointed to fill the unexpired portions of vacated positions shall be considered to have served a term only if the vacated portion has at least 18 months, or in the case of a student, six months remaining at the time of appointment.

Upon the recommendation of the Board of Governors, the Board of Regents will consider extending the maximum two term eligibility period for Board of Governors members elected to fill the positions of Chair and Vice Chair. Under no circumstances shall a member of the Board of Governors serve more than three consecutive terms. Members who have served their maximum consecutive terms shall be eligible for reappointment only after three years of non-service.

IV. Non-Public Meetings

Article II, Section 4. Meetings and Notice (c) p6

"All meetings of the Board shall be public meetings except that the Board may vote to hold a non-public meeting in those circumstances in which the Board of Regents are permitted by their Bylaws to hold a non-public meeting, when the Board of Governors is carrying out the functions of, reviewing or acting on the recommendations of a health care review organization, or when the Board of Governors is otherwise required by law to maintain confidentiality."

Should the Board be permitted to hold non-public meetings to discuss specific marketing activity and contracts that might be entered into pursuant to the marketing activity where the hospital is in competition with organizations offering similar services?

Alternative Language Endorsed: "All meetings of the Board shall be public meetings except that the Board may vote to hold a non-public meeting in those circumstances in which the Board of Regents are permitted by their Bylaws to hold a non-public meeting, when the Board of Governors is carrying out the functions of, reviewing or acting on the recommendations of a health care review organization, or when the Board of Governors is otherwise required by law to maintain confidentiality." **All meetings of the Board of Governors shall be public meetings except that the Board, when permitted to [illegible] law, may vote to hold a non-public meeting.**

V. Eligibility to Hold Office

Article III, Section 1. Officers. p8

"The officers of the Board of Governors shall consist of a Chair, a Vice-Chair, the Hospital Director and the Secretary..."

Should the Bylaws specify that the Chair and Vice-Chair should be selected from the non-University employee Board members?

Alternative Language Endorsed: The officers of the Board of Governors shall consist of a Chair, a Vice Chair, the Hospital Director, and the Secretary. The Chair and Vice Chair shall be elected by the Board of Governors **from the thirteen (13) non-University employee Board members** at their annual meeting.

VI. Term of Chairman's and Vice Chairman's Office

Article III, Section 1. Officers. p8

"...The Chair and the Vice Chair shall be elected by the Board of Governors at their annual meeting."

Should the Bylaws specify that the election takes place in January which is defined as the annual meeting?

Should the Bylaws specify that the chair serve some predetermined number of annual terms?

Should the Bylaws specify that the Vice Chair serve some predetermined number of annual terms?

Alternative Language Endorsed: "...The Chair and the Vice Chair shall be elected by the Board of Governors at their Annual Meeting **annually by the Board of Governors from the thirteen (13) non-University employee Board members."**

Article IV, Section 6. Nominating Committee. p18

"...Nominating Committee...shall serve to nominate one or more candidates for the positions of Chair and Vice Chair to be filled by election at the Annual Meeting of the Board of Governors **annually.** The Committee shall meet as needed to develop and **annually** report a slate of candidates for inclusion in the notice of the Annual Meeting to the **to the Board of Governors."**

VII. **Committee Leadership; Committee Membership**

Article III, Section 2. Chair. p9

"...He or she shall perform all of the acts usually attendant upon the office of Chair, shall appoint the members and chairs of all committees except the Executive Committee and shall be an ex officio member without vote of all standing and special committees."

Should there be fixed term for committee chairpersons?

Should there be fixed terms for committee membership or a fixed rotation between committees?

Alternative Language: **No changes to Bylaws proposed.**

VIII. **Necessity of an Executive Committee**

Article IV, Section 1. Executive Committee (b) p12

"The Executive Committee shall have the power to transact such business of the Board as may be necessary during the interim between meetings of the Board of Governors "

Should the Board of Governors continue to have an Executive Committee?

Alternative Language Endorsed: **No changes to Bylaws proposed.**

IX. **Duties of the Planning and Development Committee**

Article IV, Section 2 (b) Duties p13

(1)"...monitoring the physical status..."

(2)"...reviewing and monitoring hospital programs and community health planning activities..."

(3)"...review and monitor purchasing practice..."

Should responsibility for strategic planning, physician outreach and marketing be included as formally designated responsibilities?

Alternative Language Endorsed:

(1) The Committee shall be responsible for reviewing and monitoring the physical status of The University of Minnesota Hospital and Clinic (including additions, alterations, repair and maintenance) and for formulating appropriate recommendations to the Board of Governors.

(2) The Committee shall be responsible for reviewing and monitoring hospital programs and for formulating appropriate recommendations to the Board of Governors.

separated (2) from (3)

(3) The Committee shall be responsible for reviewing and monitoring community health **strategic** planning, **marketing and outreach** activities and for formulating appropriate recommendations to the Board of Governors.

(4) The Committee shall be responsible for reviewing and monitoring The University of Minnesota Hospital and Clinic's purchasing policies and practices and for formulating appropriate recommendations to the Board of Governors.

X. Duties of the Joint Conference Committee

Article IV, Section 4 (b). Duties p15-17

"...a forum for the discussion of matters of The University of Minnesota Hospital and Clinic medical policy and practice, relating to efficient and effective patient care..."

(1) "...it shall require that the Joint Commission's survey forms be used as review method to estimate the accreditation status..."

(2) "...it shall adopt and periodically review a written plan to safeguard patients at the time of an internal disaster..."

(3) "...appointment or reappointment to the Medical Staff..."

(4) "...professional privileges permitted to each member of the medical staff..."

(5) "...recommend to the Board of Governors all Medical Staff Bylaws and Rules and Regulations for the control of the Medical Staff..."

(6) "...made recommendations to the Board of Governors regarding any communications, requests or recommendations presented by the Medical Staff..."

(7) "...receive and consider all reports on the work of the Medical Staff..."

(8) "...receive and consider issues that may arise in the planning and operation of The University of Minnesota Hospital and Clinic that effect the relationship of the Board, The University of Minnesota Hospital and Clinic's management and Medical Staff."

Should the responsibilities of the Joint Conference Committee be updated to include new areas of emphasis? i.e. quality assurance monitoring and evaluation.

Alternative Language Endorsed:

...a forum for the discussion of matters of The University of Minnesota Hospital and Clinic medical policy and practice, relating to efficient and effective patient care **the quality of patient care...**

(1) To acquire and maintain J.C.A.H. accreditation for which purpose it shall form a committee that includes key hospital personnel who are involved in implementing the accreditation program. From time to time, it shall require that the Joint Commission's survey forms be used as a review method to estimate the accreditation status of The University of Minnesota Hospital and Clinic and for the purpose of constructive self-criticism in the interim years between surveys. It shall identify areas of suspected non-compliance with Joint Commission on Accreditation of Hospital standards and shall make recommendations to the Executive Committee of the Board of Governors and to the Medical Staff for appropriate action. **To review the survey findings of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other regulatory or accreditation bodies. It shall identify areas of suspected non-compliance with accreditation standards or regulations and shall make recommendations to the Board of Governors and Medical Staff for appropriate action.**

(2) To review the implementation and results of the Hospital's quality assurance program.

renumber 2 through 8 as 3 through 9

XI. Nominating Committee: Criteria for Selection of the Chairman

Article IV, Section 6. Nominating Committee p18

"...In nominating individuals for the position of Chair, the Nominating Committee shall give special consideration to those individuals who have experience in Medical Staff - Board interrelationships."

Should this selection criteria be maintained?

Alternative Language Endorsed: **Eliminate this criteria completely; too specific.**

XII. Medical Staff Appointment: Sequence of Activities

Article V, Section 4 (f) Procedures for Board Actions Pertaining to Medical Staff Members or Applicants for Membership. p24

"After the Board of Governors agrees to the appointment or reappointment...Hospital Director shall make available...Bylaws and Rules and Regulations."

Should the Bylaws be changed to reflect the fact that applicants receive and acknowledge receipt of Bylaws and Rules and Regulations as part of the application process?

Alternative Language Proposed: **Incorporate all of Section 4(f) into Section 3.** Staff members so appointed shall have full responsibility for the treatment of the individual patient subject only to such limitations as the Board of Governors and its designees may impose, and to the Bylaws, Rules and Regulations of the Medical Staff as adopted by the Board of Governors. After the Board of Governors agrees to the appointment or reappointment of an applicant to membership on the Medical Staff, the Hospital Director shall make available to that applicant a copy of the Bylaws and Rules and Regulations of the Medical Staff in force at that time. **...A copy of the Bylaws, Rules and Regulations of the Medical Staff shall be available to each applicant.** The applicant shall sign a statement furnished him or her by the Hospital Director that states he or she has read and understood these Bylaws, Rules and Regulations and that he or she specifically agrees to the following undertakings: (1) An obligation as a member of the Medical Staff to provide continuous care and supervision to all patients within The University of Minnesota Hospital and Clinic for whom he or she has responsibility; and (2) An agreement to abide by all such Bylaws, policies and directives of The University of Minnesota Hospital and Clinic, including all such Bylaws, Rules and Regulations as shall be given to him or her by the Board of Governors and the Medical Staff. **the Board of Governors Bylaws, the Medical Staff Bylaws and Rules and Regulations and the policies and directives of The University of Minnesota Hospital and Clinic.** No appointment or reappointment shall take effect until such a statement has been signed...

XIII. Access to Information Used in the Credentialling Process

Article 5, Section 3. Appointment to the Medical Staff and Assignment of Clinical Privileges

"...information which is gathered in the credentialling process shall be available for review by the applicant, the Board, The University of Minnesota Hospital and Clinic Administrative Staff, Medical Staff Officers, Members and Committees, and their representatives for use in conducting their official duties..."

Who should have access to information which is gathered in the credentialling process?

Alternative Language Proposed: ...information which is gathered in the credentialling process shall be available for review by the applicant, the Board, The University of Minnesota Hospital and Clinic Administative Staff,

Medical Staff Officers, members and committees, and their representatives **and Chiefs of the applicant's clinical service, their appointees or designated representatives** for use in conducting their official duties...

XIV. Medical Staff Appeals Process

Article V, Section 4 (b) Procedures for Board Actions Pertaining to Medical Staff Members or Applicants for Membership

Article V, Section 4 "(c) Whenever the Board of Governors determines on its own motion and without prior Joint Conference Committee action to decrease the clinical privileges of a member of the Medical Staff or revoke his or her staff membership, the Board shall refer such determination to the Joint Conference Committee for its consideration and recommendation. Whenever the Board of Governors determines to reject a recommendation of the Joint Conference Committee favorable to an applicant for staff membership, either with respect to membership or to clinical privileges, or determines to reject a recommendation of the Joint Conference Committee favorable to a Medical Staff member with respect to reappointment, promotion in staff category or increase in clinical privileges, before taking final action the Board shall notify the applicant or Medical Staff member in writing, sent by certified mail or registered mail, return receipt requested, of this decision of the Board. Such applicant or staff member shall have 10 days following the date of receipt such notice within which to request a hearing by a Hearing Committee to be appointed by the Board. Request for a hearing shall be by notice to the Hospital Director in writing, sent by certified or registered mail, return receipt requested. In the event the applicant or Medical Staff member does not request a hearing within the time and in the manner required, he or she shall be deemed to have accepted the action involved and it shall become effective immediately. If a hearing is requested it shall be conducted under the procedures set forth in Article VII of the Medical Staff Bylaws, with the following exceptions: (a) the members of the Hearing Committee shall be appointed by the Board of Governors and, (b) at the conclusion of the hearing, the committee's decision and report shall be sent directly to the Board for action. Thereafter, the applicant or staff member or the Credentials Committee of the Medical Staff shall have the right to an appeal to the Board of Governors which shall be conducted under the procedures set forth in Article VII, Part D, of the Medical Staff Bylaws."

Is the medical staff appeals process consistently described in the Medical Staff and Board of Governors Bylaws?

Alternative Wording Proposed: **(c) In those situations where the Board of Governors rules adversely to the applicant or member either with respect to membership or to clinical privileges, the person adversely affected may request a review by the Board of Governors. The written request for review shall include a brief statement as to the reason for review. Said written request shall be delivered to the Hospital Director either in person, or by certified or registered mail. If such a review is not requested within 30 days, the action or ruling involved shall thereupon become final and shall be effective immediately.**

If the Board of Governors rules adversely to the applicant or member upon a positive recommendation by the Credentials Committee and Medical Staff

Hospital Council, the applicant or member shall have a right to a hearing under the procedures set forth in Article VII, Part B of the Medical Staff Bylaws with the following exceptions: (a) the members of the Hearing Committee shall be appointed by the Board of Governors and (b) at the conclusion of the hearing, the committee's decision and report shall be sent directly to the Board for action. Thereafter, the applicant or staff member shall have the right to an appellate review by the Board of Governors which shall be conducted under the procedures set forth in Article VII, Part D of the Medical Staff Bylaws.

If the Board of Governors undertakes by its own motion, without prior Credentials Committee and/or Medical Staff Hospital Council action to decrease the clinical privileges of a member of the Medical Staff or to revoke his or her staff membership, the member shall have a right to a hearing under the procedures set forth in Article VII, Part B of the Medical Staff Bylaws with the following exceptions: (a) the members of the Hearing Committee shall be appointed by the Board of Governors and (b) at the conclusion of the hearing, the committee's decision and report shall be sent directly to the Board for action. Thereafter, the applicant or staff member shall have the right to an appellate review by the Board of Governors which shall be conducted under the procedures set forth in Article VII, Part D of the Medical Staff Bylaws.

If the applicant or member is requesting a review by the Board subsequent to an adverse ruling by the Credentials Committee or Medical Staff Hospital Council, the Board review shall be conducted according to the appellate review mechanism set forth in Article VII, Part D of the Medical Staff Bylaws.

XV. Reapplication

Article V, Section 4 (e) Procedures for Board Actions Pertaining to Medical Staff Members or Applicants for Membership

"If an application is finally denied by the Board of Governors, the applicant after the expiration of one year from the date of such denial may reapply for membership on the Medical Staff unless the Board of Governors provides otherwise in the formal written denial."

Is the reapplication eligibility described in the Board of Governors Bylaws consistent with the eligibility described in the Medical Staff Bylaws?

Alternative Wording Proposed: If an application is finally denied by the Board of Governors, the applicant after the expiration of one year from the date of such denial may reapply for membership on the Medical Staff unless the Board of Governors provides otherwise in the formal written denial. **Nothing in these Bylaws shall restrict the right of the applicant to reapply for membership on the Medical Staff at a future date or restrict the right of a member of the Medical Staff to apply for an increase in clinical privileges at a future date.**

XVI. **Criteria for Clinical Chiefs Appointments**

Article V, Section 5. (b) Medical Staff Clinical Services p25

"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..."

Should the Bylaws set forth criteria for Chiefs appointments and reappointments?

Alternative Language Endorsed: **Criteria should not be set forth in the Bylaws.**

XVII. **Board of Governors Affiliations**

No reference in Board of Governors Bylaws.

Should the Board of Governors affiliations policy be reiterated in the Bylaws?

Alternative Language Endorsed: **The members of the Board of Governors shall be guided by the provisions set forth in the policy on affiliations adopted by the Board on January 22, 1986 and as amended from time to time.**

XVIII. **Names of Auxiliaries Serving UMHC**

Article VI, Section 1. Composition p2f

"The activities may be performed by...the University Hospital Volunteer Association, the Masonic Memorial Auxiliary, the Women of Variety Tent #12, the Faculty Women's Club-Hospital Auxiliary, and such other support volunteers as the Board may from time to time recognize."

Should the auxiliaries named in the Bylaws be updated to reflect the current organizations servicing UMHC?

Alternative Language Endorsed: **Delete Article VI Hospital Auxiliaries Incorporate responsibility for designating auxiliaries under Article II, Section (3) Powers and Reservations. (b) Specific Delegation.**

(5) to delineate the purpose and function of any auxiliary organizations.

November 2, 1989

Board of Governors
Bylaws
Minor Editorial Changes

Article II, Section 2
Terms of Office
typographical error

The regular term of office of each members shall commence...

Article II, Section 4
Meetings and Notices
failure to capitalize a proper noun

Special meetings may be called by the chair **Chair** at his or her own discretion or shall be called at the request of ~~five~~ (5) members of the **Board** at such time and place as the chair **Chair** may determine.

Article III, Section 4
Secretary
insure and ensure are used interchangeably in Bylaws: uniformly use ensure

...furnish timely copies to each member of the Board and to the President of the University, and insure **ensure** that copies of all minutes...

Article III, Section 5
Hospital Director
insure and ensure are used interchangeably in Bylaws: uniformly use ensure

(f) To insure **ensure** that all members of the Medical Staff comply with the Bylaws...

Article III, Section 3
Specific Delegation
insure and ensure are used interchangeably in Bylaws: uniformly use ensure
new name of Joint Commission

...oversee all aspects of Medical Staff operations in order to insure **ensure** compliance with applicable federal and state laws and regulations, the requirements of the Joint Commission on Accreditation of Hospitals **Joint Commission on Accreditation of Healthcare Organizations** ...

Article IV Section 4
Joint Conference and Accreditation Committee
duplicate word

...to recommend to the Board of Governors all Medical Staff Bylaws **Bylaws** Rules and Regulations...

Article V Section 3
Appointment to the Medical Staff and Assignment of Clinical Privileges
"medical staff" is official term
no promotion procedure exists

...A staff member shall be eligible for regular appointment to membership on the attending staff **Medical Staff** after serving a provisional appointment of at least six (6) months. Regular appointments to the attending staff **Medical Staff** shall be for two (2) years only, renewable biennially in accordance with the reappointment procedures and promotion procedures set forth...

Article V Section 4
Procedures for Board Actions Pertaining to Medical Staff Members or Applicants for Membership
no promotional procedure exists
clinical privileges can be increased or decreased

...or determines to reject a recommendation of the Joint Conference Committee favorable to a Medical Staff member with respect to reappointment, promotion in staff category or increase **change** in clinical privileges...

American Hospital Association

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

December 27, 1989

Dear AHA Liaison Trustee

Enclosed is a liaison trustee briefing paper on issues of aging and long-term care. "Emerging Hospital Roles in Caring For The Elderly" provides a profile of the elderly population and discusses how hospitals can define and deliver services most effectively to this group. The paper also includes suggestions for what trustees can do to assure that hospitals are best meeting the health needs of the elderly in their communities.

Please review the enclosed paper and distribute it to your board as you see fit. Best wishes for a happy holiday season and a wonderful new year.

Sincerely

Mary Totten

Mary Totten
Program Director
Division of Hospital Governance

cc: Allied Hospital Associations
Hospital CEO
Congress of Hospital Trustees Members
AHA Regional Directors

MT/ec

Enclosures

American Hospital Association

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

"EMERGING HOSPITAL ROLES IN CARING FOR THE ELDERLY"

An AHA Briefing Paper for Hospital Governing Boards
December 1989

Introduction

The over-65 patient population has long been a significant element in the total picture of hospital operations. The introduction of Medicare solidified the impact of this group of patients even further because it rendered payment for their care a consistent and substantial portion of total hospital revenues. In turn, this change in financing physician and hospital care for patients over 65 became a major factor in the hospital industry's rapid expansion during the ensuing two decades.

As the industry enters the last decade of this century, the convergence of two other phenomena related to the elderly seems to have produced an impact on hospitals at least as dramatic as was the introduction of Medicare. The first of these changes was the imposition of prospective pricing on the Medicare financing structure, which imposed financial limits on acute care services to older adults. The second phenomenon has been--and will continue to be--an increase in the elderly population in general and in the proportion of patients 65 years and older who now constitute the average hospital's service population.

The first purpose of this briefing paper is to examine the character of this increase from the perspective of the hospital governing board. It would be a mistake to assume that an increase in numbers requires that a hospital simply provide more of the same kinds of services. Its second purpose is to suggest a range of the most appropriate responses that hospital governing boards can consider, once they study the needs of their elderly patients as well as of the older adults in the community who have never used the hospital's services. And finally, the ultimate purpose of this paper is to convince hospital governing boards that a change in the way services are provided to this population is no longer a matter of choice. Without a comprehensive, coordinated response to the wide range of needs present in this population, hospitals risk impairing both the quality of their services and their financial stability.

Older Adults: A Profile

If we paint a picture of the older adult population in the broadest strokes, we see first that their numbers are increasing at a much greater rate than most other segments of the population. While those 65 years or older made up 28 million of the total population in 1988, by 1990 their numbers will have increased to 32 million. By 2030, this group will number 55 million and constitute 18-20 percent of the total population, an increase of about 5-7 percent in just 40 years. These numbers become even more meaningful to governing boards if we rephrase them in hospital terms. In 1988, this population accounted for:

-- 11 million hospital admissions
-- $8000 revenue generated per average admission
-- 8.8 days per average hospital stay
-- 98 million patient days
-- $53 billion in Medicare payments to hospitals
-- $35 billion in Medicare payments to physicians

If these statistics are further broken down to the level of an average 200-bed hospital, the impact of this population on hospital operations is even more startling:

-- 34 percent of this hospital's admissions
-- 45 percent of its patient days
-- 48 percent of hospital revenues

Beyond their numbers, what are the other characteristics of this patient group? And is there reason for the hospital to establish links with the older adults in the community who have not yet walked through its doors? To begin with, both hospitalized elderly and those who are generally well tend to suffer from chronic illness; 80 percent of older adults have at least one chronic disorder, and on the average, they have four or five. These include heart disease, high blood pressure, arthritis, diabetes, glaucoma or cataracts, and hearing loss; in addition, about 10 percent suffer from Alzheimer's disease, which causes mental dysfunction.

Related to their high rates of chronic disease is the fact that older adults ingest an average of 3.2 prescribed medications and an unknown number of over-the-counter drugs. A frequent result of these regimens is adverse drug reaction, which accounts for 20 to 25 percent of all hospital admissions among the elderly. Hospitalization also puts the elderly at risk, because they are more susceptible to iatrogenic illness than are younger patients, and their recovery is more difficult.

Most of the elderly's chronic conditions are managed outside the acute care setting. However, 20 percent of the elderly do have minor problems completing some of their simple daily activities, such as bathing,

dressing, and eating, and another 20 percent actually require assistance with these activities. Eighty percent of long-term care is provided informally by spouses, relatives and friends; however this type of informal caregiving is being threatened by trends such as smaller families and more working women.

In addition to needing acute care services, older adults who are sick also need and use nursing home care and home health services. Although 5 percent of the elderly are in nursing homes at any one time, 85 percent of nursing home bed days and home health visits are devoted to the elderly, especially to the frail elderly who tend to comprise the oldest segment of this group. And in fact, this group --those aged 85 and older-- is experiencing the most rapid growth.

Redefining Services for the Elderly

These characteristics make older adults' needs for health services quite different from those of younger generations in many ways except one. Most older adults wish to remain active and independent as much as possible. To this end, hospitals can provide education and health promotion that is appropriate to the interests and abilities of older adults, that can help them to keep fit as well as avoid such unnecessary risks as misuse of medications, and that can help establish positive links to the hospital before illness makes hospitalization unavoidable.

While acute care for episodes of severe illness is essential for all age groups, chronic illness among the elderly usually demands longer term and more complex management outside the inpatient setting. Patients themselves and their families must receive education in self-management. This can enable patients to return home and remain relatively independent, especially if other support services are made available, such as home health, Meals-on-Wheels, transportation for physician and hospital visits, telephone follow-up, housekeeping, and respite care to periodically relieve the burden and stress on home-based care givers. Indeed, one of the marks of a successful outcome for an elderly patient discharged from a hospital is the degree to which the care provided has helped that patient restore or maintain independent living. When this is not possible, the principles of high quality care demand that the hospital help the patient make a smooth transition to another, less acute setting.

A recent AHA report of the Ad Hoc Committee on Special Care for the Elderly concludes that older adults' and their families' satisfaction with hospital care is not likely to be based solely on "cure" versus "non-cure." "Factors of equal or greater importance ... are the presence of a sympathetic staff, the facility's physical and functional

convenience, the clarity and completeness of communication from doctors and nurses, the expediency of financial arrangements, and the existence of support and guidance in decision making."

The Range of Options

As hospital governing boards consider which of these needs their institution can plan to fill and which are already being filled by other providers in the community, they will be weighing alternatives that include many of the following services:

- Skilled nursing facility
- Intermediate nursing facility
- Rehabilitation service
- Cooperative housing
- Senior citizen center
- Hospice
- Geriatric social work
- Monitoring of patients at home
- Visiting nurse
- Home health aide
- Meals
- Transportation
- Senior membership program/ preadmission registration
- Chronic care unit
- Home care agency
- Day care
- Respite care
- Senior mental health service
- Family counselling
- Care giver support
- Outreach to senior centers/housing
- Legal services
- Assistance with insurance forms
- Homemaker/chore services
- Training for professionals in geriatric care
- Patient education/health promotion

Coordination is Crucial

The hospital that recognizes the needs of its elderly patients and wishes to broaden the scope of its senior services must make coordination the hallmark of its planning and implementation. Given the complexity of the above list of service options, effective and efficient service can be achieved only if cooperation is assured at several levels.

** Internally, multidisciplinary interaction will ensure that the findings of an initial patient assessment will help define the treatment and discharge plan. This initial evaluation should include an assessment of the patient's functional status and availability of household and social supports. If systems are in place to identify and resolve problems early, the patient is more likely to move through appropriate levels of care in a timely fashion that is helpful for ensuring quality care and monitoring costs.

** Coordination with providers external to the hospital is also important if a comprehensive network of care and support is to be assured. Few hospitals are able to provide the entire range of services that elderly patients are likely to need. Therefore, established agreements with agencies that offer post-discharge care are essential to continuity; in fact, some hospitals find that referral protocols or preferred provider arrangements with other community agencies increase their ability to assure their patients home health, nursing home, and primary care. Some of these arrangements may also help increase hospital volume and/or payment predictability, especially if the hospital's partner is a fiscally sound health maintenance organization or a community-based case management program.

Making the Hospital Attractive to Seniors

While such broad-based coordination is no simple task, it is not the only element in the successful development of programs for older adults. As hospitals begin to understand the needs and interests of this large service population, they will recognize that a thoughtful but active response can enhance not only the quality of service and the institution's financial viability, but also increase its market share and its ability to attract health care professionals who are especially committed to serving this population. Some hospitals have already achieved such results by establishing one or more of the following programs or activities:

** The process of dealing with the health care system is made easier for older patients in a variety of ways. Senior membership programs permit them to preregister for hospital admission before the trauma of illness makes this process stressful. This service can be offered not only directly at the hospital, but also through physicians' offices and senior citizen centers. Transportation for physician and hospital appointments is also a major barrier for the elderly, who are much more likely to use an institution that removes the barrier for them. Additionally, older patients give high marks to hospitals that help them apply for third-party reimbursement and provide counselling about legal issues, financing, and insurance matters. In return for the little effort such services require, hospitals benefit from higher and faster collection of payments for hospital services.

** Senior health care services that are physically centralized must be those that cater to the functional disabilities of the older adults who use them. Calling an existing group of services a "senior center" for marketing purposes only shows little sensitivity to the needs of this group and will likely receive a cool reception. Ease of physical access

is also improved by signs that are more easily apparent and readable; because the elderly often have diminished acuity of the senses, colors, wall and floor coverings, furniture, and space design that simplify and maximize sensory cues create an environment in which seniors can move around more easily and safely and are therefore more appealing.

** Training hospital staff to be knowledgeable about caring for the elderly and more sensitive to the needs and limitations of older patients and their home-based care givers is also a crucial element in the quality of programming for the elderly. A hospital with a serious commitment to senior services will recruit health care professionals who specialize in caring for this population. However, considering the wide range of personnel who must be involved in providing comprehensive service to older patients, a hospital should consider establishing training programs for all levels of health care professionals -- from the nurses aide, who interacts with elderly patients more than does any other hospital worker, to nurses and physicians who must define and implement the care plans that help patients return to some level of independent activity. Recruiting active older adults as volunteers is another excellent way to immediately raise the level of sensitivity to older clients, especially in such services as telephone follow-up and consumer information and referral programs.

What Trustees Can Do

From their vantage point as members of families and communities in which older adults are constantly more visible, trustees can be especially helpful in defining the needs of older adults in their own community and forging the hospital's responses to those needs. Suggested activities for trustee involvement are listed below.

** Governing boards can spearhead a senior health services project by helping to organize a community forum in which older adults and their families can describe the breadth of the need for services.

** A subcommittee of the governing board could continue to investigate the recommendations made at such a forum, with input from a seniors advisory board as well as primary physicians in the community who are especially familiar with their own older patients' medical, social and psychological needs.

** Trustees should become familiar with the range of senior services that are already available in the community and that currently support older patients at home or after they have been discharged from the hospital to those other settings. As the hospital's own plan for

complementing these services is developed, trustees should ensure that cooperation and coordination with relevant external agencies are arranged through formal or informal affiliation agreements.

** Representatives of the governing board can help guarantee that their hospital has current information about the community network that serves the elderly by participating in the deliberations of community umbrella organizations --such as Area Agencies on Aging-- that presently coordinate social services to this population.

** Trustees can help the hospital to establish linkages with local industry and other employers who are concerned about the cost of pension benefits and the negative impact of caregiving on employee productivity. The hospital can assist these employers with such services as pre-retirement counselling, special employee rates for adult day care, educational programs on care giving, support groups, and other such programs.

** As their hospital develops a range of older adult services, trustees should scrutinize how well these service are designed from the perspective of quality. To ensure high quality, these services must respond to the special needs of older adults and must balance the use of high technology, life-sustaining measures with the patient's and family's concern for the quality of life. To this end, a trustee committee, with input from a hospital ethics committee, should consider how less use of expensive technology can free resources for more person-intensive care, such as nursing, counseling, and other supportive services.

** If the hospital chooses to include such non-revenue generating services as health promotion, assistance with completing insurance forms, and senior consumer information programs, the governing board should make certain that both program managers and hospital administration subscribe to the service rather than to the revenue-generating goals of the program. Once these programs are in place and begin to attract patients, eliminating them may do more damage to the hospital's image than continuing to support a program that is not totally self-sustaining.

Summary

The report of the AHA Ad Hoc Committee on Special Care for the Elderly has been mailed to AHA member hospitals. Trustees interested in reviewing the report, titled Hospitals and Older Adults: Meeting the Challenge, should contact their hospital CEO. Additional copies can be purchased by calling AHA Order Processing at 1-800-AHA-2626. The cost is $15 for AHA members and $25 for nonmembers. When ordering, please ask for AHA catalog number 130101.

1. American Hospital Association. Hospitals and Older Adults: Meeting the Challenge. Chicago: AHA, 1989.

2. The Hospital Research and Educational Trust. Hospitals and Older Adults: Current Actions and Future Trends. Chicago: the Trust, 1982.

3. The Hospital Research and Educational Trust. The Hospital's Role in Caring for the Elderly: Leadership Issues. Chicago: the Trust, 1982.

BRIEFING PAPERS IN THIS SERIES ARE:

Name of Briefing Paper	Date of Briefing Paper
Medical Liability Insurance Crisis	June, 1985
Current Issues in Hospital Directors' and Officers' (D & O) Liability Insurance	December, 1985
Hospital Governing Board Self-Evaluation	April, 1986
Care for the Medically Indigent: The Trustee's Role	April, 1987
Board's Responsibility for Assuring Quality Care	July, 1987
Granting Medical Staff Appointments and Privileges--The Board's Key Role in Assuring Quality Care	November, 1987
What Trustees Need to Know about HCFA Mortality Data	December, 1987
Aids: A Special Report	June, 1988
What Trustees Need to Know about the Nursing Shortage	September, 1988
Medicare Advocacy Campaign Update	October, 1988
Hospital Tax-Exempt Status and the Unrelated Business Income Tax: An Overview for Trustees	December, 1988
The Rise of Hospital CEO Turnover	March, 1989
Hospital Closings: The Board's Role in the Hospital's Survival	June, 1989
Emerging Hospital Roles in Caring for the Elderly	December 1989

December, 1989

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
ANNUAL REPORT
to the
BOARD OF REGENTS

JANUARY 11, 1990

1989 POINTS OF PROGRESS OR CHANGE

Summary of Comments
Made By
Mr. Robert Nickoloff

I. Activity Levels and Financing

Hospital Utilization Statistics

Hospital admissions declined slightly during the 1988-89 Fiscal Year (FY) and are projected to remain at that lower level this year. Although admissions have only declined slightly, the Hospitals average daily census has been significantly lower for the first 5 months of FY 1989 and will likely remain lower for the rest of the year. The decline in daily census is attributable to a strong effort to manage care so that patients are discharged when they no longer require acute inpatient care. The 1989 calendar year began with average lengths of stay of 9.1 days in Janaury and 9.0 days in February. During the second six months in 1989, the length of stay droped to an average of 8.1 days.

The growth in outpatient clinic visits has slowed somewhat. This growth may be expected to remain slower given that several of our clinics are operating at their facility capacity.

Financial Summary

During the fiscal year ending on June 30, 1989, both revenues and expenses exceeded budget, resulting is a positive $2.5 million bottom line for the year. A positive bottom line of $4 million had been budgeted. This $1.5 million variance from budgeted bottom line represents .5% variance on revenues for the year that totalled $310 million.

A significant amount of effort was exerted toward the end of 1989 in controlling the Hospital's operating expenses. Operations during the

months of July - November, 1989 resulted in a positive variance of $1.3 million in net revenue. Cash collections have also improved significantly over the past 6 months.

II. Managing in the Marketplace

Hospital Affiliations
Referring Physician Relationships

As competition for provision of tertiary care services has and will continue to intensify, area hospitals are forming linkages with other providers and trying new methods to enhance relationships with referring physicians. Many of the hospitals in the Twin Cities have been very aggressive in the development of networks and systems. Activities include acquisition of hospitals, mergers, acquisition of physician practices, and extensive development of alternative delivery programs.

UMHC has developed affiliation agreements with several physician practices and medical communities. Discussions are underway with additional providers to establish some level of affiliation, joint program development, or other cooperative relationships.

In 1989, the hospital installed 30 computer linkages to outstate physician locations. The computers are used to transmit test results, operative reports and discharge summaries. They are considered an effective method for enhancing our relationships with out-state providers.

State Health Plan Participation

A very important new relationship for UMHC in 1990 is its participation in the new State Health Insurance Plan. University employees should have access to the facilities, programs, and expertise of the Hospital and the Health Sciences. The State Plan is, however, the only health insurance option for employees allowing direct access to UMHC without prior approval. The Board of Governors is aware of the recently established task force on fringe benefits and are hopeful that these efforts can successfully address the myriad of issues relating to health care for State and University employees.

III. University Hospital Leadership and Staff

Vice President for Health Sciences

As you know, the Vice President for Health Sciences is a member of the Board of Governors and acts as a sponsor for all agenda items going from the Board of Governors to the Board of Regents. Beyond that defined interface with the Board of Governors, the Vice President for Health Sciences is a vitally important advisor and advocate for the Hospital.

The departure of Dr. Neal Vanselow very early in 1989 was of concern to the Board of Governors. Vice President Cherie Perlmutter, however,

quickly laid that concern to rest. Her insightful guidance and support have become extremely valuable to the members of the Board of Governors.

Clinical Chairman

For most of the 1980's The University of Minnesota Hospital and Clinic experienced vacancies among our departmental chairman, or clinical chiefs as they are called in their clinical oversight capacity. In 1989, four new Chairmen were recruited to the University. Dr. Roberto Heros assumed the Chairmanship in Neurosurgery, replacing the widely respected, Dr. Shelley Chou. Dr. Richard Price became Chairman of Neurology, Dr. Richard Palahniuk became the Chairman in Anesthesiology and Dr. James Swift became the Chairman in Oral Surgery. With those new appointments, all but two of the 18 positions are filled, those in Laboratory Medicine and Pathology and Otolaryngology where active recruitments are now underway.

Healthcare Manpower Shortages

There are seven primary professional groups employed at the Hospital that are increasingly in demand or increasingly short in supply. Industry wide, professional groups viewed as being difficult to recruit include radiation technologists, pharmacists, nurses, physical therapists, occupational therapists, respiratory therapists and nurse anesthet
At The University of Minnesota Hospital and Clinic we have experi
shortages in most of these areas. The personnel delegation from the Board of Regents to the Board of Governors has been particularly helpful in that it has afforded us the flexibility to develop responsive compensation packages for these professional groups.

Teamsters, AFSCME Negotiations

As you know, representatives from University personnel act as lead participants in the Teamsters contract discussions while Hospital personnel representatives lead AFSCME negotiations. We were pleased that both contracts were successfully negotiated and ratified by union memberships in 1989.

Pay Equity

On July 1, 1985, The University of Minnesota Hospital and Clinic began funding pay equity adjustments for our employees. Our six year implementation plan for employees in hospital dominated classifications is scheduled to conclude in July of 1990.

Managing a Diversified Work Force

The University of Minnesota Hospital and Clinic undertook a special project in 1989 geared toward enhancing the ability of our managers to manage and retain a multicultural, diverse work force. Equal employment opportunity and affirmative action goals have long been appreciated by our managers. Beyond recruiting employees from diverse backgrounds, we felt it important to evaluate the treatment of our multicultural work force as long term employees. Mr. George Caldwell from the University's Affirmative Action Office has been particularly helpful to us in developing and leading those enrichment sessions for our managers.

Employee Appreciation

Employee appreciation is something The University of Minnesota Hospital and Clinic considers to be an institutional priority. Over the past five or six years, we have allocated greater resources toward employee recognition activities. Perhaps more importantly, we have involved hospital administrators very personally in those recognition activities and events. That increased participation seems to have been well received by Hospital employees.

IV. Quality Assurance in Patient Care

Clinical Program Development

During 1989 several notable clinical services at The University of Minnesota Hospital and Clinic were initiated or expanded. A Cutaneous Surgery Clinic and a Low Back Center serve as examples of newly initiated programs. The Dermatology Clinic, which currently sees about 14,000 patients annually, expanded into a new facility designed to accommodate an expanding practice of cutaneous or dermatologic surgery. The Cutaneous Surgery Clinic is located on the fourth floor of the Phillips-Wagensteen Building and has the capacity to accommodate 4000 patients annually. The University's Orthopedic Surgeons and Neurosurgeons joined together with rehabilitation specialists to implement an innovative program for patients with chronic low back disorders. The program is specifically geared toward rehabilitating patients who have had low back pain for more than four months and who are not surgical candidates. That program is located on the fifth floor of the Mayo Building.

The University's heart and heart-lung transplant service is thriving under the leadership of Dr. R. Morton "Chip" Bolman. 21 heart transplants were done in 1989, a number approximately equal to those done in 1988. 9 heart-lung transplants were done in 1989; that number is triple the number of heart-lung transplants done in any prior year. 6 single lung transplants were also done in 1989. Only one single lung had been done at the University before 1989.

The Bone Marrow Transplant program is also thriving. The program is considered by many to be the best bone marrow transplant program in the country.

In 1989, 185 bone marrow transplants were done here. The University of Minnesota performs all types of bone marrow transplant including related donor transplants, transplants where the recepient serves as a self-donor, and, most recently, unrelated donor transplants. The unrelated donor transplants grew in number from 11 to 42 from 1988 to 1989. Our participation in the National Marrow Donor Program enabled that unrelated donor transplant growth.

Quality Monitoring Efforts

UMHC is perceived both internally and externally as a very high quality health care provider. To maintain these high standards the Hospital has a very extensive quality assurance and utilization review program. In late 1990, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private organization which certifies the quality standards of hospitals, will conduct a site visit at UMHC.

Biomedical and Ethical Issues

The development of new medical technology is accompanied by an increase in the complexity of ethical decision-making. Providers such as the University of Minnesota who are working at the leading edge of medicine and technology development also play a role in setting precedents dealing with biomedical and ethical issues. One issue confronting [illegible] and other health care providers is care of the terminally ill, including foregoing or withdrawing treatment and recent legislative changes providing for advance treatment directives or "living wills".

The Living Will

Hospitalized patients routinely make decisions with regard to accepting or rejecting medical treatment. A Minnesota Statute, which took effect in 1989, allows patients to insure that their specific wishes are honored should they become incompetent by preparing advance treatment directives or "living wills". The patient may also through the living will, designate a proxy decision maker to make medical decisions on their behalf should they become incompetent.

Living wills are one example of a trend in health care towards greater patient involvement in and influence over treatment decision making.

Patients First

In addition to greater patient involvement in decision making health care providers increasingly view patient service as an important component of health care delivery.

Large complex academic health centers have not always specialized in the service aspects of the care they provide. Patients First is UMHC's effort to ensure that all Hospital staff regard patients as their primary priority and interface with patients and families in a spirit reflective of that philosophy.

Robert Wood Johnson Grant to Nursing Services

In 1989, UMHC received a grant entitled "Strengthening Hospital Nursing: A Program to Improve Patient Care" from the Robert Wood Johnson Foundation. 80 institutions were awarded monies to develop a plan for restructuring nursing care through a strategic planning process. The project is viewed as an opportunity to explore new and creative ways of providing high quality patient care with limited resources.

V. Facility and Technology Development

Renewal Project: Phase II

In October of 1988 the Board of Regents approved a $62 million construction and renovation project for the University Hospital, referred to as Renewal Project, Phase II. The project is intended to provide updated facility for the departments that were not included in the "new" University Hospital building.

Detailed reviews of the renovation plans prompted the Board of Governors to evaluate two separate renovation strategies. Option one proposes expanding the new University Hospital vertically and renovating the old Mayo building. Option two proposes demolishing part of the Mayo building and constructing a new wing on that site. In recent months, we have devoted more intensive effort in reviewing option two. Although it would require more time to complete than option one, the end product appears to have several advantages over the original plan.

Either construction option would be funded entirely from University Hospital cash reserves and operating cash flow. The alternative option under consideration generally retains the same programmatic objectives, budgeted expenditure levels and financing plans set forth originally.

The Board of Governors is planning to conclude our evaluation of the reconfiguration option by March and to make a recommendation to the Board of Regents shortly thereafter.

Technology Development and Acquisition

As part of the University Hospital's commitment to providing state of the art patient care, we have a commitment to maintain state of the art equipment. Major equipment expenditures are generally concentrated in the departments of Diagnostic Radiology, the Laboratories, the Operating

Rooms, Computer Services, Therapeutic Radiology and Respiratory Therapy. During 1989, the Board of Governors approved a second magnetic resonance imaging unit for the hospital. A hyperthermia unit for use in heating tumors to enhance the effects of radiation therapy was acquired. In 1985, the hospital installed a shock wave lithotritor for non-invasive treatment of kidney stones. In 1989, the hospital accepted a similar machine for experimental treatment of gall stones.

Policy on Capital Expenditures

In February of 1989, the Board of Governors revised a policy on managing capital expenditure approvals. While our policy utilizes Hospital specific budget parameters, we essentially followed the lead of the Board of Regents by strengthening our involvement in the approval process for capital expenditures and expenditure overages.

Conclusions

In conclusion, 1989 has been a year of significant change for The University of Minnesota Hospital and Clinic. Our activity levels are reflecting an appropriately shorter length of hospital stay. Our financial position, with some effort, continues to be strong. Our marketplace has always been a competitive one. Referring physician relationships and third party influence on access to hospitals are important considerations in keeping census strong.

We, like the University at large, are a very labor intensive organization. We consider the leadership provided by the Vice President for Health Sciences and the Clinical Chiefs to be important strengths. We have also gone to some lengths to ensure our ability to recruit and retain a qualified pool of hospital personnel.

Issues of clinical program advancement and quality monitoring will be prominent ones in our industry for years to come. With those developments come a broad range of biomedical and ethical issues. We as a Board feel confident in the commitment of our clinicians to achieve excellence in these pursuits.

The Board of Governors expects to be back before the Board of Regents early in 1990 to discuss the Renewal Project: Phase II and to discuss some changes to the Board of Governors Bylaws.

Thank you.

OVERVIEW OF CRITICAL CARE CLINICAL INFORMATION MANAGEMENT SYSTEM PURCHASE REQUEST

What do we want to purchase?

The product we propose to purchase is a Clinical Information Management System which automates all record keeping functions from Physician Order Entry, to Kardex, to Nurse Care Plans, to Flowsheet. The system communicates on-line to bedside monitoring instruments for automatically acquiring data on vital signs as well as the hospital's laboratory system.

This system developed for use in the ICU will be a building block for a hospital-wide patient care information system. Its purpose is in accord with the Hospital's goals for productivity, quality, financial decision making, regulation and competition. Additionally, this system provides a Research Data Management System which will meet the data needs of medical and nursing research, as well as a quality assurance program.

How would we proceed?

We would propose to begin with 4D, the surgical ICU, early in 1990. Therefore our request for funding covers this part of the plan. However, if the criteria for evaluation are met and additional funding approved, we will expand to 4C, medical ICU, and 4E, pediatric ICU, some time in 1990-1991.

The network technology that EMTEK provides is compatible with our hospital's direction of network development with intelligent work station components. Ultimately, this approach decreases the demand for ever larger mainframe computers and dependence on the mainframe for being "up" to keep work going. This approach facilitates the linking together of many networks throughout the hospital.

What will it do for us?

This critical care system will provide benefits in three areas, i.e., costs, quality and management. While we anticipate both "hard" and "soft" savings in the three categories (see benefits section in attached report), the acquisition of this system will be a first step in building a hospital patient information system to support and improve patient care. Data management is an essential component of quality care in the critical care units, where there is a plethora of data produced over the course of a day. While we are currently producing reams of data, having that data readily available for decision making in a manageable format will only be achieved through a system such as EMTEK. This decision support will benefit the care of individual patients as well as provide a data base for quality assurance and research purposes to identify the most effective programs, care modalities, services, etc.

Finally, our interdisciplinary approach to system selection and implementation has been noted by the vendors as unique, and has kept our focus on the patient, and an integrated approach to patient care issues. Ultimately, improvements in decision making through the availability of timely, organized data will facilitate more efficient utilization of costly critical care beds, so that the average length of stay in the critical care unit can be decreased.

hp>hp1213891pd

Nursing FTE Savings continued:

The UMH nursing staffing and patient assignments and workflow will be affected in increments. The FTE projections are a conservative projection of the summary of these incremental savings.

Critical care staffing is a key target area due to the shortage and extensive skill level requirement.

3. Other Benefits

Other benefits that will be achieved include:
- Productivity gains within other departments.
- Reimbursement audits and charge capture.
- Improved decision support for management.
- Research and quality assurance support.

Soft benefits will be:
- Positive affect on recruitment and retention of staff.
- Staff satisfaction.
- Marketing advantage.

GENERAL INFORMATION

- Dunn and Bradstreet report is very favorable; company is well financed, research and development is very strong, excellent financial backing from parent company, Motorola, Inc.
- Contract will include phased payment schedule.
- Negotiations reflect reduction for development and alpha-beta partnership agreement.
- Benefit study is to be done.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

FEBRUARY 28, 1990

TABLE OF CONTENTS

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

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
FEBRUARY 28, 1990
2:30 P.M.
555 DIEHL HALL

AGENDA

I.	Approval of the January 24, 1989 Minutes	Approval
II.	Chairman's Report -Mr. George Heenan	Information
III.	Hospital Director's Report -Mr. Robert Dickler	Information
IV.	Special Presentation: Ms. Marcia Fluer -Director of University Relations	Information
V.	Committee Reports	
	A. Joint Conference Committee	
	-Mr. George Heenan	
	1. Medical Staff-Hospital Council Report Credentials Committee Recommendations	Approval
	2. Joint Commission on Accreditation of HealthCare Organizations	Information
	B. Planning and Development	
	-Mr. Robert Latz	
	1. Renewal Project: Phase II	Information
	2. Quarterly Purchasing Report	Approval

C. Finance Committee

-Mr. Jerry Meilahn

1. January 31, 1990 Financial Statements	Information
2. Special Project: ICU Information System	Approval
3. Special Project: CT Scanner	Approval
4. CHC Waste Disposal Project	Endorsement
5. Major Capital Expenditure: Heart Cath Remodeling	Information
6. Major Capital Expenditure: Frontal Plane Image Chain Upgrate	Information
7. Admissions Policy	Approval

VI. Other Business

VII. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

January 24, 1990

Call To Order

Mr. Robert Dickler called the January 24, 1990 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. Robert Dickler Phyllis Ellis George Heenan Robert Latz Margaret Matalamaki Robert Maxwell, M.D. Jerry Meilahn Robert Nickoloff Cherie Perlmutter Jan Withers
Not Present:	Paula Clayton, M.D. Gordon Donhowe Kris Johnson Barbara O'Grady

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the December 20, 1989 meeting as submitted.

Special Presentation: Dr. James Q. Swift

Mr. Dickler introduced the Board to Dr. James Q. Swift, Clinical Chief of Dentistry Services. Dr. Swift received his D.D.S. Degree from the University of Iowa College of Dentistry and his post graduate education from the University of Oklahoma College of Medicine. Dr. Swift presented to the Board an overview of the Department of Dentistry and Oral and Maxillofacial Surgery.

Chairman's Report

Mr. Robert Nickoloff introduced new Board members, Margaret Matalamaki and Jan Withers, to the Board of Governors. Margaret Matalamaki is from Grand Rapids, recently served as 4th District Itasca County Commissioner and is Chair of Charles K. Blandin Foundation. Jan Withers is from Golden Valley, is currently a second year medical student and has infection control nursing background.

Mr. Nickoloff referred the Board to a narrative of the Annual Report to the Board of Regents. The report was presented to the Board of Regents on January 11, 1990.

Mr. Nickoloff recognized Ms. Barbara Tebbit for outstanding service as a Trustee of the Minnesota Hospital Association.

Director's Report

Mr. Dickler overviewed the Renewal Project: Phase II options currently under examination. Each is being reviewed in detail by the involved clinical services and the Council of Clinical Chiefs as a group. Renewal project options will be reviewed with the Board of Governors during the months of February and March.

Mr. Dickler overviewed the 1990-91 budget planning process for the Board. This year, hospital department heads will work under more centrally established revenue and expense targets.

Mr. Dickler announced that a Nominating Committee was being formed to recommend a slate of candidates for Chair and Vice Chair of the Board. The Nominating Committee report will be given at the February 28, 1990 Board of Governors meeting.

Planning and Development Committee Report

Mr. Robert Latz called on Ms. Mary Ellen Wells to present the CUHCC Facility Project to the Board. Following a detailed review of the budgetary modifications, Ms. Wells requested endorsement of the Board to increase the scope of the project from $1.5M to $2.35M. The Board of Governors seconded and passed a motion endorsing the CUHCC Facility Project at a $2.35M expenditure.

Mr. Al Dees presented a proposal to purchase a new CT Scanner to replace a CT Scanner which was originally installed in 1984. This proposal will be brought to the Board in February for review and approval.

Ms. Helen Pitt presented a proposal for a new ICU Information System to the Board of Governors. This patient care computer system was developed for use in the intensive care setting and will allow hospital-wide patient care information system. Additionally, this system provides a Research Data Management System which will meet the data needs of medical and nursing research.

Mr. Dickler presented to the Board a proposal from the Council of Hospital Corporations for a Medical Waste Incineration. The proposal calls for the formation of a corporation consisting of interested CHC hospitals for the purpose of jointly researching, planning, constructing and operating a Medical Waste Incinerator in or near the Minneapolis/St. Paul metro area. The University Hospital is currently being asked to commit to a dollar level not to exceed $107,416. Based on CHC's preliminary estimates the anticipated aggregate capital commitment for the University, if the project were to be brought to fruition, is anticipated to be in the range of $600,000-$625,000. The CHC Medical Waste Incinerator Project will be brought back to the Board in February for review and endorsement.

Finance Committee Report

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the financial report. Mr. Fearing reported the Hospitals Statement of Operations for the period July 1, 1989 to December 31, 1989 shows revenues exceeding expenses by $3,209,290, a favorable variance of $1,154,619.

Mr. Fearing reported inpatient admissions for December, 1989 totaled 1,434, which was 27 below budgeted admissions of 1,461. Overall length of stay for the month was 7.6 days. Outpatient clinic visits for the month of December totaled 19,646 which was 1,932, or 9.0%, below budgeted visits of 21,578.

Fiscal year to date, admissions are almost exactly on budget, while the average length of stay has dropped to 8.0 from the budgeted 8.4 days. 78,854 patient days had been anticipated during the first six months; 75,797 days of care were rendered.

Mr. Fearing presented the Hospital Admissions Policies to the Board. The policy reinforces the importance of establishing a payor source for patients, prior to non-emergent admissions. This policy will be brought back to the February Board meeting for review and approval.

1989-90 second quarter bad debts were reviewed. 1,612 accounts were proposed for write-off. Those accounts represented $523,936.71 in write-offs, or 0.66% of gross charges. The Board of Governors seconded and passed a motion to approve the Second Quarter 1989-90 Bad Debt report as submitted.

Bylaws Committee Report

The proposed Board of Governors Bylaw changes were discussed at some length. The Bylaws propose two three year terms in favor of the current three three year terms; eligibility for a third term could be recommended for Board of Governors members elected to fill the positions of Chair and Vice Chair. This issue received considerable debate. In conclusion, the Board of Governors endorsed the Bylaw changes by a vote of nine to one; Mr. Bienias voted not to endorse the changes. The Bylaws will be forwarded to the Board of Regents for approval.

Adjournment

There being no further business, the January 24, 1990 meeting of the Board of Governors was adjourned at 4:10 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 22, 1990

TO: Members of the Board of Governors

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

We are pleased to welcome Ms. Marcia Fluer as our enrichment speaker this month. Ms. Fluer is the Director of University Relations. We have invited Ms. Fluer to comment on the University Hospital's public image and on the relationships between the Hospital and metro area media representatives.

This 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.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Relations
6 Morrill Hall
100 Church Street S.E.
Minneapolis, Minnesota 55455
(612) 624-6868

Basic Resume

Marcia Fluer

Born: Toledo, Ohio

Career History

1989-	Director, University Relations
1984-88	WCCO TV,Reporter,Co-anchor, "Newsday"
1972-84	KSTP TV, Political Reporter, Weekend Anchor
Previous:	High School and College English teacher, theater, traveling performer
Education:	M.A. English, University of Toledo B.S. Speech, Northwestern University

Personal

Married, two children. Hobbies: Baseball, most sports, theater, gardening

MINUTES
Joint Conference Committee
Board of Governors
February 14, 1990

CALL TO ORDER:

Chairman Heenan called the February 14, 1990 meeting of the Joint Conference Committee to order at 4:41 P.M. in Room 8-106 in the University Hospital.

Attendance:

Present:
George Heenan
Amos Deinard, M.D.
Robert Dickler
Phyllis Ellis
Jan Withers
Bruce Work, M.D.

Absent:
Robert Maxwell, M.D.

Staff:
Nancy Janda
Shannon Lorbiecki
Helen Pitt
Ann Russell

APPROVAL OF MINUTES:

The minutes of the December 13, 1989 meeting were approved as submitted.

JCAHO UPDATE

Ms. Nancy Janda presented an update on the schedule for the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) next site visit and the Hospital's preparation for the visit. The site visit is expected sometime late in 1990. Two issues highlighted were JCAHO's "Agenda for Change" and the privacy of survey information.

The primary goals of the "Agenda for Change" are to improve the standards and survey practices and to create a national data base which will allow for comparison of hospital data on quality. Several major standard revisions have been completed. Five Joint Commission task forces are developing outcome indicators to compare quality between institutions.

Confidentiality in the relationship between JCAHO and the organization surveyed has been a cornerstone of the program's success. Traditionally, government has respected the right to privacy. The Health Care Financing Administration has accepted JCAHO accreditation as evidence of acceptable quality for participation in the Medicare program. As a result of demands for more public accountability, JCAHO has begun to release information to HCFA if a hospital has deviated significantly from its standards.

The presentation led to a discussion of the value of our current quality assurance program, including JCAHO participation, to the Hospital and its medical staff and how that value can be increased by planning for the future. Members of the Committee suggested that administrative staff continue to prepare for the expected visit this year and also explore long range alternatives for the quality assurance program. The Committee would like to consider this in the discussion of its work plan for 1990.

COMMITTEE WORK PLAN

The Joint Conference Committee's 1989 work plan was presented as a starting point for the Committee to for development of a 1990 work plan. Mr. Robert Dickler noted that items under the "routine" items and quality assurance activities are required activities of the Committee and the greatest flexibility is in the issue development/monitoring category. In preparation for the March meeting, members of the Committee will review the previous work plan and consider what specific issues they would like to include in the 1990 plan.

COUNCIL OF CLINICAL CHIEFS REPORT

Dr. Bruce Work reported that meetings of the Council of Clinical Chiefs have included discussion of a group established by MAPTH (Minnesota Association Public Teaching Hospitals) to provide support for residents, the Phys Impairment Committee, new admissions guidelines which are being incorporated into Hospital policy, the Hospital's Renewal Project: Phase II, the Vice President for Health Sciences search, Social Security withholding for residents, medical school space concerns, and the State Employees Health Insurance Plan.

MEDICAL STAFF HOSPITAL COUNCIL REPORT: CREDENTIALS COMMITTEE RECOMMENDATIONS

In Dr. Robert Maxwell's absence, Mr. Robert Dickler presented the recommendations of the Credentials Committee which were endorsed by the Medical Staff-Hospital Council. It was noted that the recommendations include waiving the period of provisional status for the privileges of Dr. Heros as has been the custom for the Chief of a Clinical service.

The recommendations of the Credentials Committee were unanimously endorsed including waiving the provisional status of Dr. Heros' clinical privileges.

OTHER BUSINESS

Mr. Dickler provided an update to the Committee on the status of a patient whose case received widespread media attention recently.

ADJOURNMENT

There being no further business, the meeting was adjourned at 6:15 P.M.

Respectfully Submitted:

Shannon L. Lorbiecki

Shannon L. Lorbiecki
Administrative Fellow

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 15, 1990

TO: Members of the Board of Governors

FROM: Robert E. Maxwell, M.D., Chief of Staff REM
Chairman, Medical Staff-Hospital Council

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

The Medical Staff-Hospital Council on February 13 and the Joint Conference Committee on February 14 have endorsed the attached Credentials Committee Report and Recommendations.

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

REM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 7, 1990

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

Department of Medicine	Category
Robert J. Helgren	Attending Staff
Department of Neurosurgery	
Roberto C. Heros	Attending Staff
Department of Ophthalmology	
Dan A. Nichols	Clinical Staff
Department of Pediatrics	
Carroll A. Brennan	Attending Staff
Kumud Sane	Clinical Staff
Department of Psychiatry	
Anne F. Kolar	Attending Staff
Robert M. Rose	Attending Staff
Department of Radiology	
Stephen W. Trenkner	Attending Staff
Department of Surgery	
Mark E. Lovaas	Clinical Staff

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

Department of Medicine	Category
M. Wayne Saville	Attending Staff

Privileges: Add--bone marrow harvest

Department of Ophthalmology

J. Douglas Cameron	Attending Staff

Privileges: Add--retinal lesions, including detachment, laser-Argon/Dye; glaucoma-iris and ciliary body lesions, lasers-YAG and Argon/Dye; capsulotomy, laser-YAG

George T. Tani	Clinical Staff

Privileges: Delete--detachment - photo-coagulation and laser

Department of Otolaryngology

George Adams	Attending Staff

Privilege: Add--middle or inner ear surgery, laser-Argon

Samuel C. Levine	Attending Staff

Privilege: Add--middle or inner ear surgery, laser-Argon

Robert Maisel	Attending Staff

Privilege: Add--middle or inner ear surgery, laser-Argon

Department of Hospital Dentistry	Present Category	Recommended Category
Richard T. Ford	Clinical Staff	Attending Staff

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

Department of Dermatology	Category	Date Eligible
Christopher B. Zachary	Attending Staff	October 26, 1989
Department of Medicine		
James R. Johnson	Attending Staff	October 26, 1989
David J. Ridley	Clinical Staff	October 26, 1989
Department of Obstetrics & Gynecology		
Penny A. Wheeler	Clinical Staff	October 26, 1989
Department of Ophthalmology		
Edwin H. Ryan	Attending Staff	December 28, 1989
Department of Pediatrics		
Thomas J. Pokora	Clinical Staff	December 28, 1989
Department of Psychiatry		
Boyd K. Hartman	Attending Staff	October 26, 1989
Department of Urology		
Nizamuddin J. Maruf	Clinical Staff	October 26, 1989

The Committee recommends acceptance of the leave of absence from the Medical Staff for the following physician

Department of Orthopedics	Category
Robert Hunter	Attending Staff

LOA from January 1, 1990 through December 31, 1990

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

Department of Laboratory Medicine and Pathology	Category
Michael W. Chopek	Attending Staff
Glauco Frizzera	Attending Staff
Paul E. Swanson	Attending Staff
William H. Vine	Attending Staff
Department of Medicine	
Maria Teresa Olivari	Attending Staff
Paul D. Savage	Attending Staff
Department of Physical Medicine and Rehabilitation	
John Speed	Attending Staff
Department of Psychiatry	
Barry R. Rittberg	Attending Staff
Department of Surgery	
Victor A. Gilbertsen	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 23, 1990

TO: Members of the Board of Governors

FROM: Nancy Janda
Associate Director
Secretary to Board of Governors

RE: Joint Commission on Accreditation of Healthcare Organizations

The University of Minnesota Hospital and Clinic was last surveyed by the Joint Commission on Accreditation of Healthcare Organizations on November 13-16, 1987. Our next triennial survey will likely occur in November of 1990.

Three background documents are attached for your review:

- Estimated Timeframes for 1990 Site Visit
- Summary of Contingencies from 1987 Site Visit
- JCAHO Overview of the "Agenda for Change"

We will be keeping the Joint Conference Committee abreast of preparations for the fall site visit. Thank you.

NCJ/gs

Joint Commission on Accreditation of Healthcare Organizations
1990 Site Visit
Estimated Time Frames

Receive Application for Survey sent to UMHC 7 months before anniversary date	@ April 15, 1990
Return Application for Survey return within 2 weeks	@ May 1, 1990
Receive Statements of Construction sent to UMHC upon receipt of application	@ May 15, 1990
Return Statements of Construction return within 6 weeks	@ July 1, 1990
Mock Survey	@ July 13, 1990
Joint Commission Site Visit	@ November, 1990

JCAH Communique

The University of Minnesota Hospital and Clinic

November 13-16, 1987 Site Visit

THREE YEAR ACCREDITATION AWARDED
Summary of Contingencies

1. **GOVERNANCE:** The Board of Governors documentation of quality assurance reviews were limited.

2. **AMBULATORY CARE:** Medical records did not routinely include complete summary sheets.

3. **AMBULATORY CARE:** Examples of effective action taken as part of the Ambulatory Care Q.A. plan were limited.

4. **AMBULATORY CARE:** The effectiveness of actions taken to improve care should be evaluated more thoroughly.

5. **MEDICAL STAFF HOSPITAL COUNCIL:** The Medical Staff Hospital Council does not receive or act upon the findings of the all clinical departments' Q.A. plans.

6. **CLINICAL DEPARTMENT Q.A.:** Clinical departments do not uniformly hold monthly meetings to consider quality assurance findings.

7. **CLINICAL DEPARTMENT Q.A.:** Minutes of the clinical departmental meetings do not document conclusions, recommendations, actions and evaluations of actions taken as part of the quality assurance monitoring and evaluation plans.

8. **TISSUE AND PROCEDURE:** The Tissue and Procedure Committee meets every other month rather than every month. Documentation did not consistently indicate that all cases were reviewed at the meetings.

9. **MEDICAL STAFF MEDICAL RECORD REVIEW:** Medical Staff involvement in review of medical records for clinical pertinence was initiated only recently.

10. **MEDICAL STAFF MEDICAL RECORD REVIEW:** Only nine records have been reviewed by medical staff for clinical pertinence.

11. **BLOOD USAGE REVIEW:** Blood usage review does not include review of the ordering practices of all blood and blood products. Review activities addressed only the ordering of platelets.

12. **BLOOD USAGE REVIEW:** Blood usage review does not include criteria for the review of cases involving whole blood. Criteria for the review of cases involving the use of cryoprecipitates, fresh frozen plasma and red blood cells have been developted, but not implemented.

13. **NUCLEAR MEDICINE:** Actions taken to improve care are not sufficiently documented as part of Nuclear Medicine's Q.A. plan.

14. **NUCLEAR MEDICINE:** Evaluation of the effectiveness of actions taken as part of Nuclear Medicine's Q.A. plan is not documented.

15. **NUCLEAR MEDICINE:** The findings from and conclusions of the quality assurance activities should be reported; there was no evidence that findings are reported.

16. **OPERATING ROOMS:** Nonregistered nurses are assigned to the circulating nurse position in the O.R.

17. **PLANT, TECHNOLOGY:** Employee lockers on the first floor of Mayo are not protected by one hour fire resistant construction. The (C) in the margin of page 16 corresponding to recommendation 60 (a) is duplicative of this contingency.

18. **EMERGENCY PREPAREDNESS:** Emergency preparedness drills are not being conducted at six month intervals.

19. **EMERGENCY PREPAREDNESS:** Neither of the 1987 drills involved an influx of patients from outside of the hospital.

20. **PLANT, TECHNOLOGY:** Although weekly generator exercises have been conducted, the emergency generator has not been tested under full load.

A Brief Overview of the Joint Commission's "Agenda for Change"

The Joint Commission's mission is "to enhance the quality of health care provided to the public," and the Agenda for Change is dedicated to finding better ways to carry out that mission.

For the past three years the Joint Commission has been engaged in an intensive research and development effort to fundamentally improve our standards, surveys, and accreditation decisions and to create a data-driven monitoring and feedback system. These changes should stimulate enhanced attention to quality and improved patient care in the organizations we accredit.

The philosophical context for the Agenda for Change is set by the theories of Continual Quality Improvement which emphasize:

- Quality as a central priority: organization-wide devotion to quality, leadership involvement in promoting and improving quality
- Customers: attention to customer needs, feedback from internal and external customers, customer-supplier dialogue
- Work processes: describing key clinical and managerial processes, systems approach, cross-disciplinary teams
- Measurement: use of data, understanding variation, search for underlying causes
- Improvement: never-ending commitment to improvement

The flavor of Continual Quality Improvement is captured by Don Berwick, MD, in the New England Journal of Medicine (1/5/89, pp. 53-56):

> Quality can be improved much more when people are assumed to be trying hard and are not accused of sloth. Fear of the kind engendered by the disciplinary approach poisons improvement in quality, since it eventually leads to disaffection, distortion of information, and the loss of the chance to learn. Real improvement in quality depends on understanding and revising the production processes on the basis of data about the processes themselves. ...when the hearts and talents of all workers are enlisted in the pursuit of better ways, the potential for improvement in quality is nearly boundless.

The Agenda for Change has two major goals:

1. stimulation of health care organizations to create an environment focused on quality of care, whose governance, management and clinical leaders are devoted to quality improvement, and

2. development and implementation of a national performance measurement database that will help to stimulate continual improvement.

Goal #1 will be advanced by having fewer standards, and by focusing those standards on the functions that are essential to good patient outcomes. Using the "Principles of Organizational and Management Effectiveness" as a blueprint, our standards revision efforts over the next several years will streamline existing standards by focusing them on key fuctions and by adding standards that describe:

- Key Leadership Functions
- Methods for Quality Assessment and Continual Improvement
- Information Management Centered on Quality Assessment and Improvement

Coupled with improved standards will be enhancements in the Joint Commission's survey processes -- changes designed to stimulate better organizational performance. Accreditation reports and decisions will reflect how effectively all staff are contributing to good patient care and are truly engaged in "the pursuit of better ways."

Goal #2 is driven by our belief that health care quality improvement requires a standardized, universal, affordable, flexible and reliable data system which can provide risk-adjusted, comparative feedback to health care providers. As an accrediting body, the Joint Commission is developing indicators that can test how effectively organizations perform the key clinical and management functions (described in our standards) which are the antecedents of good patient outcomes.

Good indicators prompt investigation of clinical, managerial, governance and/or support processes in order to remedy problems or produce even better patient outcomes. Five sets of such indicators are now undergoing rigorous testing in a representative group of pilot hospitals; additional expert task forces will be convened to help select measures for other aspects of hospital care (e.g., medication use and infection control) as well as monitoring other organizations accredited by the Joint Commission (mental health facilities, nursing homes, home health agencies, hospices, managed care and ambulatory care organizations).

Use of performance measures poses two challenges. The first -- to the Joint Commission -- is to develop indicators that, in a high proportion of instances, identify activities that the organization can and should improve. The second challenge -- to health care providers and managers -- is to use quality improvement methods to analyze variation and correct systemic factors and people factors that cause problems or constrain optimal performance.

"Agenda for Change" development and testing work now underway will lead to implementation over the next several years of improved accreditation "tools":

- standards focused on key governance, managerial, clinical and support activities essential to achieving good outcomes,
- a national database of performance indicators that helps us and accredited organizations monitor and improve patient care and outcomes,
- survey methods that better assess the organization's engagement in continuous improvement of key processes,
- accreditation reports and decisions that are more informative, more balanced, and more helpful in stimulating organizational change.

These tools will promote more effective collaboration between the Joint Commission and health care providers in service of our mutual goal of enhancing patient care quality.

MINUTES
Planning and Development Committee
January 19, 1990

CALL TO ORDER
B. Kristine Johnson called the January 19, 1990 meeting of the Planning and Development Committee to order at 10:38 a.m. in room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Leonard Bienias Robert Dickler William Jacott, M.D. Ted Thompson, M.D.
	Absent	Clint Hewitt Geoff Kaufmann Robert Latz Peter Lynch, M.D.
	Staff	Fred Bertschinger Al Dees Cliff Fearing Greg Hart Nancy Janda Mark Koenig John LaBree Shannon Lorbiecki Carter McComb Lisa McDonald Helen Pitt Mary Ellen Wells
	Guests:	Judy Beck, RN Bonnie Blake, RN Jed Hamoud

APPROVAL OF MINUTES
The minutes of the December 4, 1989 meeting were approved as distributed.

ICU INFORMATION SYSTEM
Mr. Dickler said that one of UMHC's goals is to improve its data collection in the ICU units to increase productivity; enhance quality; improve financial data; comply with regulations; and remain competitive. A steering committee headed by Mrs. Pitt has reviewed several systems and is recommending that UMHC purchase the EMTEK system. EMTEK is a Clinical Information System that automates all record keeping functions at the ICU beds. The system may be the building block for a hospital wide patient information system.

The committee recommended a pilot program on the surgical ICU, 4D. The capital costs for 29 workstations is $718,070 ($19.67/occupied bed). EMTEK will provide $100,000 to measure nursing productivity savings. Operational

cost savings should be realized from reduced staffing, not repeating expensive tests; duplicate orders; medication waste; repeated transcriptions and errors and form costs. If the criteria for evaluation are met and additional funding approved, the units will be placed in the medical and pediatric ICUs in 1990-91.

Ms. Johnson questioned the proposed savings. Mr. Dickler said that the FTE reduction and other savings will be equivalent to the investment. Long term the issue is if it's cost justified beyond the ICUs.

OTHER BUSINESS

Mr. Dickler, Mr. Fearing and Dr. LaBree reviewed the discussions that have occurred with the Interstate Medical Group of Red Wing. UMHC along with several other hospital and health care corporations are discussing possible ventures with the Group. Any contractual agreements will be approved by the Board.

CUHCC FACILITY PROJECT

Ms. Wells discussed the CUHCC project which was originally approved by the Board for $1.5 million but is now estimated at $2.35 million. Alternatives have been reviewed to reduce the cost. However, administration's recommendation is to continue with the project and to seek other funding sources. UMHC's commitment from reserves will not exceed the amount originally approved. Funds of $850,000 have been identified ($800,000 from Variety Club of the Northwest and $50,000 from Honeywell) and CUHCC is applying for the Kresge Challenge Grant. Additional contributions are also being sought.

Ms. Johnson noted that additional savings should have been looked at and that other uses could have been found for the Variety Club of the Northwest's donation, and inquired of other operating cost implications of the higher capital budget. Mr. Dickler said that other than a higher depreciation cost the operating impact should be the same as when the project cost $1.5 million. It was agreed that the operating impact of the $2.35 million project would be reviewed. Also, UMHC has given CUHCC an operating loss limit.

Mr. Bienias strongly supported the CUHCC project and made a motion that it be endorsed up to $2.5 million. The motion was seconded by Dr. Jacott and was carried.

CT SCANNER REPLACEMENT

Mr. Dees said that UMHC acquired the oldest of its three scanners in 1984. The lease expires on 4/30/90. Volume has continued to grow and the Siemens DR3 scanner is slower and doesn't have the imaging capability of the newer models. One service is sending 30-40 patients/month outside of UMHC for CT scans. The revised cost of the proposed CT scanner is $1,200,000 plus $17,000 for installation.

The other two scanners are scheduled to be replaced in the next two years. In response to a question on the impact of the MRI, Mr. Dees replied that the MRI hasn't yet reduced CT volume and that the impact of the second MRI which has been installed is unknown.

Ms. Johnson suggested that it would be helpful for the committee to have an overview of UMHC's experience with imaging and its future.

This project will be brought back to the P&D Committee next month for approval.

COUNCIL OF HOSPITAL CORPORATIONS (CHC) MEDICAL WASTE INCINERATOR PROJECT
Mr. Dickler introduced the Council of Hospital Corporations medical waste incinerator project. Based on an external evaluation, 90% of the hospitals have committed to supporting or utilizing the CHC-sponsored incinerator. The initial investment is $71,600 or no more that $107,416 to get the project started plus a longer term commitment to participate in the project if it is brought to fruition.

This project will be brought back to the P&D Committee next month for approval.

SECOND QUARTER DEVELOPMENT REPORT
Mr. Bertschinger reported that there was $244,833 collected in second quarter including $185,717 from the Variety Club Pledge. Year to date through 12/89 there have been contributions of $774,928 processed and one irrevocable future gift of $100,000.

ADJOURNMENT
Ms. Johnson adjourned the Planning and Development Committee at 12:12 p.m.

Respectfully submitted,

Lisa McDonald

Lisa McDonald
Assistant Director
Planning and Marketing

MINUTES
Planning and Development Committee
February 5, 1990

CALL TO ORDER
In the absence of B. Kristine Johnson, Robert Latz called the February 5, 1990 meeting of the Planning and Development Committee to order at 1:00 p.m. in room 8-106 in the University Hospital.

Attendance:	Present	Leonard Bienias Robert Dickler William Jacott, M.D. Robert Latz Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	B. Kristine Johnson, Chair Clint Hewitt Geoff Kaufmann
	Staff	Al Dees Cliff Fearing Greg Hart Nancy Janda Mark Koenig John LaBree Shannon Lorbiecki Lisa McDonald Helen Pitt
	Guests:	William Thompson, M.D.

APPROVAL OF MINUTES
The minutes of the January 19, 1990 meeting were approved as distributed.

RENEWAL PROJECT UPDATE
Mr. Hart said that because of additional work on the renewal project options, the complete analysis is about two weeks away from completion. Significant construction issues being addressed for a new facility include temporary hospital linkages and minimization of different elevations to facilitate patient transport. A major problem is if the new building lines up with Unit J it can't line up with Phillips Wangensteen on the second level.

Investigations have also been occurring on options to make the building more cost efficient. One of the ways discussed to make the building more efficient is to build eight larger floors instead of nine and combine inpatient psych from three floors to two floors. It would give the programs the same square footage but would make the building more efficient and cost about $2 million less to construct.

The budget for the original plan of adding two floors to Unit J and remodeling Mayo was $62 million. The revised budget is now estimated to be somewhat lower. The new building construction cost is currently estimated at $61 million including temporary links, elevators, etc. plus $4-5 million for relocation costs for a total of $65 million for a nine-story structure and $63 if it's eight-story. The alternatives that are being reviewed fall within the range of the original $62 million budget. This is especially true since the relocation costs were never part of the project budget.

Administration will be talking to the departments impacted by the building and the Chiefs before coming back to this committee for further discussion. Mr. Dickler said that in terms of disruption to patients, putting up a new building would probably be as disruptive as adding two floors to Unit J.

Mr. Dickler said recommendations should be for the Board on February 28. Discussion followed on holding a P&D meeting before the Board meeting on February 28 so that the necessary review could occur.

In answer to a question about shelled space, Mr. Hart said that the ninth floor of Unit J would contain 32,000 square feet of shelled space. In the new building proposal one floor or two floors could be shelled and contain between approximately 17,000 and 38,000 square feet.

CHC WASTE DISPOSAL PROJECT

Mr. Dickler said that there was no changes to the Council of Hospital Corporation (CHC) medical waste incinerator project proposal. It is a joint venture with the medical community to develop alternatives for managing hazardous waste. The committee unanimously endorsed the hospital's participation in this venture.

EXTERNAL DISCUSSIONS

Dr. Thompson reported that the proposal for Red Wing should be done within a week. Mr. Fearing reviewed three options that are being considered. Mr. Dickler explained that all the options include outreach involvement. Dr. LaBree said that a UMHC presence in Red Wing would be part of our commitment.

Mr. Dickler reported that a meeting has been held with central administration to update them on the discussions with Red Wing. Additional discussions will be held with the committee and Board as things evolve.

Mr. Latz raised concerns regarding the proposal and urged caution and careful legal review before final proposals are developed.

SPECIAL PROJECT: ICU INFORMATION SYSTEM

Ms. Pitt requested the committees endorsement of a critical care clinical information system on 4D which costs $718,000 and was presented last month. The committee endorsed the system unanimously.

SPECIAL PROJECT: CT SCANNER
Mr. Dees said they are asking to replace UMHC's oldest CT scanner. A question was raised about the future of CT scanning as opposed to MRI. Dr. W. Thompson explained that the CT scanner and the MRI each serves its own purpose. Endorsement of the replacement CT scanner at an estimated cost of $1,217,000 was unanimously endorsed.

MAJOR CAPITAL EXPENDITURE: HEART CATH REMODELING
Mr. Hart reported on the remodeling of the heart cath area which costs $98,000 plus $68,471 for equipment. The remodeling will include a four-bed holding area and related equipment which will reduce turnover time between cases. Future plans will involve a three-step process that will eventually lead to a new heart cath lab.

The project will be brought back before the committee next month for approval.

MAJOR CAPITAL EXPENDITURE: FRONTAL PLANE IMAGE CHAIN UPGRADE
Mr. Dees reported on the upgrade of the fluroscopic x-ray equipment in the heart cath lab. The images were acceptable for the types of procedures being performed in 1985-86 when the equipment was purchased. At the present time the equipment provides a marginal image for some coronary angioplasty procedures. Therefore UMHC proposes to purchase an upgrade for $120,000. If this upgrade proves successful, a similar upgrade will be planned for an additional room during the 1990-91 fiscal year.

QUARTERLY PURCHASING REPORT
Mr. Koenig reviewed the quarterly purchasing report included in the handout. He said that they are working on bringing additional information to the committee in future reports. The quarterly purchasing report was unanimously endorsed by the committee.

UMCA UPDATE
Dr. Lynch reported the following: 1) UMCA has paid off the hospital loan and is now working in the black; 2) they are in the final stages of selecting a COO; 3) Dr. Ted Thompson and Dr. Henry Buchwald are doing part-time medical directors' work for UMCA; 4) for the first time in two years a news letter is going out; and 5) the UMCA Planning and Marketing Committee chairperson is a full member of the UMCA Board.

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

Respectfully submitted,

Ann Frohrip
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

February 21, 1990

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Renewal Project II

A discussion of Renewal Project II is planned for the Board of Governors meeting on February 28, 1990. This item is not being presented for action at this meeting; we will request endorsement of a recommendation in March.

Attached is a set of documents on three alternative facility approaches to Renewal Project II. We will discuss the three options and their pros and cons at the meeting on Wednesday.

We look forward to your questions and comments.

GH:th

Attachment

RENEWAL PROJECT PHASE II
DISCRIPTION OF OPTIONS

Option A2

This is the original Phase II renovation proposal. Unit J expands by two floors, one for Inpatient Psychiatry and one left unfinished. The Mayo Building (floors 1-7) undergoes a major mechanical system upgrade and is renovated to varying degrees throughout. OB and Cysto/Urology relocate to remodeled Mayo 4. Rehab inpatient and therapies relocate to remodeled Mayo 7 and/or 5. Psychiatry outpatient, Day Hospital and offices are remodeled on Mayo 6. Specified faculty office renovation occurs as planned.

Option A2 Modified

In this option Unit J expansion occurs as in Option A2 to accommodate Psychiatry inpatient. All inpatient beds and high tech activity is excluded from the southeast wing of Mayo Building to facilitate future development of a new facility on this site. These changes cause Rehab to remodel in place (or on Rehab 5) and OB to relocate to a modified Unit J med/surg unit (7D). Cysto renovation on Mayo 4 and Rehab therapies on Mayo 5-7 occur as in A2. Building upgrade and non-clinical remodeling are reduced approximately 30%. Psychiatry outpatient, Day Hospital and offices occur as in A2. Faculty office renovation as planned.

Option C3

In lieu of major Mayo renovation, the southeast wing of Mayo is demolished to allow construction of a nine story building accommodating all clinical programs and shell space as follows:

Floor 9	Shell floor
Floors 6-8	Psychiatry Inpatient/Outpatient/Day Hospital
Floor 5	ICU/Bone Marrow Shell
Floor 4	OB/Cysto-Urology
Floor 3	Rehab Inpatient/Therapies
Floor 2	Rehab Therapies/Shell
Floor 1	Pharmacy

The Mayo Building upgrade is reduced approximately 40% (from A2) and non-clinical remodeling is reduced by approximately 30% (from A2). Faculty office renovation cccurs as planned.

2/13/90

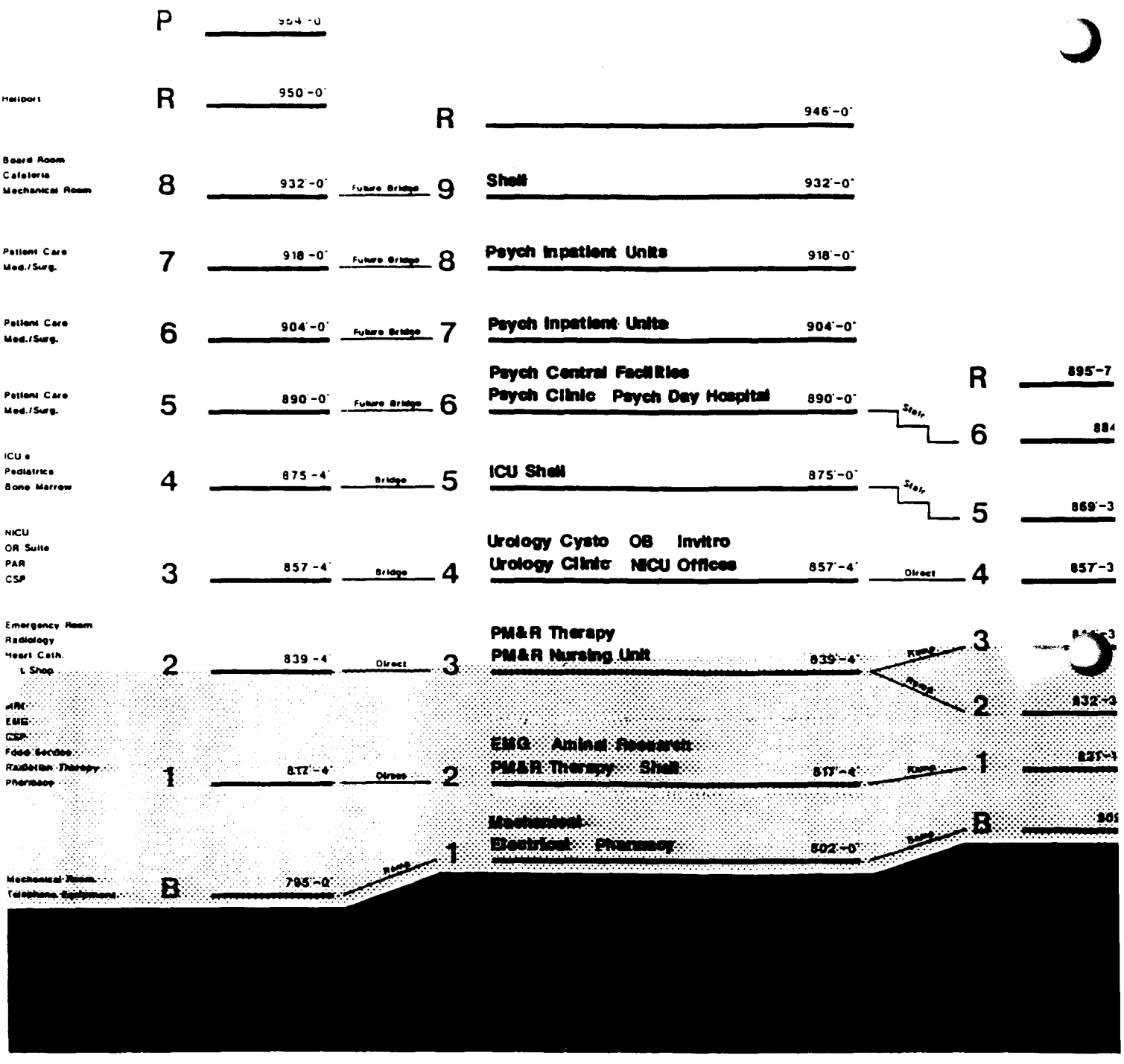
RENEWAL PROJECT PHASE II
MASTER PLANNING OPTIONS

COMPONENT	**OPTION A2**
PROGRAM LOC/COMPLETE	
OB	MAYO 4/JAN '92
UROLOGY CLINIC/CYSTO	MAYO 4/JAN '92
REHAB NSG	MAYO 5/JAN '93
REHAB THERAPY	MAYO 5-7/JAN '93
PSYCH INPT	UNIT J 10/JULY '92
PSYCH OP/DAY HOSP	MAYO 6/ UNK
ADD'TL MED/SURG UNIT	7D/NOW
DAY HOSP RELOCATE	N/A
FACULTY OFFICE RENOVATION	INCLUDED AT $1.5M
SHELL SPACE AVAIL	32,000 NSF
UNASSIGNED MAYO AVAILABLE	0 NSF
MAYO BLDG UPGRADE SCOPE	$12.3M
MISC. MAYO RENO SCOPE	$ 9.5M
PROJECT COST	$58.2M
SPECIAL RELOCATION ISSUES	-
SPECIAL RELOCATION COST	-
RELOCATION/RENTAL COST	$ 2.5M
TOTAL COST	$60.7M
FUTURE NEEDS	
BONE MARROW EXPANSION	$ 3.3M/ 1/2 UNIT J 9
ICU EXPANSION/REMODEL	$ 2.5M/ UNIT J 4A
HEART CATH EXPANSION	$ 1.9M/ UNIT J 9
CARDIAC CLINIC	$ .7M/ ?
RADIOLOGY EXPANSION	$ 1.2M/ UNIT J 2

2/13/90

RENEWAL PROJECT PHASE II
MASTER PLANNING OPTIONS

COMPONENT	OPTION C3
PROGRAM LOC/COMPLETE	
OB	NEW BLDG/ MAR '93
UROLOGY CLINIC/CYSTO	NEW BLDG/ MAR '93
REHAB NSG	NEW BLDG/ MAR '93
REHAB THERAPY	NEW BLDG/ MAR '93
PSYCH INPT	NEW BLDG/ MAR '93
PSYCH OP/DAY HOSP	NEW BLDG/ MAR '93
ADD'TL MED/SURG UNIT	7D/ NOW
DAY HOSP RELOCATE	N/A
FACULTY OFFICE RENOVATION	INCLUDED AT 1.5M
SHELL SPACE AVAIL	36,000 NSF
UNASSIGNED MAYO AVAILABLE	30,000 NSF
MAYO BLDG UPGRADE SCOPE	$ 7.4M
MISC. MAYO RENO SCOPE	$ 6.7M
PROJECT COST	$61.4M
SPECIAL RELOCATION ISSUES	AUTOPSY, STA.60-61 PHARMACY, DIALYSIS TODD
SPECIAL RELOCATION COST	$ 1.1M
RELOCATION/RENTAL COST	$ 2.7M
TOTAL COST	$65.2M
FUTURE NEEDS	
BONE MARROW EXPANSION	$ 3.3M/ NEW BLDG 5
ICU EXPANSION/REMODEL	$ 2.5M/ UNIT J 4A
HEART. CATH EXPANSION	$ 1.9M/ NEW BLDG 2
CARDIAC CLINIC	$ .7M/ MAYO4
RADIOLOGY EXPANSION	$ 1.2M/ UNIT J 2



Unit J

Option C

Mayo
Elliott

Proposed Functional Zoning
Proposed Floor To Floor Elevations • Option X

2/13/90

RENEWAL PROJECT PHASE II
MASTER PLANNING OPTIONS

COMPONENT	**OPTION A2 MODIFIED**
PROGRAM LOC/COMPLETE	
OB	7-D/DEC. '91
UROLOGY CLINIC/CYSTO	MAYO 4/SEPT '91
REHAB NSG	REHAB 4-5/DEC '91
REHAB THERAPY	MAYO 5-7/JAN '92
PSYCH INPT	UNIT J 10/JULY '92
PSYCH OP/DAY HOSP	MAYO 6/ UNK
ADD'TL MED/SURG UNIT	MAS I/ FEB '91
DAY HOSP RELOCATE	MAYO 3/ MAY'90
FACULTY OFFICE RENOVATION	INCLUDED AT 1.5M
SHELL SPACE AVAIL	32,000 NSF
UNASSIGNED MAYO AVAILABLE	0 NSF
MAYO BLDG UPGRADE SCOPE	$ 8.4M
MISC. MAYO RENO SCOPE	$ 6.7M
PROJECT COST	$51.7M
SPECIAL RELOCATION ISSUES	DAY HOSPITAL
SPECIAL RELOCATION COST	INCL ABOVE
RELOCATION/RENTAL COST	$ 1.1M
TOTAL COST	$52.8M
FUTURE NEEDS	
BONE MARROW EXPANSION	$ 3.3M/ 1/2 UNIT J 9
ICU EXPANSION/REMODEL	$ 2.5M/ UNIT J 4A
HEART CATH EXPANSION	$ 1.9M/ UNIT J 9
CARDIAC CLINIC	$ .7M/ MAYO 4
RADIOLOGY EXPANSION	$ 1.2M/ UNIT J 2

2/13/90

RENEWAL PROJECT PHASE II
MASTER PLANNING OPTIONS

COMPONENT	OPTION A2	OPTION A2 MODIFIED	OPTION C3
PROGRAM LOC/COMPLETE			
OB	MAYO 4/JAN '92	7-D/DEC. '91	NEW BLDG/ MAR '93
UROLOGY CLINIC/CYSTO	MAYO 4/JAN '92	MAYO 4/SEPT '91	NEW BLDG/ MAR '93
REHAB NSG	MAYO 5/JAN '93	REHAB 4-5/DEC '91	NEW BLDG/ MAR '93
REHAB THERAPY	MAYO 5-7/JAN '93	MAYO 5-7/JAN '92	NEW BLDG/ MAR '93
PSYCH INPT	UNIT J 10/JULY '92	UNIT J 10/JULY '92	NEW BLDG/ MAR '93
PSYCH OP/DAY HOSP	MAYO 6/ UNK	MAYO 6/ UNK	NEW BLDG/ MAR '93
ADD'TL MED/SURG UNIT	7D/NOW	MAS I/ FEB '91	7D/ NOW
DAY HOSP RELOCATE	N/A	MAYO 3/ MAY'90	N/A
FACULTY OFFICE RENOVATION	INCLUDED AT $1.5M	INCLUDED AT 1.5M	INCLUDED AT 1.5M
SHELL SPACE AVAIL	32,000 NSF	32,000 NSF	36,000 NSF
UNASSIGNED MAYO AVAILABLE	0 NSF	0 NSF	30,000 NSF
MAYO BLDG UPGRADE SCOPE	$12.3M	$ 8.4M	$ 7.4M
MISC. MAYO RENO SCOPE	$ 9.5M	$ 6.7M	$ 6.7M
PROJECT COST	$58.2M	$51.7M	$61.4M
SPECIAL RELOCATION ISSUES	-	DAY HOSPITAL	AUTOPSY, STA.60-61 PHARMACY, DIALYSIS TODD
SPECIAL RELOCATION COST	-	INCL ABOVE	$ 1.1M
RELOCATION/RENTAL COST	$ 2.5M	$ 1.1M	$ 2.7M
TOTAL COST	$60.7M	$52.8M	$65.2M
FUTURE NEEDS			
BONE MARROW EXPANSION	$ 3.3M/ 1/2 UNIT J 9	$ 3.3M/ 1/2 UNIT J 9	$ 3.3M/ NEW BLDG 5
ICU EXPANSION/REMODEL	$ 2.5M/ UNIT J 4A	$ 2.5M/ UNIT J 4A	$ 2.5M/ UNIT J 4A
HEART CATH EXPANSION	$ 1.9M/ UNIT J 9	$ 1.9M/ UNIT J 9	$ 1.9M/ NEW BLDG 2
CARDIAC CLINIC	$ .7M/ ?	$ .7M/ MAYO 4	$ .7M/ MAYO4
RADIOLOGY EXPANSION	$ 1.2M/ UNIT J 2	$ 1.2M/ UNIT J 2	$ 1.2M/ UNIT J 2

2/13/90

QUALITATIVE COMPARISON

	OPTION A2	A2 MODIFIED	OPTION C3
REHAB INPATIENT IMPROVEMENTS	REMODELED	UPGRADED	NEW
REHAB THERAPIES IMPROVEMENTS	REMODELED	REMODELED	NEW
OB IMPROVEMENTS	REMODELED	UNIT J	NEW
CYSTO/UROLOGY IMPROVEMENTS	REMODELED	REMODELED	NEW
PSYCHIATRY INPATIENT IMPRVMTS	NEW	NEW	NEW
PSYCH OP/DAY HOSP IMPRVMTS	REMODELED	REMODELED	NEW
INPATIENT PROGRAMS COMPLETE	SOONER	SOONER	LATER
PSYCH OP/DAY HOSP COMPLETE	LATER	LATER	SOONER
PSYCH INPT/OP RELATIONSHIP	SEPARATE	SEPARATE	CONTIGUOUS
PROJECT COST	AT BUDGET	SAVE $8-12M	AT BUDGET
RELOCATION COSTS	MODERATE	LOW	HIGH
IMPACT ON DAY HOSPITAL	NONE	MAJOR	NONE
RELOCATION PROBLEMS	MODERATE	MODERATE	MAJOR
CONSTRUCTION DISRUPTION	MAJOR	MAJOR	MAJOR
UNIT J EXPANSION PRESERVED	NO	NO	YES
S.E. MAYO EXPANSION PRESERVED	YES	YES	NO
PROJECT SEGMENTATION ABILITY	GOOD	VERY GOOD	POOR
BMT/ICU EXPANSION	AVAIL 7/92	AVAIL 7/92	AVAIL 3/93
HT CATH EXPAN. (QUAL/TIME)	NEW/SOON	NEW/SOON	NEW/LATE
INVESTMENT IN NEW SPACE	SOME	SOME	MOST
30,000 NSF MAYO AVAILABLE	NO	NO	YES
SHELL SPACE AVAILABLE/TIME	32K, 7/92	32K, 7/92	21-36K, 3/93
BED ALLOCATION COMPLEXITY	NEUTRAL	NEGATIVE	NEUTRAL
REGULATORY CONSIDERATIONS	NEUTRAL	NEUTRAL	UNKNOWN

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 22, 1990

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

RE: Quarterly Purchasing Report

Attached is a copy of the Hospital's Purchasing Activity report for the period of October through December, 1989. This report is being submitted for your approval at the February 28, 1990 Board of Governors meeting.

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

/gs

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF OCTOBER – DECEMBER 1989

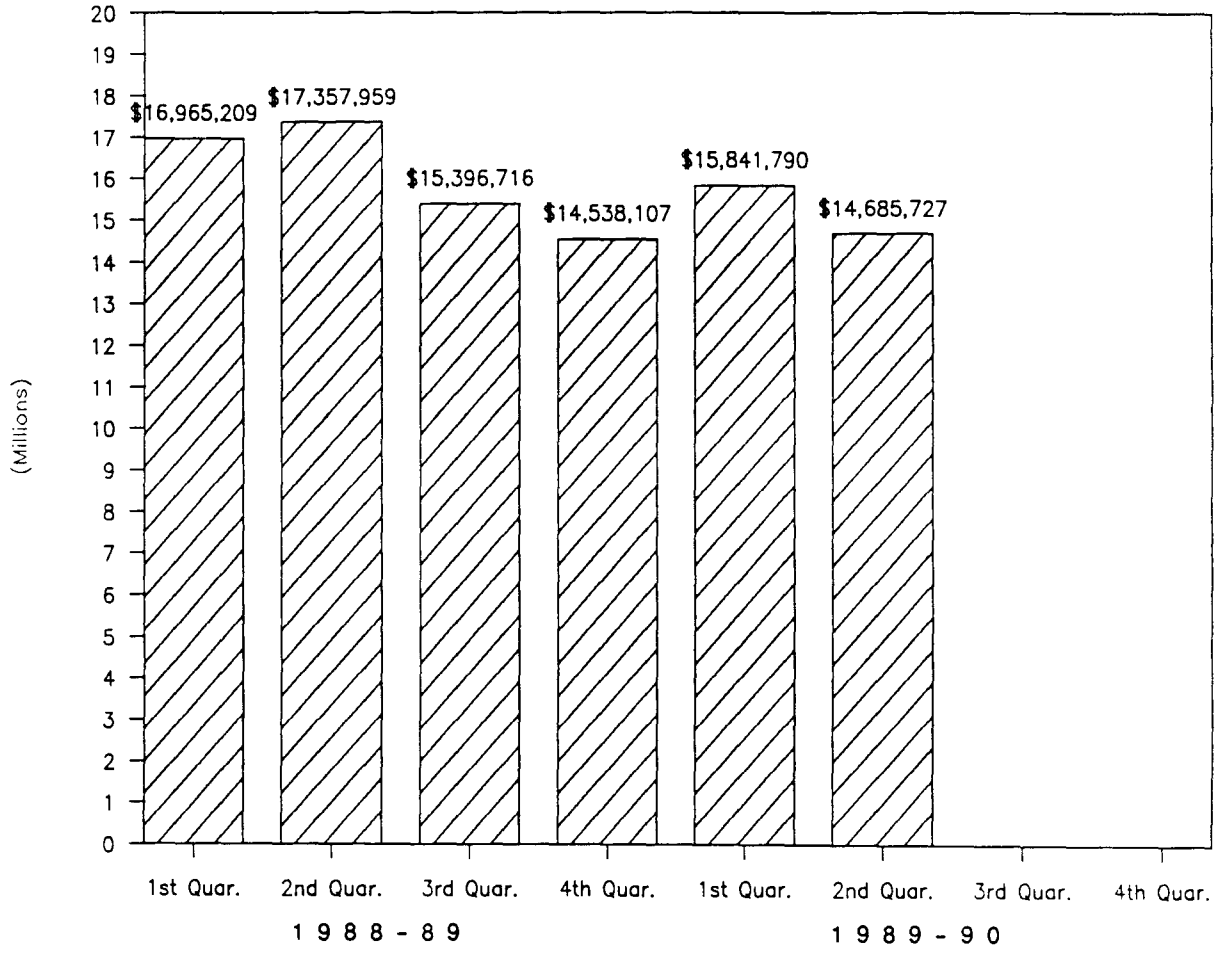
I. PURCHASE ORDER ACTIVITY

II. AWARDS TO OTHER THAN APPARENT LOW BIDDER

III. SOLE SOURCE ACTIVITY

IV. VENDOR APPEALS

PURCHASE ORDER ACTIVITY



SECOND QUARTER, FISCAL YEAR 1989–90, ACTIVITY:

	NUMBER	VALUE
PURCHASE ORDERS	8332	$14,352,371.80
CONFIRMING ORDERS	348	$333,355.20
TOTAL THIS QUARTER	8,680	$14,685,727.00

II. PURCHASE AWARDS TO OTHER THAN LOW BIDDER ($10,000 OR MORE)

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Dressing, Sterile 4.5" x 4 yds.	Sherwood $ 41,335.20	Kendall $ 41,752.80	Materials
		Weave of the dressing is too loose and does not stretch adequately; ends fray and particles may enter wounds and promote infection.		
2.	Portable X-Ray Systems	Northern X-Ray $ 93,000.00	General Electric $ 95,550.00	Radiology
		Equipment offered did not have several desirable features, which were considered to be in UMHC's best interest to purchase for an additional $2,550.00.		
3.	Reverse Osmosis System	Culligan $ 17,792.00	Millipore Water Systems $ 23,062.00	Nursing/K.D.
		System offered did not have an automatic sanitization control feature which is an essential part of the system upgrading.		
4.	Electrodes	MedHome $ 12,768.60	Owens & Minor $ 16,848.00	Materials
		Samples were not submitted for evaluation.		
		Lectec Corp. $ 16,470.00	Owens & Minor $ 16,848.00	Materials
		Electrodes did not pass UMHC biomedical testing and were not packaged in singles as requested.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
5.	Typing Trays	Pelfreeze $ 16,452.00 Gentrak $ 19,800.00	Biotest $ 23,040.00	Labs
		Trays offered did not identify all DR antigens.		
6.	Scrub Pants	Tabb Textiles $ 30,888.00	Fashion Seal $ 32,532.00	Materials
		Pants offered were extremely short in length.		
7.	Oxygenators	Medtronics $ 73,200.00 Bard Cardio $ 80,400.00	Central Medical $ 84,000.00	Materials
		Oxygenators offered lacked arterial reservoirs.		
8.	Surgical Blades	Lobdell $ 12,444.22	Medix $ 19,330.65	Materials
		Blades offered are too dull and do not cut properly.		
9.	Scrub Apparel, Disposable	Medix $ 13,291.36	Owens & Minor $ 23,130.76	Materials
		Material has inadequate fluid repellency and is harsh and irritating to the skin.		
		Baxter $ 20,168.54	Owens & Minor $ 23,130.76	Materials
		Scrubs tear easily and the material has inadequate fluid repellency and rips easily.		

III. SOLE SOURCE-$5,000 and Over

VENDOR	CONTRACT/ P.O. #	VALUE	DEPT.	PRODUCT
Curatech	H099793	OPEN	Amb. Care	Blood Derivative
Olympus	H102064	$9,600.00	Cardio.	Bronchoscope
MSA	H395784	$9,000.00	I.S.D.	System Support
APT	H102039	$5,580.00	I.S.D.	B38 License Fees
Medical Blood Services	H101585	$500,000.00	Labs	Factor VIII
Curatech	H394754	$9,300.00	Labs	Blood Derivative
Cobe	H103351	$38,000.00	Labs	Blood Cell Separator
Whittaker Bioproducts	H099792	$23,660.00	Labs	Monkey Kidney Cells
Microfilm Comm.	H099765	OPEN	Labs	Microfiching
Knowledge Data	H107344	$12,230.00	Labs	Tuning Software
Hacker Instrument	H102761	$25,816.00	Labs/Neuro.	Microtome Cryostat
Quantum Industries	H102777	$14,300.00	M. & O.	Pneumatic Tube Software
Fashion Seal	H101576	$23,478.00	M.S.	Surgeons' Gowns
Pharmacia Deltec	H102347	$62,920.00	M.S./C.S.P.	CADD-PCA Pumps
Millipore	H102040	$5,514.00	Nursing	Reverse Osmosis Sys. Conversion to Stainless Steel
Baxter/Edwards	90-163	OPEN	O.R.	Implants-Cardio Valves & Rings
CPI	90-160	OPEN	O.R.	Implants-Pacemaker Generators & Leads
Cryolife	90-164	OPEN	O.R.	Implants - Cardio Graphs/ Valves
St. Jude Medical	90-158	OPEN	O.R.	Implants-Cardio Valves
Medtronic	90-159	OPEN	O.R.	Implants-Pacemaker Leads, Generators & Conduit
SIA	90-157	OPEN	O.R.	Implants-Cardio Graphs
Karl Storz	H103962	$21,873.60	O.R.	Video System for Sinus Endoscope
Sharplan Laser	H102303	$5,950.00	O.R.	Microslad Accessory for Laser
Midwest Surgical	H102271	$33,707.00	O.R./Amb.	Ophthalmology Microscope
TOTAL		$800,928.60		

IV. VENDOR APPEALS

NO APPEALS RECEIVED DURING THIS QUARTER

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
January 24, 1990

MINUTES

ATTENDANCE:

Present:	Carol Campbell Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Jerry Meilahn
Not Present:	Elwin Fraley, M.D. Barbara O'Grady Vic Vikmanis
Staff:	Al Dees Greg Hart Teri Holberg Nancy Janda Geoff Kaufmann Nels Larson Shannon Lorbiecki Barbara Tebbitt Mary Ellen Wells

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on January 24, 1990 at 12:05 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the December 20, 1989 meeting as written.

JULY 1, 1989 THROUGH DECEMBER 31, 1989 FINANCIALS:

Mr. Clifford P. Fearing reported to the Finance Committee for the month of December inpatient admissions totaled 1,434, which was 27 below budget; average length of stay was 7.6 days; patient days totaled 11,982, which were 243 days below budget; and the average daily census was 386. The first three weeks of January were reported to have an average daily census of 400 and admissions were 2% over budget. Ancillary revenue was reported to be 5.8% under budget and operating expenditures were reported to 4.7% below budget. Mr. Fearing stated the Hospital's year-to-date Statement of Operations showed revenues over expenses by $3,209,290, a favorable variance of $1,154,619.

Lastly, Mr. Fearing stated as of December 31 the balance of accounts receivable totaled $87,042,644 and represented 97.3 days of revenue outstanding.

HOSPITAL ADMISSIONS POLICIES:

Mr. Fearing brought before the Committee, for information, the Hospital admissions policy that has been approved by the Medical Staff-Hospital Council and Council of Clinical Chiefs. Mr. Fearing reviewed the policy, which had been presented to the Finance Committee on August 23, 1989, and reported one change that had been suggested by Mr. Robert Latz.

In item 8 of the policy, Mr. Latz suggested the sentence reading "Concurrently UMHC acknowledges that it has an obligation to assist its patients to secure coverage whenever possible." should read "Concurrently UMHC will assist its patients to secure coverage whenever possible."

Mr. Fearing stated the policy will be brought before Finance Committee and the Board of Governors for approval at the February 28, 1990 meeting.

CUHCC:

Ms. Mary Ellen Wells presented a proposal to the Committee, for endorsement, to increase the CUHCC project from the originally endorsed amount of $1,500,000 to $2,350,000. This proposal had been presented to the Finance Committee at the December 20, 1989 meeting for information.

Ms. Wells stated the additional $850,000 will come from the Variety Club of the Northwest, which will contribute $800,000 over a four year period, and the Honeywell Foundation, which will contribute $50,000, $25,000 in cash and the remaining in building systems.

The Finance Committee seconded and passed a motion to endorse the CUHCC project increase to $2,350,000.

CT SCANNER:

Mr. Al Dees presented a proposal to the Finance Committee, for information, to acquire a new CT scanner.

The new CT scanner will replace a CT scanner that had been acquired in 1984 with an operating lease which will expire on April 30, 1990. The new scanner will provide to the Diagnostic Radiology Department state-of-the-art CT imaging services, that the older scanner is not able to provide.

Mr. Dees stated the total estimated cost of the CT scanner and installation would be $1,217,000. This item was included in the capital budget which had been approved by the Board last spring.

This proposal will be brought before the Committee for endorsement at the February meeting.

ICU INFORMATION SYSTEM:

Ms. Helen Pitt presented to the Committee, for information, a proposal to acquire the EMTECK Critical Care Clinical Information Management System at a cost of $718,000. This cost includes hardware, software, installation, implementation staff, as well as service and maintenance over a five year period.

The EMTECK Critical Care Clinical Information Management System is specially designed for critical care environment. Ms. Pitt stated this is a bedside computer system that will automatically record nursing data, medical data, laboratory data, pharmacy data and patient monitoring equipment. Once this proposal is approved, the system will first be installed in 4D, the surgical ICU, in early 1990 with one workstation at each bedside, a total of 24 workstations.

Ms. Pitt stated the proposal will be presented to the Committee for endorsement at the February meeting.

CHC WASTE DISPOSAL PROJECT:

Mr. Dickler brought before the committee, for information, a proposal by CHC to build and operate a medical waste incinerator. The proposal calls for the formation of a corporation consisting of interested Council of Hospital Corporation hospitals for the purpose of jointly researching, planning, constructing and operating a medical waste incinerator in or near the Mpls/St. Paul metro area. At the present time there is only one commercial vendor, BFI, that provides a source for disposing of infectious waste.

Mr. Dickler reported the Hospital/University commitment of funds for Phase I at this time is limited to 150% of $71,611 or $107,416. This amount will be refunded unless hospitals representing more than 75% of the biological waste volume agree to participate in the initial phase; permits, environmental studies, determination of the site, etc., as well as offer a line of credit for the actual capital development of the project. Since a commitment has been made from 82% of the hospitals that produce biological waste, UMHC is committed to its portion of the funding for Phase I. Based on CHC's preliminary estimates the anticipated aggregate capital commitment of the University, if the project were to be brought to fruition, is anticipated to be in the range of $600,000-$625,000.

This proposal will require Regents approval and will be sought after it is presented to the Board of Governors for endorsement. Board of Governors approval is anticipated to occur at the February meeting.

SECOND QUARTER, 1989-90 BAD DEBTS:

Mr. Fearing reported the bad debts for the second quarter totaled $546.932.58, representing 1,612 accounts. Recoveries amounted to $22,995.87, leaving a net charge-off of $523,935.71. This amount represents .66% of gross charges and compares to a budgeted level of bad debts of 1.22%.

The Finance Committee seconded and passed a motion to endorse the Second Quarter 1989-90 Bad Debt report as submitted.

1990-91 COMMITTEE WORK PLAN:

Mr. Fearing highlighted the Finance Committee work plan for 1990 which was developed at the 1989 Board of Governors retreat.

Financial and Capital Planning; Financial Policies and Guidelines, Capital Planning and Financing, Support of Research and Education, Development and Acquisition of New Technology, Foundation and Development Activities, Level of State Appropriation.

Manpower and Personnel Considerations; Manpower Trends and Issues, Personnel Policies and Delegation, Affirmative Action, Equal Opportunity, and Managing a Diverse Workforce, Child Care.

Red Wing

Mr. Fearing reported to the Committee Dr. Ted Thompson, Dr. John LaBree, and Geoff Kaufmann have been conducting discussions with physicians in Red Wing in order to develop a joint venture corporation between them and UMHC. This would be a first step in developing a long term referral network for UMHC. Mr. Geoff Kaufmann stated one of the main reasons these physicians would want to make this type of arrangement is that the affiliation would enhance their practice by giving them direct access to the specialized areas that UMHC has to offer.

Three proposals are being developed to present to the physicians. 1) UMHC would purchase the physicians medical office building and lease it back to the practice on a 10 year lease basis. The cost to UMHC would be approximately $3,000,000; 2) UMHC would purchase the physician's medical office building with a sell back to them of approximately 30% of the equity of the building. This would be at a cost of approximately $2,000,000 to the Hospital. 2) UMHC would purchase the entire practice at a cost of approximately $6-7 million.

Mr. Fearing stated he will continue to keep the Committee informed on the progress of this project.

There being no further discussion, the January 24, 1990 meeting was adjourned at 1:40 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

February 28, 1990

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1989 through January 31, 1990**

The Hospital's operations for the month of January reflect inpatient admissions and outpatient visit activity above budgeted levels and patient days below budget. Both ancillary revenue and routine revenue are below budgeted levels for the month.

INPATIENT CENSUS: For the month of January, inpatient admissions totaled 1,626, which was 57 above budgeted admissions of 1,569. Our overall average length of stay for the month was 8.3 days. Patient days for January totaled 12,503 and were 836 days below budget. The increase in admission levels from budget was primarily in the areas of Pediatrics, Gynecology, Surgery, Otolaryngology, and Adult Psych. The increases were partially offset by decreases in Urology, Medicine, and Obstetrics.

To recap our year-to-date inpatient census:

	1988-89 Actual	1989-90 Budget	1989-90 Actual	Variance	% Var
Admissions	11,125	10,911	10,960	49	0.4
Patient Days	93,727	92,193	88,300	(3,893)	(4.2)
Avg Length of Stay	8.4	8.4	8.1	(0.3)	(3.6)
Avg Daily Census	435.9	428.8	410.7	(18.1)	(4.2)
Percent Occupancy	74.8	73.2	70.8	(2.4)	(3.3)

OUTPATIENT CENSUS: Clinic visits for the month of January totaled 22,516 which was 614, or 2.8%, above budgeted visits of 21,902. Visits were significantly above budget in Radiation Therapy, Emergency Room, Medicine, and Otolaryngology. Areas that reported visits considerably below budgeted levels were Adult Psych, Dermatology, Urology, Dentistry, Sports Medicine and OB/GYN. Community University Health Care Center (CUHCC) visits for the month of January totaled 4,516 which was 609, or 15.6%, over budgeted visits of 3,907, while Home Health visits of 846 for the month were 156, or 15.6%, below budgeted visits of 1,002.

To recap our year-to-date outpatient census:

	1988-89 Actual	1989-90 Budget	1989-90 Actual	Variance	% Var
Clinic Visits	156,660	159,039	156,639	(2,400)	(1.5)
CUHCC Visits	26,846	26,978	30,566	3,588	13.3
HHA Visits	6,973	6,951	6,455	(496)	(7.1)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows revenues over expenses by $5,393,456, a favorable variance of $4,104,602. Reflected in this months Statement of Operations is a dividend distribution from RUMINCO LTD, to the Hospital, in the amount of $1,965,000. The dividends being returned by RUMINCO LTD are to those who had contributed premium and expenses to RUMINCO LTD since inception (August 1, 1977) to December 31, 1986. As a part of this declaration of dividends by RUMINCO LTD, the Hospital will receive an additional $655,000 on December 31, 1990.

Patient care charges through January totaled $187,770,051, which was 4.6% under budget. Routine revenue was 2.6% under budget and reflects our unfavorable inpatient census variance.

Ancillary revenue was $7,661,875 below budget (5.5%) and primarily reflected the unfavorable variance in clinic visits. Inpatient ancillary revenue averaged $8,627 per admission compared to the budgeted average of $8,922 per admission. Outpatient revenue per clinic visit averaged $244 compared to the budgeted average of $271.

Operating expenditures through January totaled $161,290,379 and were $8,445,784 (5.0%) below budgeted levels of $169,736,163. The overall favorable variance relates primarily to the decreased demand for patient services, and is reflected across most expense categories.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of January 31, 1990, totaled $86,131,643 and represented 96.7 days of revenue outstanding. The overall decrease in our patient receivables in January of .6 days occurred primarily in Minnesota Medical Assistance and SCH-Other States.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels for the month and year-to-date January. While we have seen improvement in our expenditure levels, we are continuing to closely monitor our demand for services and make those operating changes that are necessary and appropriate to bring our expense levels into line with net revenues.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1989 TO JANUARY 31, 1990

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$196,897,955	$187,770,051	($9,127,904)	-4.6%
Deductions from Charges	46,163,384	44,087,160	(2,076,224)	-4.5%
Other Operating Revenue	5,775,026	6,236,914	461,888	8.0%
Total Operating Revenue	156,509,597	149,919,805	(6,589,792)	-4.2%
Total Expenditures	169,736,163	161,290,379	(8,445,784)	-5.0%
Net Operating Revenue	(13,226,566)	(11,370,574)	1,855,992	14.0%
Non-Operating Revenue and Expenses	14,515,420	16,764,030	2,248,610	15.5%
Revenue Over/Under Expense	$1,288,854	$5,393,456	$4,104,602	

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Admissions	10,911	10,960	49	0.4%
Patient Days	92,193	88,300	(3,893)	-4.2%
Average Daily Census	428.8	410.7	(18.1)	-4.2%
Average Length of Stay	8.4	8.1	(0.3)	-3.6%
Percentage Occupancy	73.2	70.8	(2.4)	-3.3%
Outpatient Clinic Visits	159,039	156,639	(2,400)	-1.5%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 22, 1990

TO: Members of the Board of Governors

FROM: Helen Pitt
Associate Director for
Nursing Operations

SUBJECT: Critical Care Clinical Information Management System

For a number of years the hospital has had an overall goal to develop a patient care information system. During this time, Frank Cerra, MD, Director of the Surgical Intensive Care Unit and Carter McComb, Director of Surgical Clinical Services Administration, have been pursuing the development of an ICU data management system. Then early last year the efforts of nursing, medicine, and patient monitoring were brought together to mutually evaluate and plan for a suitable solution for the ICU patient data needs.

The outcome of this collaboration is the recommendation to proceed with the EMTEK Critical Care Clinical Information Management System. The enclosed materials provide a summary of the financial expenditures associated with implementation of this system on the 24 bed surgical intensive care unit. The capital expenditure associated with this project is $718,000.

The project was presented for information at the last Board of Governors meeting. At this time we are presenting this proposal for your approval.

I will be available to respond to any further questions at your meeting. Please feel free to call me prior to that time if you have questions. (626-5300)

/pd

hp>hp0131901pd

FINANCIAL SUMMARY - EMTEK PROPOSAL

COSTS

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Hardware and Software	$143,614	143,614	143,614	143,614	143,614	718,070
Installation	$ 8,700					8,700
Implementation Staff	$ 85,000	62,500	20,000	20,000	20,000	207,500
Service and Maintenance	$ 74,709	84,761	84,761	84,761	84,761	413,753
TOTAL	$312,023	290,875	248,375	248,375	248,375	1,348,023

SAVINGS

Reduced Operational Costs	$ 0	73,000	146,000	146,000	146,000	511,000
Nursing FTE Savings	$ 0	40,000	80,000	100,000	100,000	320,000
TOTAL	$ 0	113,000	226,000	246,000	246,000	831,000
DIFFERENCE (Savings - Cost)	$-312,023	-177,875	-22,375	- 2,375	- 2,375	-517,023

Benefits in Addition to Savings Noted:

- Productivity gain within other departments.
- Reimbursement audits and charge capture.
- Improved decision support for management.
- Research and quality assurance support.

General Information:

- Dunn and Bradstreet report is very favorable; company is well financed, research and development is very strong, excellent financial backing from parent company, Motorola, Inc.
- Negotiations reflect reduction for development and alpha-beta partnership agreement.
- Benefit study is to be done.

Note: Opportunity cost will be calculated.
Note: Above dollar figures are not adjusted for inflation.

jb0109901nm

DETAIL FOR FINANCIAL SUMMARY

COSTS

1. Hardware and Software

The EMTEK proposal outlines in detail the hardware and software costs. The 4D North and South proposal includes one workstation at each bedside, and one at each desk in each resident's room. The proposal also includes a workstation for training and for the Research subsystem. The patient care unit 4D requires 29 workstations.

The hardware and software total is $718,070. This amount includes several one-time costs associated with this project. One-time costs include:

- Interface to Labs Tandem computer, Unisys, and IBM; connectivity to Space Labs Monitors and other instruments; and the research database and query language.

The total of the one-time costs quoted is $132,867. This cost will not be repeated with future expansion.

4D/North and South	Average Daily Census 83% Occupancy	Total Patient Days Over Five Years	Hardware and Software Costs (29 Workstations)
24 Beds	20	36,500	$718,070 ($19.67/occupied bed)

2. Installation

Installation costs are estimated at $300 per workstation. This includes $250 for cable pulling and $50 for the wall mount per workstation ($300).

$300 X 29 = $8700

3. Implementation Staff

The project will have a Steering Committee, a project leader, and implementation support associated with the PCU. As implementation progresses, involvement from hospital departments is anticipated (e.g., forms review, medical records, pharmacy). Operational details will be addressed at the user and operational support level (e.g., flowsheet design). Initial support will be needed from Labs and Technical Services.

The implementation support will be provided from Nursing, Information Systems, and Cardio-Respiratory Services. The anticipated support is expected to be as follows, with support from Cardio-Respiratory Services reassigned from the Dasicup project.

Implementation Staff continued:

	Year 1	Year 2	Year 3	Year 4	Year 5	Total	Salary (incl. fringe)	Total
ISD Prog. Effort	1.0 45,000	.5 22,500	0	0	0	1.5	45,000 (21.55/hr)	67,500
Implem. Leader	.5 20,000	.5 20,000	0	0	0	1.0	40,000 (19.15/hr)	40,000
Systems Adm. (Conf. Screens	.5 20,000	.5 20,000	.5 20,000	.5 20,000	.5 20,000	2.5	40,000 (19.15/hr)	100,000
GRAND TOTAL						5.0		$207,000

4. Service and Maintenance

We have received a comprehensive maintenance proposal. Selecting the service best suited to UMH, the expenses are as follows: Year 1 - Level I (Standard Service) Plan A and Years 2, 3, 4, 5 - Level I Plan B (Standard Service).

	Year 1	Year 2	Year 3	Year 4	Year 5
4D N-S	56,483	64,014	64,014	64,014	64,014
Interface Subsystem	6,248	7,081	7,081	7,081	7,081
Research Mgmt System	4,033	4,571	4,571	4,571	4,571
Instrument Interface	2,400	2,720	2,720	2,720	2,720
Computer Interface	5,625	6,375	6,375	6,375	6,375
TOTAL	74,709	84,761	84,761	84,761	84,761

SAVINGS

1. Reduced Operational Costs

The projected operational cost reductions are as follows:

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Savings Per Patient Day	0	$10	$20	$20	$20	
Patient Days	7,300	7,300	7,300	7,300	7,300	
TOTAL	$0	$73,000	$146,000	$146,000	$146,000	$511,000

Reduced Operational Costs continued:

Based on the literature and experience in other settings, this estimate is based on anticipated savings at UMH in the following areas:

1) Expensive tests that are repeated
2) Duplicate orders
3) Medication waste
4) Transcription repeated or errors
5) Form cost.

2. Nursing FTE Savings

The Nursing manpower savings achievable in the Critical Care setting with this system are projected to be 1+ FTE for every 12 beds. The studies reported to date by other institutions in the literature and our consideration of the impact of this system in the 4D nursing environment supports these projections.

	Year 1	Year 2	Year 3	Year 4	Year 5
Nursing FTE Savings	0	1 FTE	2 FTE	2.5 FTE	2.5 FTE
	0	$40,000	$80,000	$100,000	$100,000

The EMTEK system has these benefits for Nursing that supports the FTE savings:

1) Data is entered once and automatically moved throughout the system. Multiple transcription steps are eliminated. Data entry can be set for entry efficiency and review convenience accommodated - trends and graphics.
2) Data acquired directly from monitors, labs eliminating transcription to flowsheet.
3) Up-to-date list of active orders and nursing activities is available.
4) Calculations are automated.

Examples of the Nursing activities that will have time savings and their frequency are listed.

Activity	Frequency
Vital signs/hemodynamic	Hourly
Plotting trends	1 per shift
I and O calculations	Hourly
Lab results - communication, transcription	2 per shift
Progress Notes/Assessment	2 per shift
Kardex/work list	2 per shift
Orders - communication, transcription	2 per shift
Report - shift to shift	1 per shift
Admission/transfer summary	
Care plan	1 per shift
Medication	Hourly

jb0109901nm

Nursing FTE Savings continued:

The UMH nursing staffing and patient assignments and workflow will be affected in increments. The FTE projections are a conservative projection of the summary of these incremental savings.

Critical care staffing is a key target area due to the shortage and extensive skill level requirement.

3. Other Benefits

Other benefits that will be achieved include:
- Productivity gains within other departments.
- Reimbursement audits and charge capture.
- Improved decision support for management.
- Research and quality assurance support.

Soft benefits will be:
- Positive affect on recruitment and retention of staff.
- Staff satisfaction.
- Marketing advantage.

GENERAL INFORMATION

- Dunn and Bradstreet report is very favorable; company is well financed, research and development is very strong, excellent financial backing from parent company, Motorola, Inc.
- Contract will include phased payment schedule.
- Negotiations reflect reduction for development and alpha-beta partnership agreement.
- Benefit study is to be done.

jb0109901nm

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 21, 1990

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: CT Scanner Replacement

UMHC acquired the oldest of its three CT Scanners in 1984. To enable the Diagnostic Radiology Department to continue to provide state-of-the-art CT imagining services and to handle the volume of procedures ordered on a timely basis, we are proposing to replace this scanner.

The proposal was presented to the Planning and Development Committee, the Finance Committee and the Board of Governors for information during the January meetings. It is being presented in February for approval.

GH:th

Attachment

PROPOSAL FOR CT SCANNER REPLACEMENT
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

INTRODUCTION

The University of Minnesota Hospital and Clinic (UMHC) installed the oldest of its three CT scanners in 1984. Based on the results of an analysis of financing alternatives completed at that time, the unit was acquired through a five year, operating lease. In April 1989, the decision was made to extend the lease for an additional one year period. The lease will now expire on April 30, 1990.

PROPOSAL

Acquire a new CT scanner to replace the Siemens DR3 scanner originally leased and installed in 1984.

RATIONALE

A. Providing timely service for the volume of CT scans being ordered requires operation of three, state-of-the-art scanners.

Annual increases in the total volume of CT scans performed have continued during the past three fiscal years:

	NO. PROCEDURES	% CHANGE
1985-86	8783	--
1986-87	9728	10.8%
1987-88	10008	2.9%
1988-89	10435	4.3%

Annualization of the volume from the first five months of the current fiscal year indicates that the total for the year may fall back to the 1987-88 level. If this occurs, it will be the first year since CT was introduced at UMHC that an increase over the prior year is not experienced.

The increased availability and usage of Magnetic Resonance Imaging (MRI) has had a negative impact on the volume of head and spine scans ordered. The volume fell from a peak of 5220 in 1986-87 to 4507 in 1988-89. However, the increase in body CT scans, from 4300 in 1986-87 to 5657 in 1989-90, has more than offset the head and spine decline. In addition, Roberto Heros, M.D. and Richard Price, M.D., chairpersons of Neurosurgery and Neurology, project that the demand for head and spine scans will plateau or increase again during the next several years as they work to increase the caseloads in their departments and as the relative strengths of CT versus MRI scans for certain types of imaging become better defined.

The trends in CT usage at UMHC are similar to those being experienced elsewhere. In August 1988, the journal Diagnostic Imaging contained a

report on the survey of ten community hospitals of 300 to 600 beds and six university hospitals. All reported increases ranging from 3 to 25% from the prior year.

B. The Siemens DR3 scanner does not have the following state-of-the-art features and capabilities:
   1. Bore size large enough to enable utilization for interventional procedures such as biopsies or drainage procedures.

   2. High and low contrast spatial resolution factors which produce higher quality images and enable detection of smaller lesions.

   3. High scanning and image reconstruction speeds which decrease procedure times and provide capability for scanning more patients. UMHC is currently not able to fulfill all demands for same day scanning of clinic patients who live outside the metropolitan area.

   4. 3D image reconstruction to enable usage for measuring volumes of tumor masses.

   5. Very high speed scanning enabling capture of multiple images while the patient holds his/her breath which improves the accuracy of volume measurements of tumor masses.

ESTIMATED COST

CT Scanner	$1,200,000
Installation and Control Room Remodeling	17,000
TOTAL	$1,217,000

FINANCING

Several financing alternatives are available: lease through the vendor or a third party, borrow from the University's equipment loan fund or a commercial vendor, or purchase with UMHC reserve funds. The alternative used will be the one which is determined to be the least costly at the time the acquisition contracts are written.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 23, 1990

TO: Members of the Board of Governors

FROM: Robert Dickler

RE: CHC Medical Waste Incinerator Project

Attached is Council of Hospital Corporations proposal to build and operate a medical waste incinerator facility.

As discussed at our last meeting, the University and Hospital have concluded that it is beneficial to participate in this venture.

We are seeking endorsement for hospital participation in this venture including participation in the corporation outlined in the attached proposal, a near-term commitment of up to $107,000, and a total financial commitment (probably in the form of a loan guarantee) of the Hospital/University of up to $625,000.

Board of Regents approval will be sought on this project following Board of Governors endorsement.

/gs

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 18, 1989

Allan N. Johnson, Ph.D., President
Council of Hospital Corporations
Suite 221 North
2550 University Avenue West
St. Paul, Minnesota 55114

Re: Medical Waste Incineration Project

Dear Mr. Johnson:

In accordance with the Infectious Waste Disposal Business Entry Plan, November 1989 and the November 20, 1989 Council of Hospital Corporations Board discussion, the University of Minnesota hereby signifies its intention to request approval from the Board of Regents for authority to participate in the medical waste incineration project. To signify our intention to seek Board authority to participate, the University of Minnesota hereby agrees to a cash assessment not to exceed 150 percent of $71,611.21, the exact cash assessment being dependent upon the percentage of hospitals participating in the project. Pursuant to the representations of the Council of Hospital Corporations, the cash assessment will be refunded unless hospitals representing more than 75 percent of the biological waste volume agree to participate.

The University of Minnesota is governed by the Data Practices Act, Minnesota Statutes Sec. 13.01 et. seq. and its treatment of data related to the medical waste incineration project will be governed by that statute.

The University of Minnesota agrees that it will not make any new commitments to biological waste disposal entities other than this project until a final decision is made with respect to the feasibility of the project and final decisions regarding operational permits.

bcc: Clifford Fearing
Jan Halverson, Esq.
Gregory Hart
Mark Koenig

Sincerely,

Gordon Donhowe
Vice President
Finance and Operations
University of Minnesota

GD/hg

I. EXECUTIVE SUMMARY

A. Project Incentive

General Management Services (GMS) and the associated firm of Richard, Crisman & Opitz, Inc., as part of their consulting work, have been following the developing legislation and regulations pertaining to the handling and disposal of infectious wastes for over two years. It was thus possible to forecast that the financial impact of complying to the pending regulations would force hospitals to shut down their existing on-site incinerators.

Commercial infectious waste disposal capacity is not available to absorb the infectious waste volumes disposed at on-site hospital incinerators, which is the largest portion of the infectious waste being generated.

It was also evident that a commercial infectious waste disposal organization would be able to, and as is indeed occurring currently, charge disposal costs significantly above those previously paid by hospitals.

The cost of obtaining permitting is sufficiently high to discourage others seeking entry into the infectious waste incineration business once the first party has received a permit. Thus future commercial infectious waste disposal pricing would also be affected only nominally by competition.

B. Project Purpose

In view of the above, the Council of Hospital Corporations contracted with GMS to develop a business entry (action) plan having the following objectives:

1. To maintain hospital control of the costs associated with medical waste disposal.

2. To collectively address this pressing environmental, political and public relations problems in the most effective, efficient and publicly safe manner.

3. To retain the flexibility to respond to the disposal needs of physicians on hospital medical staffs, clinics or other hospitals.

C. GOVERNANCE

A review and evaluation of alternatives with the law firm of Dorsey & Whitney led to the conclusion that a separate Board be formed for this subsidiary consisting of 3 members of the CHC Board, three outside board members and the President of the CHC serving as board chairman. The subsidiary board would need to have decisions affecting hospitals not represented on the board ratified by the CHC board.

The Executive Director of the subsidiary would report to the subsidiary board.

D. CORPORATE STRUCTURE

A for-profit CHC subsidiary was determined to be the structure most suited to meet the project goals after evaluation of several alternatives. Among its advantages is that it is simple to create and is flexible as far as the entities which may use the subsidiaries services.

E. INFECTIOUS WASTE VOLUMES GENERATED

The economics are fairly sensitive to the waste volume to be incinerated. Thus, the amount of infectious waste (as defined at the time) generated by each of the 24 participating hospitals was either weighed or was determined from invoiced received from the commercial disposal company. The resulting amount, annualized for 1989 (8,141,200 pounds) was then adjusted to obtain the equivalent volume after all of the participating hospitals have adopted the new definition for infectious waste legislated in Minnesota on July 1, 1989. The resulting "base" volume of 5,814,800 pounds was used for 1989.

The throughput capacity of the plant and its operating costs are based on this base volume for the 24 participating hospitals only, increasing at 3%/year compounded. The maximum capacity of the plant is 11,800,000 pounds/year. This leaves more adequate capacity for disposal of the infectious wastes for generators other than the participating 24 hospitals before additional capacity, for which space has been provided, needs to be added.

F. CURRENT DISPOSAL COSTS

The actual current infectious waste disposal costs at each hospital, including packaging and sharps disposal costs were extracted from hospital cost accounting records. This inclusive cost average for the 24 participating hospitals is $0.378/pound.

G. COST IMPACT OF REGULATIONS

Disposal cost increases from $37,800/ year to $264,100/year and added capital investments from $297,000 to $712,000 accompanied by a significant public relations burden are projected for 1990/91 depending on the volumes generated, the current disposal method and when existing disposal contracts expire.

H. PLANT INVESTMENT

The investment required for an infectious waste incineration plant sized for a maximum throughput of 11,000,000 pounds /year was estimated from quotations received for the major equipment incorporating the latest (8/25/98) proposed permanent standards

to become effective on January 1, 1992 for infectious waste incinerators. Rosewood Construction provided the estimate for the site preparation and building costs.

The total financing required is estimated to be as follows:

Capital investment	$3,007,800
Working capital	598,000
Start-up costs	441,000
Total	$4,047,200

I. OPERATING COSTS AND PRO FORMAS

The final income statement, cash flow and balance sheet pro formas prepared by Arthur Andersen Company are in Appendix I-1, pages 61-69. The assumptions are in Appendix H-5 & 6, pages 57-59.

The disposal price which the subsidiary charges to its participating hospitals would be set by the Board of the subsidiary. The price which would generate an annual profit of about $100,000 for the operation is $0.31/pound and if the steam generated is sold, which appears to be a good possibility, the price would be $0.29/pound. This is the total disposal price which includes packaging supplies including sharps packaging, transportation and disposal costs. This compares directly to the average cost of $0.378 paid by the 24 participating hospitals, prior to further cost increases.

This price assumes that 6,376,000 pounds of infectious waste would be incinerated for the 24 hospitals in 1992. If only 5.4 million pounds are incinerated the price without steam credit is $0.35/pound and at 4.4 million pounds it is $0.40/pound without steam credit.

This scenario assumes that all of the investment except that for land and building needs to be replaced in years 7 & 8 at current cost inflating at 5%/year compounded ($3,362,645). It is possible that new technology may generate more regulations following those to be effective in 1992 which could require some additional investment. If the investment required exceeds the cash flow generated, some additional borrowing, backed by price increases, may be needed. It is difficult to visualize that such potential regulations would cause such a catastrophic result.

All other costs in the operating statement and pro formas are at constant dollars.

J. SITING, PERMITTING AND ASH DISPOSAL

An initial survey identified 35 potential sites in Minnesota for the disposal operation all but one of which is within a 60 mile radius of the Twin Cities,

K. INCINERATION TECHNOLOGY

Controlled air, two stage incineration in a fixed hearth incinerator followed by a heat recovery unit to produce steam and a wet scrubber to meet and exceed the proposed permanent standards for infectious waste incinerators published on August 25, 1989 will be used. These formed the basis of the quotation received for the incineration equipment and monitoring devices.

The technology is not new, the controls and monitoring devices and operating conditions all having been commercially available and used for many years. The newness is that infectious waste incinerators installed heretofore have never had to use these more sophisticated process, pollution control and monitoring devices to meet prior, uninforced and less comprehensive standards.

Other technologies for decontamination of infectious wastes exist and all have their niche application. Some, such as autoclaving may in future years capture a small portion of the market created by new generators of infectious waste. It is generally agreed, however, that incineration will continue to be the dominant method used to dispose of infectious waste.

L. FINANCING

Outside financing of the entire $4,047,200 is planned. This financing would be backed by a contract from each participating hospital to commit their infectious waste volume to the CHC subsidiary. In addition, each participating hospital would provide a letter of credit for their portion of the loan, based on volume. The loan would be obtained by the CHC subsidiary. No financing would be sought from the local community nor from any other public agency.

The financing would be obtained in two steps. The initial amount to be financed would be the $565,000 required to obtain the permit. Aportion would be financed via letter of credit, the balance using a line of credit. Financing of the remaining $3,482,200 would take place after the permit has been issued.

M. CHECK POINTS

Three check point have been built in as the project develops.

1. After all hospital contracts and their letters of credit have been received. This is anticipated to occur on or before the end of 1989.

2. During the fifth month after project initiation, using quotations and preliminary approvals received to confirm that the project goals and objectives contained in this report are still on track. This could occur during May, 1990.

3. After the permit has been granted and before final arrangements for the financing of the remaining $3,482,200 are undertaken. This could occur in November/ December 1990.

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review:	2/5/90
Finance Committee Review:	2/28/90
Board of Governors Review:	2/28/90

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT:
Four bed holding area and related equipment - Heart Cath Lab

PURCHASE PRICE:
Remodeling $98,000
Equipment $68,471

DESCRIPTION:

The four bed holding area will be used by Cardiac Catheterization Laboratory and Cardiovascular Radiology for:

- Patient reception and preparation. This will improve efficiency and reduce the time conflicts between Patient Care Units and the Laboratory. Currently, the patients frequently have to wait in the hall before a procedure room is available.

- Care after catheterization, including removal of intravascular cannulae. This will reduce turnover time between cases, reduce the ICU use by providing a site for brief monitoring, provide smooth transfer to ICU and Patient Care Units and provide better observation of arteriotomy sites.

- Reception and post-catheterization monitoring (up to 8 hours) for outpatient cardiac catheterization.

The Cardiac Catheterization Laboratory's activity has increased by 240% in the past three years. It is important that an appropriate holding area is provided for the patients in this very busy clinical facility in order to accommodate current volume levels and increase the throughput capability of the lab to accommodate future growth in volume.

Submitted By: Greg Hart
Title: Senior Associate Director

Approved By:
Title:

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review:	2/5/90
Finance Committee Review:	2/28/90
Board of Governors Review:	2/28/90

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Frontal Plane Image Chain Upgrade
Heart Cath Lab: Room 2

PURCHASE PRICE: $120,000

DESCRIPTION:

The University of Minnesota Hospital and Clinic (UMHC) purchased the fluoroscopic x-ray equipment for Rooms 2 and 3 in the Heart Cath Lab from CGR Corporation during fiscal year 1985-86. The quality of the fluoroscopic images produced was deemed to be acceptable for the types of procedures being performed in the lab at that time by the Cardiology and Radiology staff involved in reviewing and recommending the equipment to be purchased.

Subsequent to the selection and purchase of this equipment, recruitment of Carl White, M.D., and Robert Wilson, M.D., resulted in the use of the rooms and the equipment for high volumes of coronary angioplasty procedures. For these procedures the fluoroscopic image quality achievable on the video monitors with this equipment is very marginal. The resolution is inadequate to enable accurate visualization of the fine guidewires (0.014 inch diameter) utilized during angioplasty. Frequently, the procedure must be interrupted for 15-30 minutes while film is developed to provide adequate images for decision making. This results in prolongation of the procedure, increased patient discomfort and increased risk of complications.

Approximately one year ago, CGR was purchased by General Electric (GE). GE has now developed an upgraded camera, image intensifier, and TV monitor to improve the fluoroscopic image quality for the CGR equipment. Based on observation of this upgrade at the GE factory, it appears they have been successful. Therefore, UMHC is planning to purchase the Image Chain Upgrade for one plane of the biplane system in Room 2. If this upgrade proves successful, a similar upgrade will be planned for purchase for Room 3 during the 1990-91 fiscal year.

Submitted By: Al Dees
Title: Associate Director

Approved By: [signature]
Title:

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 21, 1990

TO: Members, Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Hospital Admissions Policies

Attached is a copy of the Hospital Admissions Policy which has been approved by the Medical Staff-Hospital Council and Council of Clinical Chiefs.

This policy is presented to you this month for your endorsement.

/th

Attachment

From existing UMHC Policy 5.14 regarding UMHC's Hill-Burton Community Service and Emergency Service obligations HHS 42 C.F.R. Section 124(G)

BACKGROUND

The Department of Health and Human Services (HHS) requires health care facilities that accept funds under Title VI (Hill-Burton Act) to provide uncompensated services and ensure that services are offered to the public without discrimination.

As of January 1, 1981, UMHC met its uncompensated services requirement. Under Subpart G of 42CRF Part 124, UMHC continues to have a community service obligation.

POLICY

In compliance with 42CRF, Part 124, Section G, The University of Minnesota Hospital and Clinic shall make **emergency services** available to all persons residing in UMHC's service area, which is the state of Minnesota. These services shall be rendered without regard to "race, color, national origin, creed, or any other grounds unrelated to an individual's need for the service or the availability of the needed service in the facility." UMHC shall post the appropriate notices required under Subpart G and shall report on its compliance with its Title VI obligation.

PROCEDURE

1. Under Section 124.603 of Subpart G (42CRF Part 124), UMHC must make emergency services available to all persons residing within our service area, the state of Minnesota. Therefore, all such persons shall be permitted access to the hospital's Emergency Department for **emergency services.** Subpart G does not change other legal or ethical requirements related to the rendering of **emergency services.**

2. Acceptance of such patients for **emergency services** does not require UMHC to render non-emergency services once the patient is stabilized. However, UMHC must accept Minnesota residents who are covered under Medicare or Medicaid/Medical Assistance Programs for all necessary services per the rules and regulations governing these programs.

3. Signs indicating UMHC's obligations under Subpart G shall be posted in the Emergency Department, Admissions Department, and Registration Office/Cashiers area. The wording and placement of these signs shall be the responsibility of the Director of Admissions in consultation with appropriate administration staff in the Emergency Department and the Finance Division.

4. All UMHC departments involved with the rendering of care shall coordinate with the Associate Director of Finance responsible for Hill-Burton obligations to ensure that all reporting required under Subpart G is completed. These departments shall include but not be limited to Admissions, Emergency, Outpatient Clinics, Patient Relations, and Social Work.

5. Any questions regarding the eligibility for admission of a patient for emergency and/or elective services shall be referred to the Director of Admissions or her/his designee.

6. Section G does not require UMHC to accept patients not physically present at UMHC for emergent or elective services. All such requests for services (usually occurring via phone or in writing) shall be referred to the Director of Admissions or her/his designee.

7. **Emergency Services** are defined as the reasonable diagnosis and treatment services necessary to eliminate any immediate threat to a patient's life or well-being and the referral or transfer to the appropriate facility for follow-up or ongoing care.

   UMHC shall treat, on an emergency basis, any patient who presents himself/herself, in person, to UMHC in Minneapolis, MN, for emergency service. Such persons shall receive medical care, as required, until the emergency condition is eliminated. Medical care beyond that point shall be dictated by the medical condition of the patient, the patient's or the patient's guardian's expressed desires and the requirements of the patient's third party payer.

8. Non-Emergency Health Care Services

   UMHC recognizes that in order to continue to support its tripartite mission of patient care, education, and research, proper business practices must be used to ensure the financial support of UMHC. Concurrently UMHC will assist its patients to secure coverage whenever possible. To this end UMHC will work with the patient or patient guarantor to obtain any and all financial support that may be available. To accomplish these objectives UMHC requests the medical staff notify Hospital Admissions or Registration five (5) working days prior to any pending admission or clinic visit to allow for a pre-admission or outpatient visit financial screening. UMHC shall provide non-emergency care to patients who meet the following financial criteria.

   Admission Requirements (non-emergency):

   1. All non United States citizens must have made a deposit, verified a credit line or have insurance coverage equal to the estimated procedure expense, and such deposits credit lines or insurance must be accepted and/or confirmed prior to the day of admission in writing.

   2.a. All out-of-state patients except Medicare patients must make a deposit, verify a credit line and/or have written confirmation of insurance or public assistance coverage equivalent to at least 85% of the estimated procedure expense prior to admission. The remaining 15% must be paid under a payment plan established prior to admission. If a contract or agreement exists between UMHC and the patient's third party payor that prohibits this practice, this provision will not be required.

2.b. The University of Minnesota Hospital and Clinic will accept Medicare coverage as meeting the financial requirements in 2.a.

2.c. For elective admissions The University of Minnesota Hospital and Clinic will not accept Medical Assistance as adequate coverage from states whose medical assistance program do not meet the expected payment levels established from time to time by UMHC. (At the present time UMHC financial criteria is a minimum of 85% of charges.) UMHC will accept emergency out-of-state Medical Assistance patients without regard to coverage limits. However, UMHC will not be responsible for any transportation services for these patients.

3.a All State of Minnesota patients will be provided care without regard to their ability to pay for their care. However, every Minnesota resident will be expected to contribute to the cost of their care at levels consistent with their ability to pay. Deposit requests will be based on ability to pay but not mandatory before admission is approved.

Minnesota Patients With or Pending Medical Assistance, or Other Public Assistance Programs:

3.b. Prior to a non-emergency admission of any Minnesota resident eligible for Medical Assistance, General Assistance Medical Care, Services for Children with Handicaps, or other public assistance programs, the patient must be certified by the county as eligible and all necessary actions associated with eligibility must be completed. Admissions will be deferred until such certifications and/or agreements are completed.

4. The Hospital Director, Senior Associate Directors, Associate Directors, the Director of Admissions, or the administrator on call shall have the authority to waive any or all of the above requirements and will work with the medical staff in making exception decisions.

5. All exceptions or lack of proper procedure will be reported to the Board of Governors when a bad debt does occur.

To facilitate the implementation of these policies, the admissions and registration departments will work with the clinical departments to review coverage and secure deposits where appropriate and defer elective admissions until appropriate coverage has been secured. It will be the responsibility of the clinical department to notify admissions and registration of the pending admission or clinic visit, and all non-emergency or non-urgent admissions or clinic visits should not be scheduled for at least five (5) working days.

It will be the responsibility of admissions and registration to perform the financial review and to defer the admission or clinic visit when appropriate.

A physician who believes an immediate admission or clinic visit is imperative due to the medical condition of the patient may admit the patient or schedule the clinic visit without regard to the financial condition of the patient.

HEALTH CARE IN THE '90s: PREDICTIONS & PRESCRIPTIONS

"Will the Acute Care Market Survive"

Thursday, March 22, 1990

A TRUSTEE FORUM • 7:30-9:30 A.M. • Whitney Hotel, Minneapolis

What is the diagnosis for Twin City hospitals? Why have local hospitals endured a greater decline in inpatient days and revenues than nearly any other metropolitan area?

Is there any relief in sight? With continued growth in managed care plans, growing competition between hospitals and physicians for the ambulatory care dollar and new forms of technology encouraging outpatient treatment, can the acute care market survive?

Alternatively, is an acute care "fix" in sight, fueled by the dramatic growth of the elderly population, AIDS patients and "crack" babies?

What's the prescription for the future? What should be hospitals' strategic response? Should hospitals concentrate on building inpatient treatment via "feeder systems" or do more to deliver a continuum of services to patients in their homes and communities? Should the role and mission of hospitals shift from infectious disease to chronic care?

Trustees will be facing these and other issues in the 1990s. Come learn about future options and opportunities first-hand!

Speaker:

Earl C. Joseph, Futurist
President
Anticipatory Sciences Incorporated

General Information

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

Location and Date:
The Forum will be held on Thursday, March 22, 1990, from 7:30 a.m. to 9:30 a.m.:
Whitney Hotel
150 Portland Avenue
Minneapolis, Minnesota
Breakfast will be served.

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

For Further Information:
Pat Pardun 641-1121.

MINNESOTA HOSPITAL TRUSTEE CONFERENCE

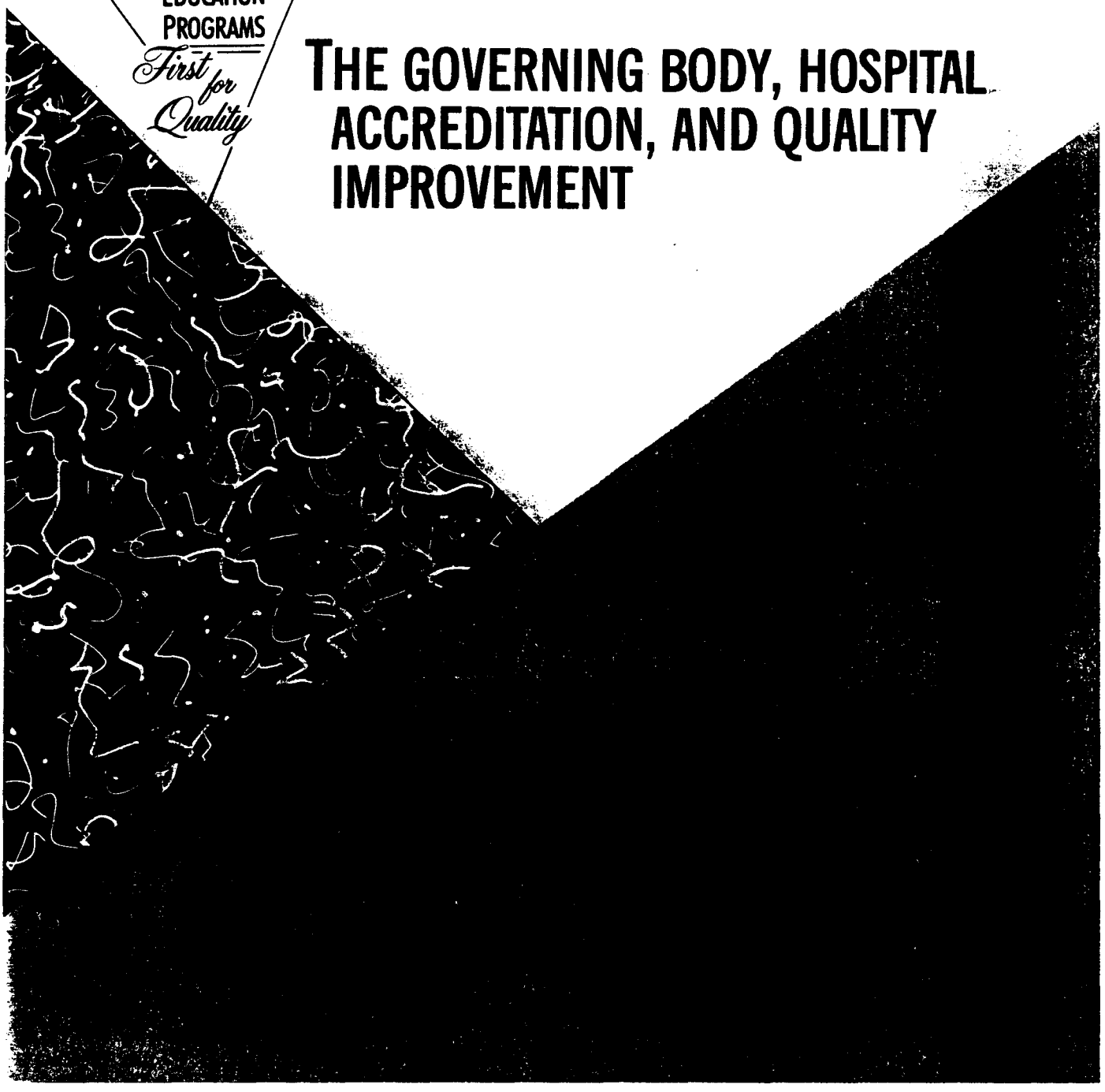
Conference Committee Members:

Geoffrey Kaufmann, Chairman
Vernon Hoium
Naomi Johnson
David Hunt
Pat Pardun, Coordinator

JOINT COMMISSION
EDUCATION
PROGRAMS
First for Quality

REVISED

THE GOVERNING BODY, HOSPITAL ACCREDITATION, AND QUALITY IMPROVEMENT



FROM THE ORGANIZATION THAT SETS THE STANDARDS . . .

This important seminar, developed specifically to address the responsibi
ties of the governing body, will provide you with the insight and techni
you need to effectively oversee the quality of care offered throughout your hospi

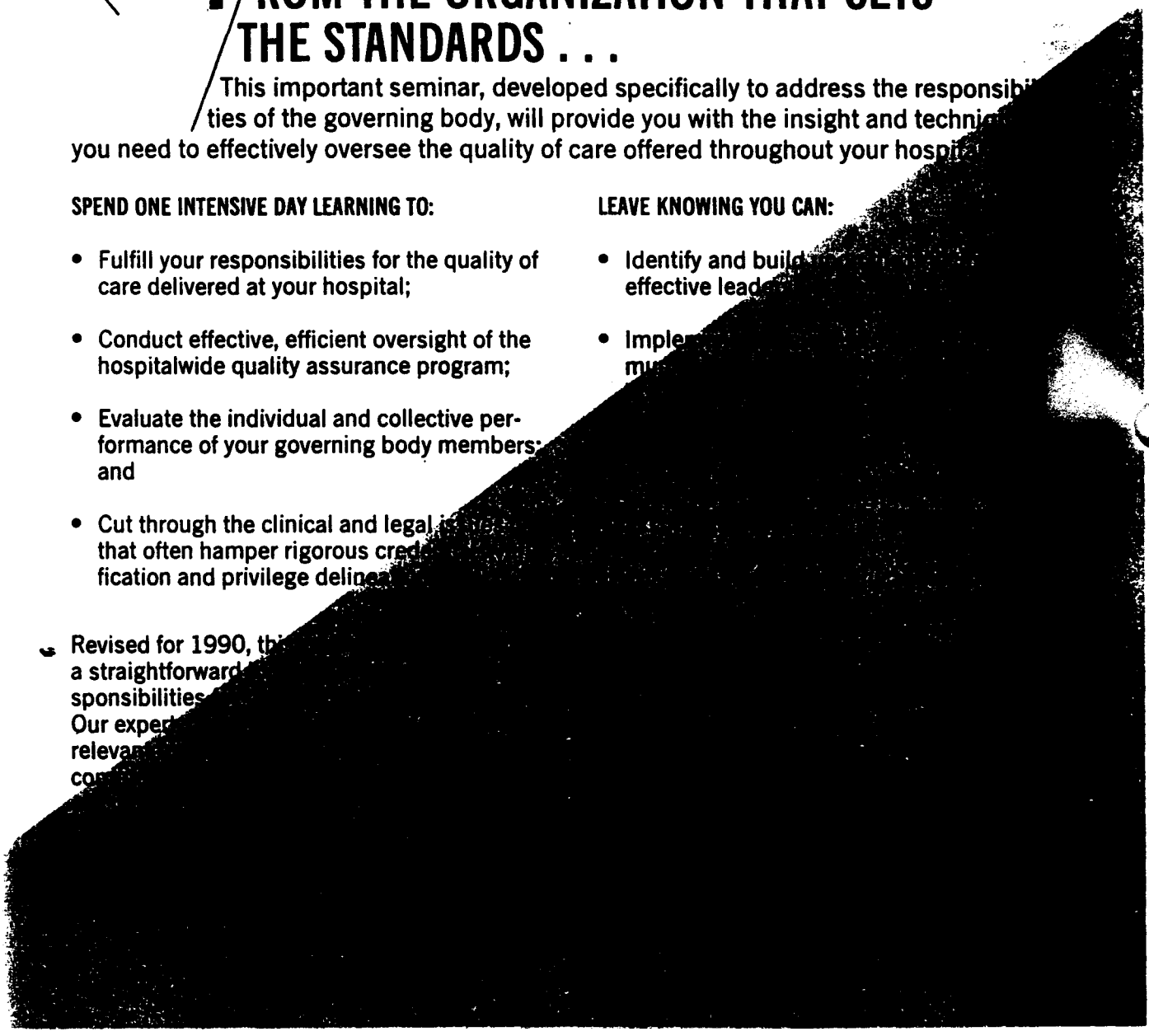
SPEND ONE INTENSIVE DAY LEARNING TO:

- Fulfill your responsibilities for the quality of care delivered at your hospital;
- Conduct effective, efficient oversight of the hospitalwide quality assurance program;
- Evaluate the individual and collective performance of your governing body members; and
- Cut through the clinical and legal i
that often hamper rigorous cred
fication and privilege delin

LEAVE KNOWING YOU CAN:

- Identify and build
effective lead
- Imple
mu

Revised for 1990, th
a straightforward
sponsibilities
Our exper
relevan
co



REGISTRATION

Attendance is limited and early registration is strongly recommended. Registrations are accepted in the order received.

All registrations must be confirmed by the Minnesota Hospital Association. Registrations made within two weeks prior to the program must be made by phone. The registration cut-off is five business days prior to the beginning of the program. For phone registrations, please call the Minnesota Hospital Association at 612/331-5571, ask for Peggy Westby.

Please complete and return the registration form with full payment made payable to:

Minnesota Hospital Association
Attn: Peggy Westby
Education Coordinator
221 University Avenue, SE
Suite 425
Minneapolis, MN 55414
Fax: 612/331-5571

FEE

The registration fee is $295 per participant and includes a seminar workbook, the current edition of the *Accreditation Manual for Hospitals*, lunch, and refreshment breaks.

FURTHER INFORMATION

Contact the Joint Commission at 312/649-8100.

DISCOUNT AIR FARES

Special discount fares to cities served by American Airlines are available to attendees at most Joint Commission education programs. Discounts range from 40% off full coach fare to 5% off any restricted fare in the market. To take advantage of the special fares, please call American Airlines at 800/443-1790. Be sure to mention STAR file number 03ZOK2.

REFUNDS

The registration fee, less a $50 service charge is refundable if notice is received five business days prior to the program. If you must cancel, please ask for a cancellation confirmation.

Substitutions and Transfers: Registrants unable to attend may send an alternate. Transfers from one Joint Commission education program to another are not permitted due to variability in program sponsors.

The Joint Commission reserves the right to cancel or reschedule a program due to an insufficient number of registrants or other unforeseen circumstances.

RESTRICTIONS

This program may be electronically recorded by the Joint Commission. By attendance or participation in discussion, the registrant agrees that the Joint Commission may electronically record, copy and distribute the registrant's attendance at and involvement in program discussion and question and answer periods. No individual or entity other than the Joint Commission may electronically record any portion of this program for any purpose without the prior written consent of the Joint Commission.

By their registration, program participants agree to refrain from marketing services or products during the course of the program.

WHO SHOULD ATTEND

This seminar is designed primarily for hospital governing board members. Chief executive officers, medical staff leaders, and hospital attorneys will also benefit from this program. To ensure successful application of this seminar's purpose and objectives, it is recommended that two or more individuals from the same organization attend.

PROGRAM SCHEDULE

Day 1

• Registration	8:00 am–9:00 am
• Program Sessions	9:00 am–4:30 pm

WHAT YOUR COLLEAGUES ARE SAYING ABO
THIS SEMINAR:

"Should be required atten
governing board memb

"Don't hesitate t

"A real mu
board, a

CONTINUING EDUCATION

The Joint Commission is accredited as a provider of continuing education for physicians and nurses. Physicians earn 6 credi hours in Category I of the Physicians' Recognition Award of the American Me Association.

HOTEL INFORMATION

The program wi
location:

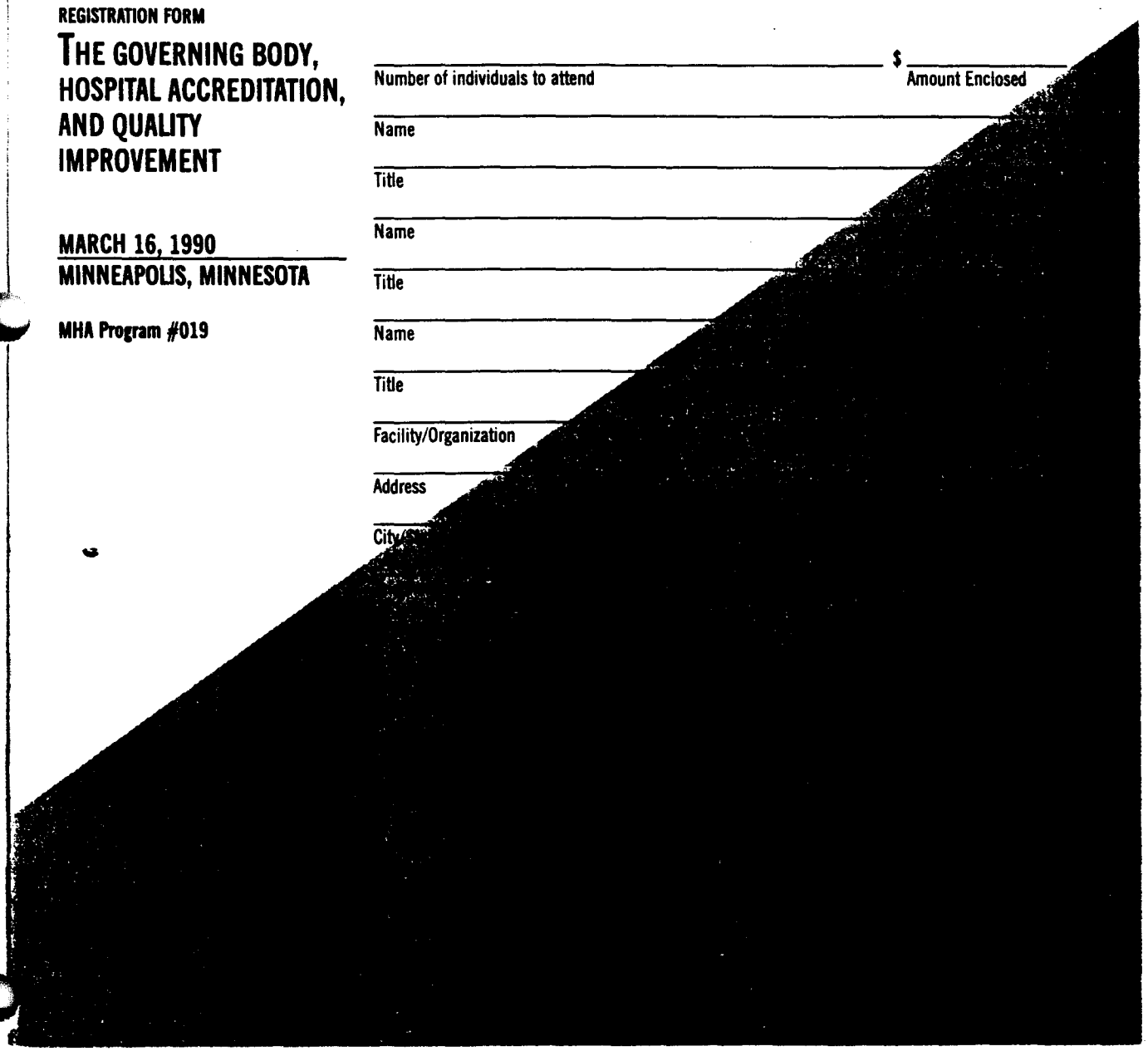
Sher

REGISTRATION FORM

THE GOVERNING BODY, HOSPITAL ACCREDITATION, AND QUALITY IMPROVEMENT

MARCH 16, 1990
MINNEAPOLIS, MINNESOTA

MHA Program #019



_____ $ _____
Number of individuals to attend — Amount Enclosed

_____
Name

_____
Title

_____
Name

_____
Title

_____
Name

_____
Title

_____
Facility/Organization

_____
Address

_____
City/

MHTC

Metro Hospital Trustee Council

Recent events in Minnesota and throughout the nation, assure that hospitals' tax status will remain a topic of major importance for some time to come.

Congress has begun discussions over whether to tie hospitals' access to tax-exempt bonds to the levels of charity care which they provide. State legislatures are also reviewing tax exemptions to nonprofit hospitals with renewed interest.

In Minnesota, a flurry of activity was generated by Governor Perpich's proposal last summer, to allow cities to charge municipal service fees to tax-exempt property owners, including hospitals.

This report represents the position of the Metro Hospital Trustee Council, a voluntary association of hospital trustees representing over twenty metropolitan area hospitals and hospital corporations.

We commend it to hospital boards, CEO's, and the broader community, for study and action as part of the ongoing debate surrounding these issues.

Vernon Hoium
President
Metro Hospital Trustee Council

6425 Nicollet Avenue South • Suite 320 B • Minneapolis, Minnesota 55423 • 612/869-1909

PRESERVING HOSPITALS' TAX EXEMPTIONS

AND

PUBLIC ACCOUNTABILITY

Metro Hospital Trustee Council
6425 Nicollet Avenue South
Suite 320B
Minneapolis, MN 55423
612/869-1909

June, 1989

TABLE OF CONTENTS

FOREWORD

Recent events in Minnesota and throughout the nation, assure that hospitals' tax status will remain a topic of major importance for some time to come.

Congress has begun discussions over whether to tie hospitals' access to tax-exempt bonds to the levels of charity care which they provide. State legislatures are also reviewing tax exemptions to nonprofit hospitals with renewed interest.

In Minnesota, a flurry of activity was generated by Governor Perpich's proposal last summer, to allow cities to charge municipal service fees to tax-exempt property owners, including hospitals.

This report represents the position of the Metro Hospital Trustee Council, a voluntary association of hospital trustees representing over twenty metropolitan area hospitals and hospital corporations.

We commend it to hospital boards, CEO's, and the broader community, for study and action as part of the ongoing debate surrounding these issues.

Sincerely,

Vernon Hoium
President
Metro Hospital
Trustee Council

EXECUTIVE SUMMARY

This report maintains that hospitals deserve their tax-exempt status and should remain exempt from state property and sales taxes.

Minnesota hospitals' community contributions exceed the cost to the public of their tax exemptions. Taken together, the cost of hospitals' 1988 sales and property tax exemptions was between $100 million to $128 million. In return, hospitals provided over $19 million in charity care and over $165 million in discounts to Medicare and Medicaid. Hospitals also contribute to the state's economy, provide needed and often unprofitable community services, and subsidize graduate medical education and research.

Despite these efforts, however, hospitals' future claims to tax-exempt status are in danger of being seriously eroded.

* Minnesota's private hospitals devote less than 1 percent, (.5%), of gross revenues to charity care, a level of effort which does not compare favorably with other states.

* In contrast, public hospitals now provide over two-thirds of Minnesota's charity care.

* This situation is occurring at a time when many hospitals have met their Hill-Burton obligations and hospitals are less able to shift charity care costs to private patients.

* Private hospitals are unable to accurately document the charity care that they do provide because of reporting difficulties in separating charity care from bad debt.

Hospitals' nonprofit tax status is under scrutiny in Congress and in at least twenty other states. Some states now require hospitals to "earn" their tax-exempt status by providing a predetermined amount of charity care.

In Minnesota, the debate about nonprofits' tax status is well underway. In fact, some business leaders are contending that if the state picks up the tab for indigent care, (via HealthSpan), then hospitals' tax exemptions are expendable.

In this context, it is clear that even though hospitals deserve their tax-exempt status, they will be held to a higher standard of public accountability than in the past. The Trustee Council recommends that hospitals take two proactive steps to meet this challenge.

First, hospitals (through the Council of Hospital Corporations and the Minnesota Hospital Association), should develop a uniform method of defining and reporting charity care expenditures to the public. Second, individual hospitals ought to consider whether to voluntarily pay municipal service fees.

WORK OF THE TASK FORCE

This report is the product of many months of intensive study and discussion.

The initial charge to the Task Force was to:

1. Identify the current rationale in support of taxation of not-for-profits in Minnesota.

2. Identify the major positions of those in opposition to taxation of not-for-profits in Minnesota.

3. Review the formal and informal positions taken by organized hospitals on this issue, both locally and nationally.

4. Consider the taxation of hospitals in the context of taxation of not-for-profits in general, and in the context of the wider community interest.

5. Develop a consensus position statement on the tax-exempt status of hospitals for Trustee Council deliberation and approval.

The members of the Task Force included:

Stanley R. Cowle, Piper, Jaffray and Hopwood
Gordon Donhowe, former Chief Executive Officer, Fairview Hospital and Health Care Services
Gayle Hallin, Trustee, HealthEast
Phil Helland, Trustee, Fairview Southdale
David Lavine, MHTC Past President
Chuck Moos, Trustee, Abbott Northwestern
Janet Mott, Trustee, Minneapolis Children's Medical Center
Allen Olson, Executive V.P., Independent Bankers of Minnesota
Sung Won Sohn, Chief Economist and V.P., Norwest Corporation
Florence Gray, MHTC Past President

Their efforts are gratefully acknowledged.

The Task Force met seven times during 1988 and 1989 and heard from the following speakers/resource persons:

Scott Anderson, CHC, President, North Memorial Medical Center
Curt Johnson, Executive Director, Citizens League
Tom Triplett, Commisioner of Finance, State of Minnesota
Professor Tony Filipovitch, Mankato State University
John Kingrey, V.P. of Government Relations, MN Hospital Assoc.
Jon Pratt, Executive Director, Minnesota Council on Nonprofits
Glenn Dorfman, Staff V.P. Govert. Affairs, MN Assoc. of Realtors

Tom Satre, Attorney, Opperman and Paquin
Ann Schleuter, Attorney, Opperman and Paquin
Mike Stutzer, Economist, Federal Reserve Bank of Minneapolis

The Task Force submitted its report to the Metro Hospital Trustee Council in April, 1989 and a modified report was approved by the Council in June, 1989.

I. FINDINGS ABOUT NONPROFITS NATIONALLY

A. THE HISTORICAL ORIGINS OF NONPROFIT TAX EXEMPTION.

The origins of nonprofit organizations are somewhat obscure. It is clear, however, that they have been around for centuries. Prior to the 17th century, charitable causes were principally religious in nature. Later, private "philanthropies" assisted the church in providing funds for a wide range of goods and activities which today are the province of government. These activities included: schools, hospitals, toll-free roads, volunteer fire departments, public parks, bridges, dikes, wharfs and docks, waterworks, libraries, care of prisoners in jails, and charity to the poor.

In 1601, the English Parliament passed the Statute of Charitable Uses which helped to define and enumerate charitable purposes of that time. The essence of the statute conceptually, was rudimentary notions of public benefit and the relief of poverty. The early American colonists followed established English precedents. However, they followed these traditions so earnestly and vigorously that Alexis de Tocqueville quickly came to regard these "associations" as a hallmark of American democracy. In his book, Democracy in America, de Tocqueville applauded Americans' tendency to form organizations to meet common needs rather than wait for government to do so.

Burton Weisbrod, author of The Nonprofit Economy, has noted that initially, the existence of nonprofits "had nothing to do with tax considerations, for the history of private nonprofit organizations long antedates the existence of taxes on personal income and corporate profits." Exemption from the property tax was granted to religious and educational organizations early on in the United States and was extended to private charities in the nineteenth century when charities became widespread. Most of the state constitutions in the United States empower their state legislatures to prescribe what property should be taxed and what should be exempt.

The U.S. deduction for charitable giving was added to the federal income tax law in 1917, four years after the adoption of the Sixteenth Amendment, which permitted taxation of personal income. In 1918, an estate tax deduction was added for charitable bequests, but it was 1935 before corporations were allowed to make tax-deductible contributions. These tax deductions presumably had only a small effect on giving prior to World War II, for income tax rates were small until then. Now, with far higher rates of personal and corporate taxation, tax rates are a major

influence on charitable giving.

The underlying motivation for tax exemptions may have been best expressed by the Filer Commission Report, which stated:

> "tax exemptions...reflect an underlying quid pro quo -- the belief that society is well compensated for tax revenues foregone because the activities and services thereby aided and encouraged are of benefit to society. Government, in fact, would itself have to supply many of the services, fill many of the functions, of such organizations if they did not exist."

While there have been various statements regarding the underlying historical rationale for granting exemption from taxation to nonprofit organizations, one of the best summaries of these policies has been provided by the Nonprofit Tax Policy Study Committee of the Minnesota Council on Foundations. In their January 1989 report, "Preserving Diversity: The Effect of Tax Policy on Nonprofit Organizations", the Council found six arguments for exempting nonprofit organizations. These arguments are reproduced below in their entirety:

FAIRNESS: It has been argued that nonprofit organizations deserve a tax exemption to compensate for the resources and opportunities which are closed to them by the nature of the sector. Unlike for-profit businesses, nonprofits cannot obtain capital by selling stock on the market. Organizational growth can be financed in any of three ways: by using retained earnings, by borrowing money, or by taking equity partners. The tax exemption allows nonprofits to offset their inability to attract equity partners by using amounts not paid in taxes to increase their working capital.

MARKET GAPS: There are some goods and services which the market cannot supply - housing for those who cannot afford to pay market price for it, food for those who have no money to buy it, health care for those who do not know how to obtain it or cannot afford it, clean air and water, among others. In return for supplying what the market cannot, nonprofits are not taxed on the resources they use to provide those goods and services.

SUBSIDY: As far back as 1896, a common argument for exempting nonprofits from taxation is that government has an interest in subsidizing nonprofits, (Hall, 1987). This argument has two sides. On the one hand, nonprofits serve minority interests which are not sufficiently served by government action. It would not be possible for a government to satisfy the interests of all the small groups within its domain. In effect, by providing for individual choice, nonprofits are lifting a burden from government. On the other hand, if nonprofits were not providing their

services, government would be constrained to provide them; but, through the nonprofit sector, government can leverage its subsidy against donations from the private sector. Even if government could afford to take up the slack, (which it cannot), it can get a service provided for fewer of its own dollars through the nonprofit sector.

EXCLUSION: Since Colonial times, it has been argued that the exclusion of religious and other nonprofit organizations from paying taxes is not an exemption, (a permission not to pay the tax), but a right. The voluntary sector, it is argued, does not operate according to the rules of the market. To the extent that tax policy is designed to direct market transactions, it makes no sense to apply those controls to nonprofit organizations. To the extent that tax policy is designed to draw on private income to support public activity, it again makes no sense to extend it to nonprofits. Nonprofits have no net income, (profit), in any usual sense since any surplus is not available for distribution to shareholders and all resources are devoted to serving the organization's mission.

REGULATION: In return for an exemption from taxation, nonprofits submit to special regulation to minimize competition with the private sector and duplication with the government sector. Private business is not similarly regulated; it is not required to make its tax returns public or to abstain from political activity. The special status of nonprofit activity is recognized by special tax treatment.

PRACTICALITY: Clearly, it is argued, some nonprofits perform such patently public purposes that they should be exempt from taxes directed to private consumption. While there may be some loss of clarity at the margins, it is easier and less expensive for the government to administer policies which treat all nonprofits alike, rather than turning to case-by-case analyses. "Make it difficult to be granted tax-exempt status initially," they argue, "but as long as the initial purposes are being served by an organization, it should be left alone". The cost of setting up and regulating multiple categories of tax exemption is not justified by the modest income it would generate.

B. INTEREST IN TAXING THE NONPROFIT SECTOR HAS INCREASED AS NONPROFITS HAVE BECOME A LARGER PART OF THE NATIONAL ECONOMY.

1. There are now nearly one million nonprofit organizations in the United States.

   According to Burton Weisbrod, author of The Nonprofit Economy, there are now nearly one million tax-exempt nonprofit institutions in the United States. Although the total number of nonprofit organizations grows by tens of thousands every year, such figures may over-represent the actual size of the nonprofit sector since many nonprofit organizations discontinue operations each year. Data on the total number of ongoing, active nonprofits is not available.

2. The rate of employment growth in nonprofit organizations has outpaced both government and the private sector.

   Nonprofit jobs have grown faster than either private business or government over the last two decades. Jobs in nonprofits increased nearly 50 percent from 1972 to 1986, compared with a 33.4 percent increase in employment in for-profit businesses.

   Nonprofits employed 7.2 million people in 1986, or approximately 1 in 16 working Americans, according to the Independent Sector, a Washington, D.C. research group. The nonprofit labor force is projected to reach 8.6 million in 1990 and 9.3 million in 1995.

3. Nonprofits now account for more than 8 percent of the total gross national product.

   In 1974, nonprofit organizations accounted for about 1.2 percent of the nation's gross national product. By 1980, nonprofit activities accounted for 5.5 percent of the GNP. By 1987, nonprofit organizations had become one of the fastest growing segments of the economy and represented more than 8 percent of the GNP.

4. Federal budget cuts and tax law changes have encouraged nonprofits to rely less on government and more on sales.

   A combination of federal budget cuts in the early 1980s combined with the Federal Tax Reform Act of 1986, have resulted in major changes in the ways nonprofits operate.

   With fewer federal funds available, nonprofits were forced to become less dependent upon government revenues. To become more independent, nonprofits largely increased their sales activities.

   Nationally, nonprofit revenue increased from $114.6 billion in 1975 to $314.4 billion in 1983. The

difference is largely attributable to increased nonprofit sales activity. Total sales by nonprofits amounted to $240 billion in 1983, or more than twice what the nonprofits' total sales were eight years earlier.

Sales now account for three-fourths of the revenue for nonprofit organizations according to the most recent figures available from the IRS.

5. As nonprofits' revenues have increased, the sector has become a more tempting target for taxation.

   According to the Treasury Department, the tax-exempt sector had annual gross revenues of $250 billion to $300 billion in 1985. Of that, only $118 million was taxed, with receipts totaling about $39 million. The IRS estimates that $165 million in Unrelated Business Income Taxes, (UBIT), goes uncollected because of improper reporting.

   Thus, as nonprofits' revenues have increased, they have become a more inviting target to the IRS. It is worth noting that hospitals account for about 60 percent of total nonprofit sector revenues.

6. As nonprofits have increased their sales activities, they have faced growing opposition from small business.

   In late 1983, the Office of Advocacy of the Small Business Administration issued a report entitled "Competition by Nonprofit Organizations with Small Business: An Issue for the 1980s". Although the report presented largely anecdotal data on the issue of unfair competition by nonprofit organizations, it served to galvanize the growing negative feelings of small business owners, some of whom had legitimate complaints.

II. FINDINGS ABOUT MINNESOTA'S NONPROFIT SECTOR

A. THE NUMBER OF ACTIVE NONPROFIT ORGANIZATIONS IN MINNESOTA IS UNKNOWN.

Over 45,000 nonprofits are registered with the Minnesota Secretary of States Office. However, as nonprofits are not required to notify state officials when they dissolve, as many as a third of these entities may no longer exist.

The National Center for Charitable Statistics identified 8,960 nonprofit organizations operating in Minnesota in 1987 based on forms filed with the Internal Revenue Service.

The Attorney Generals Office has a file of 2,200 I.R.S. returns from nonprofit organizations which operated in Minnesota in 1987 and which had annual income exceeding $25,000 from public, (i.e. not governmental), sources. About 600 of these returns were from organizations headquartered outside of Minnesota but which seek funding in the state.

While this data appears to be the best available, it has three serious limitations. First, many small organizations are not required to file with the state. Second, all of the information is self-reported. Third, the majority of hospitals are absent, as are all of the higher education institutions.

The 1988-89 Minnesota Nonprofit Directory published by the Council on Nonprofits, lists 1,507 nonprofit organizations in the state.

B. FEWER NONPROFIT ORGANIZATIONS ARE BEING CREATED TODAY THAN IN THE PAST.

According to a recent study by the Center for Urban and Regional Affairs, (CURA), most Twin Cities nonprofits formed after 1960. "Approximately three out of four local nonprofits were formed after 1960, and half after 1970."

State officials have found a leveling-off in the incorporation rate for new nonprofit organizations. The number of applications for nonprofit corporations fell from 1,526 in 1983 to 1,271 in 1987.

C. NONPROFIT REVENUES ARE LESS DEPENDENT ON GOVERNMENT SUPPORT TODAY THAN IN THE PAST.

Lester Salamon, (1987), estimated that in 1981, nonprofits received about 41 percent of their support from the federal government, 28 percent from fees, 20 percent from private donations and 10 percent from other sources.

Similar figures were found locally. Barbara Lukerman of CURA, found that government provided 40 percent of revenues to Twin Cities nonprofits in 1981.

However, there has been a dramatic reversal of dependence on government support since 1981. (See table below.)

SELECTED NONPROFIT REVENUES, 1987
(IN THOUSANDS)

	Government Support	Contributions	Program Revenue	Membership Dues	Other
Human Services	14% $83,462	16% $94,630	45% $266,181	23% $137,972	2% $13,779
Arts & Culture	3% $ 7,239	30% $66,204	40% $ 88,474	22% $ 48,144	4% $ 9,039
Public Benefit	16% $39,808	30% $81,706	52% $141,631	2% $ 6,833	0% $ 725

% = Percent Of Total Revenue
Source: Minnesota Attorney General, IRS Form 990s

Across all categories of 501(c)(3) organizations, program revenues and contributions represent significantly larger sources of support than governmental funds.

D. LITTLE IS KNOWN ABOUT THE TOTAL ASSETS OF NONPROFIT ORGANIZATIONS.

Total assets of all Minnesota nonprofits are unknown. However, information about one type of nonprofit asset, property, is available. This data shows that the value of nonprofit and government property increased 40 percent between 1980 and 1986, from $16 billion to $22.6 billion.

While the value of exempt property is large and growing, it does not match the increase in the value of taxable property which grew 88 percent, from $66.5 billion in 1980 to $123.2 billion in 1986.

The value of property owned by various types of exempt organizations is shown in the following table:

MARKET VALUE OF TAX-EXEMPT PROPERTY

K-12 Schools	$ 5,980,122,402
Colleges and Universities*	$ 2,175,500,016
Public Burying Grounds	$ 135,683,294
Church Property*	$ 2,662,435,947
Hospitals	$ 2,005,442,770
Charitable Organizations	$ 849,226,839
Forests	$ 994,290,535
Indian Reservations*	$ 139,354,600
Public Property	$ 7,652,118,495
TOTAL	**$22,594,174,898**

* Indicates Constitutionally-Exempt Property
Source: 1986 Exempt Property Values, Local Government Aids and Analysis Division, Minnesota Department of Revenue

Tax-exempt property amounts to 22.6 percent of the property in Minnesota. In 1974, the tax-exempt share of total property value was highest in outstate regional centers where exempt property accounted for at least 30 percent of the total value in each city. Suburban areas had the lowest percentage of tax-exempt land, (usually between 10 and 20 percent). In Minneapolis and St. Paul, tax-exempt property averaged 26 percent of total property values.

Significantly, only about one-third of Minnesota's nonprofit entities own property. Thus, most nonprofits already pay property taxes, albeit indirectly through their rent. Ironically, it is precisely the poorest of the nonprofits which must pay these indirect taxes. Nonprofit organizations which are financially able to own property do not pay property taxes.

E. EMPLOYMENT

The total number of persons employed by Minnesota nonprofits is unknown. However, the annual average of Minnesota state and local government employees increased from 232,776 in 1978 to 248,746 in 1986.

Minnesota 501(c)(3) organizations vary substantially by category in terms of their use of labor. Almost half the expense of human service organizations is from payroll, a third for arts and culture, but only 16 percent for public benefit organizations.

F. NONPROFITS IMPACT ON THE ECONOMY.

Nonprofits impact the economy in a variety of ways including:

1. Service Provision
2. Direct Economic Activity
3. Indirect Economic Activity, (quality of life, etc.)

Attempts to measure the economic impact of universities and arts organizations have found that nonprofits generally create at least two to three times their own budgets in economic activity. This appears to be due to the fact that nonprofits use more labor and less capital than their for-profit counterparts. Given their high use of volunteers and lower wages, nonprofits also tend to get more labor for their payroll dollars.

Within the Twin Cities metropolitan area, 17 of the top 25 nonprofit corporations are in the health care business, (see chart below). These 17 entities have revenues of $2.9 billion and employ 48,000 people. Of those 48,000 employees, 38,000 work in hospitals.

THE TOP 25 MAJOR NONPROFIT TWIN CITIES CORPORATIONS

NAME	REVENUES	EMPLOYEES
Physicians Health Plan	377,540,000	335
Blue Cross & Blue Shield	350,806,000	2,400
Health One Corporation	334,764,722	9,000
LifeSpan	285,589,000	9,750
Fairview	249,076,000	6,483
Medcenters Health Plan	232,117,035	342
HealthEast Corporation	220,000,000	5,015
Share Health Plan of MN	196,919,000	170
Group Health, Inc.	178,995,000	2,500
St. Paul-Ramsey Med. Ctr.	107,013,000	2,300
North Memorial Med. Ctr.	105,073,208	2,774
Methodist Hospital	80,747,959	2,200
College of St. Thomas	69,900,000	1,249
Hennepin Faculty Assoc.	41,876,084	320
Hazelden Foundation	39,286,000	920
Ramsey Clinic	38,695,000	585
Children's Hosp. of St. Paul	31,780,000	700
Macalester College	27,651,059	522
Bethel College	25,994,400	450
Mpls. Med. Research Foundation	25,422,473	600
Hamline University	23,869,255	406
Amherst K. Wilder Foundation	23,067,459	857
College of St. Catherine	22,555,022	550
Lutheran Social Service of MN	21,121,643	1,275
Minnesota Public Radio	17,296,000	164

Source: Reece Report, April 1989 Issue, Volume 4, No. 1

III. FINDINGS ABOUT HOSPITALS

A. CONCERNS ABOUT HOSPITALS' TAX-EXEMPT STATUS TAKE MANY FORMS. SOME ARE CONCERNED THAT NONPROFIT HOSPITALS DO NOT PROVIDE ENOUGH CHARITY CARE TO JUSTIFY THEIR TAX-EXEMPT STATUS.

In a study published in the Harvard Business Review, January/February 1987, "Who Profits From Nonprofits?", Regina Herzlinger and William Krasker contended that non-profit hospitals don't deliver enough free care to justify the social support they get in the form of tax breaks. According to the authors, "for-profits do not deny the poor access to care, in fact, we found that the for-profits gave slightly more access to patients who carry little or no health insurance than did the nonprofits."

However, a study by Lewin and Associates, "Setting the Record Straight: The Provision of Uncompensated Care by Not-For-Profit Hospitals", published in the New England Journal of Medicine, May 5, 1988, has seemingly refuted that assertion. The Lewin study found that nonprofits provide significantly greater amounts of free care in states where they compete with investor-owned facilities. For example, nonprofits' uncompensated care burdens are 50 to 90 percent higher than proprietary facilities in Florida, Virginia, and North Carolina. Nationally, nonprofit hospitals deliver more than 60 percent of all uncompensated care, according to the report.

Nonetheless, states are taking a closer look at how much benefit they receive from the tax exemptions awarded to nonprofit hospitals. A California study found $300 million in federal, state, and local taxes went uncollected thanks to automatic tax breaks for not-for-profit hospitals. The institutions' claims of $82 million in charity care in 1985 failed to offset this loss in tax revenues.

B. SOME ARE CONCERNED THAT HOSPITALS ARE NONPROFIT IN NAME ONLY AFTER CREATING FOR-PROFIT SUBSIDIARIES.

In the past twenty years, many hospitals have evolved from small community institutions into conglomerates. These systems typically have for-profit subsidiaries. A survey of 700 nonprofit hospitals by the accounting firm of Ernst and Whinney, showed that in 1985, one-third of nonprofit hospitals were already involved in joint-ventures with for-profit entities and most of the others were considering it.

Despite concerns about their corporate structure, hospitals insist that what matters is not whether portions of their

activities are for-profit, but whether there is any net income or surplus at the end of the year. As hospitals have no shareholders, any remaining net income is spent on activities which promote hospitals' nonprofit mission.

C. OTHERS ARE CONCERNED THAT AS HOSPITALS HAVE BECOME MORE BUSINESS-LIKE IN THE WAKE OF COMPETITION, THEY HAVE BECOME ISOLATED AND ALOOF FROM THE COMMUNITY.

Many believe that the evolution from community institution to health care entrepreneuer has distanced the hospital from the community. Critics contend that various hospital services are nothing more than sophisticated marketing devices to boost admissions. Such services include:

1. Health Information Hot-Lines
2. Physician Referral Services
3. Senior Center/Adult Day Care Centers

Such critics charge that even unprofitable hospital services such as burn and trauma units, emergency rooms, and pediatric services are, in effect "loss leaders" designed to attract patient loyalty long-term. Hospitals must provide these services to remain full-service institutions over time, critics say.

Finally, critics question whether the composition of some hospitals' boards of directors are representative of the local community and why hospitals no longer rely as much on community contributions and donations. They note, for example, that in 1987, hospital gift shops produced $3.6 billion in revenues compared to community donations of $2.9 billion.

But such critics often overlook the fact that hospitals do provide a vital community support network of health services. Such services are as much a part of the community's infrastructure as fire and police services, roads and bridges and water and sewage systems. Hospitals provide a range of unprofitable services even in times of low financial margins.

If hospitals have become less dependent on community donations, it is because the passage of the Hill-Burton Act took hospitals out of the fund-raising business by providing a subsidized source of capital. Further, hospitals which once were heavily church-supported and religiously affiliated, are no longer so today. Even so, charitable contributions to Minnesota hospitals increased 37 percent from 1986 to 1987 and hospitals have continued to rely heavily on volunteer labor from auxiliaries to staff their gift shops.

D. STILL OTHERS ARE CONCERNED THAT HOSPITALS NONPROFIT STATUS GIVES THEM AN UNFAIR COMPETITIVE ADVANTAGE VIS-A-VIS SMALL BUSINESS AND PROPRIETARY HOSPITALS.

Congress has come under intense pressure from small business to tighten UBIT to force hospitals to pay more taxes on profitable business ventures such as: gift shops and bookstores, catering businesses, cafeteria sales, sale or rental of medical supplies and equipment such as hearing aids, sale of pharmaceutical drugs to nonpatients, provision of lab work for non-staff M.D.s, and rental of hospital space and/or facilities.

While Congress has rejected controversial proposals to tax any hospital revenues not directly related to patient care, such arguments continue to be heard.

Further, the proprietary hospitals, while supposedly having no position on the subject, continue to protest the fact that they paid $508 million in federal taxes, $129 million in local property taxes and $98 million in sales and other taxes in 1986 while nonprofits were assessed only token amounts.

E. THESE CONCERNS HAVE SPAWNED INCREASING SCRUTINY OF HOSPITAL TAX EXEMPTIONS AT BOTH THE NATIONAL, STATE AND LOCAL LEVELS.

In the summer of 1986, Congress removed the 50 year old tax exemption for Blue Cross and Blue Shield. Powerful critics such as House Ways and Means Subcommittee Chairman Pete Stark, (D-Ca.), continue to insist that hospitals should earn their tax status by providing evidence of charitable works.

Hospitals nonprofit tax status is under scrutiny in no less than 20 state and local authorities. For example:

1. Utah - Since 1985, Utah hospitals wanting property tax exemptions have to prove their charity care loads. The Utah Supreme Court, in Utah County v. Intermountain Health Care Inc. and Tax Commissioner of the State of Utah, eliminated hospitals' automatic tax-break and substituted a six-point test of nonprofit status. Hospitals are challenging the ruling on grounds that the criteria are vague.

2. Florida - An agreement between the state's nonprofit hospitals and the State Department of Revenue has resulted in a rule that would link tax exemptions to a minimum amount of indigent care. Under the rule, a nonprofit hospital would have to devote at least 2.5 percent of its patient days to charity or Medicaid care. Hospitals with a large percentage of Medicare patients

would be required to devote 5 percent of patient days to charity or Medicaid exclusive of what they provide to Medicare. Hospitals unable to meet these targets could lose their exemptions from state property and sales taxes.

3. Vermont - In a widely discussed case, the Medical Center Hospital of Burlington Vermont fought the city's attempt to collect $2.83 million in property taxes. City officials contended that the facility "no longer remotely resembled a charitable hospital" because less than 1 percent of its gross revenues came from public or private charity care. While the hospital ultimately prevailed, bad feelings remain.

4. West Virginia - The State Department of Revenue has proposed that hospitals be required to meet charity care tests in order to qualify for property tax exemptions.

5. Pittsburgh - Three not-for-profit hospitals have agreed to pay the city $11.1 million over three years to defray costs of municipal services they use. In another Pennsylvania case, Allentown Hospital-Lehigh Valley Hospital Center agreed to donate $638,000 in cash and community health services rather than pay $1.2 million in local taxes.

6. Minnesota - A 1987 proposal by House member Tom Osthoff would have eliminated hospitals' exemption from the state property tax. While legislative leaders took no formal action on the matter in 1989, Governor Perpich proposed a local option municipal service fee on hospitals as part of his property tax reform plan.

Public pressures for further accountability from hospitals on the tax-exempt issue, is likely to continue in light of the fact that government, at all levels, is searching for new sources of revenue. In particular, with property tax rates escalating at double digit rates, homeowners and businesses may question why they should continue to subsidize hospitals property tax exemptions through even higher tax rates.

Cities are especially unlikely to ease up on hospitals. A recent National League of Cities survey showed that half of all U.S. cities had budget deficits in fiscal 1988. About two-thirds of the cities increased their fees and 40 percent raised property taxes to meet these needs.

Further, county hospitals are becoming more open in their charges that nonprofit hospitals are illegally transferring indigent patients to their facilities.

IV. MINNESOTA'S NONPROFIT HOSPITALS RECEIVE A MAJOR BENEFIT FROM THEIR TAX-EXEMPT STATUS. IN TURN, THEY PROVIDE UNCOMPENSATED CARE TO THE POOR AND SUBSTANTIAL PRICE DISCOUNTS TO MEDICARE AND MEDICAID. WHETHER THEY PROVIDE ENOUGH BENEFIT TO JUSTIFY THEIR TAX-EXEMPT STATUS, IS LIKELY TO BE THE SUBJECT OF ONGOING DEBATE.

A. THE VAST MAJORITY OF MINNESOTA HOSPITALS ARE NONPROFIT.

Minnesota has 164 acute care, community based hospitals. Of those, most are nonprofit while the rest are predominantly governmental institutions. Minnesota has one for-profit hospital.

B. AFTER GOVERNMENT AND K-12 EDUCATION, HOSPITALS BENEFIT MOST FROM PROPERTY TAX EXEMPTIONS.

Government and K-12 education account for 77.6 percent of the cost of property tax exemptions. Hospitals rank third overall, accounting for 11.3 percent of the cost of property tax exemptions.

SHARE OF COST OF PROPERTY TAX EXEMPTIONS

Property Type	1988 Fiscal Year Impact	Percent Of Total
Government	$325,900,000	44.6%
Elem./Sec. Schools	241,500,000	33.0%
Hospitals	82,700,000	11.3%
Gov. Parks Refuges	43,400,000	6.0%
Chairitable Insti.	32,100,000	4.4%
Pub. Burying Grounds	5,400,000	.7%
TOTAL	**$731,000,000**	**100.00%**

Source: Tax Expenditure Budget, 1987

The property tax expenditure for Minnesota Hospitals is estimated at $82,700,000 in 1988 and $88,000,000 in 1989.

(From Tax Expenditure Budget for the State of Minnesota, Fiscal Year 1986-1989, January 1987).

C. THE BURDEN OF HOSPITAL TAX EXEMPTION IS NOT SPREAD EQUALLY. METROPOLITAN HOSPITALS RECEIVE PROPORTIONATELY MORE OF THE TOTAL BENEFIT THAN OUTSTATE HOSPITALS DO.

The value of exempt hospital property for the entire state is $2,005,442,770. Hospitals represent a little over 10 percent of all exempt property in Minnesota.

Estimated market value for hospital property grew by 30 percent over the 1980 to 1986 period, a slower rate than for all other state tax-exempt market values, (40 percent).

The burden of hospital tax exemption is not spread equally. Thirteen counties have 80 percent of the exempt valuation of hospital property.

County	Value Of Exempt Hospital Property	% Of All Exempt Hospital Value
Hennepin	$687,251,970	34.2%
Ramsey	$268,822,000	13.4%
Olmstead	$134,210,000	6.7%
St. Louis	$126,661,900	6.3%
Anoka	$ 80,953,900	4.0%
Stearns	$ 72,662,000	3.6%
Dakota	$ 51,241,300	2.5%
Isanti	$ 45,226,200	2.2%
Nicollet	$ 34,733,900	1.7%
Chisago	$ 29,093,000	1.4%
Crow Wing	$ 28,817,000	1.4%
Kandiyohi	$ 27,555,800	1.3%
Carlton	$ 22,251,900	1.1%

Source: Minnesota Department of Revenue

In particular, hospitals located in the four major metropolitan counties of Hennepin, Ramsey, Anoka and Dakota, accounted for 54 percent of all exempt hospital property valuation. However, this distinction is "earned" to some extent as metro area hospitals provide substantially more charity care than outstate hospitals.

D. GOVERNMENT ASIDE, HOSPITALS RECEIVE THE GREATEST BENEFIT FROM MINNESOTA'S SALES TAX EXEMPTION.

Hospitals and local governments were expected to receive $55.2 million of the $78.1 million cost of state sales tax exemptions in 1988. Of that total, the Department of Revenue estimates that nonprofit hospitals account for $9.9 million and local governments for $45.3 million.

Nonprofit hospitals, however, place a higher value on the benefit which they receive from the sales tax exemption, estimating its worth to them to be $16.5 million annually. Government aside, the tax expenditure for sales tax exemptions to nonprofits was $32.8 million in 1988. Hospitals received slightly over half of that.

ESTIMATED 1988 SALES TAX EXPENDITURES

Organization	Amount	Percent of Total
State Government	Unknown	Unknown
Local Government	45,300,000	58
Nonprofit Hospitals	16,500,000	21.9
All Other Nonprofits	16,300,000	21.1
TOTAL	**78,100,000**	**100**

Source: Minnesota Department of Revenue

When examined as a percentage of total spending, however, hospitals benefit from the sales tax exemption only slightly more than most other nonprofit organizations.

ESTIMATED EFFECT OF SALES TAX EXEMPTIONS ON DIFFERENT TYPES OF NONPROFITS

Nonprofit Type	6 Percent Sales Tax* FY 1988	FY 1989	Tax As Percent Of Total Spending
Char./Some Education	$ 6.400	$ 6.700	0.6%
Nonprofit Hospital	9.900	10.300	0.6
Private, Nonreligious Elem./Sec. Education	.100	.100	0.3%
Private Foundations	.100	.100	0.6%
Religious	6.000	6.300	0.6%
Religious Elem./Sec.	.800	.800	0.3%
Senior Citizens	.004	.004	1.8%
Post Secon. Education	2.100	2.000	0.3%
TOTAL	**$25.304**	**$26.304**	**0.5%**

* In Millions
Source: Minnesota Department of Revenue, September 1986

E. TAKEN TOGETHER, THE TOTAL VALUE OF MINNESOTA HOSPITALS' PROPERTY AND SALES TAX EXEMPTIONS RANGED FROM $100 TO $127.5 MILLION IN 1988.

VALUE OF VARIOUS TAX EXEMPTIONS TO MINNESOTA HOSPITALS

MN Hospitals' Property Tax Exemptions:	$82.7 M. - $111 M.
MN Hospitals' Sales Tax Exemptions:	$16.5 M.
TOTAL	**$99.2 M. - $127.5 M.**

Beyond the value of hospitals' property and sales tax exemptions, they have continued to benefit from a substantial amount of tax-exempt financing.

F. WHETHER THE PUBLIC RECEIVES SUFFICIENT BENEFIT FROM ITS TAX EXEMPTIONS TO MINNESOTA HOSPITALS, IS LIKELY TO BE THE SUBJECT OF ONGOING DEBATE.

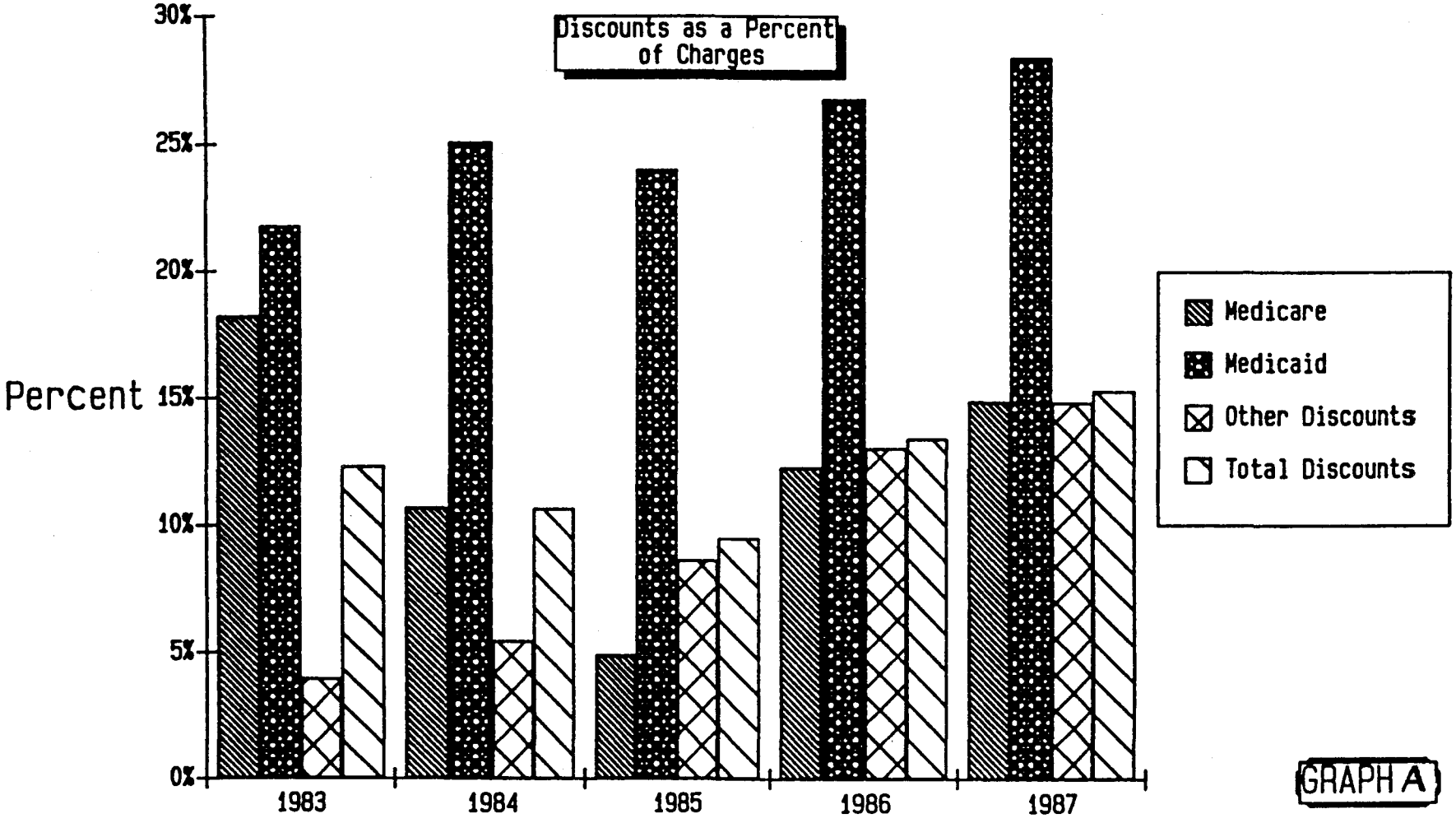
Because of reporting difficulties in separating charity care from bad debt, it is impossible to calculate hospital charity care expenditures with much precision. However, some estimates are available. A 1986 survey by the Minnesota Hospital Association, the Council of Hospital Corporations and the Minnesota Department of Health found that the state's public and private hospitals provided over $19 million in charity care to persons unable to pay for health care in fiscal year 1984. This represents 1.02 percent of those hospitals' gross revenues.

Public hospitals provided $12.5 million or nearly two-thirds of the statewide charity care total. Public hospitals devoted an average of 2.19 percent of gross revenues to charity care.

In contrast, Minnesota's private, nonprofit hospitals provided $6.5 million in charity care in fiscal year 1984. Private nonprofit hospitals provided, on average, only .5 percent of gross revenues to charity care.

Minnesota hospitals may have increased the amount of charity care which they have provided since 1984. The latest estimates from the Minnesota Hospital Association suggest that Minnesota hospitals provided more than $61.2 million in charity care and bad debt in 1986.

Further, Minnesota hospitals provided an additional $165 million in discounts to Medicare and Medicaid. The size of



GRAPH A

SOURCE: Minnesota Hospital Association Report:
"Minnesota Hospital Financial Trends", Fiscal Year 1987

these discounts has fluctuated since 1983. Although Medicare discounts as a percent of charges has declined from 18 percent in 1983 to 15 percent in 1987, Medicaid discounts have climbed from 22 percent in 1983 to almost 30 percent in 1987. See Graph A.

It is also worth noting that due to the complexity of their caseloads, large urban hospitals are among the last to be paid by government programs. The average bill is in accounts receivable nearly three months before it is paid. Accordingly, this practice acts as an interest-free loan to public purchasers.

G. EXTENDING THE PROPERTY TAX AND THE SALES TAX TO MINNESOTA'S NONPROFIT HOSPITALS COULD YIELD UP TO $134 MILLION IN NEW STATE REVENUES.

Using a classification rate of 43 percent of market value, estimates of potential property tax for Minnesota tax-exempt hospitals would range from $81.4 million to $111.8 million, according to a recent study by the Minnesota Hospital Association. Based on this analysis, these amounts can conveniently be estimated at five percent, (5%), of market value for individual hospitals.

Including nonprofit hospitals in property tax assessment can both broaden the tax base and lower the average tax rate in counties throughout the state. Based on these estimates, tax-exempt hospitals would account for as much as 3 to 4 percent of total 1986 property tax collected in Minnesota. In a macro sense, a property tax on hospitals could broaden the tax base with a marginal lowering of mill rates by an average of 2.5 percent among counties.

MHA estimates of a 6 percent sales tax on tax-exempt hospital purchases could amount to $22.1 million or 1.6 percent of sales tax collected in Minnesota during 1986.

FISCAL IMPACT OF EXTENDING PROPERTY/SALES TAXES TO HOSPITALS

Property Tax (@ 5% Of Market Value):	$ 81.4 M. - $111.8 M.
Sales Tax (@ 6% of sales):	$22.1 M.
TOTAL	**$103.5 M. - $133.9 M.**

Source: Financial Implications of Property and Sales Tax On Minnesota Not-For-Profit Hospitals. Minnesota Hospital Association, 1988.

H. HOWEVER, EXTENDING PROPERTY TAXES TO MINNESOTA HOSPITALS WOULD LIKELY REDUCE GEOGRAPHIC ACCESS TO HOSPITAL CARE, FURTHER DEPRESS HOSPITALS' NET INCOME, AND POTENTIALLY INCREASE HOSPITAL PRICES. NORTHERN MINNESOTA HOSPITALS AND TWIN CITIES HOSPITALS WOULD BE MOST DIRECTLY AFFECTED.

1. GEOGRAPHIC IMPACT

Hospitals in counties with lower levels of economic activity would pay a higher proportion of property tax than hospitals in counties with substantially higher levels of economic activity. Thus, hospitals in northern Minnesota counties would be taxed at substantially higher rates than their Twin Cities counterparts even though Twin Cities hospitals would bear the majority of the total tax burden.

2. IMPACT OF PROPERTY TAX ON NET INCOME

Financial indicators from Fiscal Year 1987 demonstrate hospitals' growing financial distress:

* Hospitals lost $6.8 million on operating revenue of $2.38 billion. In FY 1986, hospitals reported an operating surplus of $36 million on revenue of $2.16 billion.

* The median operating margin dropped nearly 50 percent, from 2.1 percent in FY 1986 to just 1.1 percent.

* 69 hospitals, (43 percent), suffered operating losses. By comparison, 55 hospitals, (35 percent), had operating losses in FY 1986.

* 59 percent of the 29 hospitals in the Minneapolis/St. Paul area lost money in 1987. Collectively, Twin Cities hospitals lost $22 million and saw their median operating margin fall to -1.9 percent.

* 53 percent of the 85 hospitals with less than 50 beds reported operating losses.

* 25 percent of all hospitals suffered such severe losses that they are at risk of closing.

* Five hospitals did close, the most that have closed in any one year.

If one assumes that hospitals cannot pass property tax on to patients in the form of higher charges, then property taxes would have to be financed from hospital net income. The Minnesota Hospital Association has calculated the effects of applying a statewide property tax to hospitals 1986 net income. The study found that 26 hospitals with

less than 50 beds had negative incomes in 1986. An additional 26 hospitals would have had negative incomes if a property tax had been added. Only 40 percent of the study's hospitals retained a positive net income in 1986 after property tax was added. Roughly one-third, (38 percent), of the hospitals in the study would have gone from a positive to a negative net income in 1986 with the imposition of the property tax.

The drop in net income from a potential sales tax would be, on average, 17 percent among the 117, (72 percent), hospitals whose net income would remain positive after imposition of a sales tax.

3. IMPACT OF PROPERTY TAX ON PRIVATE PATIENT CHARGES

If one assumed that property taxes could be passed on to only private pay patients, small rural hospitals would have to increase their charge "per private patient day" an average of 16 percent to offset potential property taxes. Large, urban hospitals would have to raise rates to private pay patients by 7.9 percent to recoup these taxes.

A potential sales tax would require about a 2 percent increase in charges per private patient day irrespective of bed size.

4. DISTRIBUTION AND AVERAGE POTENTIAL PROPERTY TAX BY BED SIZE

The MHA study examined the impacts of property taxes on hospitals according to four licensed bed classes. Small, rural hospitals, (0-49 beds), account for 58 percent of hospitals and would pay 10 percent of statewide property taxes, (1986 data), whereas the large, specialty hospitals, (200+ beds), account for 14 percent of hospitals but 63 percent of statewide property tax. The two mid-sized hospital groups, (50-99 beds and 100-199 beds), account for 13 and 14 percent of statewide property taxes, respectively.

Licensed Bed Size Classes	Average Potential Property Tax-1986 (Rounded in 000s)	% Statewide Hospital Property Tax
0 - 49	$ 128,000	10%
50 - 99	$ 419,000	13%
100 - 199	$ 910,000	14%
200+	$3,349,000	63%

5. TWIN CITIES HOSPITALS WOULD PAY $49 MILLION IN PROPERTY TAXES

The following chart, from analysis done by the Council of Hospital Corporations, shows metro area hospitals would likely pay $49.1 million in property taxes. This figure assumes an annual tax rate of between 4.2 to 5.2 percent of market value on aggregate hospital market value of $982.5 million.

HOSPITAL ASSESSED MARKET VALUATION, POLITICAL TAXATION

HOSPITAL	MARKET VALUE IN MILLIONS	ESTIMATED ANNUAL TAX
Abbott Northwestern		
Sister Kenny Institute	$ 63.4	$ 3,170,000
Bethesda	19.7	985,000
Divine Redeemer	9.2	460,000
Fairview Ridges	11.0	550,000
Fairview Southdale	30.2	1,510,000
Hennepin County Medical Ctr.	85.2	4,260,000
Lakeview Memorial	6.2	310,000
Mercy Medical Center	47.7	2,380,000
Methodist	52.2	2,610,000
Metropolitan-Mount Sinai	83.8	4,190,000
Midway	11.5	575,000
Minneapolis Children's	13.2	660,000
North Memorial	143.7	7,185,000
Riverside Medical Center	64.4	3,220,000
St. Francis	2.4	120,000
St. John's Northeast	10.2	510,000
St. Joseph's	39.2	1,960,000
St. Paul-Ramsey	37.8	1,890,000
Shriner's	3.5	175,000
United/Children's	95.3	4,750,000
Unity Medical Center	31.4	1,570,000
University of Minnesota	76.1	3,805,000
Waconia Ridgeview	2.6	130,000
TOTAL	**$982.5**	**$49,105,000**

NOTES:
1. Effective annual property tax rates vary by municipality, from 4.2 to 5.2 percent of market value.
2. The "service fee" proposal in the 1987 legislative session was for approximately 10 percent of annual property taxes to be paid.
3. In the past, municipalities have appraised non-profit property every six years. At issue is whether it would be immediately appraised subject to taxation, and how high the appraisal might be above current valuations.

I. VARIOUS PROPOSALS HAVE SUGGESTED THAT HOSPITALS AND OTHER NONPROFITS SHOULD PAY MUNICIPAL SERVICE FEES FOR FIRE AND POLICE SERVICES. WHETHER HOSPITALS SHOULD PAY SERVICE FEES, HOWEVER, REMAINS CONTROVERSIAL.

A "service fee" proposal was introduced in the 1987 legislative session. The proposal would have required the payment of a fee equal to approximately 10 percent of annual property taxes. The Citizens' League made the same proposal, but with less specificity, in 1988. A local option municipal service fee was proposed by Governor Perpich last summer as part of his property tax reform plan.

Whether hospitals should pay municipal service fees remains a subject of legitimate disagreement.

Those opposing the idea argue that paying service fees could be difficult for financially marginal hospitals. Paying service fees appears to be a tacit admission that hospitals should be taxed and may be a "foot in the door" to full taxation. It is difficult to estimate what portion of city services hospitals "consume" and hence, difficult to develop an equitable formula for assessment. Service fees may be costly and will be an annual, ongoing expense.

Proponents, on the other hand, emphasize that there is a distinction between taxes and fees. While hospitals as nonprofit organizations should not be expected to pay taxes, it is reasonable to expect them to pay municipal service fees voluntarily in return for the provision of city services which they consume.

Paying municipal service fees would promote greater equity between hospitals and other taxpayers, (businesses and home owners), as well as greater equity within the nonprofit sector. (Most Minnesota nonprofits do not own property and thus already pay service fees indirectly via their rent.)

As a result, proponents of the idea believe that asking hospitals to voluntarily pay service fees is more likely to enhance hospitals' ability to retain their tax-exempt status than the present "just say no to taxes" strategy. Thus, proponents view the idea as a proactive rather than a reactive strategy which is a bargain in price or cost compared to what hospitals would pay if their property and/or sales tax exemptions were removed.

V. CONCLUSIONS

A. CHANGING PUBLIC PERCEPTION IS THE MOST SIGNIFICANT FACTOR FUELING DISCUSSION OVER WHETHER NONPROFITS SHOULD BE TAXED.

A silent revolution in nonprofit finances have forced most nonprofits to become less dependent upon government grants and revenues and more dependent on sales and other business type activities.

Similiar trends have affected hospitals. As public reimbursement rates have failed to keep pace with medical inflation and steep declines in patient utilization have allowed private payors to insist upon steep price discounts, hospitals too have had to become more business-like in order to survive. As a result, hospitals have affiliated with hospital corporations. In the face of market segmentation and diversification, hospitals have had to rely more on marketing and advertising techniques to find and maintain their position in a highly competitive market. Words like products, pricing, positioning, packaging and promotion have become standard parts of hospital vocabulary.

As hospitals and other nonprofits have come to be recognized as a larger part of the economy, their activities have come under greater scrutiny. While the debate over nonprofits' tax status is partly attributable to government's search for new revenues, to characterize this discussion only in those terms trivializes the issues.

The debate over nonprofits' tax status is a healthy phenomenon. It is not so much an attack on nonprofits as it is an affirmation of the nonprofit ethic. Nonprofits say that they deserve special tax treatment because they offer important but unprofitable services to the poor and the economically disadvantaged, services which the public sector would otherwise be forced to provide. The public merely asks that they prove it.

The public expends an ever larger sum each year on tax exemptions to nonprofit organizations. This type of public expenditure receives little, if any, legislative scrutiny. Local citizens subsidize this expense through their property taxes. The public is simply asking for a greater measure of accountability in return for this privileged status.

We are confident that hospitals and other nonprofits are more than capable of meeting this challenge and establishing that they merit nonprofit status on an ongoing basis. Both nonprofits and the community they serve will likely be stronger as a result.

B. HOSPITALS DESERVE AND SHOULD CONTINUE TO RECEIVE INSTITUTIONAL EXEMPTIONS FROM BOTH THE STATE SALES TAX AND LOCAL PROPERTY TAXES.

The public is currently getting its money's worth from the property and sales tax exemptions which hospitals receive. Together, the estimated total value of Minnesota hospitals' property and sales tax exemptions was between $100 to $127.5 million in 1988. In return, hospitals provided over $19 million in charity care and over $165 million in discounts to public programs to Medicare and Medicaid. Based on these figures, (totaling $184 million), it would appear that the public received more than it invested in hospitals' tax exemptions.

Even these figures are conservative in the sense that they do not account for hospitals' significant contributions to the local and state economy. In the metro area alone, the 25 major hospitals provide employment for over 45,000 persons. Hospitals' economic activities have a further multiplier effect on the economy.

Although the popular perception is that hospitals' tax-exempt status is derived solely from the provision of charity care to the poor, this perception is incorrect. Hospitals provide many other additional benefits to the community in return for their tax-exempt status.

Nonprofit hospitals perform a quasi-public role in providing guaranteed access to emergency services, regardless of people's ability to pay. Hospitals provide many other services such as burn units, neonatal intensive care, and rehabilitation services, regardless of their profitability. By doing so, hospitals provide critical community services which are as much a part of the underlying community "infrastructure" as fire and police services.

In providing unprofitable community services, hospitals demonstrate their commitment to the community's present needs. By "reinvesting" any net surplus at the end of each fiscal year and by continuing to provide graduate medical education and research, hospitals demonstrate their ongoing commitment to meet future community needs.

As hospitals merit their current tax status, they should not be required to pay sales and property taxes. Applying these taxes to hospitals could have serious detrimental effects on service provisions and access to acute care facilities, particularly those in northern Minnesota.

C. WHILE HOSPITALS DESERVE THEIR TAX-EXEMPT STATUS, THEY ARE INCREASINGLY VULNERABLE ON THIS ISSUE.

Whether hospitals are able to preserve their tax-exempt status long-term, will ultimately depend on how well they serve the poor. On this issue, more than any other, hospitals are becoming increasingly vulnerable. Public hospitals provided over two-thirds of all Minnesota charity care in 1984. Minnesota's private, nonprofit hospitals provided the rest, but exactly how much of that was bad debt as opposed to charity care, no one can say. On average, private hospitals devoted only .5 percent of gross revenues to charity.

That level of effort does not compare favorably with hospitals in other states.

Moreover, this situation is occurring at a time when most hospitals have met their Hill-Burton obligations and hospitals are less and less able to shift the costs of charity care to private pay patients.

Though some believe that hospitals' capacity to provide charity care will be considerably enhanced by the eventual passage of HealthSpan or similiar proposals, they may not fully appreciate the consequences of that action. Some members of the business community, for example, argue that if government takes on the central obligation for funding charity care, then the rationale for hospitals' tax exemptions, (granted partly for that purpose), could be perceived as obsolete. That is, for government to finance indigent care and preserve hospitals' tax exemptions, could be seen as taxing the public twice for the same function.

Beyond the issue of charity care, the fact remains that hospitals look different to the public today. Most hospitals are no longer religiously affiliated. Nor are they purely nonprofit. The vast majority of metro hospitals have become affiliated with one of four local hospital corporations and now represent a confusing combination of for-profit and not-for-profit enterprises.

As a result, hospitals should take additional steps in order to preserve their tax-exempt status.

VI. RECOMMENDATIONS

A. **HOSPITALS MERIT THEIR TAX-EXEMPT STATUS AND SHOULD NOT BE SUBJECT TO EITHER SALES OR PROPERTY TAXES.**

B. **HOWEVER, HOSPITALS MUST BE PREPARED TO DEMONSTRATE THAT THEIR COMMUNITY CONTRIBUTIONS MEET OR EXCEED THE COST OF THEIR TAX EXEMPTIONS:**

1. A uniform, industry-wide definition of charity care is needed. The Council of Hospital Corporations should play a lead role in developing such a definition in cooperation with senior hospital financial officers. The definition of charity care should be sophisticated enough to separate charity care from bad debt.

2. Using this new definition, hospitals should quantify and document to the public how much charity care they provide to the poor as a percentage of gross hospital revenues. CHC should report such information to the public on an annual or biannual basis.

3. Similarly, hospitals should also begin to quantify the costs of graduate medical education and research as well as the costs of community services which hospitals provide.

4. Hospitals should place a greater emphasis on community fundraising as a means of documenting public support.

5. Hospitals should document the number of volunteer hours of labor which they receive from hospital auxiliary members.

C. **IN THE FUTURE, HOSPITALS MAY WISH TO CONSIDER WHETHER TO PAY MUNICIPAL SERVICE FEES ON A VOLUNTARY BASIS.**

Some hospitals, such as the Mayo Clinic, already pay municipal service fees voluntarily. This is commendable. Other hospitals could consider doing likewise.

D. **FEDERAL UNRELATED BUSINESS INCOME TAX RULES SHOULD BE APPLIED TO MINNESOTA HOSPITALS FOR MINNESOTA TAX PURPOSES.**

(Action taken by 1989 Minnesota Legislature)

E. **IN ORDER TO FACILITATE BETTER PUBLIC INFORMATION ABOUT NONPROFITS IN GENERAL, AND KNOWLEDGE OF NONPROFIT HOSPITALS IN PARTICULAR, HOSPITALS SHOULD VOLUNTARILY FILE FEDERAL INFORMATION RETURNS, (FORM 990'S), WITH THE MINNESOTA ATTORNEY GENERAL'S OFFICE.**

(Action taken by 1989 Minnesota Legislature)

UMHC
Renewal Project Phase II
Estimated 10 Year Financial Summary as of 2/22/90

	OPTIONS		
	A2	A2M	C3
Capital Costs:			
Project Cost	$ 58,200,000	$ 51,700,000	$ 61,521,000
Relocation Costs	2,500,000	1,100,000	3,800,000
Principal Payments	36,452,000	36,452,000	36,452,000
Total Equipment and Remodeling	$174,927,000	$174,927,000	$174,927,000
Total 10 Year Capital Costs	$272,079,000	$264,179,000	$276,700,000
Source of Funds:			
Operating Cash Flows	$163,021,000	$163,021,000	$163,021,000
Reserve Interest Income	35,873,000	40,492,000	36,595,000
Reserves	73,185,000	60,666,000	77,084,000
Total Fund Sources	$272,079,000	$264,179,000	$276,700,000
Minimum Reserve Balance	$ 37,300,000	$ 49,826,000	$ 35,000,000
Year of Minimum Reserves	1998	1998	1998

UNIVERSITY NEWS SERVICE MEDIA GUIDE

DO...

- CALL THE UNIVERSITY NEWS SERVICE - 625-5551- FOR ASSISTANCE IN PREPARING FOR INTERVIEWS, OR TO INFORM US THAT A STORY IS IN THE WORKS.
- WRITE DOWN THE REPORTER'S NAME, AFFILIATION, AND PHONE NUMBER
- ASK FOR THE REPORTER'S DEADLINE.
- ASK WHAT THE STORY IS ABOUT, WHO ELSE WILL BE CONTACTED, AND HOW YOU AND YOUR INFORMATION WILL FIT IN.
- ASSUME THERE *WILL* BE A STORY, WITH OR WITHOUT YOUR HELP.
- SET THE GROUND RULES WITH THE REPORTER DURING THE INITIAL CONTACT : (WHAT YOU WILL CONTRIBUTE FOR THE RECORD; WHAT IS OUT OF YOUR AREA OF EXPERTISE.)
- CONSIDER ALL MEDIA CONTACTS AN OPPORTUNITY TO MAKE A POINT, CORRECT A MISPERCEPTION, OR TELL THE UNIVERSITY'S SIDE OF THE STORY.
- GIVE YOURSELF TIME TO GATHER THE INFORMATION NEEDED. REPORTERS RARELY CALL "ON DEADLINE." TAKE THE REPORTERS SPECIFIC QUESTIONS AND CALL BACK *ONLY* WHEN YOU ARE SATISFIED WITH THE ANSWERS.
- REHEARSE. CONTACT THE NEWS SERVICE FOR A MOCK INTERVIEW, WHICH CAN BE TAPED AND ANALYZED (IF TIME PERMITS.)
- REMEMBER YOUR AUDIENCE IS THE PUBLIC, NOT THE REPORTER
- IF YOU FEEL OTHERS ARE MORE QUALIFIED TO ANSWER THE QUESTIONS, RECOMMEND OTHER SOURCES.
- HAVE YOUR OWN RECORD OF THE INTERVIEW. PUT A TAPE RECORDER IN PLAIN SIGHT OF THE REPORTER AND BE SURE HE/SHE SEES YOU TURN IT ON. DURING TELEPHONE INTERVIEWS, TAPE YOUR END OF THE CONVERSATION AND WRITE DOWN THE REPORTER'S QUESTIONS.
- WORK FROM NOTES IF YOU ARE DEALING WITH COMPLEX SUBJECT MATTER.
- USE CONCISE DECLARATIVE SENTENCES. FOR BROADCAST INTERVIEWS, PRACTICE TEN TO FIFTEEN SECOND "SOUND BITES."
- ASK FOR CLARIFICATION IF YOU DON'T UNDERSTAND A QUESTION.

- ENCOURAGE THE REPORTER TO CALL YOU FOR CLARIFICATION DURING THE PREPARATION OF THE STORY. CALL THE REPORTER BACK IF YOU HAVE ADDITIONS OR CORRECTIONS BEFORE THE STORY IS PUBLISHED OR AIRED.

DON'T...

- USE JARGON OR TECHNICAL LANGUAGE.
- OFFER ANY INFORMATION "OFF THE RECORD."
- ASK OR EXPECT TO "PREVIEW" THE STORY.
- SAY "NO COMMENT." IF YOU ARE SURE ANYTHING YOU SAY WILL MAKE THINGS WORSE, SIMPLY SAY YOU ARE NOT FREE TO TALK ABOUT IT.
- LIE....EVER!

Board of Governors
Nominating Committee

Motion

February 28, 1990

In accordance with the Bylaw changes endorsed by the Board of Governors on January 24, 1990 and currently pending before the Board of Regents, the Nominating Committee hereby recommends that the term of office for the Chair and Vice Chair of the Board of Governors extend from January 1, 1990 through June 30, 1991.

Further, the annual election of the Chair and Vice Chair of the Board of Governors shall be held during the month of May or June each year, so that the regular term of office shall become July 1 through June 30.

The Nominating Committee recommends that Mr. Robert Nickoloff be reelected to the position of Chair and Ms. B. Kristine Johnson be reelected to the position of Vice Chair for the January 1, 1990 through June 30, 1991 term.

Board of Governors Nominating Committee

Vice President Cherie Perlmutter, Chair
Mr. Jerry Meilahn
Ms. Barbara O'Grady