

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JULY 25, 1990

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**** Other Items ****

American Hospital Association Briefing Paper for Hospital Governing Boards,
"Toward a National Health Policy: Where do we Stand?" - June 1990

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
JULY 25, 1990
2:30 P.M.
555 DIEHL HALL

AGENDA

- | | | |
|------|--|-------------|
| I. | <u>Approval of the June 27, 1990 Minutes</u> | Approval |
| II. | <u>Chairman's Report</u>
-Mr. Robert Nickoloff | Information |
| III. | <u>Hospital Director's Report</u>
-Mr. Robert Dickler | Information |
| IV. | <u>Special Presentation: Dr. Christopher Zachary</u>
-Assistant Professor - Dermatology | Information |
| V. | <u>Committee Reports</u> | |
| | A. <u>Joint Conference Committee</u>
-Mr. George Heenan | |
| | 1. Extension of Reappointments -
Department of Otolaryngology | Approval |
| | B. <u>Planning and Development</u>
-Mr. Robert Latz | |
| | 1. Quarterly Purchasing Report | Approval |
| | 2. Long Range Capital Planning | Information |
| | C. <u>Finance Committee</u>
-Mr. Jerry Meilahn | |
| | 1. June 30, 1990 Financial Statements
(To be distributed at the meeting) | Information |

2. Preliminary 1989-90 Year-End Financials
(To be distributed at the meeting)

Information

3. Third Quarter, 1989-90 Bad Debts

Endorsement

D. Committee on Process

-Mr. George Heenan

Approval

VI. Other Business

VII. Adjournment

MINUTES

**BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic**

June 27, 1990

Call To Order

Mr. Robert Nickoloff called the June 27, 1990 meeting of the Board of Governors to order at 2:40 p.m. in 555 Diehl Hall.

Attendance

Present: Leonard Bienias
David Brown, M.D.
Paula Clayton, M.D.
Robert Dickler
Gordon Donhowe
George Heenan
Kris Johnson
Nellie Johnson
Bob Latz
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
Jerry Meilahn
Robert Nickoloff
Barbara O'Grady
Jerry Olson
Cherie Perlmutter
Jan Withers

Not Present: Phyllis Ellis

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the May 23, 1990 meeting as submitted.

Chairman's Report

Mr. Nickoloff introduced and welcomed new Board of Governors members, Nellie Johnson, David Lentz and Jerry Olson.

Special Presentation: Dr. Michael Osterholm

Mr. Robert Dickler introduced Dr. Michael Osterholm, State Epidemiologist and Chief with the Minnesota Department of Health. Dr. Osterholm presented an overview of the Epidemiology Section of the Minnesota Department of Health and their role and responsibilities in the State.

Director's Report

Mr. Dickler reported that June is Employee Recognition Month at The University of Minnesota Hospital and Clinic. Recognition was given to employees in the following categories: Distinguished Service Awards, Value Awards and Longevity and Attendance Awards.

Mr. Dickler reported that many Olympic Festival events will be occurring on the University campus in July.

Mr. Dickler reported that the 1990-91 budget had been presented to the Board of Regents in June and will be presented for Regents approval in July.

Mr. Dickler reported that Interstate Medical Center in Red Wing has signed an exclusive negotiating agreement with UMHC for the purpose of establishing a formal relationship. Definition of the scope of the relationship and various financial and organizational issues will be worked out over the next several months.

Joint Conference Committee Report

Mr. George Heenan called on Dr. Robert Maxwell to present the Credentials Committee recommendations which were endorsed by the Medical Staff-Hospital Council on June 12 and the Joint Conference Committee on June 13. Included in the report was reappointment of Medical Staff in Unit II and Specified Professional Personnel - Psychology Staff for the years 1990-1992. The recommendations of the Credentials Committee were unanimously endorsed as presented.

Dr. Maxwell recommended the names of 13 individuals to serve as clinical chiefs for the 1990-91 fiscal year. Six individuals are serving in an initial three year term as Chief of Clinical Services, therefore, their reappointment is not required this year. The Board of Governors seconded and passed a motion to approve the appointments of the Clinical Chiefs as recommended.

Dr. Maxwell presented the Medical Staff-Hospital Council Committee Chairmen appointments which were endorsed by the Medical Staff-Hospital Council on June 12 and the Joint Conference Committee on June 13. The Board of Governors seconded and passed a motion to approve the appointments of the Medical Staff-Hospital Council Committee Chairmen.

Planning and Development Committee Report

Mr. Robert Latz called on Mr. Dickler to present the obstetrical remodeling project. Extended discussions with the department of OB/GYN have resulted in agreement on an appropriate course of actions which provides for limited investment in current facilities in Mayo and the completion of new facilities contingent on a number of changes in the scope and volume of deliveries during the timeframe between a remodeled facility and the creation of a new unit.

The Board of Governors, upon recommendation from the Planning and Development Committee, seconded and passed a motion to approve obstetrical remodeling and equipment acquisition in the amount of \$339,420.

Finance Committee Report

Ms. Margaret Matalamaki called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported the Hospital's Statement of Operations for the period July 1, 1989 through May 31, 1990 shows revenues over expenses of \$4,918,930, a favorable variance of \$3,646,032.

Mr. Fearing reported inpatient admissions for May totaled 1,523 which was 114 below budgeted admissions of 1,637. Overall average length of stay for the month was 7.9 days. Outpatient clinic visits for the month of May totaled 24,604 which was 266, or 1.1%, below budgeted visits of 24,338.

The Hospital Personnel Policies require that the Board of Governors approve changes in those policies or major changes in personnel procedures. Mr. Greg Hart presented changes in the Recruitment and Employment Policy, the Probationary Period and Orientation policy and the Authorized Leaves of Absence policy for Board approval. The Board of Governors seconded and passed a motion to approve these policies.

Mr. Hart presented the 1990-91 employee compensation plan to approve recommendations for annual pay relating to "Hospital-dominated classes". The Board of Governors seconded and passed a motion to approve the 1990-91 employee compensation plan.

Mr. Fearing asked Mr. Ken Kaufman of Kaufman, Hall and Associates, Inc. to present an analysis of the Hospital's ability to finance its long range capital plan. The Board of Governors requested this analysis when Renewal Project Phase II was approved. The results created significant concern about the Hospital's ability to finance the capital plan with current revenue and expense levels.

Mr. Dickler reported that planning for Renewal Project Phase II had been placed on hold for 90 days. Several Faculty members from the Department of Psychiatry were present to indicate their support of new facilities for the Psychiatry program. A motion was seconded and passed to support temporary suspension of planning for Renewal Project Phase II with periodic progress reports to the Board of Governors over the following 90 days.

Committee on Process Report

Mr. George Heenan suggested, due to the lateness of the hour, that this agenda item be put on the July Board of Governors agenda.

Adjournment

There being no further business, the June 27, 1990 meeting of the Board of Governors was adjourned at 5:15 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

July 17, 1990

TO: Members of the Board of Governors

FROM: Shannon Lorbiecki
Administrative Fellow
Secretary to the Board of Governors

We are pleased to welcome Dr. Christopher Zachary as our enrichment speaker this month. Dr. Zachary is an Assistant Professor of Dermatology.

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.

/gs

CURRICULUM VITAE

NAME: Christopher Bransby Zachary

HOME ADDRESS: 2404 Thomas Lane
Minneapolis, MN 55405

TELEPHONE: (612) 374-9232

DATE OF BIRTH: October 19, 1949

SECONDARY
EDUCATION: 1963-1968 Ratcliffe College
Leicester, England

MEDICAL
SCHOOL: 1968-1974 Royal Free Hospital
School of Medicine
University of London

STUDENT
ACTIVITIES: President Students Union

DEGREES AND
POST GRADUATE
QUALIFICATIONS: 1974 LRCP, MRCS, MBBS, ECFMG

1979 MRCP (UK) Internal Medicine

1985 Royal College of Physicians
Accreditation in Dermatology

1986 FLEX

1988 FMGEMS

MEDICAL
LICENSES: 1986 Michigan

1988 Minnesota

PRIZES: 1983 Montgomery Award: American
Society for Dermatopathology

1984/86 Professorial Research Prize
St. John's Hospital

PRESENT APPOINTMENT:

July 1988 Assistant Professor,
Department of Dermatology
Director, Cutaneous Surgery Center
University of Minnesota
Minneapolis, MN USA

APPOINTMENTS:

01/88-06/88 Director, Cutaneous Surgery Center
Barnes Hospital
Washington University
St. Louis, MO USA

04/87-12/87 Research Fellow
Department of Dermatology
Washington University School of Medicine
St. Louis, MO USA

07/85-08/86 Cutaneous Surgery Fellow
Department of Dermatology
University of Michigan
Ann Arbor, MI USA

05/84-04/87 Senior Registrar and Tutor
in Dermatology
St. John's Hospital for Diseases of
the Skin
Lisle Street, Leicester Square
WC2H 7BJ

05/83-05/84 Senior Registrar
Department of Dermatology
Guy's Hospital
London, England

08/81-04/83 Clinical and Research Registrar
Department of Dermatology
Guy's Hospital
London, England

02/81-08/81 Senior House Officer
St. John's Hospital for Diseases of
the Skin
London, England

11/80-02/81 Medical Registrar (locum)
Lister Hospital
Stevenage

08/80-11/80 Medical Registrar (locum)
Whittington Hospital
London, England

APPOINTMENTS: (con't)

11/79-07/80	Medical Resident American Hospital Intensive Care Unit Paris, France
09/77-11/79	Medical Registrar King George and Barking Hospital General Medicine, Cardiology, Thoracic Medicine and Neurology Essex
01/77-07/77	Senior House Officer Royal Marsden Hospital Medical Oncology and Dermatology London, England
01/76-01/77	Senior House Officer Whittington Hospital Cardiology, Thoracic Medicine, Accident and Emergency London, England
07/75-01/76	Senior House Officer Royal Northern Hospital General Medicine London, England
01/75-07/75	House Physician Royal Free Hospital London, England
08/74-01/75	House Surgeon Enfield District Hospital

CLINICAL EXPERIENCE:

- 1) General Medicine: see appendix "A"
- 2) Dermatology: see appendix "B"

RESEARCH EXPERIENCE:

Practical experience in basic laboratory techniques including:

- Separation of peripheral blood mononuclear cells
- Indirect fluorescein labelling of lymphocytes using monoclonal antibodies
- Quantitative analysis of fluorescein labelled cell suspension by fluorescence activated cell sorter (FACS)
- Indirect immunoperoxidase tissue techniques
- Two-stage polyacrylamide gel filtration analysis of polyethylene glycol (PEG) probe molecules following gut absorption and urinary excretion
- Isolation of Amiodarone and major metabolites by ether extraction

-High pressure liquid chromatographic separation and spectrophotometric analysis

CURRENT RESEARCH INTERESTS:

-Post-fixation of Cryostat sections
-Panning techniques for fibroblast separation using immunoabsorbed materials

TEACHING EXPERIENCE:

As Senior House Officer:

-12 months of tutorials and clinical bedside teaching to undergraduates

As Medical Registrar:

-Two years of regular tutorials to undergraduates
-Lectures to Nurses
-Demonstrations at clinical meetings
-MRCP, Part II tutorials

As Dermatology Registrar:

-Out-patient instruction to undergraduates
-Systematic series of weekly tutorials and lectures to undergraduates
-Lectures to General Practitioners
-Lectures to National Eczema Society
-Lecture to the Allergy Unit, Department of Medicine
-Demonstrations to the Staff Round, Department of Medicine
-Lectures to Pharmacists

As Senior Registrar:

-Lectures and Tutorials to Post Graduate Students
-British Derm Surgery Group Annual Workshop

As Fellow in Dermatologic Surgery:

-Lectures to Dermatology Residents
-San Diego Laser Course
-Basic Surgery Course, American Academy
-Schering Cutaneous Surgery Workshop

DERMATOLOGY MEETINGS ATTENDED:

Regular attendance at;

-St. John's Hospital Saturday morning clinical meetings
-Royal Society of Medicine, Section of Dermatology meetings
-St. John's Hospital Dermatology Society clinical meetings
-St. John's Hospital Tuesday evening histopathology meetings
-British Associate of Dermatologists
-British Society for Investigative Dermatology
-British Society for Dermatopathology

DERMATOLOGY MEETINGS ATTENDED: (con't)

Regular attendance at: (con't)

-European Society for Dermatological Research	
-Society for Cutaneous Ultrastructure Research	
-Societe Francaise de Dermatologie	
-American Academy of Dermatology	
-American Society for Dermatopathology	
-Dowling Club Educational Week-End	
-Immunodermatology Symposium	1983 London
-Second International Symposium on Atopic Dermatitis	1984 Loen
-Fifth CIRDS Symposium	1984 Nice
-British Derm. Surgery Group Workshop	1985 Newcastle
-Superficial Anatomy and Advanced Surgery Laser Course	1986 San Diego
-Kentucky Dermatologic Society Meeting	1986 Louisville
-American Society for Dermatologic Surgery	1986 Palm Springs
-American College of Chemosurgery	1986 Palm Springs
-Michigan Dermatological Society	1986 Ann Arbor
-Schering Surgical Workshop	1985 Ann Arbor
-International Society for Dermatological Surgery	1986 London
-13th Congres Esthetique et Chirurgie Dermatologique	1986 Paris

Course and Conference Administration Experience:

Immunodermatology Symposium. Guy's Hospital, London 1982

Lasers in Cutaneous Surgery. Course Director. UMHC Minneapolis, MN, April 1990

RADIO:

"Does He take Sugar"	Radio 4	1985
"Tuesday Call"	Radio 4	1985
"You and Yours"	Radio 4	1985
"British Forces Broadcasting Services"	BFBS	1985
"Healthwatch"	Capitol Radio	1987

TELEVISION:

"Health Talk and You"	Channel 17	1989
Various Interviews for News Features on Local T.V.	Channel 11	1989
	Channel 5	1989

VIDEO AND AUDIO TAPE:

Dermatology Dialogues "Closure Materials" 1989
Dermatology Dialogues "Local Anesthetic Allergy" 1990

SOCIETY MEMBERSHIP:

British Dermatological Surgery Group	1984
British Medical Association	1974
Royal College of Physicians, London	1979
Dowling Club	1981
European Society for Dermatological Research	1981
British Society for Dermatopathology	1982
St. John's Hospital Dermatological Society	1982
British Society for Investigative Dermatology	1982
International Society for Dermatologic Surgery	1986
Royal Society of Medicine	1983
American Society for Dermatologic Surgery	1989
American Society for Mohs Micrographic Surgery and Cutaneous Oncology	1989
Minnesota Dermatological Society	1988

CASES PRESENTED AT MEETINGS:

1981	"Pityriasis Lichenoides Acuta associated with gross vasculitic changes" St. John's Hospital Dermatological Society
5.11.81	"Erythromelalgia" St. John's Hospital Dermatological Society
17.12.81	"Hand-Schuller-Christain Disease, with secondary cutaneous involvement" Clinicopathological Conference, Royal Society of Medicine
21.01.82	"Behcets Disease with severe neurological and thrombotic complications Royal Society of Medicine
19.11.82	"Blue rubber bleb naevus syndrome" Royal Society of Medicine
18.11.82	"Centrifugal lipodystrophy" Royal Society of Medicine
16.12.82	"Amiodarone photosensitivity and pigmentation" Clinicopathological conference, Royal Society of Medicine
5. 5.83	"An unusual presentation of Mycosis Fungoides" St. John's Hospital Dermatological Society
5. 5.83	"Chronic Protothecosis eyebrow infection" St. John's Hospital Dermatological Society
20.10.83	"Acral Darier's Disease" Royal Society of Medicine
1.11.84	"Hyper IgE Syndrome (Job's Syndrome) St. John's Hospital Dermatological Society

MINUTES
Joint Conference Committee
Board of Governors
July 11, 1990

CALL TO ORDER:

Chairman Heenan called the July 11, 1990 meeting of the Joint Conference Committee to order at 4:38 P.M. in Room 8-106 in the University Hospital.

Attendance:

Present:	Debbie Day, M.D. Robert Dickler George Heenan Robert Maxwell, M.D. Barbara O'Grady Jan Withers
Absent:	Amos Deinard, M.D. Phyllis Ellis Bruce Work, M.D.
Staff:	Greg Hart Shannon Lorbiecki Carol Miles Helen Pitt Ann Russell

APPROVAL OF MINUTES

The minutes of the June 13, 1990 meeting were approved as submitted.

QUALITY ASSURANCE UPDATE

Dr. Maxwell and Ms. Miles presented an updated evaluation of the clinical services' quality monitoring programs. Significant progress has been made by most of the 33 clinical services and divisions and the 5 special care units. Several services need improvement in documenting review of the monitoring report for trends and patterns. Several services or divisions need further work on establishing thresholds for their clinical indicators. Timely completion of meeting minutes and submission to Quality Assurance has been a problem in some areas.

Areas which continue to require additional efforts have been given written and verbal notification from the Quality Assurance Steering Committee regarding what they need to do to achieve compliance with the quality assurance program requirements.

Departments which need further assistance have been asked to attend Quality Assurance Steering Committee meetings to discuss their programs.

No further action is viewed as necessary at this time by the Joint Conference Committee or the Board of Governors.

Dr. Maxwell reported that some clinical departments have taken the lead in moving beyond the requirements of the program to potential benefits including clinical research integration of quality assurance and clinical research. For example, one of the clinical departments is working with three other academic medical centers to gather quality assurance data.

It was suggested that following the fall site visit by the Joint Commission on Accreditation of Healthcare Organizations the Hospital begin efforts to explore our current program and to develop a plan for the future quality assurance program. These efforts might include joint meetings between the Quality Assurance Steering Committee and members of the Joint Conference Committee. Considerations would include benefits of quality assurance program in developing clinical research and marketing the Hospital, positive rewards and incentives for efforts associated with the quality assurance program, and interrelationship of the departments in establishing an institutional quality assurance program.

EXTENSION OF REAPPOINTMENTS-DEPARTMENT OF OTOLARYNGOLOGY

At the June Board of Governors meeting members of the Department of Otolaryngology were reappointed until September 1, 1990, at the request of the Clinical Chief. Dr. Maxwell reported that due to the Board of Governors meeting schedule and the Medical Staff-Hospital Council meeting schedule there may be logistical problems in bringing forward recommended changes in clinical privileges prior to September 1. It was recommended that the reappointments for the members of the Department of Otolaryngology be extended until November 1, 1990.

The Joint Conference Committee unanimously endorsed the recommendation to reappointment members of the Department of Otolaryngology until November 1, 1990.

CLINICAL CHIEFS REPORT

In Dr. Work's absence, Bob Dickler reported that the Council of Clinical Chiefs has spent several weekly meetings discussing the Hospital's long range capital plan. The Council of Clinical Chiefs has also discussed establishing a primary care relationship with an HMO.

ADJOURNMENT

There being no further business, the meeting was adjourned at 6:14 P.M.

Respectfully Submitted:

Shannon L. Lorbiecki

Shannon L. Lorbiecki
Administrative Fellow

SL



UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 19, 1990

TO: Members, Board of Governors

FROM: Robert Maxwell, M.D.
Chief of Staff

SUBJECT: Reappointments - Department of Otolaryngology

Last month the Board of Governors approved the biannual reappointments for several departments. The members of the Department of Otolaryngology were recommended for reappointment until September 1, at the request of the Clinical Chief.

Now that the Board of Governors are likely to move to a new schedule, some logistical problems are created. Specifically, the Board may not meet in August and September. This creates timing problems for the Otolaryngology appointments. I would therefore recommend that the reappointments for the members of the Department of Otolaryngology be extended until November 1, 1990. We would then plan on bringing recommended changes in clinical privileges to the Joint Conference Committee and the Board in October.

/kj

MINUTES
Planning and Development Committee
June 21, 1990

CALL TO ORDER

Robert Latz called the June 21, 1990 meeting of the Planning and Development Committee to order at 3:15 p.m. in room 8-106 in the University Hospital.

Attendance: Present	Robert Latz, Chair Clint Hewitt Peter Lynch, M.D. Ted Thompson, M.D.
Absent	Leonard Bienias Robert Dickler William Jacott, M.D. B. Kristine Johnson Geoff Kaufmann
Staff	Cliff Fearing Greg Hart Shannon Lorbiecki Lisa McDonald Helen Pitt
Guests:	Sharon Bertrand Ann Kincaid David Link

Helen Pitt reported that University Hospital has made the cut to 30 hospitals still being considered for the Robert Wood Johnson Strategic Planning Grant.

APPROVAL OF MINUTES

The committee members present had no objections to the minutes of the May 17, 1990 meeting. The minutes could not be approved because there was not a quorum at the meeting.

SPECIAL PRESENTATION: SURVEY OF MINNESOTA PHYSICIANS

As part of a second year management course, four students conducted a survey of Minnesota physicians and their relationship to UMHC. Mr. Link distributed copies of a survey sent to 678 referring Minnesota physicians in greater Minnesota. The mailing excluded physicians in Duluth, Rochester and the seven county metro area. The return rate was 40%. Sixty-four percent of the respondents reported having a referring relationship and say that they are loyal to the physician rather than the hospital in which the physician works.

Mr. Link then reviewed the four tables included in the study. Overall, 74% said that the referring relationship had gotten better over the past five years. Seventy-eight percent said that new programs were not a factor in their referral patterns. The problem most often mentioned is communication.

A hospital needs more than expertise to draw patients because expertise is available in more places now than in the past.

Dr. Thompson shared what outreach is presently doing to address issues raised in the survey. The survey has been presented to the pediatric department and Chiefs and will be presented to UMCA Planning and Marketing. It was also reported that the nurse coordinators are helping with faster communications. Mr. Latz thanked the students for their report.

SYSTEM AND NETWORK DEVELOPMENT TASK FORCE

Dr. Ciriacy reviewed the draft report of the System and Network Development Task Force Position Paper.

He noted the internal and external assumptions as well as specific goals for the future.

He said that outreach activities are an important part of the networking options available to accomplish the goals of the task force. Implementation strategies include the metro area, outstate, and out-of-state service areas. The approaches to each market must be geared toward that particular audience with our first priority being the metro area. General discussion of the report followed.

Dr. Ciriacy said that the report would probably be finalized in six weeks and that it would be presented at Planning and Development in August and then on to the Board and Governors for their retreat agenda in October.

REMODELING OF OBSTETRIC UNIT

Mr. Hart reported that there are concerns about the volume of patients in obstetrics. The hospital has communicated to Dr. Work and the obstetrical department that the hospital is willing to provide for limited investment in current facilities and in the new facility contingent on a number of changes in the department's scope and volume during a specified time frame.

Discussion on the memo concerning future obstetrical service recommendations and plans followed. Mr. Hart said that an expenditure of about \$350,000 would be needed and that further program expenditures would be contingent on the department's ability to meet the stipulations noted in the memo.

RED WING UPDATE

Mr. Fearing said that the agreement with Red Wing has been written and verbally accepted. Signatures will be obtained in a meeting in Red Wing on Tuesday, June 26. After that the media will be notified of the agreement. UMHC is optimistic about the relationship with the Red Wing group.

AD HOC COMMITTEE ON BOARD OF GOVERNORS PROCESS

It was decided in the interest of time to postpone this topic until the next meeting. Ms. Lorbiecki requested that the committee members review the document and be prepared to discuss it at the next meeting.

UMCA UPDATE

Dr. Lynen reported that the number of State Health Plan visits are lower than expected and are discouraging. PHP and UMCA have a contract that is waiting for PHP signatures. He told the committee that UMCA will have to vacate their space and move off campus.

Joint venturing with Group Health on affiliate campuses was also discussed

ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 4:40 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

July 19, 1990

TO: Members of the Board of Governors
FROM: Greg Hart
RE: Quarterly Purchasing Report

Attached please find the quarterly purchasing report for the period April - June, 1990. The report will be reviewed at the July Committee meeting. Following the review we will be seeking endorsement of the report.

Please contact me if you have any questions regarding the quarterly report.

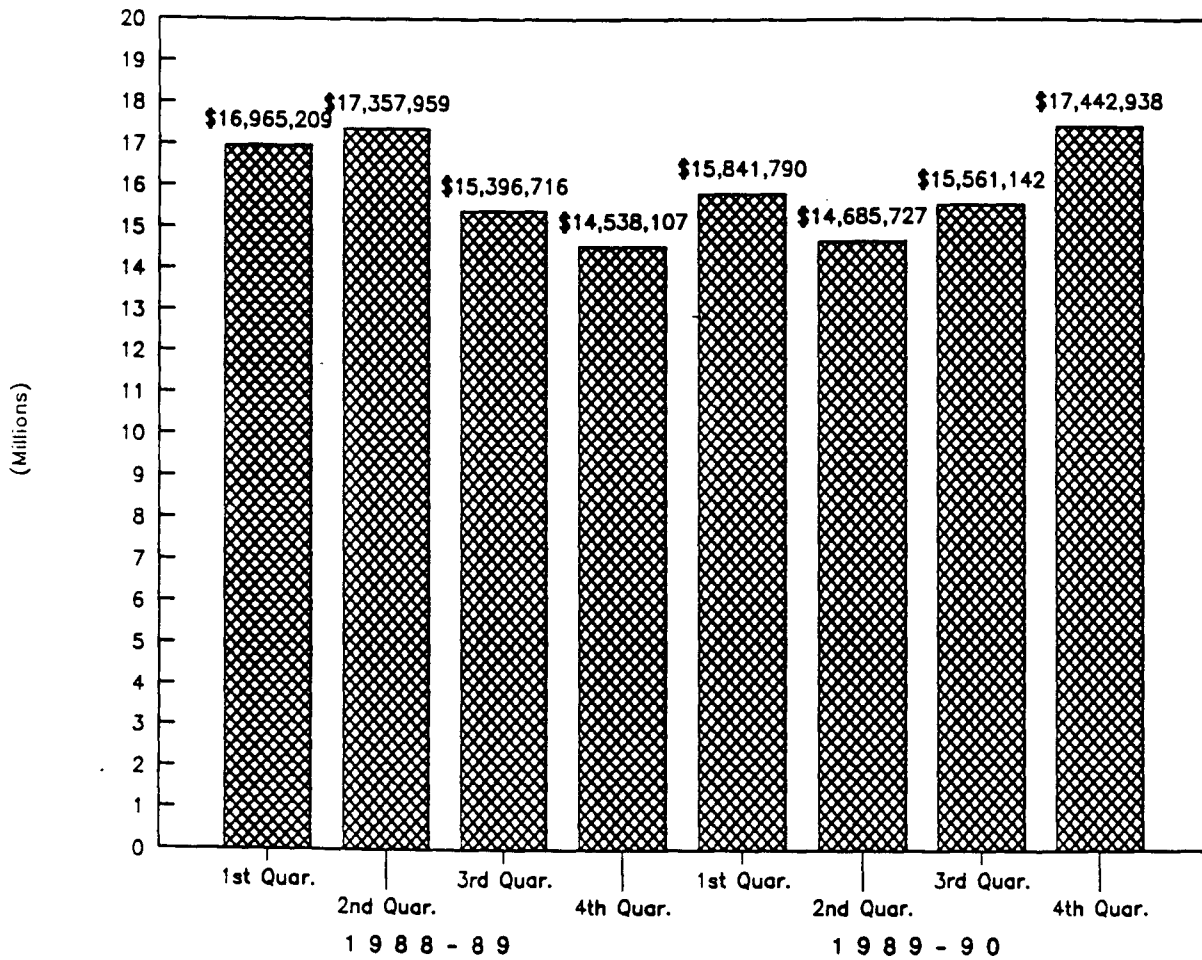
/gs

attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY
PERIOD OF APRIL - JUNE 1990

- I. PURCHASE ORDER ACTIVITY
- II. AWARDS TO OTHER THAN APPARENT LOW BIDDER
- III. SOLE SOURCE ACTIVITY
- IV. VENDOR APPEALS

PURCHASE ORDER ACTIVITY



FOURTH QUARTER, FISCAL YEAR 1989-90, ACTIVITY:

	<u>NUMBER</u>	<u>VALUE</u>
PURCHASE ORDERS	8409	\$15,330,020.12
OTHER PAYMENTS	540	\$1,806,803.11
CONFIRMING ORDERS	323	\$306,114.51
TOTAL THIS QUARTER*	<u>9,272</u>	<u>\$17,442,937.74</u>

*Total does not include a standing purchase order issued for the sale-leaseback of existing MRI equipment in the amount of \$2,988,849.60 over a period of 60 months.

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

<u>ITEM</u>	<u>UNSUCCESSFUL VENDOR/AMOUNT</u>	<u>SUCCESSFUL VENDOR/AMOUNT</u>	<u>DEPARTMENT</u>
1. Isolation Gowns	Walter Mayer \$ 72,288.00	Standard Textile \$ 91,200.00	Materials
	The gown's body cloth was of insufficient weight and threadcount, and the seams puckered after washing.		
2. Slippers	Medix \$ 14,500.80	Bird & Cronin \$ 14,913.70	Materials
	The slippers fit poorly and did not provide adequate traction.		
3. Robinson Catheters	General Medical \$ 10,312.74	Bard \$ 19,847.16	Materials
	The holes on the catheter are too big and too close together, the tip bends too easily, and the flanged end does not accommodate an irrigation syringe.		
	LBB Marketing \$ 12,618.00	Bard \$ 19,847.16	Materials
	The catheter is too soft to handle and insert.		
4. Cysto Pack	Boundary \$ 15,800.00	Surgikos \$ 18,160.00	Materials
	The screen drains poorly, the gripper closures tear off the gown, and the package is not double wrapped to ensure sterility.		
	Baxter \$ 13,874.00	Surgikos \$ 14,504.00	Materials
	The cover drape allows strike-through and the package is not double wrapped to ensure sterility.		

	Cysto Pack (cont'd)	Medix \$ 14,084.00	Surgikos \$ 14,504.00	Materials
		The screen is too small, the outside packaging tears easily, and the package is not double wrapped to ensure sterility.		
		Medline \$ 14,369.60	Surgikos \$ 14,504.00	Materials
		The pack has an offensive odor, the drainage hole is too small, and the drapes are folded in a manner that makes it difficult to maintain aseptic technique.		
5.	Consultant for Contingency Management Plan	Sunbelt \$ 23,000.00	Unisys/AIM \$ 26,400.00	I.S.D.
		Proposal did not include a cost-benefit analysis, the plan required a full-time UMHC coordinator plus additional team support, and a word processor was included for plan maintenance rather than a software planning package.		
6.	Stereotactic Radio-surgery Equip.	Leibinger & Fischer \$158,293.00	Philips \$500,000.00	Therapeutic Radiology
		Beam target accuracy was not independent of the accuracy of either the gantry or the patient support system, equipment would not be made available for acceptance testing, and FDA approval is still pending.		
7.	Consultant for Organizational & Operational Review of I.S.D.	Anderson Consulting \$ 27,500.00	Coopers & Lybrand \$ 37,000.00 - \$ 42,000.00	I.S.D.
		Approach of developing a generic model against which to compare I.S.D. appeared ineffectual and the staff designated for the project did not have an acceptable depth of data management experience.		

8. Laparotomy Drape Mars White Knight J & J Materials
\$ 23,158.20 \$ 25,712.70

Drape has an offensive odor, the seams are weak and the aperture is too small.

Baxter J & J Materials
\$ 23,868.00 \$ 25,712.70

The aperture is too stiff to fold around a small incision site.

9. Double Draw Sheet Mars White Knight Baxter Materials
\$ 13,025.00 \$ 13,900.00

The drape is stiff and does not lay well on patients.

III. SOLE SOURCE--\$5,000 and Over

<u>VENDOR</u>	<u>CONTRACT/ P.O. #</u>	<u>VALUE</u>	<u>DEPT.</u>	<u>PRODUCT</u>
Riverside Market	90-396	OPEN	Amb. Care	Misc. Food
Playscapes	H107365	\$5,198.00	Amb. Care	Play Center
Baxter	H108771	\$16,950.00	Cardio.	Autosyringe Pumps
Applied Biometrics	H107357	\$9,500.00	Cardio.	Cardiac Monitor
CCI Survey	H106753	\$13,500.00	Human Res.	Assessment Surveys
Caere Corp.	H107352	\$5,445.00	I.S.D.	OCR/Bar Code Wands
Micromedex	H106740	\$13,485.00	I.S.D.	Software License
Therakos	90-349	\$17,575.00	Labs	Photopheresis Kits
Incstar	H099886	\$5,725.95	Labs	ACTH Kits
Pharmacia LKB	90-479	\$13,200.00	Labs	Mats & Sample Bags
Honeywell	H106761	\$10,762.35	M & O	Electronic Equip.
Mpls./St. Paul Magazine	H099873	\$17,000.00	Marketing	Advertising
Minn. Parent Magazine	H099874	\$8,000.00	Marketing	Advertising
Fashion Seal	H105981	\$24,757.20	M.S.	Surgeons' Gowns
Modern Bin	H106760	\$33,619.33	M.S.	Medical Records Shelving
Electronic Design	H107298	\$26,409.00	Nursing	Intercom/Nurse Call
Jansens	90B-51	OPEN	Nutrition	Misc. Food
Twin City Poultry	90-432	OPEN	Nutrition	Kosher Foods
Impra	90-469	OPEN	O.R.	Implantable Grafts
Lee Medical	90-434	\$10,000.00	O.R.	Bone Marrow Harvest Needles
Aesculap	90-433	OPEN	O.R.	Burs & Blades
Imaging Systems/3M	H107324	\$36,536.00	Radiology	Laser Imager Enhancement
* Siemens	H108161	\$75,000.00	Radiology	MRI Updgrade
* Siemens	H107307	\$75,000.00	Radiology	MRI Upgrade
Eastman Kodak	H094242	\$39,723.00	Radiology	Imaging System
TOTAL		<u>\$457,385.83</u>		

* Over \$50,000

IV. VENDOR APPEALS

- | | | |
|----|---------------------------------------|----------------------------------|
| 1. | VENDOR NAME/DOLLAR AMOUNT: | Lotus Healthcare/\$11,160 |
| | NATURE OF PURCHASE: | Static Air Mattresses |
| | INTENDED VENDOR/DOLLAR AMOUNT: | Baxter/\$12,600 |
| | REASON FOR APPEAL: | |

Vendor contended that their mattress had an automatic shut-off valve as specified, when, in fact, this feature was available on another product which was not offered on the bid.

STATUS: Purchase order awarded to Baxter.

- | | | |
|----|---------------------------------------|-----------------------------------|
| 2. | VENDOR NAME/DOLLAR AMOUNT: | P.M. Uniforms/\$ 8,562.36 |
| | NATURE OF PURCHASE: | Nutrition Uniforms |
| | INTENDED VENDOR/DOLLAR AMOUNT: | American Linen/\$ 8,926.35 |
| | REASON FOR APPEAL: | |

Vendor was initially found to have an unacceptably long delivery time. Vendor provided a clarification of delivery time on the initial order vs. subsequent orders, which made their terms acceptable to UMHC. This clarification was determined to be allowable within established purchasing procedure.

STATUS: Contract awarded to P.M. Uniform.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
June 27, 1990

MINUTES

ATTENDANCE:

Present: Carol Campbell
Edward Ciriacy, M.D.
Robert Dickler
Clifford Fearing
Margaret Matalamaki
Barbara O'Grady
Vic Vikmanis

Not Present: Elwin Fraley, M.D.
Jerry Meilahn

Staff: Greg Hart
Teri Holberg
Nels Larson
Shannon Lorbiecki
Bruce Work, M.D.

Guests: Catherine Friedman
Ken Kaufman

CALL TO ORDER:

The Finance Committee was called to order by Ms. Margaret Matalamaki on June 27, 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 May 23, 1990 meeting as written.

JULY 1, 1989 THROUGH MAY 31, 1990 FINANCIALS:

Mr. Clifford Fearing reported to the Finance Committee the month of May inpatient admissions totaled 1,523, which was 114 below budget; average length of stay was 7.9 days; patient days totaled 12,119, which were 1,388 days below budget. The May average daily census was 391, which was below the budgeted level of 433. Clinic visits for the month of May were reported to be 1.1% above budget.

The Hospital's year-to-date Statement of Operations showed revenues over expenses by \$4,918,930 a favorable variance of \$3,646,032. Mr. Fearing stated ancillary revenue was 6.2% under budget and operating expenditures were reported to be 6.1% below budget.

Lastly, Mr. Fearing reported as of May 31 the balance of accounts receivable totaled \$85,483,434 and represented 93.5 days of revenue outstanding.

REMODELING OF OBSTETRIC UNIT:

Mr. Robert Dickler presented to the Committee, for endorsement, a proposal for equipment and remodeling the obstetric unit at a cost of approximately \$350,000 (\$165,642 for equipment and \$173,778 for remodeling).

Mr. Dickler introduced Dr. Bruce Work, chair of the Obstetric Department. Dr. Work stated the remodeling would consist of converting six rooms to a labor, delivery, recovery, post partum function; the nursery would be relocated to a central site adjacent to an upgraded main desk area; current nursery space would be dedicated to patient/family activities; renovation of patient shower room; and aesthetic upgrade of Unit 59. Dr. Work stated it is necessary to remodel the obstetric unit in order to maintain and enhance the programs' short- and long-term viability and because it is projected that it will be a minimum of three year before a new unit is available through the Renewal Project Phase II. (The equipment will be able to be used in future space.)

The Board of Governors Finance Committee second and passed the motion to remodel the obstetric unit at a cost of approximately \$350,000.

PERSONNEL POLICY CHANGES:

Mr. Dickler presented to the Committee, for endorsement, personnel policy changes.

Mr. Dickler stated the recommendations for changes in policies #4 and #5 are intended largely to clarify intent and/or have the procedures more accurately reflect current practice. The change in Policy 12, Section 8 consisted of the change in approval process for leaves of absence.

The Board of Governors Finance Committee second and passed the motion to the personnel policy changes.

LONG RANGE CAPITAL PLAN:

Mr. Fearing introduced Mr. Ken Kaufman and Catherine Friedman, from Kaufman, Hall & Associates, who assisted in developing a long range financial and capital analysis of the hospital.

Mr. Kaufman presented to the Committee a summary of the 1991 - 1998 projected financial operation and capital analysis. The result of this analysis showed that if the Hospital's operating position from 1991 - 1998 continued in its present manner, and the capital expenditures reach a total of \$221,000,000, as projected, the Hospital would have an annual cash shortfall of \$13,000,000 in 1998. Mr. Fearing indicated the Hospital would need to borrow \$13,000,000 in order to maintain a cash balance in 1998 because all usable funds would be depleted, i.e., reserves would have been totally spent. Mr. Kaufman concluded by stating that in order to avoid the projected cash shortfall the Hospital will need to either substantially improve operations through revenue enhancement or expense control, or not spend the \$221,000,000 in capital.

Based on the financial and capital analysis for 1991 - 1998, a hold on the Renewal Project II was proposed. The Board of Governors Finance Committee endorsed the motion to put the Renewal Project II on hold.

FINANCE COMMITTEE SCHEDULE:

Mr. Fearing stated the Board of Governors had requested a list of recurring committee items in order to see if the Board of Governors responsibilities could potentially be met with fewer meetings. It has been proposed that the Board of Governors' meetings not occur in March, August, or November. The annual Board's retreat would occur in September, and therefore there would not be a formal Board meeting in September.

Mr. Fearing reported that in reviewing the recurring Finance Committee items there would not be a need to have Committee meetings in March, August, September, or November, and would be able to continue to meet on the same day as the Board of Governors' meetings.

1990-91 CAPITAL BUDGET:

Mr. Hart stated that as a result of the report on the long term capital plan the 1990-91 capital budget is being reevaluated and will be presented at a future meeting. Only very limited capital expenditures (i.e., emergencies, or other explicitly approved projects) will be allowed for the first three months of the 1990-91 fiscal year.

1990-91 EMPLOYEE COMPENSATION PLAN:

Mr. Hart submitted to the Finance Committee, for endorsement, the 1990-91 Employee Compensation Plan.

Mr. Hart presented the following recommendations to the Committee for non-student, non-unionized employees in Hospital-dominated classes with an effective date of July 1, 1990. Recommendations were not included for Hospital employees in University-dominated classes, which are determined by the University-wide Civil Service pay plan, and employees in bargaining units represented by unions, who are entering the second year of an existing two year contract agreement.

1) 4% general increase consisting of a 2% change in salary ranges and a 2% progression increase, i.e., movement through salary range. The total cost of these increases is \$1,044,000.

2) Pay equity increases for classes eligible for such adjustment, continuing the previously approved plan. Cost is \$161,000 for Hospital-dominated classes, and \$291,000 for University-dominated classes. Mr. Hart stated this is the final year of the six year pay equity plan.

3) 9.4% cost increase for registered nurse related classes consistent with the existing community nursing contract. The increases include range changes, step increases, and other additions. The total cost of these increases is \$4,018,000.

4) Additional marketplace increases, where marketplace data or recruitment/retention issues evidence the need for such adjustments.

The Board of Governors Finance Committee second and passed the motion to approve the 1990-91 Employee Compensation Plan.

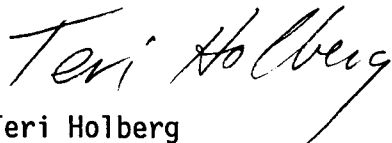
RED WING:

Mr. Fearing stated a meeting was held in Red Wing on Tuesday night, June 26, 1990 with members of the Board from Interstate Medical Center and members of the Board from St. John's Hospital. The letter of agreement for exclusive negotiation for the next nine months was signed with Interstate Medical Center at that meeting. During the next nine months a decision will be made on what type of organizational relationship or affiliation the University will have with the Red Wing physicians.

Mr. Fearing thanked Carol Campbell for all of her time and contributions to the Board of Governors Finance Committee. Ms. Campbell will be the Vice President for Finance and Operations for Carlton College effective July, 1990.

There being no further discussion, the June 27, 1990 meeting was adjourned at 2:00 P.M.

Respectfully submitted,



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

July 18, 1990

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

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

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the fourth quarter of 1989-90 is \$817,801.52 represented by 1,376 accounts. Bad debt recoveries during the period amounted to \$83,288.85 (25 accounts) leaving a net charge-off of \$734,512.67.

The net bad debts of \$734,512.67 for the quarter were 0.92% of gross charges. This compares to a budgeted level of bad debts of 1.22% (\$1,074,767).

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 fourth quarter.

Total fiscal year bad debts have amounted to \$2,366,694.02 represented by 6,003 accounts. Recoveries during the fiscal year amounted to \$119,137.39 (168 accounts), leaving a net charge-off of \$2,247,556.63.

The net bad debts of \$2,247,556.63 for the fiscal year were 0.70% of gross charges. This compares to a budgeted level of bad debts of 1.22% (\$4,171,000).

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: April 1990 through June 1990
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	\$642.32	19	\$17,321.89	40	\$15,082.13	11	\$108,498.10	32	\$193,580.29	4	\$335,124.73	106
Bad Debt (702) Charity Care	\$630.66	11	\$14,291.59	35	\$12,313.77	8	\$63,751.00	10	\$127,301.80	4	\$218,288.82	68
Total	\$1,272.98	30	\$31,613.48	75	\$27,395.90	19	\$172,249.10	42	\$320,882.09	8	\$553,413.55	174
Recoveries	(\$158.10)	5	(\$205.00)	1							(\$363.10)	6
Net Total	\$1,114.88	30 *	\$31,408.48	75 *	\$27,395.90	19 *	\$172,249.10	42 *	\$320,882.09	8 *	\$553,050.45	174 *
Outpatient												
Bad Debt (701) Write-Offs	\$18,740.33	573	\$81,364.76	319	\$10,662.22	8	\$36,397.62	10	\$14,638.89	1	\$161,803.82	911
Bad Debt (702) Write-Offs	\$5,244.63	119	\$47,407.33	151	\$18,173.33	12	\$31,758.86	9			\$102,584.15	291
Total	\$23,984.96	692	\$128,772.09	470	\$28,835.55	20	\$68,156.48	19	\$14,638.89	1	\$264,387.97	1202
Recoveries	(\$711.99)	15	(\$1,382.56)	3					(\$80,831.20)	1	(\$82,925.75)	19
Net Total	\$23,272.97	692 *	\$127,389.53	470 *	\$28,835.55	20 *	\$68,156.48	19 *	(\$66,192.31)	1 *	\$181,462.22	1202 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$19,382.65	592	\$98,686.65	359	\$25,744.35	19	\$144,895.72	42	\$208,219.18	5	\$496,928.55	1017
Bad Debt (702) Charity Care	\$5,875.29	130	\$61,698.92	186	\$30,487.10	20	\$95,509.86	19	\$127,301.80	4	\$320,872.97	359
Total	\$25,257.94	722	\$160,385.57	545	\$56,231.45	39	\$240,405.58	61	\$335,520.98	9	\$817,801.52	1376
Recoveries	(\$870.09)	20	(\$1,587.56)	4	\$0.00	0	\$0.00	0	(\$80,831.20)	1	(\$83,288.85)	25
Total Net Bad Debt	\$24,387.85	722 *	\$158,798.01	545 *	\$56,231.45	39 *	\$240,405.58	61 *	\$254,689.78	9 *	\$734,512.67	1376 *
Dollars Budgeted											\$1,074,766.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: April 1990 through June 1990
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	\$33,046.34	70	\$302,078.39	36	\$335,124.73	106
Bad Debt (702) Charity Care	\$27,236.02	54	\$191,052.80	14	\$218,288.82	68
Total	\$60,282.36	124	\$493,131.19	50	\$553,413.55	174
Recoveries	(\$363.10)	6	\$0.00	0	(\$363.10)	6
Net Total	\$59,919.26	124 *	\$493,131.19	50 *	\$553,050.45	174 *
Outpatient						
Bad Debt (701) Write-Offs	\$110,767.31	900	\$51,036.51	11	\$161,803.82	911
Bad Debt (702) Write-Offs	\$70,825.29	282	\$31,758.86	9	\$102,584.15	291
Total	\$181,592.60	1182	\$82,795.37	20	\$264,387.97	1202
Recoveries	(\$2,094.55)	18	(\$80,831.20)	1	(\$82,925.75)	19
Net Total	\$179,498.05	1182 *	\$1,964.17	20 *	\$181,462.22	1202 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	\$143,813.65	970	\$353,114.90	47	\$496,928.55	1017
Bad Debt (702) Charity Care	\$98,061.31	336	\$222,811.66	23	\$320,872.97	359
Total	\$241,874.96	1306	\$575,926.56	70	\$817,801.52	1376
Recoveries	(\$2,457.65)	24	(\$80,831.20)	1	(\$83,288.85)	25
Total Net Bad Debt	\$239,417.31	1306 *	\$495,095.36	70 *	\$734,512.67	1376 *
Dollars Budgeted					\$1,074,766.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing DepartmentBad Debt Statistics: Fourth Quarter and Year-to-Date, Fiscal Year 1990
By State

State	Fourth Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Alabama			643.13	1
Alaska			73.46	2
Arizona			2,278.15	12
Arkansas	148,368.22	5	148,368.22	5
California	1,262.86	8	9,860.88	48
Colorado	1,775.62	6	5,976.17	55
Connecticut			172.50	2
Delaware			25.00	1
Dist. of Colombia			74.00	1
Florida	12,370.55	34	17,857.70	57
Georgia			40.60	3
Hawaii			0.00	0
Idaho	27,492.52	6	27,518.18	7
Illinois	618.48	4	11,867.21	11
Indiana	779.51	6	2,511.58	23
Iowa	2,086.22	10	11,036.68	35
Kansas	221.43	2	450.76	5
Kentucky			2,397.85	2
Louisiana			2,795.93	9
Maine			0.00	0
Maryland			0.00	0
Massachusetts	42.16	1	728.66	7
Michigan			4,000.45	21
Minnesota	402,582.73	1,197	1,521,920.59	5248
Mississippi			0.00	0
Missouri	15.50	1	10,414.20	11
Montana	650.86	3	5,586.38	8
Nebraska			8,648.58	22
Nevada			605.13	12
New Hampshire			1,128.30	2
New Jersey			577.49	3
New Mexico			0.00	0
New York	612.86	5	7,046.88	29
North Carolina	167.40	2	507.92	3
North Dakota	10,250.47	15	63,710.51	83
Ohio	651.56	4	4,475.32	15

UMHC Hospital Billing Department**Bad Debt Statistics: Fourth Quarter and Year-to-Date, Fiscal Year 1990
By State**

State	Fourth		Y-T-D Total Amount	Total # of Accounts
	Quarter Amount	# of Accounts		
Oklahoma			7,474.98	6
Oregon	478.49	2	620.79	4
Pennsylvania	1,537.94	5	78,396.33	12
Puerto Rico			68.30	1
Rhode Island			4.50	1
South Carolina	122.65	1	122.65	1
South Dakota	167,087.14	95	251,687.33	173
Tennessee	201.98	1	255.98	2
Texas	48.21	1	14,681.62	17
Utah	540.00	1	1,191.03	6
Vermont			0.00	0
Virginia			23.30	1
Washington			3,261.95	4
West Virginia			0.00	0
Wisconsin	16,867.94	45	84,445.58	225
Wyoming	1,292.70	4	1,292.70	4
Out-of-Country	1,822.35	6	16,786.77	14
Total	799,948.35	1,470	2,333,612.22	6265
Medicare Bad Debt*	266.38	-99	(51,251.14)	-290
Legal Settlements	24,966.65	3	66,640.71	12
Bad Debt Agcy Und \$50			285.91	5
Bad Debt - Med NC Chgs	5,723.21	2	30,509.39	11
Grand Total	830,904.59	1,376	2,379,797.09	6003
Recoveries	(96,391.92)	26	(132,240.46)	169
Net Total	734,512.67	1,376	2,247,556.63	6,003

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

UMHC Hospital Billing DepartmentBad Debt Statistics: Fourth Quarter and Year-to-Date, Fiscal Year 1990
By Service

Admitting Service	Fourth Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Anesthesiology			0.00	0
Clinical Research	4,381.18	1	9,910.37	5
Dentistry			0.00	0
Dermatology	604.50	1	604.50	1
Family Practice			8,230.98	1
OB	174.37	3	187.87	4
NB			326.22	1
GYN	2,626.82	4	9,497.71	12
GYN-Oncology	3,628.67	3	41,437.45	29
Lab Medicine & Pathology			0.00	0
Medicine-Blue	12,659.08	4	20,662.30	14
Green	2,513.13	1	18,954.18	12
Masonic (Onc)	34,947.10	14	51,249.84	33
Purple	763.60	1	65,363.81	5
Red A	6,475.67	6	54,583.94	27
Red B			3,964.15	2
Rose A	986.06	1	6,552.14	4
Rose B	4,957.26	4	5,629.96	6
White A	3,955.31	7	20,683.96	30
White B	10,682.90	8	51,874.72	24
White C	12.60	1	12.60	1
Yellow A	13,979.73	7	21,244.29	16
Yellow B	2,201.92	3	13,511.06	12
Neurology	689.59	2	10,754.92	16
Neuro-epilepsy			0.00	0
Neurosurgery	19,265.62	8	71,140.93	32
New Born-General			8,815.56	10
Obstetrics-General	3,752.49	4	43,047.51	19
-Midwife			751.71	1
Ophthalmology	100.00	1	7,780.85	10
Orthopaedic Surgery	36,890.23	13	53,899.20	37
Otolaryngology	21,186.10	7	29,079.75	15
Pediatrics-General	137,167.44	28	194,987.52	76
Dentistry	347.31	1	347.31	1
Dermatology			0.00	0
Neonatology			650.00	1

UMHC Hospital Billing Department

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

Admitting Service	Fourth Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Neurology			45,324.21	7
Neurosurgery			2,019.08	1
Ophthalmology			10,220.30	4
Orthopaedics	507.88	2	867.88	3
Otolaryngology	12,045.49	3	12,427.99	5
Surgery Green	322.82	1	7,228.49	6
Surgery Orange			0.00	0
Surg. Transplant			504.23	3
Urology			0.00	0
Physical Med. & Rehab.	1,100.00	1	2,911.96	6
Psychiatry-Child			1,523.88	3
-Adult	16,755.11	13	87,043.11	51
Radiology			0.00	0
Surgery-Blue	176,926.17	12	271,414.09	42
Orange	13,207.16	3	35,909.20	19
Purple			30,369.60	18
Red	6,449.32	1	28,322.58	10
White	2,404.61	7	13,470.32	20
Therapeutic Radiology			0.00	0
Urology	5,127.00	4	39,161.48	26
Unknown	1,641.31	2	44,878.18	14
Outpatient	238,512.80	1,288	874,278.33	5570
Total	799,948.35	1,470	2,333,612.22	6,265
Medicare Bad Debt*	266.38	-99	(51,251.14)	-290
Legal Settlements	24,966.65	3	66,640.71	12
Bad Debt Agcy Und \$50			285.91	5
Bad Debt - Med NC Chgs	5,723.21	2	30,509.39	11
Grand Total	830,904.59	1,376	2,379,797.09	6003
Recoveries	(96,391.92)	26	(132,240.46)	169
Net Total	734,512.67	1,376	2,247,556.63	6,003

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

UMHC Hospital Billing Department

Bad Debt Statistics: July 1989 through June 1990
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	\$3,589.53	104	\$88,309.82	203	\$44,030.29	32	\$302,690.44	75	\$487,295.83	15	\$925,915.91	429
Bad Debt (702) Charity Care	\$1,929.95	39	\$50,650.01	113	\$34,251.50	23	\$157,858.80	38	\$249,551.79	11	\$494,242.05	224
Total	\$5,519.48	143	\$138,959.83	316	\$78,281.79	55	\$460,549.24	113	\$736,847.62	26	\$1,420,157.96	653
Recoveries	(\$476.14)	16	(\$2,713.32)	6	\$0.00	0	(\$3,031.46)	1	\$0.00	0	(\$6,220.92)	23
Net Total	\$5,043.34	143 *	\$136,246.51	316 *	\$78,281.79	55 *	\$457,517.78	113 *	\$736,847.62	26 *	\$1,413,937.04	653 *
Outpatient												
Bad Debt (701) Write-Offs	\$101,149.00	3074	\$350,130.42	1309	\$53,518.65	39	\$147,981.73	35	\$34,254.78	2	\$687,034.58	4459
Bad Debt (702) Write-Offs	\$18,532.41	443	\$118,205.31	392	\$47,085.11	33	\$75,678.65	23	\$0.00	0	\$259,501.48	891
Total	\$119,681.41	3517	\$468,335.73	1701	\$100,603.76	72	\$223,660.38	58	\$34,254.78	2	\$946,536.06	5350
Recoveries	(\$3,374.16)	121	(\$5,252.77)	19	(\$2,078.01)	2	(\$2,318.79)	1	(\$99,892.74)	2	(\$112,916.47)	145
Net Total	\$116,307.25	3517 *	\$463,082.96	1701 *	\$98,525.75	72 *	\$221,341.59	58 *	(\$65,637.96)	2 *	\$833,619.59	5350 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$104,738.53	3178	\$438,440.24	1512	\$97,548.94	71	\$450,672.17	110	\$521,550.61	17	\$1,612,950.49	4888
Bad Debt (702) Charity Care	\$20,462.36	482	\$168,855.32	505	\$81,336.61	56	\$233,537.45	61	\$249,551.79	11	\$753,743.53	1115
Total	\$125,200.89	3660	\$607,295.56	2017	\$178,885.55	127	\$684,209.62	171	\$771,102.40	28	\$2,366,694.02	6003
Recoveries	(\$3,850.30)	137	(\$7,966.09)	25	(\$2,078.01)	2	(\$5,350.25)	2	(\$99,892.74)	2	(\$119,137.39)	168
Total Net Bad Debt	\$121,350.59	3660 *	\$599,329.47	2017 *	\$176,807.54	127 *	\$678,859.37	171 *	\$671,209.66	28 *	\$2,247,556.63	6003 *
Dollars Budgeted											\$4,170,999.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: July 1989 through June 1990
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	\$135,929.64	339	\$789,986.27	90	\$925,915.91	429
Bad Debt (702) Charity Care	\$86,831.46	175	\$407,410.59	49	\$494,242.05	224
Total	\$222,761.10	514	\$1,197,396.86	139	\$1,420,157.96	653
Recoveries	(\$3,189.46)	22	(\$3,031.46)	1	(\$6,220.92)	23
Net Total	\$219,571.64	514 *	\$1,194,365.40	139 *	\$1,413,937.04	653 *

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Amount	Total # of Accounts
Outpatient						
Bad Debt (701) Write-Offs	\$504,798.07	4422	\$182,236.51	37	\$687,034.58	4459
Bad Debt (702) Write-Offs	\$183,822.83	868	\$75,678.65	23	\$259,501.48	891
Total	\$688,620.90	5290	\$257,915.16	60	\$946,536.06	5350
Recoveries	(\$10,704.94)	142	(\$102,211.53)	3	(\$112,916.47)	145
Net Total	\$677,915.96	5290 *	\$155,703.63	60 *	\$833,619.59	5350 *

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Amount	Total # of Accounts
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	\$640,727.71	4761	\$972,222.78	127	\$1,612,950.49	4888
Bad Debt (702) Charity Care	\$270,654.29	1043	\$483,089.24	72	\$753,743.53	1115
Total	\$911,382.00	5804	\$1,455,312.02	199	\$2,366,694.02	6003
Recoveries	(\$13,894.40)	164	(\$105,242.99)	4	(\$119,137.39)	168
Total Net Bad Debt	\$897,487.60	5804 *	\$1,350,069.03	199 *	\$2,247,556.63	6003 *
Dollars Budgeted					\$4,170,999.00	

NOTE: More than \$2,000 amount includes legal settlements totaling \$0.00

* Net total of accounts does not include recoveries.

MINUTES
Ad Hoc Committee on Board of Governors Process
Board of Governors
May 7, 1990

Minutes Revised: May 23, 1990

CALL TO ORDER:

Chairman Heenan called the May 7, 1990 meeting of the Ad Hoc Committee on Board of Governors Process to order at 9:00 A.M. in Room 8-106 in the University Hospital.

Attendance: **Present:** Leonard Bienias
 Robert Dickler
 George Heenan, Chair
 Margaret Matalamaki

Staff: Nancy Janda
 Shannon Lorbiecki

BACKGROUND DISCUSSION:

BOARD OF GOVERNORS ATTENDANCE, MEETING FREQUENCY, AND AGENDA CONTENT

From time to time, attendance at Board meetings has been problematic. Board members have commented, informally and formally, through the self-evaluation survey, that Board of Governors responsibilities could potentially be met with fewer meetings. Board members have suggested that a two month committee and a two month Board cycle may not be necessary for some routine business items. If meetings were structured to allow for more active discussion and participation by the members, there would be an increased perception that they are making a worthwhile contribution.

A desire for focused meetings in addition to the yearly retreat has also been expressed. The Committee discussed structuring future Board of Governors agendas so that priority issues are more thoroughly discussed and routine or repeat agenda items are de-emphasized. The basis for the annual operating budget and associated resource allocation decisions were cited as one topic the Governors wish to discuss in more depth. Routine Credentials Committee reports, purchasing reports, and capital equipment expenditures were cited as topics that could be de-emphasized at the Board level, presuming prior Committee endorsement.

BACKGROUND DISCUSSION:

COMMITTEE ATTENDANCE, MEETING FREQUENCY, AND AGENDA CONTENT

In discussing Board Committee attendance and meeting frequency, the Committee on Process did acknowledge some difficulties. The Joint Conference Committee has adhered to a regular meeting schedule but has some difficulty in maintaining attendance for the duration of their meetings. The Planning and Development Committee has been difficult to schedule and has difficulty agreeing upon a regular schedule. The Finance Committee routinely meets just prior to the Board of Governors meeting, but includes out of town Board members, who's attendance depends on travelling a distance.

The Committee on Process recognized the Board of Governors Committee forum as being appropriate for in-depth detailed review of agenda items. Further, the Committee on Process felt each Board Committee most qualified to recommend the management of their agenda items at the full Board; whether a one or two month review cycle is necessary and whether the agenda items require a substantive or a non-substantive review.

RECOMMENDATIONS

1. The Committee on Process seconded and passed a motion directing staff to develop a list of major Board of Governors agenda items. The list will be reviewed in an effort to establish a Board of Governors meeting schedule. This calendar should include a combination of short business meetings and some longer meetings designed to focus on such topics as the operating budget or the year end financials.

RATIONALE:

The specific agenda items which need to be covered should drive the frequency and duration of meetings.

2. The Committee seconded and passed a motion recommending the establishment of a consent agenda for use by the Board of Governors. A consent agenda would include any item recommended for non-substantive review. Items would be placed on the consent agenda by the Committee conducting the substantive review. Review of the consent agenda should precede the review of all other agenda items at the Board of Governors Meeting. Any Board member desiring more detailed discussion of an item on the consent agenda could request a more detailed review.

RATIONALE:

Development of a "consent agenda" would enable the Board of Governors to focus attention on the most substantive items and more efficiently manage items not requiring an in-depth or substantive review by the full Board.

3. The Committee on Process seconded and passed a motion recommending that Committees take a more active role in determining the review process for their agenda items. Beyond recommending items for the consent agenda, Committees would govern the purpose for which and the timing in which agenda items are brought to the Board of Governors. Solutions to the attendance and meeting frequency difficulties are best found by the Committees themselves.

RATIONALE:

At the conclusion of the substantive review, the Committee is best equipped to evaluate the level of review necessary by the Board of Governors.

4. The Committee recommended no change to the current practice of inviting enrichment speakers to the monthly Board meetings.

RATIONALE:

Enrichment speakers at the Board meetings are viewed as very educational in furthering the members' knowledge of the Hospital. The presentations also increase visibility of the Board with the medical staff.

ADJOURNMENT

There being no further business, the meeting was adjourned at 10:45 A.M.

Respectfully Submitted:

Shannon L. Lorbiecki

Shannon L. Lorbiecki
Administrative Fellow

SL

**BOARD OF GOVERNORS
RECURRING RESPONSIBILITY LIST
BY MONTH
PROPOSED**

January

Annual Meeting * Quarterly Financials (2) * Quarterly Bad Debt Report (2) * Quarterly Development Report (1) * Quarterly Purchasing Report (1) * Quarterly Capital Expenditure Report (1) * End Stage Renal Disease Policies

FEBRUARY

Mid Year Retreat

March

No Meeting

April

Operating Budget * Rate Increase Approval * Capital Budget * Quarterly Financials (3) * Home Health Program Policies * Quarterly Bad Debt Report (3) * Quarterly Development Report (2) * Quarterly Purchasing Report (2) * Quarterly Capital Expenditure Report (2)

May

Operating Budget * Capital Budget

June

Compensation Plan * Biennial Credentials * MSHC Chair Appointment
Clinical Chief Appointments

July

Year End Financials * Quarterly Bad Debt Report (4) * Quarterly Development Report (3) * Quarterly Purchasing Report (3) * Quarterly Capital Expenditure Report (3)

August

No meeting

SEPTEMBER

Annual Retreat

October

Quarterly Financials (1) * Quarterly Bad Debt Report (1) * Quarterly Development Report (4) * Quarterly Purchasing Report (4) * Quarterly Capital Expenditure Report (4)

November

No meeting

December

External Audit * Officer Elections

(#) = Quarter of the Fiscal Year



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Chicago, Illinois 60611
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**TOWARD A NATIONAL HEALTH POLICY:
WHERE DO WE STAND?
AN AHA BRIEFING PAPER FOR HOSPITAL
GOVERNING BOARDS**

June 1990

For almost a decade now, major economic and social forces have converged to press hospitals into an increasingly untenable position: they have been asked to do more and more with relatively less. Tighter constraints on resources have resulted from reimbursement limitations imposed by Medicare, state Medicaid programs, and private purchasers of care. In addition, the numbers of individuals without any insurance continues to mount. Actually in recent years, the federal government has mandated expansions in Medicaid eligibility in certain areas (especially maternal and infant care). Simultaneously the demand for hospital services has undergone significant change. The demand for outpatient services has increased. Inpatient admissions have dropped and the average inpatient is more acutely ill. Inpatients from this group have swelled the ranks of seriously ill patients whose care requires more intensive use of resources.

As federal policy makers attempt to simultaneously address problems of access and cost within the context of the continuing federal budget deficit, some are calling for sweeping change in national health policy. The Steelman Commission has been evaluating some rather radical proposals to reorganize Medicare. The Pepper Commission (chaired by Sen. Jay Rockefeller) has proposed employer/employee mandated coverage and federalization of Medicaid. Other groups that represent business (the National Leadership Commission on Health Care), the AFL-CIO, the Heritage Foundation, as well as various physician groups (Physicians for a National Health Program, the American Medical Association, the American College of Physicians, etc.) are investigating and proposing national health policies. If many policy makers' past performance in relation to hospitals is taken in evidence, hospitals are likely to feel an even greater squeeze between resource supply and service demand than is currently the case.

Considering these wide ranging discussions among many different constituent groups, it is not surprising that hospitals too must analyze the shortfalls in the current health care system and consider not only how to prevent a further worsening of the current situation but also how best to eliminate those shortfalls in the future through sound national health care reforms that will benefit all segments of society. Leading this endeavor is the American Hospital Association, through a consensus-building process that includes not only the AHA Board of Trustees but also regional and constituency section leaders and others, representing the entire range of sizes and types of hospitals in the United States. The AHA has initiated a National Health Care Strategy Project, which as a first step has identified an array of problems that must be considered in forging a responsive and responsible national health care strategy and a set of criteria to use to evaluate reform options.

The purpose of this briefing paper is to inform hospital trustees about the project and to encourage all trustees to participate in similar discussions at the local level. The summary of major problems that follows will provide an overview of the complex issues that a national health policy must address and should help trustees to consider the degree to which these issues influence their hospitals and their communities. Armed with such information, trustees will be in a better position to enlighten their communities about the delicate balance that must be maintained between the health of hospitals and the communities they serve. The better informed their communities are about these issues, the more successful hospitals can expect to be in garnering local support for a sound national health policy.

THE MAJOR PROBLEMS

The National Health Care Strategy Project began its deliberations by identifying more than 50 problems that should be addressed; these in turn were grouped into several major categories, as follows:

Access. The individual's ability to obtain appropriate health care in the United States is hampered by a variety of factors:

1. The number of individuals and families who are medically indigent has reached unacceptable proportions and continues to increase. The uninsured as a percentage of the U.S. under-65 population rose from 14.4 percent in 1980 to 17.8 percent in 1987, which translates to 37.0 million.

2. Some of these individuals have entered the ranks of the uninsured as result of constraints on government resources. Attempts to control the demand on these resources have depended largely on restriction of eligibility and provider payment under public programs.

3. Although about 70 percent of the uninsured live in families of full-time workers with a fairly consistent link to the workplace, and half live in families with full-time, full year workers, their employment does not provide health care coverage. Employers' ability and willingness to offer coverage has been eroded by the cost of such benefits, by the practice of experience rating, and by cost shifting from public to private purchasers and within the private sector.

4. A growing elderly population and changes in reimbursement and delivery patterns have been major factors contributing to the need for long-term care services, which have quickly outstripped existing capacity. Furthermore, adequate financing mechanisms for long-term care have not been established.

5. In some locations, individuals have no access to care not because of financial restrictions but because the providers simply are not there. Uneven access to health care services continues to be caused by geographic maldistribution of health care facilities and professionals and a lack of adequate capacity in some areas.

Cost-effectiveness. The ability of the health care industry to provide cost-effective care is hampered by another set of problems:

1. The state of the art of defining what is effective care and analyzing the cost-benefits of that care is still in its early stages.

2. One of the factors that slows the development of such analyses is the lack of consensus not only within the health care field but in society at large concerning the appropriate limits of treatment and the circumstances under which society should begin to impose rationing of certain kinds of treatment.

3. The general public, although it is extremely concerned about the high cost of care, continues to want access to the best care possible. Most Americans also believe that every American, regardless of ability to pay, has the right to adequate health care. They are increasingly concerned about the inaccessibility of care for the poor and uninsured and about their own ability to obtain care for major illness and long-term care.

4. The lack of consensus about how to achieve this balance between shrinking resources and unlimited expectations extends to difficult personal and ethical choices. While individuals, various groups, and many state governments are struggling to establish some guidelines in this regard, the issue of cost-effectiveness continues to loom large and to evade satisfactory definition.

5. Finally, potential tort liability multiplies the cost of many services.

Individual Responsibility. While mortality and morbidity statistics in the past few decades suggest that Americans are beginning to prevent serious chronic illness by adopting healthier life styles, the overall picture is still not a positive one. The majority of individuals do not appear sufficiently motivated to change their personal behaviors either to improve their own health or to make more effective use of the health care services that are at their disposal.

Value. Related to the issue of cost-effectiveness is the issue of the value or quality of care that is provided:

1. To begin with, the state of the art of measuring the quality of care is also in its developmental stages; however, to the extent that it is measurable, quality appears to vary widely across providers.

2. Because of their limited ability to measure quality, providers are not always able to demonstrate either the quality of the care they provide or to justify cost in relation to quality; as a result, they cannot make valid predictions about the extent to which the quality of care would be affected if costs or prices were reduced.

3. Consumers and major purchasers of care are not in a better position to make these judgments either. They are therefore limited in the degree to which they can make informed decisions on the value of the services they can expect from alternative delivery and financing arrangements and the level of accountability they can demand from such arrangements.

4. Because each of the constituencies in the health care delivery relationship cannot come to an internal consensus about the issue of quality versus cost, they have not been able to come to an agreement among themselves about what to provide, to whom, under what conditions, and at what cost.

Financing. In addition to the major problem of how much care costs is the complexity of how and to what degree purchasers pay for care:

1. Health care benefits vary widely, and the mechanisms for administering them are not only costly to manage but also very confusing to consumers, providers, and purchasers. In some instances, the confusion is such that benefits are not applied for because the consumer does not understand them.

2. Methods and levels of payment are becoming so restrictive, and the absence of patient insurance so prevalent, that hospitals and other providers are being subjected to unmanageable risks that will affect their future financial viability and impair their ability to operate effectively.

3. Despite a major shift of emphasis on outpatient care, incentives to provide inpatient acute care remain both in terms of financial arrangements and the organization of the delivery system. There is insufficient emphasis on the prevention of disease or management of chronic conditions to prevent acute episodes.

4. Overall, incentives for providing cost-effective service and emphasizing preventive care are not consistent for hospitals, physicians, and other providers. As a result, hospital expenditures between 1982 and 1987 rose just over 40 percent (nearly the same growth rate as the gross national product), while nursing home care increased by more than 50 percent and spending for professional services rose nearly 70 percent.

5. As a result of uneven application of incentives and fragmentation of financing mechanisms, some communities demonstrate duplication of technology and capacity by hospitals and other providers, services levels that exceed community needs, and attempts to shift responsibility for costs and quality to others.

Other issues. The above list certainly does not exhaust the list of issues that must be considered in reforming the health care system. The AHA National Health Care Strategy Project is focusing on the fundamental policies that relate to delivery and financing of care. The potential need for public policy reforms on issues such as medical education, human resources, and research and development will be discussed at a later time, once the basic outline of the arrangements for delivering and financing personal health care services has been defined.

CRITERIA FOR REFORM

In devising the basic outline of a delivery and financing mechanism, the AHA National Health Care Strategy Project proposed three major premises that would inform their discussions of reform options:

- Reform should build on the strengths of the pluralistic health care delivery and financing system that has evolved over the past 50 years.
- While building on its strengths, reform would likely entail substantial change in the current system of financing and delivery.
- Finally, reform should be designed to meet the needs of communities and patients.

On the basis of this framework, the Project has proposed that the following criteria be applied to all considerations of option reform:

Criterion A: Essential services available to all. All individuals should have access to at least basic health care services.

Criterion B: High quality. The delivery and financing system should be so structured as to ensure that medical conditions are effectively managed and the quality of care should be continuously monitored and improved. Specifically, this would entail: coordination of care among providers and across levels of care; continuity over time; improvement of outcome through appropriate application of innovations in technology and medical practice; delivery of effective care only; choice of the most cost-effective treatment for managing a patient's condition; and monitoring and peer review of practice to identify areas for improvement.

Criterion C: Adequately and fairly financed. Any public or private financing arrangement should bear the cost of the services that it purchases for its enrollees or beneficiaries. The cost of public programs should be

broadly and equitably distributed in the same manner that the cost of other "public goods" provided through the public sector is distributed. Providers should as a result be fairly and adequately compensated for their services.

Criterion D: Affordable. Consumers and major purchasers should be able to select benefits and delivery arrangements that emphasize "value" by providing options for obtaining the kind of care for which they are willing and able to pay. Public programs for those unable to finance their own care should explicitly limit access to care beyond "basic care" by restricting benefits or choice of provider.

Criterion E: Efficiently delivered. All provider incentives should be aligned to promote continuous improvement in the efficient use of resources to restore or preserve health. Consumer incentives should be established to encourage individual responsibility for adopting healthy lifestyles and efficient use of health care services.

Criterion F: Community-focused and patient-centered. The best reform option should recognize appropriate community variation in medical practice consistent with national standards. Locally managed delivery and financing mechanisms should be accountable and responsive to patient and consumer needs, foster appropriate expectations for care, and treat all patients with dignity and concern.

Criterion G: In sufficient supply for timely access. Delivery and financing arrangements should allow beneficiaries to obtain care when and at a level that is most likely to have a positive change on the course of a disease or prevent avoidable morbidity or mortality.

Criterion H: User-friendly. The reform option of choice should permit patients, providers, and purchasers to obtain, deliver and pay for needed care with minimum uncertainty and confusion. A "user-friendly" system will enable patients to know: how to obtain care; what care will be covered; and how much care will cost. It will also provide for timely settlement of claims and will not impose excessive administrative burdens or costs on providers.

Criterion I: Conducive to innovation. Finally, the best reform option should be flexible enough to be made better. It should promote the development and dissemination of new and more effective methods both for treating and preventing illness and for delivering services.

WHAT TRUSTEES CAN DO

Considering the breadth of the changes that are likely to take place as the nation shapes a new health care policy, every trustee in every hospital can find an appropriate role in promoting a dialogue of the options that are being or should be considered at the national level. This dialogue should certainly begin in each hospital board room, then moving out into the hospital's community, and ultimately into public policy forums at the municipal, state, and federal levels. Specifically, trustees will want to consider the following activities:

** A discussion of the options that are being advocated or evaluated by various groups and the problems that these proposals are designed to address could receive special attention on the governing board's agenda. Such discussions can take two perspectives. The first is an honest comparison of the current system and the hospital's role in it with the criteria for improvement that are outlined above. Are there any changes that the hospital can make itself now or in concert with others in the community that will not only represent real improvements but also position the hospital to better respond to more basic changes if and when these are imposed? The second

perspective is a weighing of the different options with the anticipation that any change will mean some gain and some loss. What elements of the current system is the hospital willing to forego and what elements does it consider essential to continued purposeful service to the community? Answers to these questions will prepare hospitals to better define their needs and their position as the health policy debate continues.

** Because no hospital can make many decisions without considering its environment and the other players, trustees should be encouraged to take the dialogue that begins in the board room and to continue it with its own staff and physicians and then to take it to the community. Much of the pressure for change at the state and federal levels begins in the individual communities that hospitals serve and among the businesses and other employers whom hospitals consider their clients. If trustees can help these constituencies understand their hospital's operations, recognize the financial constraints that impede these operations and drive up hospital costs, and realize the vital part that a sound health care institution plays in the life of any community, it is likely that changes in national health policies will be more realistic for hospitals and those they care for. Dialogue on these issues is appropriate in many kinds of venues in which hospital trustees interact with the community: hospital-sponsored community forums, business coalition meetings, public discussions sponsored by the media, and others.

** Trustees should also support and participate in forums on these issues at their local and state association meetings. For example, it is at the state level that advocacy for Medicaid reform can begin to focus most clearly on the special circumstances of the state's low income population and the way in which Medicaid shortfalls impede their access to care. In this effort, trustees and other hospital leaders should consider looking for nontraditional allies among those who are as interested in the economic development of low income groups as the hospital is in serving their health care needs.

** Finally, those trustees who are already involved in advocacy at both state and federal levels would serve the cause of reform if they would help to broaden the perspective of the dialogue by encouraging all the players not only to talk and demand change but also to be part of the ultimate solution. As this briefing paper suggests, the best solution will build on the best elements that are already in place. That solution will demand a better balancing of the burdens and responsibilities of health care among all players. Hospital trustees who can instill a commitment to this principle of shared responsibility in their communities will have done much to move the entire system toward responsive, optimal reform.

FURTHER READING

American Hospital Association. Key Hospital Issues. 1990 Annual Meeting Report. (Chicago: AHA, 1990).

American Hospital Association. The State of the Nation's Access to Hospital Services. Annual Meeting Report. (Chicago: the AHA, 1990).



July 25, 1990

TO: Board of Governors
FROM: Clifford P. Fearing
SUBJECT: Report of Operations for the Period
July 1, 1989 through June 30, 1990

The Hospital's operations for the month of June reflect inpatient admissions, patient days, and clinic visits activity below budget. Both ancillary revenue and routine revenue are below budgeted levels for the month.

INPATIENT CENSUS: For the month of June, inpatient admissions totaled 1,508 which was 138 below budgeted admissions of 1,646. Our overall average length of stay for the month was 7.8 days. Patient days for June totaled 11,774 and were 1,229 days below budget. The decrease in admission levels from budget was seen in almost all areas with the most significant ones being in Medicine, Neurology, Ophthalmology, Orthopedics, Surgery, and Urology.

To recap our year-to-date inpatient census:

	1988-89	1989-90	1989-90		%
	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>
Admissions	18,856	18,860	18,331	(529)	(2.8)
Patient Days	158,375	158,100	147,484	(10,616)	(6.7)
Avg Length of Stay	8.4	8.4	8.0	(0.4)	(4.8)
Avg Daily Census	433.9	433.1	404.1	(29.0)	(6.7)
Percent Occupancy	74.5	73.9	69.6	(4.3)	(5.8)

OUTPATIENT CENSUS: Clinic visits for the month of June totaled 23,618 which was 1,531, or 6.1%, less than budgeted visits of 25,149. Visits were significantly below budget in Dentistry, Dermatology, OB/GYN, Ophthalmology, Sports Medicine, Orthopedic, Infectious Disease, and Urology. Masonic Day Hospital reported visits significantly above budgeted levels. Community University Health Care Center (CUHCC) visits for the month of June totaled 4,217 which was 310, or 7.9%, over budgeted visits of 3,907, while Home Health visits of 771 for the month were 199, or 20.5%, below budgeted visits of 970.

REPORT OF OPERATIONS
 JUNE 1990
 PAGE 2

To recap our year-to-date outpatient census:

	1988-89	1989-90	1989-90		%
	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>
Clinic Visits	272,322	278,200	270,667	(7,533)	(2.7)
CUHCC Visits	48,265	46,700	53,062	6,362	13.6
HHA Visits	12,070	11,800	11,255	(545)	(4.6)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows revenues over expenses by \$6,210,945, a favorable variance of \$4,578,945. Patient care charges through June totaled \$319,819,221, which was 6.1% under budget. Routine revenue was 4.6% under budget and reflects our unfavorable inpatient census variance.

Ancillary revenue was \$16,164,924 below budget (6.6%) and reflected the unfavorable variance in both inpatient and outpatient census and the unfavorable variance in the average revenue per clinic visit. Inpatient ancillary revenue averaged \$8,874 per admission compared to the budgeted average of \$8,922 per admission. Outpatient revenue per clinic visit averaged \$239 compared to the budgeted average of \$271.

Operating expenditures through June totaled \$275,258,743 and were \$17,869,257 (6.1%) below budgeted levels of \$293,128,000. 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 June 30, 1990, totaled \$88,676,838 and represented 96.3 days of revenue outstanding. The overall increase in our patient receivables in June of 2.9 days occurred primarily in Minnesota Medical Assistance, Special Contracts - Transplants, Medicare, and Blue Cross Aware.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels for June. 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.

The June financial statements presented today are preliminary in that the University, and the Hospital, have not completed the year-end closing process. Even though these are preliminary statements, we do not anticipate any material changes to them as a result of the closing process. Financial statements reflecting the final close will be presented at the October meeting of the Board.

PRELIMINARY

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1989 TO JUNE 30, 1990

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	\$340,467,000	\$319,819,221	(\$20,647,779)	-6.1%
Deductions from Charges	79,853,000	76,887,230	(2,965,770)	-3.7%
Other Operating Revenue	9,865,684	10,797,186	931,502	9.4%
Total Operating Revenue	270,479,684	253,729,177	(16,750,507)	-6.2%
Total Expenditures	293,128,000	275,258,743	(17,869,257)	-6.1%
Net Operating Revenue	(22,648,316)	(21,529,566)	1,118,750	4.9%
Non-Operating Revenue and Expenses	24,280,316	27,740,511	3,460,195	14.3%
Revenue Over/Under Expense	\$1,632,000 =====	\$6,210,945 =====	\$4,578,945 =====	

	1989-90 Budgeted	1989-90 Actual	Variance Over/-Under Budget	Variance %
Admissions	18,860	18,331	(529)	-2.8%
Patient Days	158,100	147,484	(10,616)	-6.7%
Average Daily Census	433.1	404.1	(29.0)	-6.7%
Average Length of Stay	8.4	8.0	(0.4)	-4.8%
Percentage Occupancy	73.9	69.6	(4.3)	-5.8%
Outpatient Clinic Visits	278,200	270,667	(7,533)	-2.7%

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

AUGUST 29, 1990

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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
AUGUST 29, 1990
12:30 P.M.
RADISSON METRODOME (U OF M)

AGENDA

- | | | |
|------|--|-------------|
| I. | <u>Approval of the July 25, 1990 Minutes</u> | Approval |
| II. | <u>Chairman's Report</u>
-Mr. Robert Nickoloff | Information |
| III. | <u>Hospital Director's Report</u>
-Mr. Robert Dickler | Information |
| IV. | <u>Special Presentation: Dr. Frank Rhame</u>
-Director, Infection Control | Information |
| V. | <u>Committee Reports</u> | |
| | A. <u>Joint Conference Committee</u>
-Mr. George Heenan | |
| | 1. The Joint Conference Committee did not meet | |
| | B. <u>Planning and Development</u>
-Mr. Robert Latz | |
| | 1. Financial and Capital Reassessment | Information |
| | 2. Cardiac Catheterization Lab Expansion
Proposal | Information |
| | C. <u>Finance Committee</u>
-Mr. Jerry Meilahn | |
| | 1. July 31, 1990 Financial Statements | Information |
| | 2. Union Organizing Efforts | Information |
| VI. | <u>Other Business</u> | |
| VII. | <u>Adjournment</u> | |

MINUTES

**BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic**

July 25, 1990

Call To Order

Ms. Kris Johnson called the July 25, 1990 meeting of the Board of Governors to order at 2:40 p.m. in 555 Diehl Hall.

Attendance

Present: Leonard Bienias
David Brown, M.D.
Paula Clayton, M.D.
Robert Dickler
Phyllis Ellis
George Heenan
Kris Johnson
Nellie Johnson
Bob Latz
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
Jerry Meilahn
Barbara O'Grady
Jerry Olson
Cherie Perlmutter
Jan Withers

Not Present: Gordon Donhowe
Robert Nickoloff

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the June 27, 1990 meeting as submitted.

Mr. Robert Dickler welcomed Mr. Virgil Moline, a former Board of Governors member, and presented him with a University of Minnesota key chain.

Chairman's Report

Ms. Johnson introduced and welcomed Jennifer Corbett of the Minnesota Daily.

Ms. Johnson informed the Board of a change in the August Board meeting. The meeting will be August 29, 1990 - 12:30 to 2:30 with lunch being served at 12:00 noon. The Board members will be notified when a location has been finalized.

Special Presentation: Dr. Christopher Zachary

Mr. Dickler introduced Dr. Christopher Zachary, Assistant Professor - Dermatology. Dr. Zachary presented an overview of the Department of Dermatology's work in cutaneous surgery.

Joint Conference Committee Report

Mr. George Heenan called on Dr. Robert Maxwell to present the recommendations for the extension of reappointments for Medical Staff from the Department of Otolaryngology. The reappointments were approved to September 1 at the June Board meeting and it is recommended that they be extended to November 1, 1990. A review of all clinical privileges for Otolaryngology faculty is underway and recommendations will be brought to the Joint Conference Committee and the Board of Governors in October. The Board seconded and passed a motion to approve the extension of the reappointments.

Mr. Heenan reported that Ms. Barbara O'Grady has been welcomed as a member of the Joint Conference Committee.

Planning and Development Committee Report

Mr. Robert Latz called on Mr. Mark Koenig to present the Quarterly Purchasing Report. Purchasing activity during the fourth quarter totaled \$17,442,937.74. The Board of Governors seconded and passed a motion to approve the April - June, 1990 Quarterly Purchasing Report.

Mr. Dickler gave an update on the Long Range Capital Planning. The analysis conducted by Kaufman, Hall Associates indicates that proceeding with the current long range capital plan if volumes remain at February to June levels would result in a cash shortfall of approximately \$45 million below minimum reserve cash balance levels by 1998.

One area of the capital plan being reevaluated is Renewal Project Phase II. Several project options which would reduce the size and scope of the project are being developed. A discussion of the options considered will be presented to the Council of Clinical Chiefs on August 17. An update on the capital planning analysis and the discussions of the Council of Clinical Chiefs will be presented at the August Board meeting.

Finance Committee Report

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospital's Statement of Operations for the period July 1, 1989 through June 30, 1990 shows revenues over expenses of \$6,210,945, a favorable variance of \$4,578,945.

Mr. Fearing reported inpatient admissions for June totaled 1,508 which was 138 below budgeted admissions of 1,646. Overall average length of stay for the month was 7.8 days. Outpatient clinic visits for the month of June totaled 23,618 which was 1,531, or 6.1%, below budgeted visits of 25,149.

Mr. Fearing reviewed the Fourth Quarter Bad Debts. Bad debts for the quarter totaled \$817,801.52, representing 1,376 accounts. Recoveries amounted to \$83,288.85, leaving a net charge-off of \$734,512.67. This amount represents 0.92% of gross charges and compares to a budgeted level of bad debts of 1.22% (\$1,074,767).

Committee on Process Report

Mr. George Heenan reported on the recommendations made by the Committee on Board of Governors Process. He also presented a proposed agenda for the year. The Board seconded and passed a motion to approve the recommendations of the Committee on Process and implement the proposed calendar beginning in November 1990.

Director's Report

Mr. Dickler announced that a contract has been signed to provide cardiovascular services to members of the Middlefort Health Plan.

Mr. Dickler indicated that he would respond to any questions or welcome any suggestions regarding the hospital and clinic utilization distributed at the meeting.

Adjournment

There being no further business, the July 25, 1990 meeting of the Board of Governors was adjourned at 4:25 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

CURRICULUM VITAE

Frank S. Rhame

Updated through April 20, 1990

CURRENT POSITION:

Assistant Professor, Infectious Diseases Section, Department of Medicine,
University of Minnesota
Hospital Epidemiologist, The University of Minnesota Hospital and Clinic
Assistant Professor, Division of Epidemiology, School of Public Health,
University of Minnesota
Associate Member, Graduate Faculty in Epidemiology, University of Minnesota

Office: G-255 Mayo Building, The University of Minnesota Hospital.
Address mail to: Box 421 UMHC, Minneapolis, MN 55455
Phone: 612-626-5036
Fax: 612-625-5167

EDUCATIONAL AND PROFESSIONAL ACTIVITIES:

9/60-6/64 California Institute of Technology, Pasadena, CA B.S. in
biology with special interest in bacteriophage genetics.
9/64-6/68 Columbia University College of Physicians and Surgeons, New
York, NY, M.D.
7/68-6/69 Straight Medical Internship on the Columbia teaching service
at Harlem Hospital Center, New York, NY.
7/69-6/70 First year Resident in Internal Medicine at University of
Michigan Hospital, Ann Arbor, MI.
6/70-6/72 Epidemic Intelligence Service Officer, Centers for Disease
Control, Atlanta, GA. Worked as a Medical Epidemiologist in
Hospital Infections Section evaluating hospital infection
surveillance systems, providing consultation regarding infec-
tion control programs and evaluating and curtailing epidemics
of nosocomial infection.
7/72-6/73 Second year Resident in Internal Medicine at Stanford Univer-
sity Hospital, Stanford, CA.
7/73-6/75 Fellowship in Infectious Disease, Department of Internal
Medicine, Stanford University School of Medicine. Preceptor:
Dr. Stanton G. Axline. Participated in design of IDIS, a
system of coding and computer analysis of information from
hospital based surveillance systems, and MYCIN, a rule based
interactive computer system to advise physicians regarding
antimicrobial therapy.
7/75-12/78 Staff Physician, Spinal Cord Injury Service, Veterans Admini-
stration Hospital, Palo Alto, CA.
7/75-12/78 Hospital Epidemiologist and Chairman, Infection Control Com-
mittee, Veterans Administration Hospital, Palo Alto, CA.
7/76-6/77 Clinical Instructor, Department of Medicine, Stanford.
7/77-12/78 Clinical Assistant Professor, Department of Medicine, Stanford

- 7/77-12/78 Consultant, Infection Control Committee, Stanford University Hospital
1/79-Present Assistant Professor, Infectious Diseases Section, Department of Medicine, School of Medicine, University of Minnesota
1/79-6/81 Assistant Professor, Department of Laboratory Medicine and Pathology, University of Minnesota
8/84-Present Associate Member, Graduate Faculty in Epidemiology, University of Minnesota
7/89-Present Assistant Professor, Division of Epidemiology, School of Public Health, University of Minnesota
2/87-Present Director, HIV Clinic, The University of Minnesota Hospital and Clinic

PROFESSIONAL SOCIETIES:

American Association for the Advancement of Science
American College of Epidemiology, fellow
Society of Hospital Epidemiologists of America (Treasurer, 1982-85)
American Society of Microbiology
Association for Practitioners in Infection Control
Infectious Diseases Society of America, fellow
Society for Epidemiologic Research
Hospital Infection Society
American Public Health Association
International AIDS Society

MEDICAL LICENSURE:

Minnesota, license number 0247232

PROFESSIONAL CERTIFICATIONS:

Diplomate, National Board of Medical Examiners, 1969.
Certified, American Board of Internal Medicine, 6/20/73; Recertified, 1980.
Certified, Infectious Diseases, American Board of Internal Medicine, 10/15/74.
Certified, Certification Board of Infection Control, 1984-88.
AMA Physician's Recognition Award, 1982-4.
Advanced Achievement in Internal Medicine Examination, passed, 5/16/87

PROFESSIONAL AWARDS:

CDC Special Commendation "For outstanding participation in the recent Field investigation and/or Laboratory identification of contaminated intravenous products." April 19, 1971.

Alexander D. Langmuir Prize, 1972. Selected by the Epidemic Intelligence Service Alumni as the best manuscript of the year (see Publications: Journals, Books #1).

JOURNAL ACTIVITIES:

Conversations in Infection Control, Scientific editor, 1980-1.
Infection Control, Editorial Advisory Board, 1981-7.
Journal of Hospital Infection, Editorial Board, 1987- .
American Journal of Infection Control, Editorial Advisory Board, 1982-87.
American Journal of Medicine, manuscript consultant: 1986-7.
Antimicrobial Agents and Chemotherapy, manuscript consultant: 1984.
Annals of Internal Medicine, manuscript consultant: 1985-7, 1989.
Archives of Internal Medicine, manuscript consultant: 1986-7.
Chest, manuscript consultant: 1983-5.
Reviews of Infectious Diseases, manuscript consultant: 1986.
Postgraduate Medicine, manuscript consultant: 1986.
American Hospital Formulary Service, Drug Information monograph reviewer, 1987, 1988
New England Journal of Medicine, Manuscript consultant: 1989.

CONSULTATIVE ACTIVITIES - NIH

Member, Special Study Section, project site visit, 1 R01 AI25942, Louis Baker, PI. NY Blood Center, NY, NY, May 8-9, 1986.
Member, Ad Hoc Review Committee, RFA-87-AI-09, "Network of AIDS Clinical Studies Groups," June 15-17, 1987.
Member, Epidemiology and Technology Transfer Subcommittee, AIDS Research Review Committee (AIDSRC), NIAID, 1987-91.
RFP NIAID-AIDSP-88-6, Collaborative Prospective Cohort Studies of Perinatal Transmission of HIV and Related Retroviral Infections; 4 single applications; Nov. 17-18, 1987.
RFA 87-AI-10, International Collaboration in Acquired Immunodeficiency Syndrome Research; RFA 87-TW-01 Special International Postdoctoral Research Program in Acquired Immunodeficiency Syndrome (AIDS); Feb. 3-5, 1988.
RFA 88-AI-03, Expansion of the Pediatric AIDS Clinical Trials Group, triage meeting; May 24-25, 1988.
RFA 88-AI-05, Prospective Studies of a Cohort of Infants of HIV Seropositive Mothers; May 24-25, 1988.
RFA 88-AI-03, Expansion of the Pediatric AIDS Clinical Trials Group, Final meeting; June 27-28, 1988.
Member, Special Review Committee, RFA-88-CA-16, Epidemiological Studies of HIV-Associated Malignancies, February 12-13, 1989.
RFP NIAID-AIDSP-89-11, Community Programs for Clinical Research on AIDS; May 21-24, 1989. Ad hoc review of Stage II proposals.
RFP NIAID-AIDSP-89-11, Community Programs for Clinical Research on AIDS; Aug 7, 1989. Technical Evaluation for Source Selection Determination, Stage II proposals.

CONSULTATIVE ACTIVITIES - CDC

- Consultant to the CDC 10/10-11/85 for development of the AIDS workplace guidelines. Issued in MMWR 1985; 34:681-95.
- Consultant to the CDC 12/17-18/85 for the development of guidelines for the performance of invasive procedures by AIDS virus infected persons. Issued in MMWR 1986; 35:221-3.
- Consultant to the CDC 7/16-17/87 for the development of "Recommendations for the Prevention of HIV Transmission in Health-Care Workers." Issued in MMWR 1987; 36:Suppl 2.

CONSULTATIVE ACTIVITIES - OTHER NATIONAL

- Reviewer, National Foundation for Infectious Diseases Nosocomial Infection Fellowship Awards, 1983- .
- Member, Society of Hospital Epidemiologists of America/Association for Practitioners in Infection Control AIDS Task Force, 1986- .
- Testimony before the Presidential Commission on the Human Immunodeficiency Virus Epidemic, Implications of the HIV-induced secondary infections, Indianapolis, IN, May 11, 1988.
- Testimony on behalf of the Association for Practitioners in Infection Control at Public Hearing, Proposed Rule on Occupational Exposure to Blood Borne Pathogens, Occupational Health and Safety Administration, Chicago, IL, October 18, 1989.

CONSULTATIVE ACTIVITIES - STATE AND LOCAL

- Member, Minnesota State Commissioner of Health's Task Force on AIDS, 1st Committee, 1985-7.
- Member, Minnesota State Commissioner of Health's Task Force on AIDS, 2nd Committee, 1988-9.
- Member, Special Committee on Contagious and Communicable Diseases, Minnesota Dental Association, 1986- .
- Member, Minnesota Department of Human Services Medical Policy Directional Task Force, 1986- .
- Member, Medical Advisory Committee, Minnesota AIDS Project, 1986- .
- Member, Minnesota Chamber of Commerce AIDS Steering Committee, 1987-8.
- Member, Illusion Theater AIDS Advisory Committee, 1988
- Member, Minnesota Governor's Task Force on Lesbian and Gay Minnesotans, 1990- .

PERSONAL

- Born Pittsburgh, PA, September 11, 1942. Raised in New York, NY; San Antonio, TX; and Scottsdale, AZ.
- U.S. citizen
- Social Security Number:
- Formerly fluent in Spanish
- Military Service: U.S. Public Health Service, 7/70-6/72.
Rank: Surgeon. Discharge: Honorable.

MINUTES
Planning and Development Committee
August 13, 1990

CALL TO ORDER

Robert Latz called the August 13, 1990 meeting of the Planning and Development Committee to order at 2:35 p.m. in room 8-106 in the University Hospital.

Attendance: Present	Robert Latz, Chair Leonard Bienias Robert Dickler William Jacott, M.D. Peter Lynch, M.D. Ted Thompson, M.D.
Absent	Clint Hewitt B. Kristine Johnson Geoff Kaufmann Gerald Olson
Staff	Cliff Fearing Greg Hart Mark Koenig John LaBree, M.D. Shannon Lorbiecki Lisa McDonald
Guest	Carl White, M.D.

APPROVAL OF MINUTES

The minutes of the July 19 meeting were approved as distributed.

CARDIAC CATHETERIZATION LAB EXPANSION PROPOSAL

Mr. Hart distributed a handout which detailed the cardiac cath lab proposal, and provided the financial analysis and graphs depicting the volume growth in the cath lab. Mr. Hart said that the plans for expansion are being accelerated because the cath labs are at 98% capacity, whereas 85% is optimal. The outreach affiliations, new procedures and faculty will further increase volume.

Remodeling costs are estimated at \$400,000 including the relocation of nuclear medicine on the first floor and cardiac cath's renovation on the second floor. The equipment cost is estimated at \$2,400,000 with a payback period of 1.3 years for the entire project.

Dr. White reported that they are pleased with the growth of the cardiac lab since 1986. He said that outreach efforts have helped a great deal in increasing the volume in the cath lab. He said that procedures are being done as late as 9:00 or 10:00 p.m. which causes stress and frustration for both faculty and patients. He said that present volume alone requires another procedure room. Dr. White added that cardiac cath procedures are becoming

more an outpatient procedure but that shouldn't affect the need for these improvements. This project was presented for information only and will be brought back for final endorsement to the full board.

CAPITAL PLAN REVIEW

Mr. Dickler said that the capital plan will be discussed at the Chief's retreat at the end of this week.

He said that there are three components of the plan 1) operating expenses and revenue; 2) non-renewal capital; and 3) renewal project.

Mr. Dickler said that these three components must be rebalanced using new volume assumptions. Mr. Hart said we need increased volume, better reimbursement, and more efficient operations.

Various options for the renewal project are still being discussed. Several options and issues will be addressed at the Chief's retreat this week to get their thoughts and input. Discussions will continue and this topic will be presented to the Planning and Development Committee at a later date. The three Board retreat task forces will also present reports at the Chief's retreat.

Questions and discussion followed Mr. Dickler's and Mr. Hart's report.

UMCA UPDATE

Dr. Lynch reported that discussions with Group Health are proceeding and that all parties are working very hard to make this affiliation a reality. He said that Family Practice will be the gatekeeper for the potential Group Health Clinic at the University. Mr. Dickler said that Group Health and the State Health Plan provide different options. Group Health participants can only see a specialist if referred by their primary care whereas State Health Plan enrollees can choose any specialist they wish.


OTHER

Mr. Dickler discussed CHAMP. This home-alienation program which is one of the best in the U.S., is exploring expansion potential beyond UMHC's patient population. In order to expand and accommodate third party contracts UMHC and UMCA are looking at a joint venture opportunity. More information will be presented at a future meeting.

ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 4:10 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 Parkway
Minneapolis, Minnesota 55455

August 23, 1990

TO: Members, Board of Governors
FROM: Greg Hart
Senior Associate Director
RE: Cardiac Catheterization Lab Expansion

The Cardiac Catheterization Lab currently consists of three procedure rooms. The volume of patients in the Cardiac Catheterization Lab has grown significantly since it opened in 1986. To handle current patient volumes and anticipated growth we are proposing that the capacity be increased by one additional angiographic room.

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

/gs

Attachment

Cardiac Catheterization Lab

Expansion Proposal

Introduction and Rationale

The Cardiac Cath Lab currently consists of three procedure rooms with radiographic capabilities, and support space for registration, storage, and patient recovery. Two of the procedure rooms are equipped to do interventional angiographic studies, the third is used primarily for electrophysiologic procedures. The Lab is located on the second floor of Unit J, adjacent to the CV Radiology area. The equipment for the two angiographic rooms was purchased in 1986, along with the opening of Unit J. The equipment in the third room was purchased in 1980.

The volume of patients seen in the Cardiac Cath Lab has grown significantly since the unit was planned in the early 1980s and opened in 1986. This growth is in part a function of changes in technology (especially angioplasty) and also clearly the result of the arrival in 1986 of Drs. Carl White and Robert Wilson. Dr. Wilson is currently the Medical Director of the Cardiac Cath Lab. Dr. White and Dr. Wilson have led an extensive, successful medical outreach program in conjunction with University Hospital.

Attached are graphs which depict the growth in number of cases for six month increments beginning in 1985, through June 1990. We are now seeing nearly 3,000 cases per year, compared to approximately 1,200 cases per year in 1985. Almost all of the growth has been in adult patients. While the pediatric procedure volume has been relatively constant, it is anticipated that we will see growth in the number of pediatric cases when Dr. Rocchini arrives later this year. Dr. Rocchini will be the Head of the Division of Pediatric Cardiology and is a pediatric interventional cardiologist.

The dramatic increase in volume has led to the current procedure rooms being used to capacity. A fourth procedure room is thus needed to handle additional anticipated growth. "Industry standard" is that each procedure room should accommodate approximately 70 procedures/month. We are currently at 80-85 procedures per room per month. The non-angiographic room has a utilization rate of 86%, while the two angiographic rooms are in use 98% of the time from 7:00 a.m. to 7:00 p.m. The rooms are consistently used well into the evening and night.

The congested schedule which results from such a high utilization rate has become problematic. The frequent occurrence of emergency cases results in patients being sent home or delayed in the Hospital. When the equipment is down for repair or maintenance, patients care is further delayed or, at times, must be transferred to another hospital.

Accommodating additional growth in this situation will be very difficult. A growth potential of 450-650 cases per year over the next three years is projected. Additional capacity will need to be created in order to handle this growth in patient demand.

A key component of this projected growth is related to the Hospital's continuing outreach efforts. The volume from Red Wing and Eau Claire should add approximately 200-300 cases per year to the Cath Lab activity. It is important that we have the capacity to be responsive to these new referral sources.

Additional growth is expected to come from an increase in pediatric cardiology cases (100-150 cases per year); volume from the continued growth in the number of patients in the Cardiac Transplant Program, who return for biopsies and angiography (100-150 cases per year); and some additional increase in electrophysiologic studies, with the arrival of Dr. Pineda, an expert in electrophysiologic cardiovascular surgery (50 cases per year).

Beyond the above short term opportunities, additional growth is probable. It is anticipated, within the next three to four years, that technological advances in catheterization, particularly in interventional and electrophysiologic cardiology may increase the number of patients suitable for treatment in the Catheterization Laboratory. In interventional cardiology, the patients amenable to coronary angioplasty may be substantially increased by the use of 1) intracoronary stents (devices to hold open arteries after coronary dilation), and 2) laser or radio-frequency ablation of coronary atherosclerosis and "vascular welding".

Additional advances have been made in electrophysiology that may increase the number of patients who can undergo ablation of cardiac tissue responsible for heart rhythm disturbances. Many of these patients are currently treated with surgery. Advances in radio-frequency devices and other tissue ablation methods (chemical, electrical) may substantially increase the number of patients that can be treated in the Catheterization Laboratory. In pediatric interventional cardiology, a multitude of devices have been developed over the last several years that allow closure of defects within the heart, and permit the dilation of valves and other stenotic structures.

There has been a great deal of commercial interest applied toward the development of new devices for use in the Catheterization Laboratory. It is likely that over the life of a new radiographic facility, these devices will increase further the number of patients treated in the Catheterization Laboratory.

Proposal

It is proposed that the Cardiac Catheterization Lab capacity be increased by one additional angiographic room in order to handle current volume and anticipated growth. The estimated cost of the project is \$2,800,000. This project has been anticipated in the Hospital's long-range capital plan.

The project involves both equipment purchase and remodeling of space. Space adjacent to the existing Cath Lab will be utilized. This space is now used by Nuclear Medicine; space on the first floor of Unit J will be remodeled for the displaced Nuclear Medicine functions. The cost of remodeling both the first floor space for displaced Nuclear Medicine and the second floor space for the new Cardiac Cath procedure room is estimated at \$400,000.

Estimated equipment cost for the project is \$2,400,000. The new unit will be equipped with biplane cine-angiographic and digital angiographic capabilities. The unit will be used primarily for interventional procedures. In addition to the radiographic equipment, the project cost includes supporting equipment, including physiologic monitoring technology.

It should be noted that the cost estimates for the project are preliminary at this point. More refined costs, hopefully based on actual bids, will be included when the project is brought to the Board of Governors for approval. We are targeting for the October Board meeting for project approval.

Financial Analysis

We have approached the financial analysis for this project from more of a "product line" perspective than we have done in the past for major equipment purchases, such as CT scanners and MRI units. That is, the full range of revenue and expense for patients seen in the Cath Lab has been reviewed, as opposed to just revenue and expense generated in the Cath Lab itself. This methodology gives a more complete perspective on the financial impact of the Cath Lab activity, and, in particular, an increase in Cath Lab activity.

As indicated earlier, current Cath Lab volume is just under 3,000 patients. These patients generated over \$42 million in charges during their hospital stays, in 1989-90 dollars. Reimbursement on these charges was at 80% in 1989-90.

The patients seen in the Cath Lab generally fall into three categories. The first group, those for whom a cath procedure is the primary reason for admission, account for about 38% of the patients seen in the Lab. The second group, who have a heart biopsy or electrophysiologic study done in the Lab as part of (typically) a cardiac transplant evaluation or follow-up, account for 34% of the patients. The third group, with 20% of the patients, are those patients who are seen in the Cath Lab, but whose primary reason for admission was something other than the Cath procedure. These groupings are important, because the first two groups generate a "profit" for the Hospital (on a fully-loaded cost allocation basis) of about \$750,000 per year, while the third group generates a loss of approximately \$1,100,000 per year.

The project proposal is based upon additional volume of 500 cases per year. The additional volume will fall primarily in the first two above categories of patients. Estimated additional annual revenue (after revenue deductions) for those 500 cases is \$4,013,000.

The incremental operating costs of the additional caseload are estimated at \$1,856,000 (exclusive of depreciation). Thus before considering depreciation, the additional revenue generated exceeds the operating expense by \$2,157,000, and the project has a payback period of less than two years.

Assuming a six year life for the project, the annual depreciation on the \$2,800,000 investment is \$467,000. Subtracting this figure from the \$2,157,000 incremental profit, the after depreciation incremental annual margin is \$1,690,000.

To summarize:

Project investment:	\$2,800,000
Additional volume:	500 cases/year
Additional revenue:	\$4,013,000/year
Incremental expense (pre-depr.):	\$1,856,000
Operating margin:	\$2,157,000
Payback period:	1.3 years
Depreciation expense:	\$467,000/year
Net margin:	\$1,690,000
Rate of return:	60%

**Cardiac Catheterization Laboratory:
case load 1985-90**

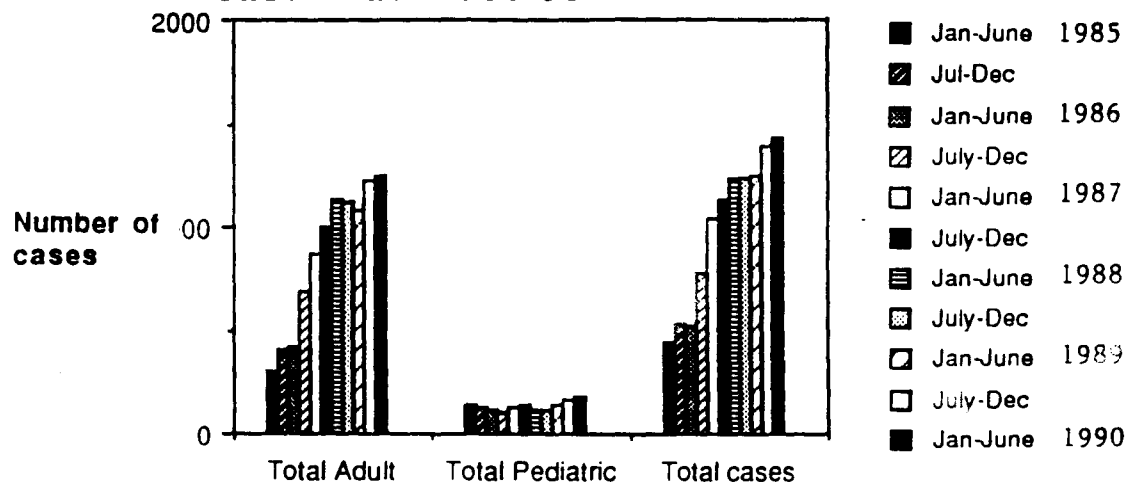


Figure 1

**Cardiac Catheterization Laboratory:
number of cases, by procedure type**

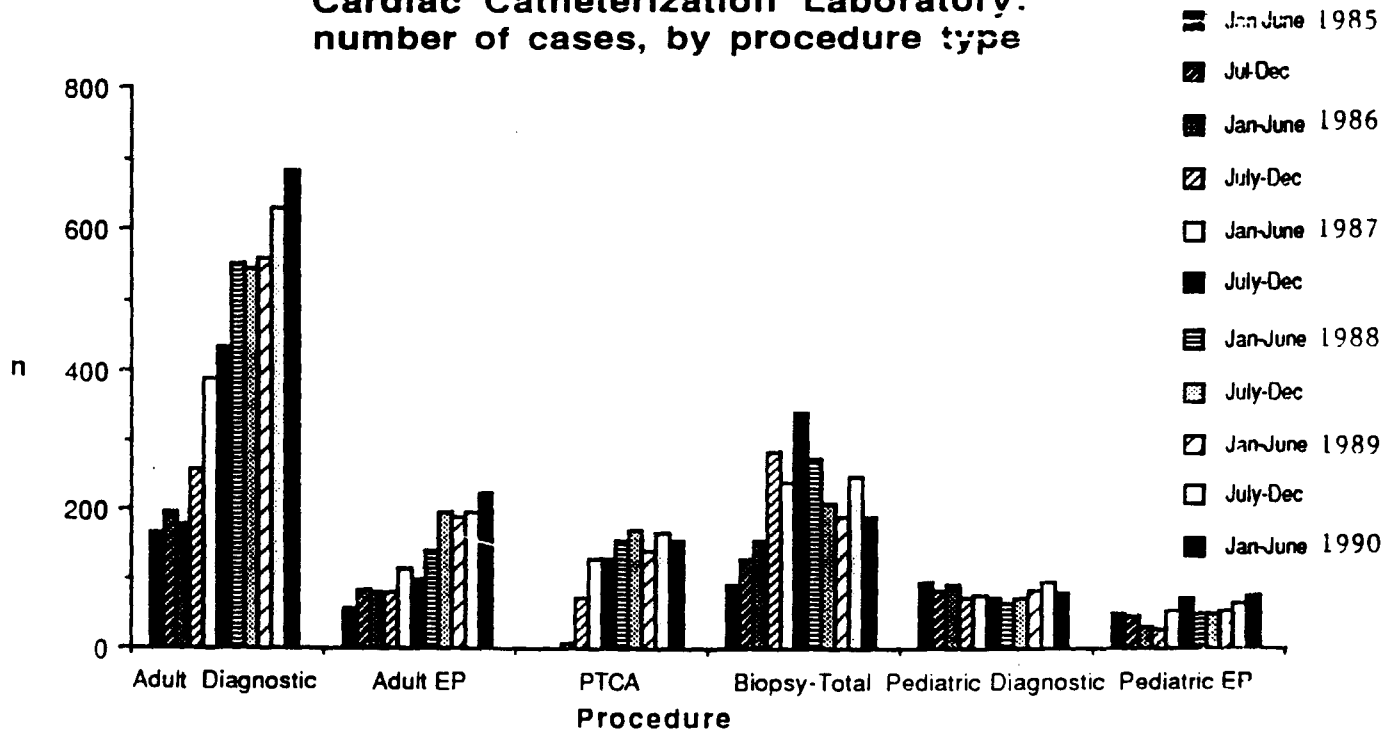


Figure 2

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
July 25, 1990

MINUTES

ATTENDANCE:

Present: Jerry Meilahn, Chair
Edward Ciriacy, M.D.
Robert Dickler
Clifford Fearing
Nellie Johnson
David Lentz
Margaret Matalamaki
Roger Paschke

Not Present: Elwin Fraley, M.D.
Vic Vikmanis

Staff: Greg Hart
Teri Holberg
Nels Larson
Shannon Lorbiecki

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on July 25, 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 June 27, 1990 meeting as written.

JULY 1, 1989 THROUGH JUNE 30, 1990 FINANCIALS:

Mr. Clifford Fearing stated what was being reported to the Committee was a preliminary year-end financial statement because the University had not closed its books as of July 25. Mr. Fearing stated there are not expected to be any substantial changes to the statement.

Mr. Fearing reported to the Finance Committee the month of June inpatient admissions totaled 1,508, which was 138 below budget; average length of stay was 7.8 days; patient days totaled 11,774, which were 1,229 days below budget. The June average daily census was 394, which was below the budgeted level of 433. Clinic visits for the month of June were reported to be 6.1% under budget, bringing year-to-date clinic visits 2.7% under budget.

The Hospital's year-to-date Statement of Operations showed revenues over expenses by \$6,210,945 a favorable variance of \$4,578,945. Mr. Fearing stated ancillary revenue was 6.6% under budget and operating expenditures were reported to be 6.1% below budget.

Lastly, Mr. Fearing reported as of June 30 the balance of accounts receivable totaled \$88,676,838 and represented 96.3 days of revenue outstanding.

Mr. Fearing stated a more detailed report of year end will be presented to the Committee after the final audit is received by Coopers and Lybrand.

CAPITAL PLAN - UPDATE:

Mr. Dickler reviewed the results of the financial analysis that was reported last month. He stated if the Hospital's operating position continued in its present manner by 1998 the Hospital would show a \$45,000,000 shortfall between minimum reserve levels and actual reserve levels. As a result of this predicted shortfall the capital plan is presently being reevaluated.

One of the areas of the capital plan that is being reevaluated is the second phase of the renewal project. Three options for the renewal project are being developed. They are: 1) proceeding with the renewal project as planned, or some modification that involves a new building, 2) meet programmatic needs or at least the key programmatic needs in the renewal project (Psych, OB, Rehabilitation, Urology) using only existing facilities, and 3) building two floors on Unit J and renovating portions of Mayo. Mr. Dickler stated the options will be reviewed at the Clinical Chiefs Retreat on August 17.

A further update on the renewal project will be presented at the August Board meeting.

FOURTH QUARTER, 1989-90 BAD DEBTS:

Mr. Fearing reported the bad debts for the fourth quarter totaled \$817,801.52 represented by 1,376 accounts. Recoveries amount to \$83,288.85, leaving a net charge-off of \$734,512.67. This amount represents 0.92% of gross charges and compares to a budgeted level of 1.22%.

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

Mr. Fearing informed the Committee a firm was recently hired who will assist patients in making application for medical assistance coverage.

FINANCE COMMITTEE CALENDAR:

There will not be a Finance Committee on August 22, instead there will be one on August 29th from 10:00-11:30 a.m. in the Board Room. There will also not be a Finance Committee meeting in September because the Board of Governors Retreat will take place October 1 and 2.

Effective October 24, 1990 the Finance Committee meeting will begin at 12:30 with a buffet lunch served at 12:00.

CHAMP:

Mr. Dickler informed the Committee of discussions, which have been held with the clinical departments medicine, surgery and pediatrics, to move CHAMP into a separate legal status. From an ownership standpoint there would be very little change, but from an operational standpoint this would permit a much larger enterprise to be developed, and it would be separate from the University of Minnesota. Mr. Dickler stated after approval by the Board a joint venture would be developed with this new organization and the University Hospital.

There being no further discussion, the July 25, 1990 meeting was adjourned at 1:50 P.M.

Respectfully submitted,



Teri Holberg
Recording Secretary

August 29, 1990

TO: Board of Governors
FROM: Clifford P. Fearing
SUBJECT: Report of Operations for the Period
July 1, 1990 through July 31, 1990

The Hospital's operations for the month of July reflect inpatient admissions, patient days, and clinic visits activity above budget. Both ancillary revenue and routine revenue are above budgeted levels for the month.

INPATIENT CENSUS: For the month of July, inpatient admissions totaled 1,631 which was 138 above budgeted admissions of 1,493. Our overall average length of stay for the month was 8.1 days. Patient days for July totaled 12,687 and were 601 days above budget. The increase in admission levels over budget was seen in almost all areas with the most significant ones being in Surgery, Medicine, Pediatrics, and Adult Psych.

To recap our year-to-date inpatient census:

	1989-90 <u>Actual</u>	1990-91 <u>Budget</u>	1990-91 <u>Actual</u>	<u>Variance</u>	% <u>Var</u>
Admissions	1,576	1,493	1,631	138	9.2
Patient Days	13,050	12,086	12,687	601	5.0
Avg Length of Stay	8.4	8.1	8.1	0.0	0.0
Avg Daily Census	421.0	389.9	409.3	19.4	5.0
Percent Occupancy	71.8	67.6	71.3	3.7	5.5

OUTPATIENT CENSUS: Clinic visits for the month of July totaled 23,509 which was 2,323, or 11.0%, more than budgeted visits of 21,186. Visits were significantly above budget in Adult Psych, Emergency Room, Medicine, Endoscopy, and Urology. Family Practice and Child Psych reported visits significantly below budgeted levels. Community University Health Care Center (CUHCC) visits for the month of July totaled 3,974 which was 470, or 10.6%, under budgeted visits of 4,444, while Home Health visits of 848 for the month were 105, or 11.0%, below budgeted visits of 953.

REPORT OF OPERATIONS
 JULY 1990
 PAGE 2

To recap our year-to-date outpatient census:

	1989-90	1990-91	1990-91		%
	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>
Clinic Visits	21,933	21,186	23,509	2,323	11.0
CUHCC Visits	4,149	4,444	3,974	(470)	(10.6)
HHA Visits	865	953	848	(105)	(11.0)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows revenues over expenses by \$2,299,862, a favorable variance of \$2,730,450. Patient care charges through July totaled \$30,088,736, which was 5.2% over budget. Routine revenue was 3.0% above budget and reflects our favorable inpatient census variance.

Ancillary revenue was \$1,221,271 above budget (6.0%) and primarily reflected the favorable variance in both inpatient and outpatient census. Inpatient ancillary revenue averaged \$9,350 per admission compared to the budgeted average of \$9,842 per admission. Outpatient revenue per clinic visit averaged \$262 compared to the budgeted average of \$259.

Operating expenditures through July totaled \$23,964,562 and were \$1,030,885 (4.1%) below budgeted levels of \$24,995,447. The overall favorable variance is primarily due to the delay in the Renewal Project Phase II and the resultant lack of relocation and rental costs.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of July 31, 1990, totaled \$89,991,945 and represented 94.9 days of revenue outstanding. The overall decrease in our patient receivables in July of 1.4 days occurred primarily in Commercial Insurance.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels for July. 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, 1990 TO JULY 31, 1990

	1990-91 Budgeted	1990-91 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	\$28,611,455	\$30,088,736	\$1,477,281	5.2%
Deductions from Charges	7,131,234	7,032,990	(98,244)	-1.4%
Other Operating Revenue	857,328	910,012	52,684	6.1%
Total Operating Revenue	22,337,549	23,965,758	1,628,209	7.3%
Total Expenditures	24,995,447	23,964,562	(1,030,885)	-4.1%
Net Operating Revenue	(2,657,898)	1,196	2,659,094	100.0%
Non-Operating Revenue and Expenses	2,227,310	2,298,666	71,356	3.2%
Revenue Over/Under Expense	(\$430,588)	\$2,299,862	\$2,730,450	

	1990-91 Budgeted	1990-91 Actual	Variance Over/-Under Budget	Variance %
Admissions	1,493	1,631	138	9.2%
Patient Days	12,086	12,687	601	5.0%
Average Daily Census	389.9	409.3	19.4	5.0%
Average Length of Stay	8.1	8.1	0.0	0.0%
Percentage Occupancy	67.6	71.3	3.7	5.5%
Outpatient Clinic Visits	21,186	23,509	2,323	11.0%

ANNUAL CAPITAL EXPENDITURE REVIEW

MAJOR FINDINGS AND CONCLUSIONS

1. UMHC has traditionally funded \$7-8 million in annual capital expenditures from its operating cash flow.

In addition, UMHC has purchased major pieces of equipment (MRI, CT scanners) from its reserves.

Each year, the management and medical staff have submitted requests for twice as much capital as the budget has allowed. Budget allocations have been made by hospital administration; a Clinical Chiefs Capital Advisory Committee has begun assisting in that process.

2. The annual depreciation expense for 1989-90 is approximately \$8,600,000 for movable equipment and about \$600,000 for fixed equipment, totaling about \$9,200,000.

3. Replacement cost of the equipment in the depreciation stream will be higher than original purchase cost.

Application of inflationary conversion values results in annual capital costs of \$14,379,000.

4. Over an eight year period, \$115,000,000 in capital funds, from reserves and operations, will be needed to replace current equipment.

5. UMHC's capital plan includes about \$101,000,000 to meet capital equipment replacement needs.

6. UMHC's capital plan also includes approximately \$43,000,000 for new technology and other program development.

7. A significant reduction in expenditures in this area will result in an increasingly aged plant/equipment and/or lesser ability to invest in new technology and program development which require capital commitments.

8. Balancing of priorities requires that some reduction to future annual capital expenditures be made.

It is recommended that a \$20 million reduction in annual capital expenditures from 1991-98 be targeted.

Depreciation/Capital Plan Summary

Annual

A. Equipment Depreciation - Historical Cost

\$8,564,000 - Movable Equipment
613,000 - Fixed Equipment

B. Future Cost Conversion

\$8,564,000 Movable Equipment
x 1.5 Replacement Cost Conversion
\$12,846,000

\$613,000 Fixed Equipment
x 2.5 Replacement Cost Conversion
\$1,533,000

C. Eight Year Replacement Cost

\$12,846,000 Movable Equipment
1,533,000 Fixed Equipment

14,379,000
x 8 Years (1991-1998)

\$115,032,000 Eight Year Capital Need

D. Funds Available

\$86,636,000 Annual Capital Budget
x .85 (85% Equipment/15% Remodeling)

\$73,641,000
+ 27,441,000 Major Equipment - Funded from Reserves

\$101,082,000 Available

E. Net Position

\$115,032,000 Eight Year Capital Need
- 101,082,000 Available

\$ 13,950,000 Shortfall (8.8%)

Objectives of Facilities Master Plan Reassessment

8/16/90

- Provide for incremental facility improvements commensurate with funding capability
- Provide for functional flexibility - improvements or new facilities must be able to accommodate changes in programs and priorities
- Provide for facility improvements consistent with strategic priorities and the Hospital's mission of patient care, research and education
- Provide immediate interim relief for facilities in the worst condition
- Maximize departmental function, zoning efficiency, efficiency of space utilization, return on capital investment and operating efficiency
- Assume that remodeled Hospital space is improved as necessary to meet current code requirements (i.e. installation of sprinklers, smoke detectors, etc.)
- Consolidate inpatients in as few buildings as possible

Conceptual Approaches to Facility Master Plan Reassessment

8/16/90

- Extend timeframe for Option C3 or A2 to potentially improve cash flow
- Extend timeframe for reassessment of the master plan until volume trends stabilize
- Assume some clinical program components relocate off site
- Develop master plan assuming no new construction
- Attempt to reduce cost of Option C3
 - Reduce/eliminate Mayo work
 - Eliminate shell floors
 - Reduce size of C3 programs and building
 - Shell entire building except for selected programs
- Revert to Option A2 with optional cost reductions/additions
 - Reduce/eliminate Mayo work
 - Eliminate shell floor
 - Reduce Psych programs
 - Avoid cooling tower relocation (notched floor)

Option Descriptions

8/15/90

- **Reduced C-3 Option-**

This option is a scaled down version of the replacement building previously planned for the southeast corner of the Mayo site. The option requires the demolition of approximately 56,500 NSF of the old Mayo Building and reconstruction of a five story, approximately 83,000 NSF building to house Psychiatry Inpatient, Day Hospital and Clinic. The Psychiatry programs would occupy approximately 45,000 NSF of the building using the historic program plan with the remaining 38,000 NSF (presumably below grade) shelled. Construction of the below grade shell is necessary to maintain vital pedestrian and supply linkages between Mayo and Unit J. Psychiatry offices would remain on Mayo 6 as previously planned. Relocation of all current occupants of the southeast corner of Mayo will be required.

- **No Construction Option-**

This option assumes that no new construction is affordable at this time. The Psychiatry Inpatient, Day Hospital and Clinic are accommodated in the Rehab Building. This assumes a significant reduction in the size of the Psychiatry programs. Additional space for the department could be provided on Mayo 3 which links to the Rehab Building. Psychiatry offices are assumed to be located on Mayo 3, 4, and 5 in a stacked configuration close to the Rehab Building.

- **Unit J Expansion Option-**

This option is a scaled down version of the previous A2 plan which provided for expansion of the J building by one or more floors. This option assumes that the ninth floor of Unit J is constructed to accommodate a reduced Psychiatry Inpatient program. The building is configured around the existing cooling towers to reduce overall cost and reduce operational disruption. Psychiatry Clinic, Day Hospital and offices would be located in Mayo.

REASSESSMENT OPTIONS

8/16/90

<u>PROJECT COMPONENT</u>	<u>REDUCED C-3 OPTION</u>	<u>NO CONSTRUCTION OPTION</u>	<u>UNIT J EXPANSION OPTION</u>
OB INPT	REDUCED C3 BUILDING	REMODEL REHAB 4, 5 & 6	EXPAND UNIT J 9 A, B & C
PSYCH OP	REDUCED C3 BUILDING	REMODEL REHAB 2 & 3	MAYO 3RD FLOOR
PSYCH DAY HOSP	REDUCED C3 BUILDING	REMODEL REHAB 2 & 3	MAYO 3RD FLOOR
PHYSICIAN OFFICES	MAYO 6TH FLOOR	MAYO 3, 4 & 5	MAYO 3RD FLOOR
UROLOGY CLINIC	PWB 1 -OLD COL/REC	PWB 1 -OLD COL/REC	PWB 1 -OLD COL/REC
UROLOGY OFFICES	MAYO 5TH FLOOR	MAYO 5TH FLOOR	MAYO 5TH FLOOR
CYSTOSCOPY	PWB 1 -OLD AM SURG	PWB 1 -OLD AM SURG	PWB 1 -OLD AM SURG
OB INPT TEMP	REMODEL MAYO 5	REMODEL MAYO 5	REMODEL MAYO 5
OB INPT FINAL	VACANT UNIT J NSG UNIT	VACANT UNIT J NSG UNIT	VACANT UNIT J NSG UNIT
REHAB INPT	VACANT UNIT J NSG UNIT	VACANT UNIT J NSG UNIT	VACANT UNIT J NSG UNIT
ADULT THERAPY	REHAB 5TH & 6TH FLOOR	MAYO 4TH FLOOR	MAYO 4TH FLOOR
PEDS THERAPY	REHAB 5TH & 6TH FLOOR	MAYO 4TH FLOOR	MAYO 4TH FLOOR
FACULTY OFFICES	\$1.5M COMMITMENT	\$1.5M COMMITMENT	\$1.5M COMMITMENT
RELOCATION/RENTAL	ANTICIPATED COST \$4.0M	ANTICIPATED COST \$2.13M	ANTICIPATED COST \$1.92
INTERIM FIXES	ALLOW \$.3M FOR PSYCH	ALLOW \$.3M FOR PSYCH	ALLOW \$.3M FOR PSYCH
AM SURG/ SAME DAY	MASONIC LOBBY	MASONIC LOBBY	MASONIC LOBBY
MAYO CODE/ASBTS	ALLOW \$2.0M	ALLOW \$2.0M	ALLOW \$2.0M
MAYO SYS UPGRADE	MINIMAL AT \$3.0M	MINIMAL AT \$3.0M	MINIMAL AT \$3.0M
AUTOPSY	MAYO FLOOR 1	MAYO FLOOR 1	MAYO FLOOR 1
PHARMACY	MAYO FLOOR 1	MAYO FLOOR 1	MAYO FLOOR 1
MISC MAYO PROG	ASSUME NO IMPROVEMENTS	ASSUME NO IMPROVEMENTS	ASSUME NO IMPROVEMENTS
<u>APROX PROJ COST</u>	<u>\$46.06M</u>	<u>\$25.57M</u>	<u>\$35.80M</u>

NOTES: DEPARTMENTAL LOCATIONS INDICATED HERE ARE FOR ESTIMATING PURPOSES ONLY AND DO NOT REPRESENT SPACE, LOCATION OR FUNDING COMMITMENTS.

THE COSTS OF PROVIDING SHELL SPACE ARE NOT INCLUDED IN THE UNIT J EXPANSION OPTION.

PREVIOUSLY PLANNED RENOVATION OF APPROXIMATELY 60 HOSPITAL DEPARTMENTS IS NOT INCLUDED IN ANY OPTION.

COMPARISON OF OPTIONS

8/14/90

<u>PROJECT COMPONENT</u>	<u>REDUCED C-3 OPTION</u>	<u>NO CONSTRUCTION OPTION</u>	<u>UNIT J EXPANSION OPTION</u>
PROJECT COST	\$46.06	\$25.57	\$35.80
MAXIMUM SEGMENTABILITY	\$29.56	\$5.39	\$16.30
OTHER CAP. REDUCTIONS REQ'D	\$30.82	\$10.33	\$20.56
QUALITY OF PSYCH INPATIENT	GOOD	POOR	GOOD
PSYCH FUNCTIONS COLOCATED	IP, OP, DAY	IP, OP, DAY	OP, DAY, OFF
QUALITY OF O.B.	NOT VARIABLE	NOT VARIABLE	NOT VARIABLE
QUALITY OF UROLOGY/CYSTO	NOT VARIABLE	NOT VARIABLE	NOT VARIABLE
QUALITY OF REHAB INPATIENT	NOT VARIABLE	NOT VARIABLE	NOT VARIABLE
QUALITY OF REHAB THERAPIES	NOT VARIABLE	NOT VARIABLE	NOT VARIABLE
AVAILABLE SHELL SPACE	34,000 NSF	NONE	NONE
ADDT'L CONSTRUCTION POTENTIAL	65,000 NSF	NONE	34,000 NSF
NET SPACE IMPACT	-28,171 NSF	-17,143 NSF	19,141 NSF
RELOCATION DISRUPTION	EXTREME	MODERATE	MINIMAL
OPERATIONS DISRUPTION	EXTREME	MODERATE	MODERATE
SCHEDULE	36 MONTHS	30 MONTHS	30 MONTHS

NOTE: ALL COSTS IN MILLIONS

Unit J Add/Deduct Costs

8/16/90

- One floor of shell space in the notched configuration (approximately 85% of a full floor) may be added to the Unit J expansion at an additional cost of approximately \$5,629,000, bringing the total cost of Unit J expansion to \$21,949,000.
- The cost of the Unit J expansion (\$16,320,000) may be reduced by \$2,264,000 if only the east side of the floor (Units A and B) are finished and the west side (Unit C) is left as shell.

Recommendations

1. Reduce capital plan by \$50,000,000
Recommendations on how this should be accomplished will follow this discussion
2. Improve operations through 1998 by \$40,000,000 - \$70,000,000
Relate to afternoon discussions on task force reports
3. Future capital planning needs to be more incremental in its approach to assure UMHC can adjust to changing economic circumstances
4. Capital plan and operating expenses need to be adjusted with changing economic demands - i.e., new program requirements, acquisition, etc. - which are related to achieving improved operation performance

Definitions

- Appropriations - Revenues received from the State of Minnesota.
- Baseline - Financial scenario based on February through June 1990 admissions and OPD volumes.
- Capital Plan - Expected expenditures for equipment, remodeling and building replacement or upgrade for fiscal years 1991 - 1998. Does not include repayment of principal.
- Capital Shortfall - Difference between minimum cash balance and actual cash balance.
- Cash Balance - Cash available for all purposes, i.e., reserves.
- Cash Provided After Interest Income - Cash provided from operations before interest income on reserves, plus appropriations plus interest income on reserves.
- Cash Provided Before Interest Income - Cash provided from operations (or lost from operations) plus appropriations not including interest income on reserves.
- Debt Service - Annual principal and interest payments on outstanding debt.
- Interest Income - Investment interest on reserves. (May be needed to offset operating losses.)
- Minimum Cash Balance - Four times debt service plus trustee held reserves is standard for double A credit rating in hospital industry.
- Net Reserves - Reserves less restricted reserves.
- Operating Expenses - Those costs associated with operating the Hospital and Clinic exclusive of capital expenditures.
- Operating Revenues - Revenues from patients services, parking ramps, cafeterias, etc.
- Reserves - Cash available for all purposes, i.e., cash balance
- Restricted Reserves - Reserves restricted as to use such as trustee held debt service reserves and reserves for third party liabilities.

Purpose of Financial Analysis' 1987 - 1989

To determine if UMHC could finance \$220,000,000 of capital through 1998

Findings

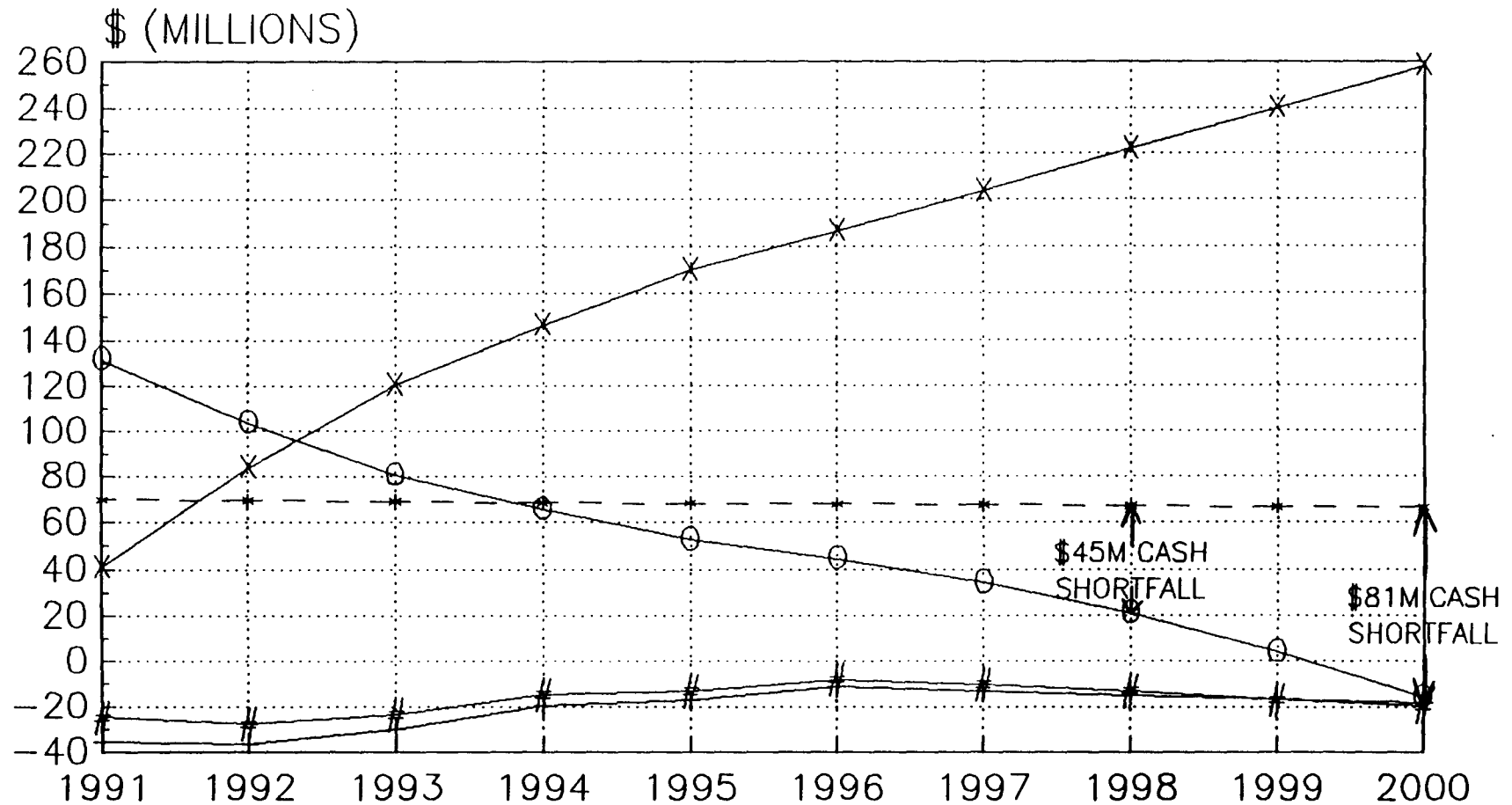
With volume at levels equal to those which were occurring until February 1990, capital plan is feasible

The June Process

- Redo previous projections that were done from 1987 - late 1989
- Establish Current Assumptions
 - Volume admissions, outpatient visits
 - Reserve requirements - industry standards
 - Patient Mix by payor type and clinical service
 - FTE requirements
 - Capital plan
 - Principal payments
 - Other operating expenses
 - Reimbursement issues
- Utilize outside resource, Kaufman/Hall to verify findings

BASELINE (ORIGINAL 10-YEAR CAPITAL PLAN) VOLUMES AT FEBRUARY-JUNE LEVELS

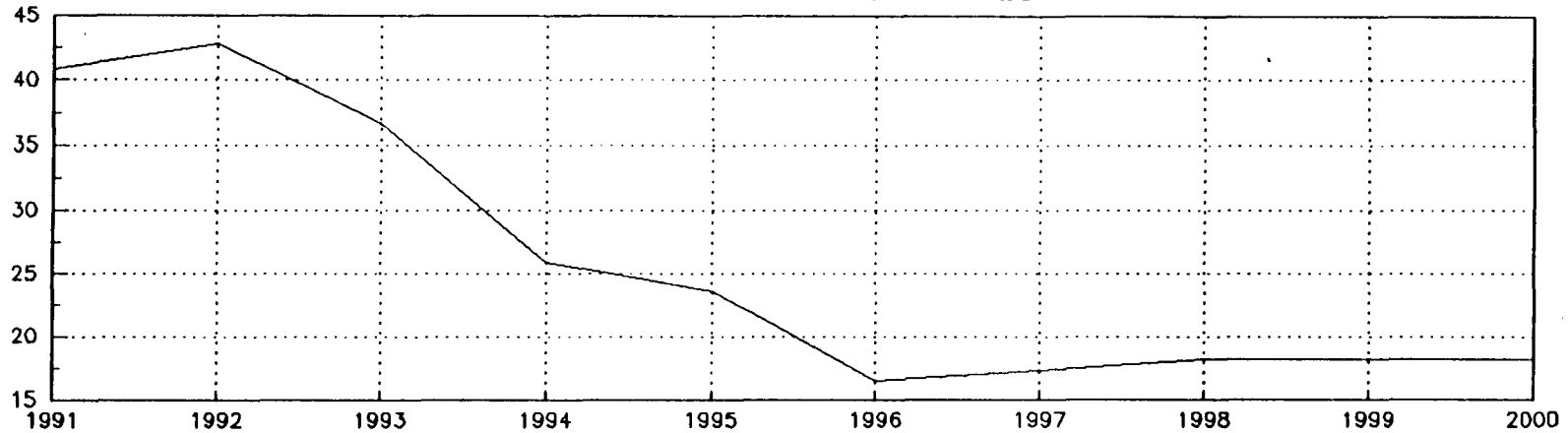
CUMULATIVE CAPITAL EXPENDITURES	CASH BALANCE (YEAR END)	MINIMUM CASH BALANCE	CASH PROVIDED BEFORE INTEREST INCOME	CASH PROVIDED AFTER INTEREST INCOME
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BASELINE

COMPARISON OF CASH PROVIDED INCLUDING AND EXCLUDING INTEREST

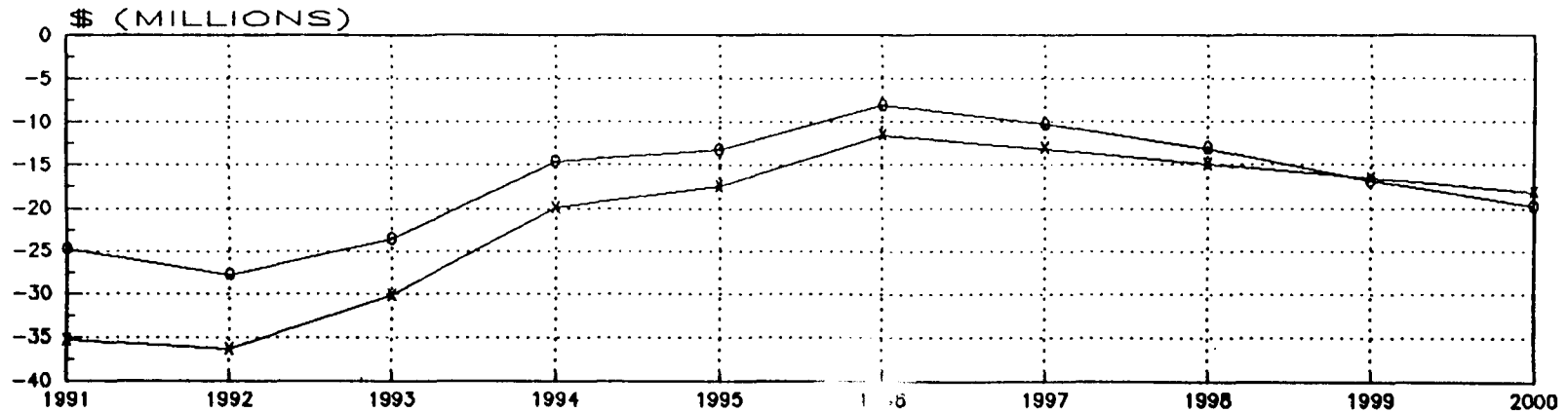
ANNUAL CAPITAL EXPENDITURES



5

CASH PROVIDED BEFORE INTEREST INCOME

CASH PROVIDED AFTER INTEREST INCOME



June Findings

1. In 1998 reserve levels are \$45,000,000 below minimum reserve levels.
2. With \$220,000,000 capital plan, and baseline projections regarding operations, financial status of UMHC continues to deteriorate - at accelerating rate - after 1998. By the year 2000, \$50,000,000 would have to have been borrowed to meet cash needs.
3. Interest expense in 1994 and 2000 exceed interest income.

Options to resolve capital shortfall and cash balance deterioration

- Capital Plan Reduction
- Operations Improvement
- Combination

Objective

To bring capital expenditures, cash earned, and cash expended into balance

Equilibrium Equation

Operating revenue		Operating Expense
Interest income	~	Capital Expenses
(Reserve levels x Interest Rate)		
Appropriations		

Option I

Capital Reduction

Reduce \$220,000,000 --> \$140,000,000

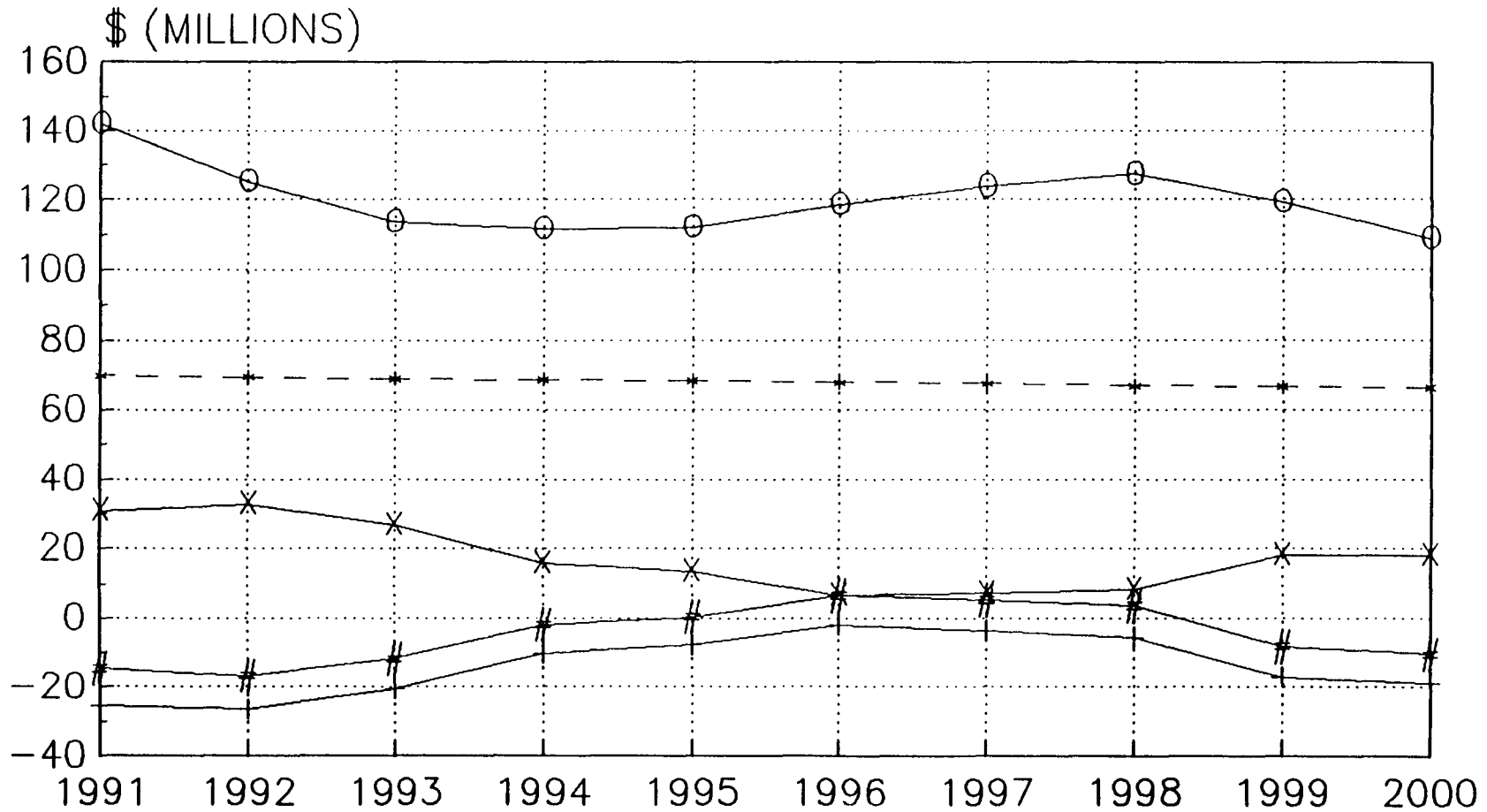
\$80 million capital reduction

OPTION 1

\$80 MILLION REDUCTION IN CAPITAL SPENDING

ANNUAL CAPITAL EXPENDITURES CASH BALANCE (YEAR END) MINIMUM CASH BALANCE CASH BEFORE INTEREST INCOME CASH AFTER INTEREST INCOME

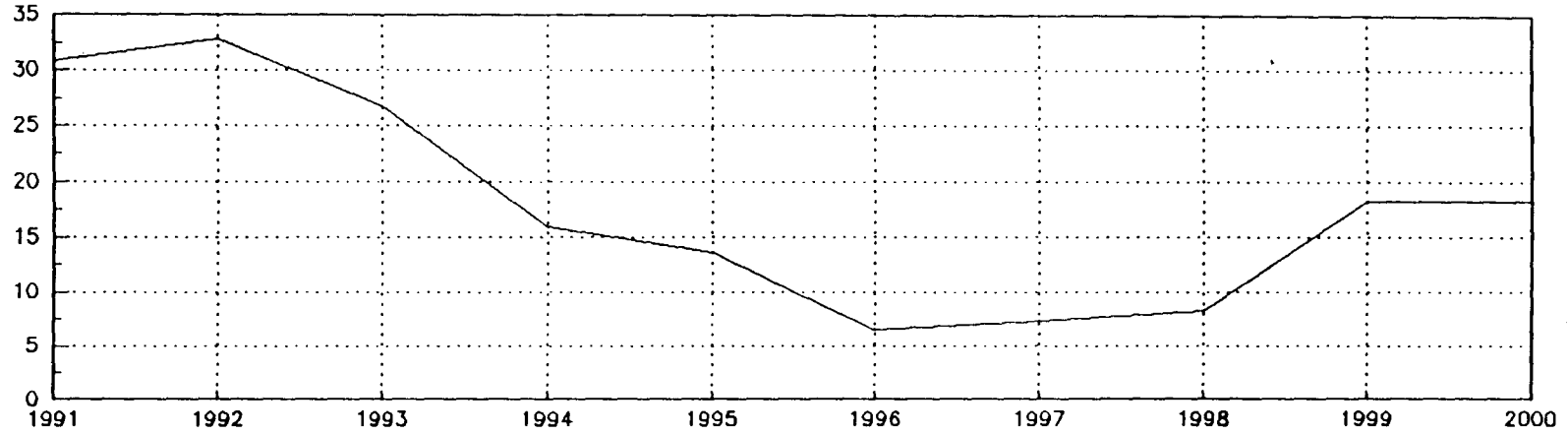
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OPTION 1 (\$80M CAPITAL REDUCTION)

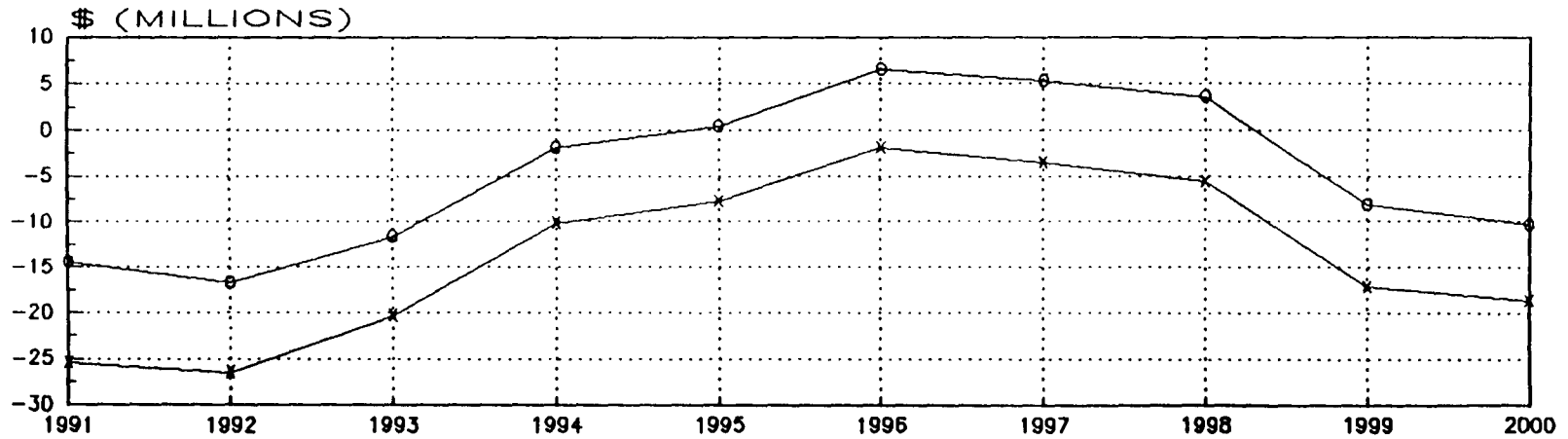
COMPARISON OF CASH PROVIDED INCLUDING AND EXCLUDING INTEREST

ANNUAL CAPITAL EXPENDITURES



CASH PROVIDED BEFORE INTEREST INCOME

CASH PROVIDED AFTER INTEREST INCOME



Findings

- Solves problem through 1998
- Since deferring most of capital have only delayed the problem
- Past 1998 rapid decline in cash balances due to higher capital and less interest earnings

Conclusion

- Equilibrium not achieved
- Actual ability to reduce \$80+M equivalent to
 - No renewal and no new technology
 - or
 - 66-100% reduction in annual replacement of current equipment
- Cannot solve issues through capital reduction alone

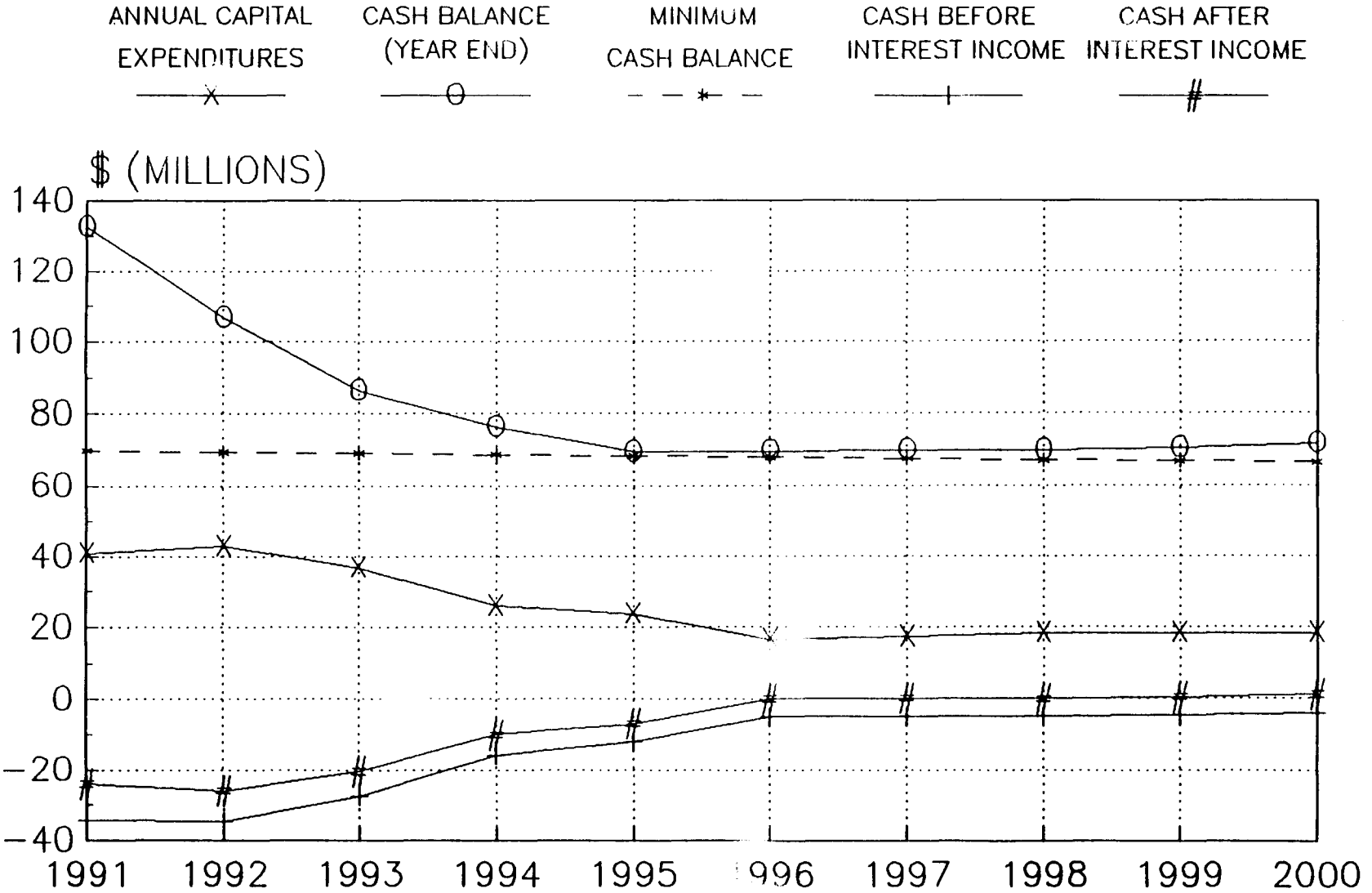
Option II

Operations Improvement

Improve operations performance by \$10,000,000 per year x 8 years =
\$80,000,000

OPTION 2

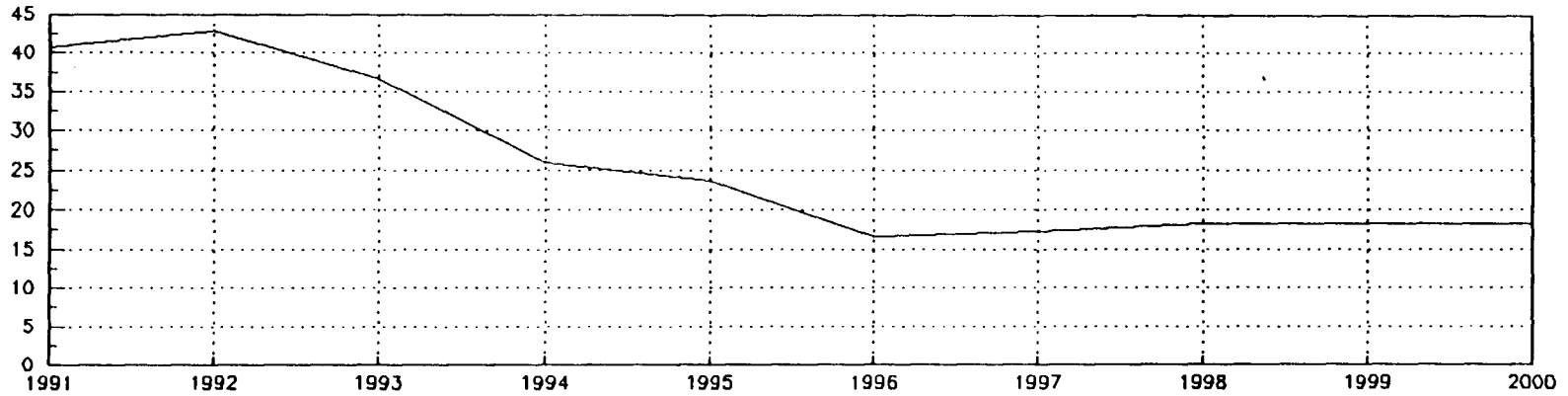
OPERATIONS IMPROVEMENT FOR BREAKEVEN CASH FLOW IN 1998



OPTION 2 (OPERATIONS IMPROVEMENT FOR BREAKEVEN CASH FLOW)

COMPARISON OF CASH PROVIDED INCLUDING AND EXCLUDING INTEREST

ANNUAL CAPITAL EXPENDITURES

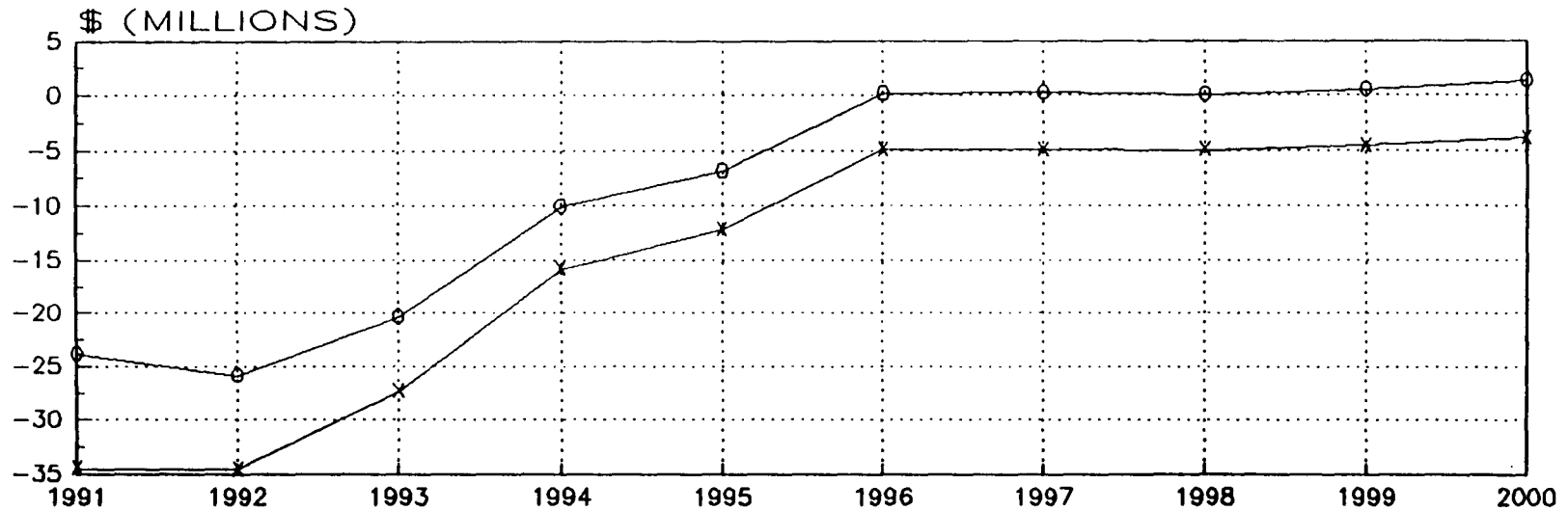


CASH PROVIDED BEFORE
INTEREST INCOME

CASH PROVIDED AFTER
INTEREST INCOME

— x —

— o —



How do you improve operations performance \$10 million/yr

Opportunities

- 1.2% cumulative admission increase
or
- 200 FTE reduction in 1992 below current levels for current volume
or
- Increased reimbursement
or
- Increased non-operating revenue
or
- Combination

Feasible?

Volume

16% cumulative increase - can't count on it

Also - can't assume volume won't go down

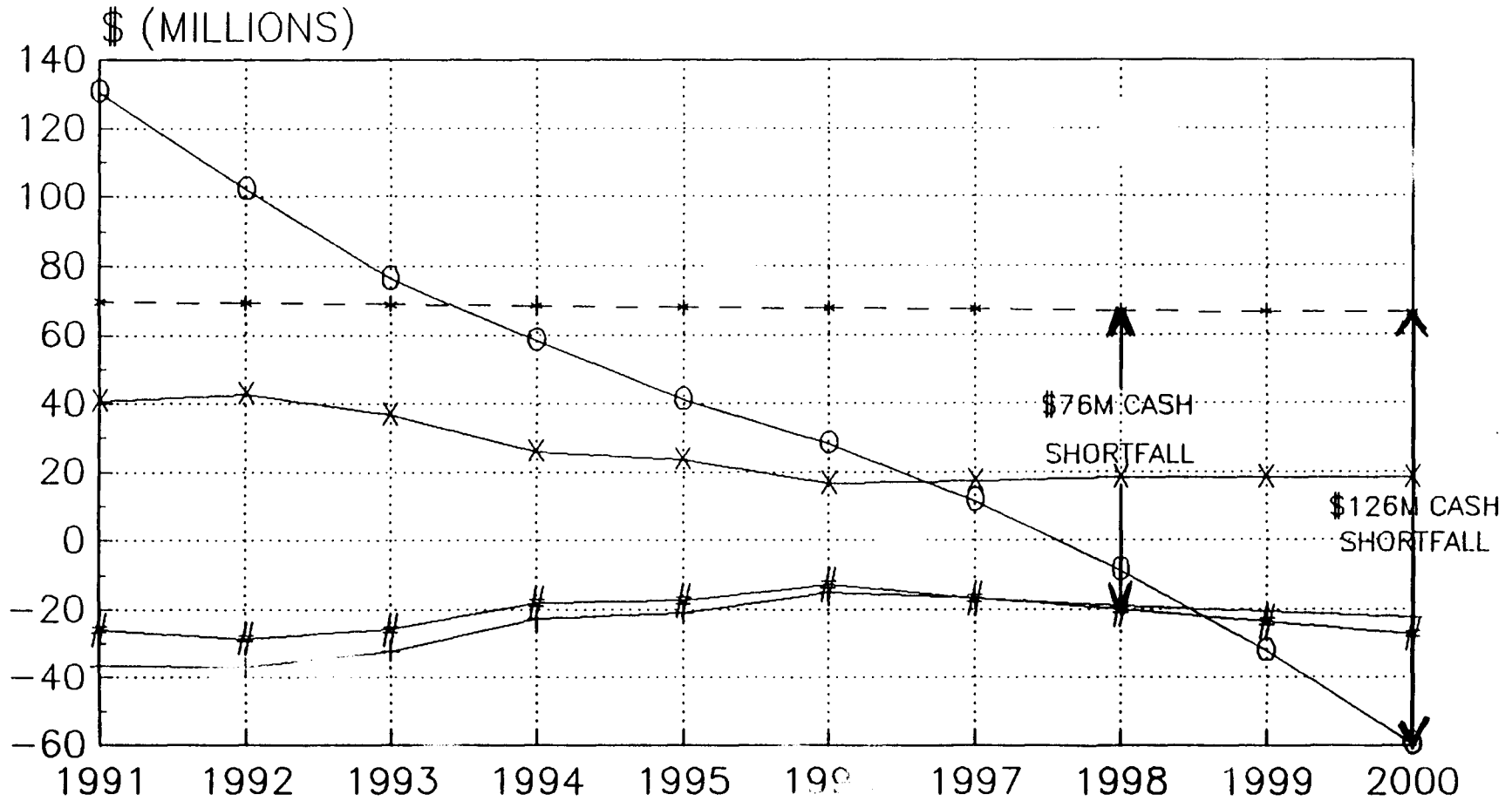
Move to Ambulatory Care

- Ophthalmology
- Heart Catheterization
- Ambulatory Surgery
- Eating Disorders
- Chemical Dependency

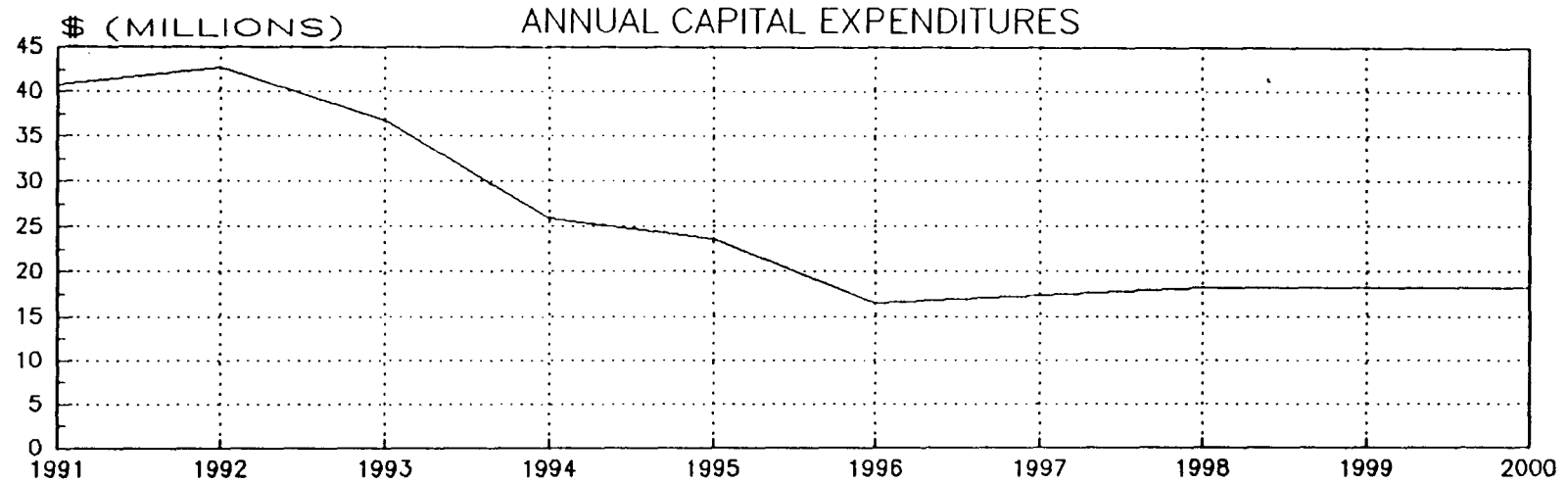
IMPACT OF A 4% DECLINE IN ADMISSIONS IN 1992-1994 ON THE CURRENT CAPITAL PLAN

ANNUAL CAPITAL EXPENDITURES	CASH BALANCE (YEAR END)	MINIMUM CASH BALANCE	CASH BEFORE INTEREST INCOME	CASH AFTER INTEREST INCOME
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17



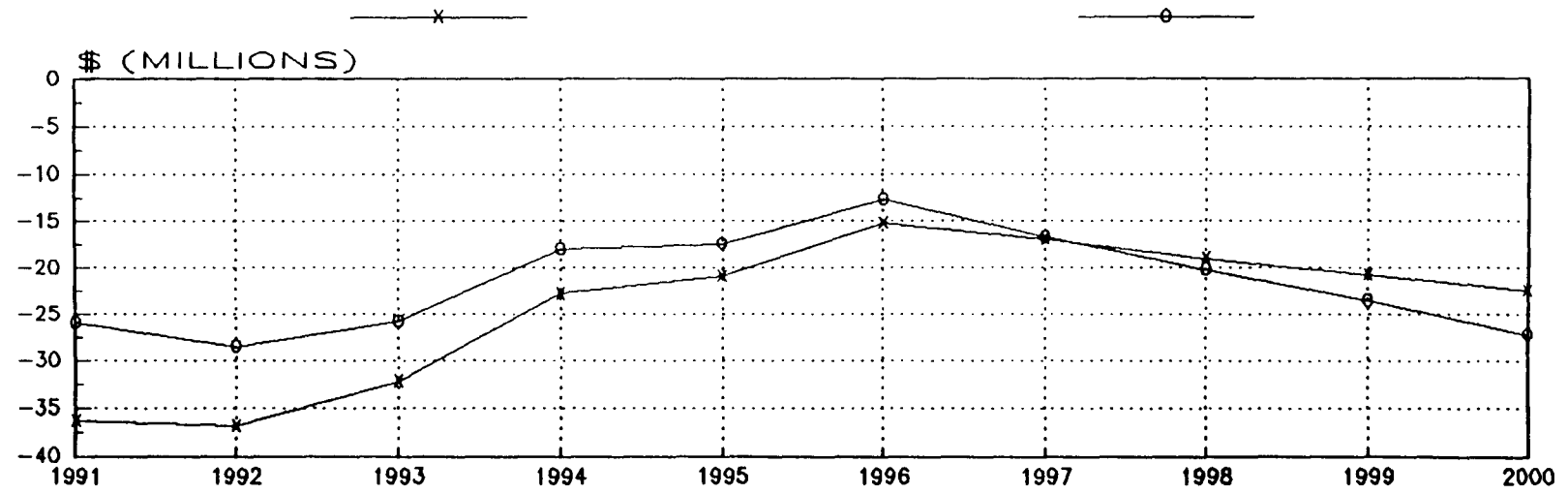
IMPACT OF 4% DECLINE IN ADMISSIONS ON COMPARISON OF CASH PROVIDED INCLUDING AND EXCLUDING INTEREST



18

CASH PROVIDED BEFORE
INTEREST INCOME

CASH PROVIDED AFTER
INTEREST INCOME



Expense Reduction

FTE's

Since 1989 FTEs have dropped from 4080 to 3780 or \$10 million per year, over eight years equivalent to \$80 million before inflation.

Operations reduction plan will require FTEs to be at 3400 by 1994. Another \$13 million per year or \$104 million for 8 years before inflation.

Other Expenditures

1989-90 budget cut by \$8.4 million. Over 8 years equivalent to \$67 million before inflation.

Can we continue these reductions

Maybe - but can't count on it

Required operations improvement per year equivalent to 60% of current Hospital support to Medical School and Clinical Departments

Also need to Consider

- New Programs
- Increased Demand for Clinical Department Support
- New Initiatives - Acquisition
- HMO Purchase/Affiliation
- New Revenue Producing Equipment

- Increased Reimbursement

Unlikely

Medicare

Wage index changes
Direct Graduate Medical Education
Indirect Graduate Medical Education
Capital DRG inclusion
Outpatient ambulatory visit groups (avg's)
Physician payment adjustments

Medicaid

1991 emphasis on outpatient mental health and chemical dependency
1991 mental health and chemical dependency payment reductions
1992 Rebasing DRG's
1992 State budget cut backs due to deficit, impact?

Blue Cross Blue Shield pays 66% of charges on average for inpatient services
Outpatient heart cath 45% of charges
Avg's 60% of charges

State Health Plan pays 62% of charges on average for inpatient services

HMO's pay 75-80% of charges

- Increased Non-Operating Revenue

66% increase in appropriation - not likely, risky.

Philanthropy approximates \$1 million per year. Increases would likely reduce MMF and other clinical department support.

Not likely

Findings/Conclusions

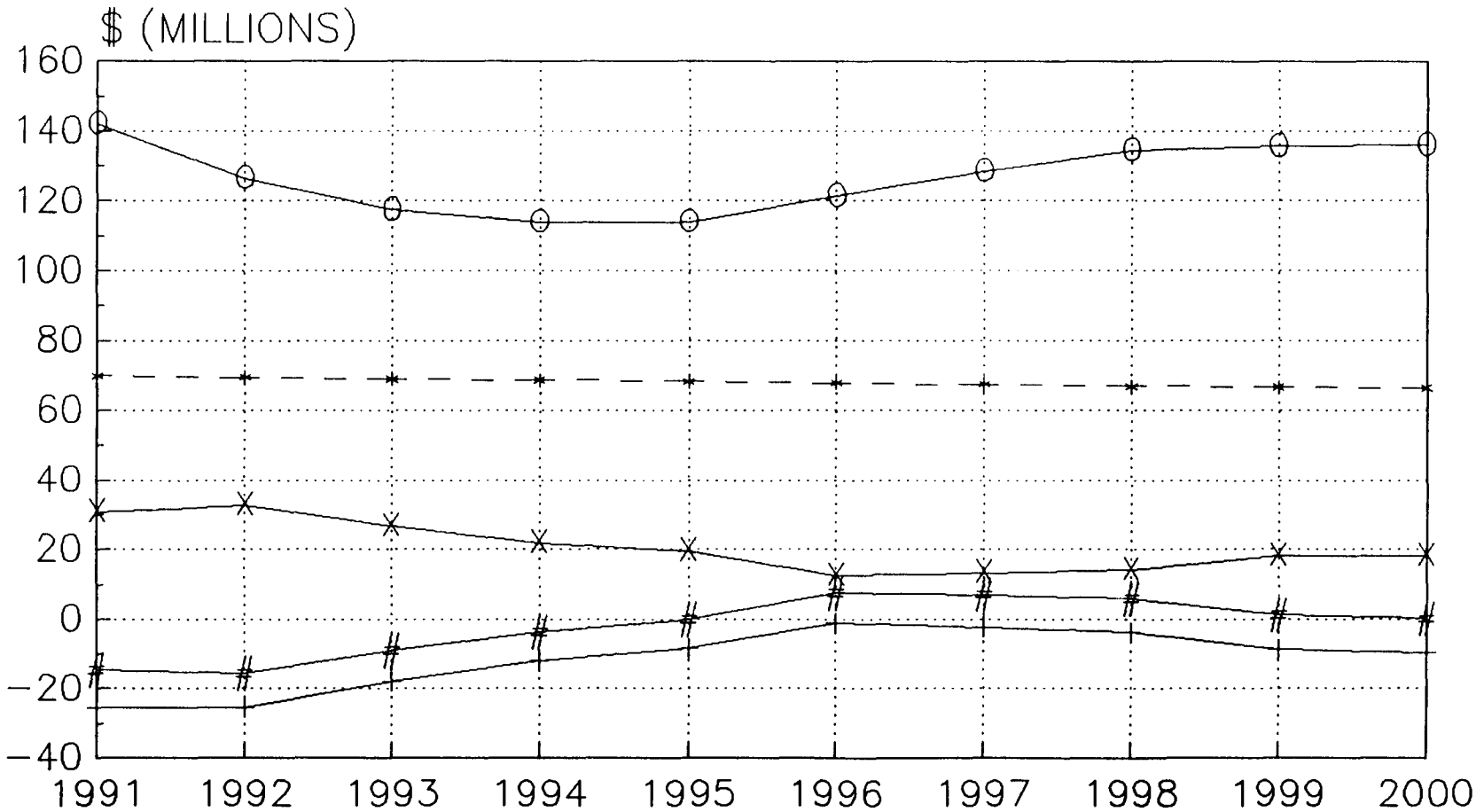
- Solving problem through operations improvement alone unlikely
- Can't count on it

Overall Conclusions

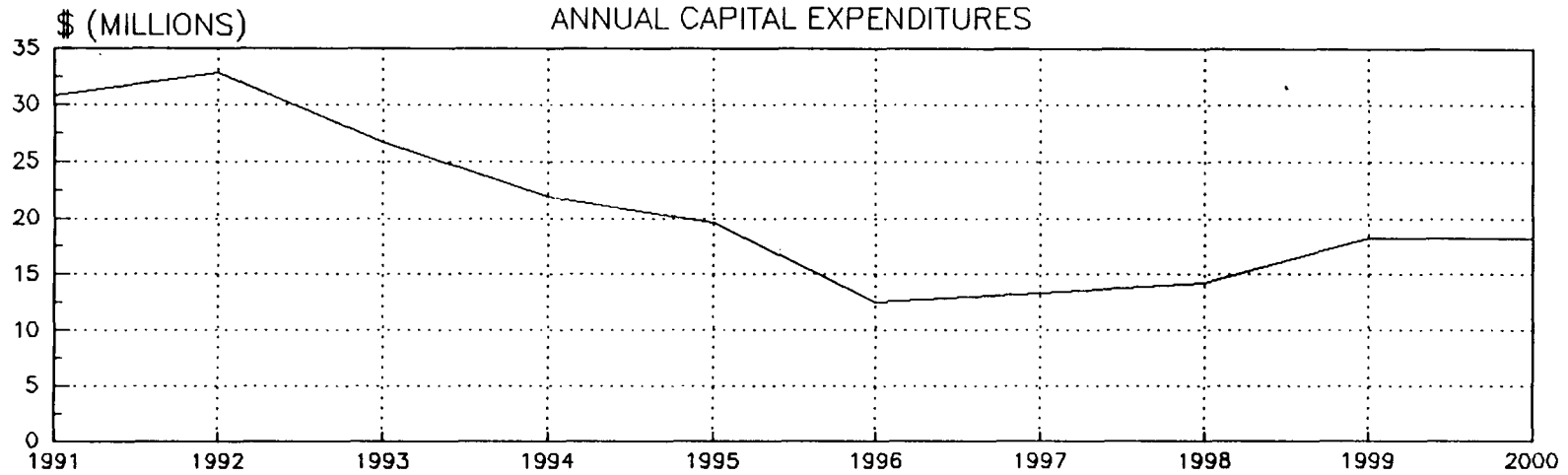
- Can't or shouldn't resolve cash inflow/outflow imbalance by capital reductions or operation improvement alone
- Need balance
 - Sufficient operations improvement to get to bottom line
 - Sufficient reserves to generate enough interest to offset operations loses
 - Sufficient capital reduction/deferment to smooth curve after renewal project
- Need to rebuild and rethink capital plan so it is incremental and can respond without major dislocations to changing conditions

\$50 MILLION REDUCTION IN CAPITAL SPENDING OPERATIONAL IMPROVEMENTS OF \$70M IN 1991-2000

ANNUAL CAPITAL EXPENDITURES	CASH BALANCE (YEAR END)	MINIMUM CASH BALANCE	CASH BEFORE INTEREST INCOME	CASH AFTER INTEREST INCOME
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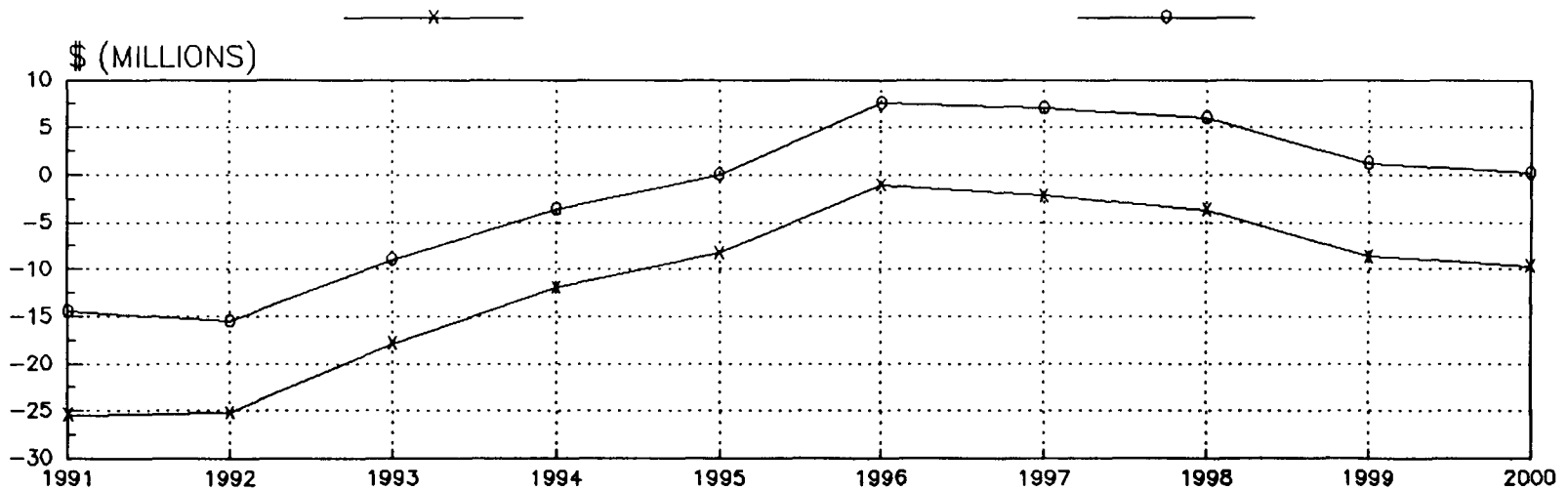
\$50 MILLION CAPITAL REDUCTION/\$70M OPERATIONAL IMPROVEMENT
 COMPARISON OF CASH PROVIDED INCLUDING AND EXCLUDING INTEREST



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CASH PROVIDED BEFORE
 INTEREST INCOME

CASH PROVIDED AFTER
 INTEREST INCOME



Recommendations

1. Reduce capital plan by \$50,000,000
Recommendations on how this should be accomplished will follow this discussion
2. Improve operations through 1998 by \$40,000,000 - \$70,000,000
Relate to afternoon discussions on task force reports
3. Future capital planning needs to be more incremental in its approach to assure UMHC can adjust to changing economic circumstances
4. Capital plan and operating expenses need to be adjusted with changing economic demands - i.e., new program requirements, acquisition, etc. - which are related to achieving improved operation performance

DEPENDENCY OF AVAILABLE CAPITAL ON CASH FROM OPERATIONS

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