CANCELLATION NOTICE

The September, 1990 Board of Governors meeting was cancelled because of lack of agenda items.

Shannon Lorbiecki
Secretary
Board of Governors

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

OCTOBER 24, 1990

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*** Other Items ***

Metro Hospital Trustee Council Dinner Forum: The Future of Hospitals' Tax-Exempt Status on Wednesday, November 7, 1990 - 5:30 - 9:00 p.m.

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

AGENDA

I.	Approval of the August 29, 1990 Minutes	Approval
II.	Chairman's Report -Mr. Robert Nickoloff	Information
III.	Hospital Director's Report -Mr. Robert Dickler	Information
IV.	Special Presentation: Dr. Leo Furcht -Professor and Head, Department of Laboratory Medicine and Pathology	Information
V.	Committee Reports	
	A. Joint Conference Committee	
	-Mr. George Heenan	
	1. Medical Staff-Hospital Council Report Credentials Committee Recommendations	Approval
	- Committee Chairman Appointments	Approval
	- Making Patient Care Decisions to Forego Life Sustaining Treatment	Approval
	- UMHC Quality Assurance and Utilization Review Plans	Approval
	2. Patient Rights and Responsibilities	Approval
	3. Medical Staff Bylaws, Rules and Regulations	Approval
	B. Planning and Development	
	-Mr. Robert Latz	
	1. Quarterly Capital Expenditure Report	Information

2.	Cardiac Catheterization Lab Expansion Proposal	Approval
3.	Major Capital Expenditure: Frontal Plane Image Chain Upgrade	Information
4.	Major Capital Expenditure: Image Processing Workstations	Information

C. Finance Committee

-Mr. Jerry Meilahn

1.	September 30, 1990 Financial Statements	Information
2.	1990-91 Capital Budget	Approval
3.	First Quarter 1990-91 Bad Debts	Approval
4.	Capital Planning Reassessment	Information
5.	Union Organizing Efforts	Information

VI. Other Business

VII. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

August 29, 1990

Call To Order

Mr. Robert Nickoloff called the August 29, 1990 meeting of the Board of Governors to order at 12:45 p.m. at the Radisson Metrodome (University of Minnesota).

Attendance

Present:
Leonard Bienias
David Brown, M.D.
Paula Clayton, M.D.
Robert Dickler
Gordon Donhowe
Phyllis Ellis
Kris Johnson
Nellie Johnson
Bob Latz
David Lentz
Margaret Matalamaki
Jerry Meilahn
Robert Nickoloff
Cherie Perlmutter
Jan Withers

Not Present:
George Heenan
Robert Maxwell, M.D.
Barbara O'Grady
Gerald Olson

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the July 25, 1990 meeting as submitted.

Special Presentation: Dr. Frank Rhame

Mr. Dickler introduced Dr. Frank Rhame, Director, Infection Control. Dr. Rhame presented an overview of the Department of Infection Control's work in the HIV Clinic and AIDS research. Dr. Rhame distributed and discussed an article he wrote which was published recently in the Journal of the American Medical Association concerniing surgeons who are infected with the HIV virus.

Chairman's Report

Mr. Nickoloff announced to the Board that the September 26, 1990 Board meeting will be cancelled due to the close proximity to the Board retreat.

Mr. Nickoloff also announced that the Joint Conference and Planning & Development Committees will meet in September.

Director's Report

Mr. Dickler announced that a contract has been signed with Group Health to develop a primary care clinic on the University campus for State and University employees enrolled in Group Health.

Mr. Dickler reported that discussions are continuing with the Interstate Medical Center in Red Wing.

Mr. Dickler reported that on August 28, 1990 Dr. James McManus, Associate Director Hospital Accreditation Program, JCAHO visited the Hospital to provide feedback on information submitted following the 1987 site visit. The JACHO survey will take place sometime in November.

Mr. Dickler reminded the Board of the annual retreat scheduled for October 1 and 2, 1990 at the Riverwood Conference Center.

Mr. Dickler announced the appointment of three new faculty/administrative staff in September: Albert Rocchini, M.D., Director, Division of Pediatric Cardiology; Gordon Ginder, M.D., Director, Division of Medical Oncology; and Keith Dunder, Hospital Attorney.

Mr. Dickler announced that the Robert Wood Johnson $1M grant application was not successful. The strategic planning process needed to complete this application was very beneficial.

Planning and Development Committee Report

Mr. Robert Latz called on Mr. Greg Hart to present the Cardiac Catheterization Lab Expansion Proposal. 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 it is proposed that the capacity be increased by one additional angiographic room. The proposal was for information and will be brought back to the Board in October for approval.

Mr. Dickler called on Mr. Cliff Fearing to provide an update on the financial assessment of the Hospital's long range capital plan. Recommendations were to reduce the long range capital plan through 1998 by $50 million. This reduction would be divided between a decrease in size and scope of the Renewal Project of $30 million and a reduction in annual capital expenditures of $20 million over the next 8 years. The reduction would leave about $35 million to finance facility solutions for the programs included in the initial Renewal Project Phase II. The recommendations also include operations improvements that would generate an additional cash flow of at least $40 million over the next 10 years to correct this imbalance.

Mr. Dickler then called on Mr. Greg Hart to present the capital planning review. UMHC's capital plan includes about $101 million to meet capital equipment replacement needs. An analysis of depreciation schedules for current equipment indicates that over an eight year period, $115 million in capital funds will be needed to replace current equipment. A targeted reduction of $20 million in annual capital expenditures from 1991-1998 was recommended.

Mr. Hart reported that several conceptual approaches to facility planning have been considered to determine what could be accomplished within a $35 million target for the Renewal Project. The alternatives range from no new construction to reducing the size the scope of the plan which the Board of Governors and the Board of Regents have approved. Without some new construction, the facility needs of the clinical departments and the Hospital's total space needs cannot be met. Conversely, demolishing a portion of the Mayo building to construct a new building does not meet the proposed budget requirements or the Hospital's total space requirements.

A very preliminary plan being developed would add space to the new University Hospital building primarily to accommodate the inpatient Psychiatry program. Within the $35 million budget, this plan would also provide funds to remodel facilities for the clinical programs included in the current project. However, the current estimates include no shell space for future program expansion and do not provide facility solutions for about 60 indirect patient care and support departments which were included in the approved Renewal Project Phase II. Further refinement of a revised facility plan will be conducted over the next several months before a more definitive proposal is brought to the Board of Governors for approval.

A motion was made to endorse the recommendation to terminate planning for a new building and that management move to planning a reduced project within the general financial parameters recommended. The general parameters are that the capital plan be reduced by $50 million to be divided between a $30 million reduction in the Renewal Project Phase II and a $20 million reduction in annual capital expenditures. The motion was seconded and passed with two negative votes.

Finance Committee Report

Mr. Jerry Meilahn called on Mr. Fearing to give the monthly financial report. Mr. Fearing reported that the Hospital's Statement of Operations for the

period July 1, 1989 through July 31, 1990 shows revenues over expenses by $2,299,862, a favorable variance of $2,730,450.

Mr. Fearing reported inpatient admissions for July totaled 1,631 which was 138 above budgeted admissions of 1,493. Overall average length of stay for the month was 8.1 days. Outpatient clinic visits for the month of July totaled 23,509 which was 2,323, or 11.0%, more than budgeted visits of 21,186.

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).

Mr. Dickler reported to the Board on the union organizing efforts. There are two groups, supervisory and middle management and clerical employees, who will be holding elections this fall.

Adjournment

There being no further business, the August 29, 1990 business meeting of the Board of Governors was adjourned at 2:45 p.m. A closed executive session of the Board of Governors was called to seek advice of legal counsel.

Respectfully submitted,

Gail Strandemo

Gail A. Strandemo
Board of Governors Office

CURRICULUM VITAE

LEO T. FURCHT, M.D.

PERSONAL DATA

Date of birth:	October 2, 1946
Place of birth:	New York, New York
Home address:	2100 21st Street West Minneapolis, MN 55405
Social Security Number:	
Minn. Medical License #:	023527-3

CURRENT POSITION

Head, Department of Laboratory Medicine and Pathology (appointed 3/1/90)
Director, Biomedical Engineering Center (appointed 1988)
Allen-Pardee Professor of Cancer Biology
Department of Laboratory Medicine and Pathology,
University of Minnesota Hospitals
University of Minnesota
Minneapolis, Minnesota 55455

EDUCATION

1961-1964	Secondary School: Westbury High School, Westbury, L.I., N.Y.
1964-1968	Undergraduate School: Columbia University, New York, N.Y.
1968-1972	Medical School: State University New York, Upstate Medical Center, Syracuse, N.Y.

ACADEMIC POSITIONS HELD

4/72-6/75	Intern and Resident, Department of Laboratory Medicine and Pathology, University of Minnesota Hospitals
7/74-6/75	Instructor, Department of Laboratory Medicine and Pathology, University of Minnesota Hospitals.
7/75-6/78	Assistant Professor, Department of Laboratory Medicine and Pathology, University of Minnesota Hospitals.
1975-1979	Associate Director Residency Fellowship Training Program
5/77-6/81	Assistant Medical Director, Regional Red Cross Blood Center; St. Paul, Minnesota, Dr. J. McCullough, Director.
7/78-7/82	Associate Professor, Department of Laboratory Medicine and Pathology, University of Minnesota Hospitals.
1979-1984 1988-1990	Director, Residency Fellowship Training Program

1980-1984 1988-1989	Director, Post-Phase B (2nd year) Medical Student Fellowship Program
7/82-present	Professor, Department of Laboratory Medicine and Pathology, University of Minnesota Hospitals.
1982-1987	Endowed Professorship, "Stone Research Professor in Pathology"
1983-1990	Director, and responsible for developing a new M.D./Ph.D. program, University of Minnesota, which involves a number of schools within the University -- Medical, Graduate, College of Biological Sciences, and the Institute of Technology (Engineering)
1987-present	Endowed Professorship, "Allen-Pardee Professor of Cancer Biology"
1988-1989	Director, Medical Fellowship Training Program, Department of Laboratory Medicine and Pathology
1988-1990	Acting Director, Biomedical Engineering Center
1990-present	Director, Biomedical Engineering Center
1990-present	Full Member, Graduate Faculty of Biomedical Science
1990-present	Medical Director, Medical Technology Program

ADMINISTRATIVE RESPONSIBILITIES

Residency Committee (member, 1975-1989)
Associate Director 1975-1979
Director 1979-1984, 1988-1990
Pathobiology Graduate Student Program: Departmental Committee 1979-1990
Departmental Space Committee
Leukemia Task Force, University of Minnesota; Program Director 1982-1983, Chairman 1987-present
American Cancer Society Local Grant Review Committee 1980-1983
Post Phase B Medical Student Fellowship Committee, Director
Honors Curriculum Committee - Medical School, University of Minnesota 1982-present; lead to development of Student Scientist Training Program 1983
Chairman, University Internal Review Committee for Graduate Programs, Department of Anatomy 1983
M.D./Ph.D. Program Director - Appointed by Deans of Graduate and Medical Schools, 1984-1990, Director, Graduate Studies M.D./Ph.D. Program. Developed a new program at the University, five students per year and secured the use of an endowment of greater than $1 million to be used for tuition and stipends; NIH MSTP grant awarded 7/1/88
Pathobiology Graduate Program - Acting Director of Graduate Studies, Spring quarter (1985) (Department Head was on quarter leave)
Development Program, Department of Laboratory Medicine and Pathology - Director 1985-present. Responsibilities are for developing corporate interactions to support research activities within the department.
Promotion Committee, Department of Laboratory Medicine and Pathology - 1983-1986; Chairman 1985-1986
Honors Curriculum Committee (Medical School), 1982-1985: led to development of Student Scientist Training Program in 1983
Department of Anatomy Internal Review Committee Graduate Programs, Chairman, 1983
Department of Laboratory Medicine & Pathology Residency Program, Director, 1988-present

Neuropatholoy Search Committee, 1984
Frontiers in Cell Biology Seminar Committee, 1983-1985
Pharmacology Department Chairman Search Committee, 1986
Pediatrics Department Chairman Search Committee, 1987
Dietrich Chair Professorship Search Committee, 1986-87
Microchemistry Facilities Committee, 1986-present
University Patent and Technology Transfer Committee 1985-present
University Conflict of Interest and Industrial Relations Committee 1986-present
Planning Committee for new Biomedical Sciences Building, 1988-present
Interim Director, Bioengineering Center, University of Minnesota, 1989
Vice President, Health Sciences Search Committee, 1989
Steering Committee for new Basic Sciences Bioengineering Building, 1989-present
Council of Clinical Chiefs, 1990-present

SCHOLARSHIPS, HONORS, AND AWARDS

Undergraduate:	Senior Honors, Research Program, Columbia University Honors List, Columbia University
Medical:	AOA National Medical Honor Society, Hoey Scholarship 1971-1972, The Lange Medical Publications Award
Fellowships:	Fellow, Department of Neurology and Department of Medicine S.U.N.Y Upstate Medical Center 6/69-9/69; 6/70-9/70; 6/71-9/71
Post Graduate:	Cecil J. Watson Award for outstanding research, University of Minnesota, 1974
Professional:	Recipient Research Career Development Award. NCI/NIH 1980-1985
	Stone Professor of Pathology. Endowed professorship in experimental pathology from the Minnesota Medical Foundation, 1982-1987
	Allen-Pardee Professor of Cancer Biology. Endowed professorship in cancer research from the Minnesota Medical Foundation, 1987-present
	Recipient of National Cancer Institute MERIT Award, 1989, for 10 years of research funding, approximately $2 million

PROFESSIONAL SOCIETIES

American Association for the Advancement of Science
American Association for Cancer Research
American Association of Blood Banks
American Association of Pathologists (and Federation Society)
American and International Society of Biophysics
American Society for Cell Biologists (and International)
American Society of Clinical and Laboratory Scientists
International Society for Differentiation
Minnesota High Technology Council
Society for Neuroscience

GRANTS

Current Support

Endowed Professorship, Eliza U. Pardee Foundation; "Allen-Pardee Professor"

N.I.H. CA21463 - This has been designated a MERIT award and will be funded until 1998.

"Molecular Mechanisms in Metastasis: Role of Fibronectin"
Principal Investigator: Leo T. Furcht
From 12/1/88 to 12/98
Total Direct Costs: ~$2,000,000

N.I.H/N.C.I. CA 29995

"Laminin Peptides/Receptors in Metastatic Cell Function"
Principal Investigator: Leo T. Furcht
From 5/1/89 to 4/30/94
Total Direct Costs: $741,895

N.E.I. EY06625

"Corneal Healing Promotion with Fibronectin Peptides"
Principal Investigator: Leo T. Furcht;
Co-Investigator: Douglas Cameron
From 8/1/86 to 7/30/91; Total Direct Costs: $417,574

Leukemia Task Force Grant:

"Role of Laminin and Fibronectin Peptides in Metastasis"
Principal Investigator: Leo T. Furcht
From 7/1/89 to 6/30/91; Total Direct Costs: $29,182

N.I.H. GM08244

Medical Scientist Training Program
Principal Investigator: Leo T. Furcht
From 7/1/88 to 6/30/93
Total Direct Costs: $486,242

PATENTS

Monoclonal Antibodies to Unreduced, Nonenzymatically-glycated Proteins
#4,797,473 issued 1/10/89

Polypeptides with Fibronectin Activity
#4,839,464 issued 6/13/89

Polypeptides with Laminin Activity
#4,870,160 issued 9/26/89

Polypeptides with Type IV Collagen Activity
#4,876,332 issued 10/24/89

Pending Patents

Isolation and Characterization of Epinectin, A Novel Adhesion Protein for Epithelial Cells

Synthetic Peptides Corresponding to Regions of Acidic Fibroblast Growth Factor that Bind Heparin

Laminin A Chain Polypeptides from the Carboxy Terminal Globular Domain

NATIONAL COMMITTEES

NCI/NIH: Site visitor 1979, 1980, 1981
Ad hoc member CSPAC
Special study section member 1980, 1981

NIGMS: Site Visitor 1980
Special study section member 1980

NHLBI: Site Visitor, Special study section member

NIAMD: Special study section member 1980, 1981

NCI/NIH: Member parent committee ad hoc review group on building programs 1980, 81, 82
Member site visit team on building programs 1980, 81, 82

Ad hoc grant reviewer NSF - 1982-present

NIH Pathology B study section - Ad hoc member 1981, 1982, permanent member 1982-86.

NIH Special Study Section - Small Business Innovative Research Program, 1983, 1984, 1985

NIH Special Study Section - Extracellular Matrix and Pulmonary Disease, 1983

NIH/NCI - Outstanding Investigator Grants reviewer 1985-present

American Society for Cell Biology Educational Committee 1982-1986;
Director - Immunological localization workshop, 1983 annual meeting.
Coordinator - Cryo-Thin Sectioning and Immunolocalization Workshop, 1984 annual meeting.

American Association of Pathologists, Program Committee 1982-1986.

NIH/NIDR - Special External Reviewer of Laboratory of Developmental Biology and Anomalies, 1983 and 1987; developed report for director of the institute

NIH - Member Special Advisory Group on Connective Tissue Disorders, Human Genetic Mutant Cell Repository, 1984.

NIH - Member, Surgery, Anesthesiology & Trauma Ad Hoc Study Section, 1984.

FASEB - Co-founder and Co-director of First Bi-Annual Summer Course on Molecular Aspects of Tumor Metastasis, 1987

NCI/NIH - Co-director of Steering Committee to Advise NCI on Organ Specific Metastasis, 1989.

NCI/NIH - Co-director, Conference on Organ Specific Metastasis, Annapolis, MD, 1989.

FASEB - Co-director, Summer Conference on Metastasis, 1990.

NIH Study Section - Pathobiochemistry, 1990-1995.

American Association of Pathologists (FASEB) - Nominations Committee, 1989-present.

Association of Pathology Chairman - 1990.

Association of Pathology Chairman - Committee on Residency Training, 1990.

MINUTES
Joint Conference Committee
Board of Governors
October 10, 1990

CALL TO ORDER:

In Chairman Heenan's absence, Ms. Barbara O'Grady called the October 10, 1990 meeting of the Joint Conference Committee to order at 4:36 P.M. in Room 8-106 in the University Hospital.

Attendance:

Present:
Amos Deinard, M.D.
Robert Dickler
Robert Maxwell, M.D.
Barbara O'Grady
Jan Withers
Bruce Work, M.D.

Absent:
Debbie Day, M.D.
Phyllis Ellis
George Heenan

Staff:
Keith Dunder
Nancy Green
Jan Halverson
Greg Hart
Carol Miles Letourneau
Shannon Lorbiecki
Ann Russell

APPROVAL OF MEETING MINUTES

The minutes of the September 12, 1990 meeting were approved as submitted.

MEDICAL STAFF BYLAWS, RULES AND REGULATIONS

Dr. Marvin Goldberg, Chairman of the Bylaws Committee, and Mr. Jan Halverson, Counsel to the Bylaws Committee, presented proposed changes to the Medical Staff Bylaws and the Medical Staff Rules and Regulations. Several changes have been recommended to assure compliance with JCAHO standards and with current practices.

A significant change is recommended in the grievance process. The Credentials Committee would hear the issues and recommendations in all grievances. Some changes bring the Bylaws up-to-date with the Health Care Quality Improvement

Act. Finally, the proposed changes would limit the number of terms which can be served by Chairmen of Medical Staff-Hospital Council committees to five one year terms.

Members of the Joint Conference Committee suggested that the Bylaws Committee consider adding a statement to Article IV. Section 5 concerning communication and relationships with referring physicians. It was also recommended that the Bylaws Committee consider incorporating departmental mentoring programs into the annual review of clinical chiefs. A motion to make these recommendations to the Bylaws Committee for their consideration during the next revision of the Bylaws was made, seconded, and passed unanimously.

A motion to endorse the proposed changes to the Medical Staff Bylaws, Rules, and Regulations was seconded and passed unanimously.

The Joint Conference Committee thanked the members of the Bylaws Committee and Lois Kelly from the Medical Staff Office for their hard work and diligence in bringing forward these proposed modifications.

MEDICAL STAFF HOSPITAL COUNCIL REPORT: CREDENTIALS COMMITTEE RECOMMENDATIONS

Dr. Robert Maxwell presented the recommendations of the Credentials Committee. It was noted that the Medical Staff Hospital Council did not recommend approval of the changes in credentials for Dr. Robert Blue from the Department of Pediatrics. This recommended change was withheld pending receipt of further documentation by Medical Staff Hospital Council.

The motion was made to endorse those recommendations of the Credentials Committee which were endorsed by the Medical Staff Hospital Council. The motion was seconded and passed unanimously.

MEDICAL STAFF HOSPITAL COUNCIL REPORT: COMMITTEE CHAIRMEN APPOINTMENTS

Dr. Maxwell reported that Dr. Jeffrey McCullough is taking a one-year leave of absence from The University of Minnesota to head the national blood program for the American Red Cross in Washington, D.C. For this reason he is unable to continue as chairman of the Bylaws Committee and Transfusion Therapeutics Committee. Dr. Marvin Goldberg has agreed to chair the Bylaws Committee and Dr. Clark Smith has agreed to chair the Transfusion Therapeutics Committee for the remainder of the year.

A motion was made to endorse the appointments of Dr. Goldberg and Dr. Smith. The motion was seconded and passed unanimously.

MEDICAL STAFF HOSPITAL COUNCIL REPORT: MAKING PATIENT CARE DECISIONS TO WITHHOLD OR WITHDRAW LIFE SUSTAINING TREATMENT

Dr. Maxwell introduced the Hospital policy concerning making decisions to withdraw life sustaining treatment. Following several incidents in the Twin Cities which received widespread media attention, it was determined that there was a need to not only revise our existing policy but also to explore current

practices when a decision is made to forego treatment. A task force was appointed in November of 1989 with membership from the Biomedical Ethics Committee and the Special/Intensive Care Advisory Committee. The task force has been chaired by Frank Cerra, M.D. and Kathy Wilde, R.N. to consider these issues.

The proposed policy changes will bring the policy in conformance with the current standard of practice and is more "user friendly" than the previous version. The policy change is only one step in the Committee's charge. The task force will now review the Hospital's resuscitation policy and develop a set of guidelines to be used when foregoing treatment. The process will also involve education and quality assurance processes to assure that the policy is being followed.

A motion was made, seconded, and passed to endorse the policy as presented.

QUALITY ASSURANCE PROGRAM UPDATE

Mr. Hart introduced the quality assurance program update by indicating that significant progress has been made in the clinical programs in establishing quality assurance programs which meet JCAHO and Hospital standards.

Ms. Carol Miles Letourneau indicated that 95 percent of the 33 services and 5 special care units have established thresholds and have reviewed quarterly trends and patterns. The three additional criteria which must be met by the programs are monthly meetings, establishment of meaningful indicators, and documentation and forwarding of meeting minutes to the Quality Assurance Department within 60 days.

The Committee thanked Mr. Hart, Dr. Maxwell, Ms. Letourneau, and Ms. Huntington for their commitment to the quality assurance program which has led to these significant improvements in the program.

PATIENT RIGHTS AND RESPONSIBILITIES

Mr. Hart introduced Ms. Nancy Green, Director of Patient Relations. Standards of the JCAHO require that the Board of Governors approve our Patients Rights and Responsibilities policy. In Minnesota we are legally mandated to have a patients rights policy and the wording is specifically prescribed by the statute. The policy was initially implemented in 1987. The Patient Relations Department also distributes a booklet to patients which describes their rights and responsibilities. A video has been produced which will air on the Hospital's closed circuit television system describing patient's rights.

A motion was made, seconded, and passed to approve the policy as submitted.

CLINICAL CHIEFS REPORT

Dr. Bruce Work reported that the Council of Chiefs of Clinical Services has discussed Social Security withholding for residents. On September 18, 1990 representatives of the Minnesota Association of Public Teaching Hospitals

recommended a 6 percent pay increase for residents which would take effect in October to partially offset the withholding and to replace an anticipated January cost of living raise.

The Clinical Chiefs are enhancing their knowledge of other departments by giving departmental presentations to the Council of Chiefs of Clinical Services.

ADJOURNMENT

There being no further business, the meeting was adjourned at 6:05 p.m.

Respectfully Submitted:

Shannon L. Lorbiecki

Shannon L. Lorbiecki
Administrative Fellow

SL

MINUTES
Joint Conference Committee
Board of Governors
September, 1990

CALL TO ORDER:

In Chairman Heenan's absence, Barbara O'Grady called the September 12, 1990 meeting of the Joint Conference Committee to order at 4:42 P.M. in Room 8-106 in the University Hospital.

Attendance:

Present:	Debbie Day, M.D. Amos Deinard, M.D. Robert Dickler Barbara O'Grady Jan Withers Bruce Work, M.D.
Absent:	Phyllis Ellis George Heenan Robert Maxwell, M.D.
Staff:	Keith Dunder Greg Hart Sally Huntington Nancy Janda Shannon Lorbiecki Helen Pitt

The Committee welcomed Keith Dunder as the new General Counsel for the Hospital.

APPROVAL OF MEETING MINUTES

The minutes of the July 11, 1990 meeting minutes were approved as submitted.

JCAHO UPDATE

Ms. Nancy Janda announced that the Joint Commission on Accreditation of Healthcare Organizations will conduct a four day site visit November 26 through 29. In addition to a hospital survey there will be focused site visits in the areas of ambulatory care, home health, and chemical dependency. The home health care and chemical dependency programs are being surveyed for the first time.

A mock survey was conducted in July to assure that all departments are familiar with the current standards and to identify any standards that needed

clarification. The Director of the JCAHO Hospital Accreditation program and the Director of the Ambulatory Care Accreditation program visited UMHC in late August to provide feedback on the 1987 site visit.

FACULTY/MEDICAL STAFF RECRUITMENT AND RETENTION TASK FORCE REPORT

Mr. Bob Dickler indicated that the report of the Faculty/Medical Staff Recruitment and Retention Task Force was presented to the Council of Chiefs of Clinical Services in August. Discussion of the report and its recommendations was deferred to a September 21 meeting.

Mr. Greg Hart summarized the recommendations of the Task Force. The issue the task force spent a significant amount of time discussing was the value of clinical excellence. The Task Force recommends establishment of a clinical track or incorporation of clinical values into the current promotions system. Changing the criteria of the current system without establishing a separate promotional track may not be feasible. The clinical track proposal developed by an ad hoc committee on promotions will be considered by the Medical School Administrative Board on September 13. The recommendation includes a provision that the Dean and the Chairman of each of the Clinical Departments negotiate prospectively a percentage of departmental faculty who may pursue a clinical track.

The Task Force considers the value of the contribution of the clinical faculty member to the organization as important as the promotion system. Establishment of a clinical track alone will not ensure that the value of clinical excellence is recognized by basic science researchers and departmental leadership.

Additional recommendations include improved mentoring of new faculty members, assistance to new investigators in technology transfer, establishing a central mechanism++++ to assist with the logistics of individual recruitment, and improved direction when recruitment needs cut across multiple departments.

Dr. William Thompson will attend the October 1 and 2 Board of Governors meeting to present the Task Force report to the Board.

MEDICAL STAFF HOSPITAL COUNCIL REPORT: UMHC QUALITY ASSURANCE AND UTILIZATION REVIEW PLANS

Mr. Hart introduced the UMHC Quality Assurance and Utilization Review plans. A motion was made and seconded to approve the plans as submitted.

Ms. Sally Huntington provided an overview of the Hospital's quality assurance plan. In response to a question, it was noted that a support services subcommittee makes a monthly report to the Quality Assurance Steering Committee so there is quality assurance review of departments providing ancillary services.

Ms. Huntington summarized the Hospital's utilization review activities. There is concurrent review in about 80 percent of our patients at some point in an inpatient stay.

The motion to approve the plans was unanimously endorsed.

CLINICAL CHIEFS REPORT

Dr. Bruce Work reported that the Council of Chiefs of Clinical Services has spent several meetings discussing governance of the Clinical Chiefs in relation to the Health Sciences. Several proposals for governance committees have been developed including an Executive Committee of the Clinical Chiefs.

Additional issues considered by the Council include the Vice Presidential search process, the contract with Group Health to provide primary care to Group Health enrollees who are State employees, and withholding of Social Security taxes from residents.

ADJOURNMENT

There being no further business, the meeting was adjourned at 6:18 P.M.

Respectfully Submitted:

Shannon Lorbiecki

Shannon L. Lorbiecki
Administrative Fellow

SL

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 11, 1990

TO: Members of the Board of Governors

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

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

The Medical Staff-Hospital Council on October 9 and the Joint Conference Committee on October 10 have endorsed the attached Credentials Committee Report and Recommendations.

I am forwarding these recommendations to you for your review and approval on October 24. If you should have any questions, please feel free to call on me.

REM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 11, 1990

TO: Board of Governors

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

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee considered the reappraisal and reappointment and reviewed new clinical privileges forms submitted by the medical staff in the Department of Otolaryngology. The Committee hereby recommends approval of all those on the attached list for reappointment with the clinical privileges contained in the new clinical privilege forms.

The Committee also reviewed and recommends approval of the reappointment of the following member of the medical staff in the Department of Pediatrics who has returned from leave of absence.

Department of Pediatrics	Category
James H. Moller	Attending Staff - LOA

The physician in the Department of Orthopaedics Surgery resigned his medical staff appointment effective June 30 of this year. He has since requested to be reinstated and has submitted an application for reappraisal and reappointment. Because of the short period of time, and because all other qualifications have been met, the Credentials Committee hereby recommends approval.

Departemnt of Orthopedics	
James D. Priest	Clinical Staff - reinstate

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

Department of Hospital Dentistry	Category
Deborah O. Strand	Clinical Staff
Department of Laboratory Medicine and Pathology	
Evan George	Attending Staff

Provisional status and clinical privileges continued:

Department of Medicine	Category
Lynn A. Burmeister	Attending Staff
Pablo Denes	Clinical Staff
Joan M. Fox	Attending Staff
Ralph J. Katsman	Attending Staff-ER
Nigel S. Key	Attending Staff
Teresa C. McCarthy	Attending Staff
Gregory J. Path	Attending Staff
Jane C. Pederson	Attending Staff-ER
Georgia L. Wiesner	Attending Staff-ER
Department of Neurosurgery	
Christine M. Cox	Attending Staff
Department of Orthopedics	
Thomas C. Kennedy	Attending Staff
Department of Pediatrics	
Paul J. Orchard	Attending Staff
Sarah L. Winter	Attending Staff
Department of Psychiatry	
Gary A. Christenson	Attending Staff
Department of Radiology	
Sandra J. Althaus	Attending Staff
David M. Drees	Attending Staff
David E. Finlay	Attending Staff
Keith M. Horton	Attending Staff
Patrick J. Juenemann	Attending Staff
Mark E. Myers	Attending Staff
Timothy M. Skopec	Attending Staff

The following Specified Professional Personnel (Psychologist) has applied for appointment to the psychology staff and has requested clinical privileges. The Committee hereby recommends approval of this applicant and his request for privileges.

Departemnt of Physical Medicine and Rehabilitation	Category
Norman J. Cohen	Attending Staff

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

Department of Hospital Dentistry	Category	Date Eligible
Brian Evensen	Clinical Staff	April 25, 1990
Department of Laboratory Medicine and Pathology		
Craig E. Litz	Attending Staff	June 20, 1990
Raouf E. Nakhleh	Attending Staff	April 25, 1990
Department of Medicine		
Vicki Morrison	Attending Staff	June 20, 1990
Laura L. Stahnke	Attending Staff-ER	June 20, 1990
Bradford G. Stone	Clinical Staff	June 20, 1990
Valerie K. Ulstad	Attending Staff	June 20, 1990
Department of Pediatrics		
Carroll A. Brennan	Attending Staff	August 28, 1990
Kumud Sane	Clinical Staff	August 28, 1990
Antoinette M. Moran	Attending Staff	June 20, 1990
Department of Physical Medicine and Rehabilitation		
Charlotte Roehr	Attending Staff	June 20, 1990
Department of Psychiatry		
Anne F. Kolar	Attending Staff	August 28, 1990
Robert M. Rose	Attending Staff	August 28, 1990
Department of Radiology		
Stephen W. Trenkner	Attending Staff	August 28, 1990
Department of Surgery		
Mark E. Lovaas	Clinical Staff	August 28, 1990
Department of Urology		
Charles L. Smith	Clinical Staff	April 25, 1990
Gang (Kevin) Zhang	Clinical Staff	April 25, 1990

The following medical staff have submitted applications requesting change in staff category. The Committee recommends approval of their requests.

Department of Dermatology	Present Category	Requested Category
Valda Kaye	Attending Staff	Clinical Staff
Department of Hospital Dentistry		
Mark S. Simmons	Clinical Staff	Attending Staff
Department of Therapeutic Radiology		
Tae H. Kim	Attending Staff	Clinical Staff

The following medical staff have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges. The Committee has reviewed and considered their requests and hereby recommends approval.

Department of Dermatology — **Category**

Maria Hordinsky — Attending Staff
Add: pulse dye laser for cutaneous lesions and destructive therapy

Department of Otolaryngology

David B. Hom — Clinical Staff
New privilege form

Department of Pediatrics

G. Scott Giebink — Attending Staff
Add: tympanocentesis

Ralph Shapiro — Attending Staff
Add: arterial puncture; central venous pressure measurement; thoracentesis; immunologic studies (cell markers, cytotoxic assays and proliferative assays); puncture aspiration of abscess, hematoma, bulla, or cyst; venipuncture catheter placement; venous catheter placement percutaneous; management complete parenteral nutrition; marrow transplantation; respiratory assistance therapy; collect and handle unusual specimen (lynph nodes, spleen, liver, etc)

John L. Bass — Attending Staff
New privilege form - no changes

Change in clinical privileges continued:

Department of Pediatrics	Category
Peter Hesslein New privilege form - no changes	Attending Staff
Helena Kosina New privilege form - no changes	Clinical Staff
John R. Priest New privilege form - no changes	Clinical Staff
David M. Steinhorn New privilege form - no changes	Attending Staff
Department of Urology	
Gang (Kevin) Zhang Add: retroperitoneal - lasers: CO_2, YAG, Argon, and KTP-532 transurethral - lasers: YAG, Argon, and KTP-532	Clinical Staff

The following physician has applied for leave of absence from the medical staff. The Committee hereby recommends approval of this leave of absence.

Department of Laboratory Medicine and Pathology	Category
Jeffrey McCullough Leave of absence from September 1990 through September 1991	Attending Staff

The Committee recommends acceptance of the resignations of medical staff appointments from the following physicians.

Department of Hospital Dentistry	Category
Harrie T. Shearer	Attending Staff
Department of Medicine	
Frank S. Becker	Attending Staff-ER
Jeffrey Buetikofer	Attending Staff
Michael W. Saville	Attending Staff-ER
Department of Pediatrics	
Gregory R. Elliott	Attending Staff - effective 10-31-90

Resignations continued:

Department of Radiology	
Robert A. Halvorsen	Attending Staff
Department of Surgery	
Edmund P. Chute	Attending Staff

Loss of Medical Staff Appointment/Completion of Temporary Faculty Appointment

Department of Medicine	Category
Pamela Ely	Attending Staff

Deceased

Department of Surgery	
Victor Gilbertsen	Attending Staff

The Committee also recommends acceptance of the resignations of the following psychologists from the Specified Professional Personnel-Psychology Staff

Department of Pediatrics	Category
Bruce L. Bobbitt	Attending Staff
William M. Grove	Attending Staff

HB/cf
Attached

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Recommendations for Reappointment to the Medical and Dental Staff

November 1, 1990 - June 30, 1992

DEPARTMENT	CATEGORY	JOINT APPOINTMENT
OTOLARYNGOLOGY		
ADAMS, GEORGE	Attending Staff	
DUVALL, ARNDT J.	Attending Staff	
GODING, GEORGE S.	Clinical Staff	
HILGER, PETER A.	Attending Staff	
HUFF, JOHN S.	Clinical Staff	
KOOP, SEVERIN H.	Clinical Staff	
LEVINE, SAMUEL C.	Attending Staff	
LISTON, STEPHEN L.	Clinical Staff	
MAISEL, ROBERT	Attending Staff	
MARENTETTE, LAWRENCE	Clinical Staff	
SIEGEL, LEIGHTON G.	Clinical Staff	
SIGEL, MELVIN E.	Clinical Staff	
SZACHOWICZ, EDWARD H	Clinical Staff	

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 1, 1990

TO: Medical Staff-Hospital Council
Joint Conference Committee
Board of Governors

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

SUBJECT: Appointment of Committee Chairman

Jeffrey McCullough, M.D. will be taking a one-year leave of absence from The University of Minnesota Hospital and Clinic to head the national blood program for the American Red Cross National Organization in Washington, D.C. For this reason he has indicated he will be unable to continue his responsibility as chairman of the Bylaws Committee and Transfusion Therapeutics Committee.

Dr. Marvin Goldberg has agreed to chair the Bylaws Committee and Dr. Clark Smith has agreed to chair the Transfusion Therapeutics Committee for the upcoming year. I hereby request approval of these appointments.

/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 18, 1990

TO: Members, Board of Governors

FROM: Robert Maxwell, M.D.

RE: Making Patient Care Decisions to Forego Life Sustaining Treatment

A special task force with membership from the Biomedical Ethics Committee and the Special/Intensive Care Advisory Committee was appointed in November of 1989 to examine issues and make recommendations related to the withdrawal of treatment or life support. We will provide you with an update on the task force's activities on October 24.

The task force has spent a considerable amount of time revising the Hospital's policy and procedures relating to forgoing treatment. The policy was presented to the Medical Staff-Hospital Council on October 9 for their approval. The Joint Conference Committee endorsed the policy on October 10. As required by the standards of the Joint Commission on Accreditation of Healthcare Organizations, we are requesting your approval of this policy.

If you have any questions prior to the meeting please call.

REM/gs

Attachment

SUBJECT:

Making Patient Care Decisions to Forego
Life Sustaining Treatment

SOURCE:

Biomedical Ethics Committee
Medical Staff-Hospital Council

PURPOSE

In some situations it is appropriate to forego (withdraw and withhold) life sustaining treatment. This policy and procedure is adopted to assist patients, patient representatives, and staff in implementing such a decision.

STATEMENT OF PRINCIPLES

1. The patient has the legal and ethical right to and the primary responsibility for self-determination, including the right to forego (withhold and withdraw) treatment. There is no legal or ethical distinction between withholding and withdrawing treatment.

2. When a patient is incompetent to participate in treatment decisions, such decisions will be made by the patient's representative. To the extent possible, the incompetent patient shall be included in these decisions. Decisions for an incompetent patient shall reflect the patient's wishes. If the patient's wishes are unknown, the decisions shall reflect the patient's best interests.

3. Whenever the decision to forego life sustaining treatment is made, the patient shall receive care that maintains dignity, comfort, and hygiene.

4. As with any plan of care, the patient's condition shall be reviewed periodically to assure that the decision continues to be appropriate.

5. When there is a decision to forego life sustaining treatment, even when the patient's or patient representative's decision and the decision making process are consistent with medical, legal, and ethical standards, the patient/patient representative and/or staff may have concerns regarding the appropriateness of a course of action. When this occurs UMHC shall provide mechanisms to address these concerns.

6. The attending staff physician or other health care providers are not obligated to comply with the patient's decision if the treatment would be contrary to professional judgment, standards of clinical practice or the law. In cases where implementing the patient's decision would be contrary to the deeply held moral beliefs of the attending physician or other health care provider, that individual has the right to withdraw from the patient's case. Should such a conflict occur, the patient shall not be abandoned, but rather shall be assisted in obtaining care that is consistent with the patient's wishes.

PROCEDURES

I. Determining the Decision Maker:

A. Competent Patient

If the patient is competent, all treatment decisions shall be made by the patient. A patient is competent if the patient has the capacity to understand, reflect upon, and reiterate the medical situation, including the consequences of the decision to forego treatment. Competency may be presumed in the absence of any impairment of judgement. Competency usually is determined by the attending physician. The physician may consult other health care providers, family members, or others who know the patient.

B. Incompetent Patient

In those instances in which the patient is not competent to make decisions on his or her own behalf, the decision regarding foregoing life sustaining treatment shall be made by the patient's representative. In the usual order of priority, the following individuals may act as the patient's representative:

1. In the case of a minor, the child's parents or legal guardian;

2. In the case of an adult,

   a. the legal guardian or the proxy if the patient has a valid living will;

   b. the spouse;

   c. an adult son or daughter;

   d. either parent;

   e. an adult brother or sister;

   f. other close family members; and,

   g. close personal friend of the patient.

3. If an incompetent patient does not have a representative to make a decision on the patient's behalf, the attending physician shall contact the Hospital Attorney's Office.

II. The Decision Making Process

A. The attending physician shall ensure that the patient or the patient's representative making the decision understands the following before the decision to forego life sustaining treatment is made:

1. his or her current medical status, including the likely course of the condition if treatment is withheld or withdrawn.

2. the interventions that might be helpful to the patient, including a description of the treatment options, their risks and anticipated benefits and burdens;

3. the attending physician's professional opinion regarding the preferred alternative; and,

B. In the case of the incompetent patient, the decision regarding treatment is consistent with the stated wishes or is in the best interests of the patient, taking into consideration the patient's values, life philosophy and/or spiritual beliefs.

C. Throughout the decision-making process, the attending physician is encouraged to consult with his or her colleagues and other members of the health care team. The ICU medical and nursing staff can be utilized as a resource for this purpose.

D. When a decision to forego treatment has been made, the attending physician shall communicate the decision to the other members of the health care team.

E. If at any time during the decision making process questions or concerns arise, see Section V.

III. Documentation

When the participants have reached a decision to forego life sustaining treatment the attending physician shall document the decision in the patient's medical record. Documentation should include:

A. Participants in the discussion

B. Who the decision maker is and the rationale for determining incompetency, if relevant.

C. Summary of the information presented and the discussion which led to the decisions.

D. Specific decisions reached including treatment to be continued and treatment to be withheld. Considerations should include, but not necessarily be limited to, ventilation, blood products, medication, hydration and nutrition, dialysis, and other interventional procedures.

IV. Implementation of the Care Plan:

The care plan shall include:

A. A statement in the chart clarifying the patient's resuscitation status

B. Orders for what specific treatments will be withheld and/or discontinued.

C. Orders for medication

1. The goal of treatment is to relieve pain and suffering to the fullest extent possible consistent with the patient's wishes.

2. Health care professionals must make every effort to relieve the pain and suffering of the dying patient. Relief of pain and suffering may require either intermittent or continued administration of large doses of analgesics and sedatives which, in circumstances other than anticipated death, would be considered inappropriate. Dying patients should be assured the maximal possible comfort even in the face of impending death as heralded by falling blood pressure, declining rate of respirations, or altered level of consciousness. Vital signs may be obtained to assess the patient's status in the dying process, but should not influence decisions about administering medications in the presence of continued pain or other distressing symptoms for which the medication is an accepted treatment. The attending staff physician shall clearly document in the patient's chart all clinical indications for administration of medication, including all dosage changes.

3. Neuromuscular blocking agents are generally excluded from these medications as they have no therapeutic value in relief of pain and suffering and their use precludes assessment of pain and suffering. When ventilator support is decreased or discontinued, neuromuscular blocking agents should not be used.

V. Decisions Which Result in Concern or Conflict

A. When a concern or conflict remains after reasonable attempts to resolve:
- who the decision maker should be,
- the decision making process, or
- the decision and plan of care,

the attending physician, patient/patient representative, or other health care provider shall seek resolution by notifying the Patient Relations Department. Patient Relations will involve other colleagues, arrange an ethics consultation, notify the Hospital Attorney, Hospital Administration, or other departments as necessary. (If a Biomedical Ethics Consultation is necessary, see Policy 15.19.)

B. In rare instances when the attending physician or other health care provider believes that all other resources have been exhausted and disagreement still remains over the appropriateness of the care plan, judicial intervention may be considered. The Hospital Attorney's office shall be contacted.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 18, 1990

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

RE: Patient Rights and Responsibilities

As you know, one of the roles of the Patient Relations Department is to act as advocates for our patients. The department is responsible for ensuring that our patients are familiar with their rights and responsibilities. The hospitalwide patient right and responsibilities policy was initially implemented in September of 1987.

As required by the Joint Commission on Accreditation of Healthcare Organizations, I am forwarding this hospitalwide policy to you for your review and endorsement on October 24. The Joint Conference Committee endorsed this policy on October 10.

GH/sl

Attachment

SUBJECT:

Patients Rights and
Responsibilities - General

SOURCE:

Patient Relations Department/
Medical Staff-Hospital Council

POLICY

Rights and Resources for University Hospital Patients

It is the policy of The University of Minnesota Hospital and Clinic and the public policy in the State of Minnesota to promote the interests and well being of patients at the University Hospital. It is also our policy that these rights shall be respected and that no patient may be required to waive his or her rights as a condition of admission to the University of Minnesota Hospital. These rights as described in Minnesota Statutes, Section 144,651, apply to all patients including neonates, children, and adolescents, admitted to our Hospital for a continuous period longer than 24 hours (except where superseded by the special provisions for patients being treated for mental illness, mental retardation or chemical dependency as governed by the Minnesota Commitment Act of 1983 - see UMHC Policy 21.3, Rights Specified in the Commitment Act of 1982). These rights; as specifically defined in the law, include the following:

1. (Information About Rights) Patients shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 7, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the data practices act, and section 626.557, relating to vulnerable adults.

2. (Courteous Treatment) Patients have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.

3. (Appropriate Health Care) Patients shall have the right to appropriate medical and personal care based on individual needs. This right is limited where the service is not reimbursable by public or private resources.

4. (Physician's Identity) Patients shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

5. (Relationship With Other Health Services) Patients who receive services from an outside provider are entitled, upon request, to be told the identity of the provider. Information shall include the name of the outside provider, the address, and a description of the service which may be rendered. In cases where it is medically inadvisable, as documented by the attending physician in a patient's care record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative.

6. (Information About Treatment) Patients shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the patients can reasonably be expected to understand. Patients may be accompanied by a family member or other chosen representative. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a patient's medical record, the information shall be given to the patient's guardian or other person designated by the patient as his or her representative. Individuals have the right to refuse this information.

   Every patient suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods.

7. (Participation In Planning Treatment) Patients shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative. In the event that the patient cannot be present, a family member or other representative chosen by the patient may be included in such conferences.

8. (Continuity Of Care) Patients shall have the right to be cared for with reasonable regularity and continuity of staff assignment as far as facility policy allows.

9. (Right To Refuse Care) Competent patients shall have the right to refuse treatment based on the information required in Right No. 6. In cases where a patient is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the patient's medical record.

10. (Experimental Research) Written, informed consent must be obtained prior to a patient's participation in experimental research. Patients have the right to refuse participation. Both consent and refusal shall be documented in the individual care records.

11. (Freedom From Abuse) Patients and residents shall be free from mental and physical abuse as described in the Vulnerable Adults Protection Act. "Abuse" means any act which constitutes assault, sexual exploitation, or criminal sexual conduct as described in section 626.557, subdivision 2d, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every patient shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a patient's physician for a specified and limited period of time, and only when necessary to protect the patient from self-injury or injury to others.

12. (Treatment Privacy) Patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.

13. (Confidentiality Of Records) Patients shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the department of health, where required by third party payment contracts, or where otherwise provided by law.

14. (Disclosure Of Services Available) Patients shall be informed, prior to or at the time of admission and during their stay, of services which are included in the facility's basic per diem or daily room rate and that other services are available at additional charges. Facilities shall make every effort to assist patients in obtaining information regarding whether the Medicare or Medical Assistance program will pay for any or all of the aforementioned services.

15. (Responsive Service) Patients shall have the right to a prompt and reasonable response to their questions and requests.

16. (Personal Privacy) Patients shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being.

17. (Grievances) Patients shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, and citizens. Patients may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care in-patient facility, every residential program as defined in section 7, and every facility employing more than two people that provides out-patient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision-maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 7 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

18. (Communication Privacy) Patients may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Patients shall have access, at their expense, to writing instruments, stationery, and postage. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. There shall be access to a telephone where patients can make and receive calls as well as speak privately. Facilities which are unable to provide a private area shall make reasonable arrangements to accommodate the privacy of patients' calls. This right is limited where medically inadvisable, as documented by the attending physician in a patient's care record. Where programmatically limited by a facility abuse prevention plan pursuant to the Vulnerable Adults Protection Act, section 626.557, subdivision 14, clause 2, this right shall also be limited accordingly.

19. (Personal Property) Patients may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients and unless medically or programmatically contraindicated for documented medical, safety, or programmatic reasons. The facility may, but is not required to, provide compensation for or replacement of lost or stolen items.

20. (Services For The Facility) Patients shall not perform labor or services for the facility unless those activities are included for therapeutic purposes and appropriately goal-related in their individual medical record.

21. (Protection and Advocacy Services) Patients shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services so that the patient may receive assistance in

understanding, exercising, and protecting the rights described in this section and in other law. This right shall include the opportunity for private communication between the patient and a representative of the rights protection service or advocacy service.

22. (Isolation and Restraints) A minor patient who has been admitted to a residential program as defined in section 7 has the right to be free from physicial restraint and isolation except in emergency situations involving a liklihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, psychiatrist, or licensed consulting psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

23. (Treatment Plan) A minor patient who has been admitted to a residential program as defined in section 7 has the right to a written treatment plan that describes in behaviorial terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and his or her parents or guardian shall be involved in the development of the treatment and discharge plan.

If a patient feels that he/she is not enjoying the rights listed above or if there are other concerns or problems regarding a patient's experience at The University of Minnesota Hospital and Clinic, the patient, friends, relatives, or guardian may request the help of the Patient Relations Department. This department exists to provide a problem-solving service to people in our hospital. Patient representatives from the department are available to help with any questions, concerns, or complaints patients may have. If patients or staff wish to report a problem or would like the help of a patient representative, please call 626-5050.

The Patient Relations Department also maintains a mechanism for the processing of formal complaints about patient care or any other matters. If a patient brings a problem to the hospital's attention within this formal mechanism, they are entitled to a written response if they request one. This formal mechanism can be used by contacting the same number as indicated above, 626-5050.

In addition to these internal services, the Minnesota Office of Health Facility Complaints has been established under the provisions of Minnesota state law to receive, investigate, and act upon complaints from anyone regarding services provided by health care institutions including this hospital. If a patient chooses to file a complaint with that office, they may do so by calling 623-5562 or writing to the Minnesota Office of Health Facility Complaints, 717 Delaware Street S.E., Minneapolis, Minnesota 55440.

Minnesota Statutes provide additional rights to individuals referred to as "residents" who are defined as, "a person admitted to a non-acute care facility including extended care facilities, nursing homes and board and care homes..." Copies of all rights noted in Minnesota Statutes, Section 144.651, are available in the Patient Relations Department in addition to rights noted in the Commitment Act of 1982.

PROCEDURES

1. Admissions Department

Patients Rights brochures will be distributed to patients or their chosen representative as part of the Admissions process. Any questions regarding the content of the brochure will be referred to the Patient Relations Department at 626-5050.

The name, office phone number, office address and medical specialty of the physician responsible for the patient's care will be provided, in written form, to the patient or to the chosen representative who is assisting with the handling of the inpatient hospital account.

As part of the admissions process, patients or their chosen representative will be provided with information describing the services included in the daily room and board charge and that other services are available at additional charges. This information should augment information previously provided to patients through the preregistration process and the inpatient brochure. For these patients who are not formally processed through Admissions, the information will be provided on the nursing unit.

2. Nursing Units

As part of the admission process on nursing units, the nursing staff will complete a Personal Rights Assessment (UMHC Form #27136) at the time of a patient's admission. This form should be completed at the same time the nursing or pediatric data base and patient profile is completed. (If the patient was admitted through the Inpatient Admissions Department, some of the information will have already been provided to the patient or his/her relative/chosen representative.)

If the patient is unable to participate in the personal rights assessment, this assessment should be completed with a parent, relative or guardian. If it is not possible to complete the form with either the patient or appropriate representative, the reason why completion was not possible should be noted on the form (e.g., emergent admission/no relative available).

Once completed, the form should be placed in the patient's medical record.

3. Patient Relations Department

Patient Relations staff are available to respond to any patient or staff questions or concerns (of a nonfinancial nature) regarding the content of the Patients Rights brochure and related legislation.

Inservice training will be provided periodically and/or at the request of nursing units or hospital departments to enhance the positive understanding and usefulness of Patients Rights within the Hospital. This information will also be included as part of the Patient Relations presentation in new employee orientation.

The Patient Relations Department will also periodically provide updated information to the chiefs of clinical services for the medical staff regarding those points within the Patients Rights legislation which are specific to the role of the physician.

MINUTES
Planning and Development Committee
September 26, 1990

CALL TO ORDER
Robert Latz called the September 26, 1990 meeting of the Planning and Development Committee to order at 12:30 p.m. in room 8-106 in the University Hospital.

Attendance:	Present	Robert Latz, Chair Robert Dickler Clint Hewitt William Jacott, M.D. B. Kristine Johnson Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.
	Absent	Leonard Bienias
	Staff	Fred Bertschinger Al Dees Cliff Fearing Greg Hart Shannon Lorbiecki Lisa McDonald
	Guest	Ed Ciriacy, M.D.

APPROVAL OF MINUTES
The minutes of the August 13 meeting were approved as distributed.

DEVELOPMENT OFFICE UPDATE
Mr. Bertschinger reviewed the Development Office Quarterly Report noting that the past fiscal year was very successful. He pointed out that the goal for FY 1990 was $950,000 while $2,247,159 was raised. He explained that the Variety Club pledge was on target in both contributions and disbursements. He noted some of the activities and events that raised monies for Child Family Life and said that we are the "charity project" for CWA Local #7200, who supports the UMHC Transplant Assistance Fund. A non-monetary goal of the Development Office is to obtain new organ donors.

Mr. Bertschinger also indicated that the Variety Club will hire a grant proposal writer to assist in raising money to fund large projects in which the Variety Club, Variety Club Children's Hospital, and the Department of Pediatrics have major interests and needs.

Mr. Latz asked if other unions had expressed interest in sponsoring programs at the University. Mr. Bertschinger said he would pursue the matter.

UMCA UPDATE

Dr. Lynch reported that UMCA is close to completing work on the Group Health Contract. He said that we cannot limit usage of the clinic to University employees. He also noted that there is continued dissatisfaction with the volume from State Health Plan enrollees. UMCA will have to vacate its current office space on the Boynton Bridge so they are looking for a new location. Concerns are that space off campus will be more expensive and that a remote location is not an ideal situation. Dr. Lynch also said that as a result of the two recent faculty retreats a committee will be formed that will assist in the decision-making process that involves the hospital, medical departments and the medical school.

SYSTEM AND NETWORK DEVELOPMENT TASK FORCE REPORT

Dr. Ciriacy reported on the System and Network Development Task Force and summarized their August 13, 1990 Position Paper. He said that the committee's charge is: 1) What should UMHC's strategy be? and 2) What specific action or actions should UMHC be taking? He discussed the current realities and observations from within the University and the Community. He reviewed the networking options which included outreach activities, contracting, purchasing of existing practices/hospitals, developing consortium network of physicians and/or hospitals, developing a University-owned managed care system, developing the University as a tertiary care component of a managed care system, developing a network of training sites, and various combinations of the above.

The report also suggested that collectively we examine: 1) alternatives to change, 2) increasing clinical emphasis, 3) providing comprehensive coordinated clinical services, 4) identifying number and type of patients needed, 5) modifying governance structure, 6) becoming an owner of a managed care organization, 7) Developing and/or increasing primary and secondary care capability, 8) continue contracting, and 9) develop geographically targeted plans.

The recommendations are: a) to create a single internal governance structure; b) develop a group practice; c) identify specific patient care needs; d) develop specific strategies by geographic area.

Mr. Dickler said that the report was comprehensive and that all task forces will report at the full retreat.

QUARTERLY CAPITAL EXPENDITURE REPORT

Mr. Hart reviewed the capital expenditure report for the period 7/1/89 - 6/30/90. He said of the $12,718,000 budget, $6.2 million was spent. The capital plan is currently being reviewed and recommendations will be made within the next few months. Mr. Hart reported that the CUHCC project is underway.

Mr. Hart told the committee that meeting had been held with the Minneapolis School District who owns the Mt. Sinai facility. The school district does not want to sell a portion of the property and the building has been torn up to remove asbestos so that renovating and renting the property would not be cost efficient.

MAJOR CAPITAL EXPENDITURE: AGE PROCESSING WORKSTATIONS

Mr. Dees said that the m for these workstations was budgeted last year but that they ha en workin th vendors since last December to find a suitable unit. JMHC ted one unit to handle both the CT and MRI functions but no vendor bid. It was necessary to purchase two workstations - one for CT and one for MRI at a cost of $120,000 per workstation.

ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 1:40 p.m.

Respectfully submitted,

Ann Frohrip
Secretary
Planning and Marketing

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
CAPITAL EXPENDITURES
7-1-89 THRu 6-30-90

RECURRING EQUIP & REMODEL:	ANNUAL BUDGET AND ROLLFORWARD: BUDGET	ROLL FORWARD FROM 6-30-89	TOTAL	ACTUAL EXPENDITURES: 89-90 ACTUAL	88-89 ROLL FORWARD	TOTAL
EQUIPMENT PURCHASES						
89-90 Budget	$6,699,010		$6,699,010	$3,051,311		$3,051,311
Rollforward		$4,418,612	$4,418,612		$2,156,951	$2,156,951
	$6,699,010	$4,418,612	$11,117,622	$3,051,311	$2,156,951	$5,208,262
REMODELING PROJECTS	$1,600,990		$1,600,990	$494,397	$535,252	$1,029,649
	$8,300,000	$4,418,612	$12,718,612	$3,545,708	$2,692,203	$6,237,911
PRINCIPLE PAYMENTS						
Lithotripter	$304,670					$308,115
CT SCANNER	$192,600					$192,600
COMPUTER EQUIP	$8,909					$8,909
MRI 2	$0					$49,814
	$506,179					$559,438
TOTAL:	$8,806,179					$6,797,349
BOND PAYMENTS:	$2,215,000	(PAID FEB. 1,1990)				

CAPITAL PROJECTS:	UMHC FUNDS FROM RESERVES	ADDITIONAL FUNDS FROM OTHER SOURCES	TOTAL AUTHORIZED BUDGET	1st Quarter EXPENDITURES 1989-90	2nd Quarter EXPENDITURES 1989-90	3rd Quarter EXPENDITURES 1989-90	4th Quarter EXPENDITURES 1989-90	TOTAL 1989-90	Current & Prior Year EXPENDITURES
ARCHITECT FEES C-3							$299,509	$299,509	$299,509
MRI II	$3,600,000		$3,600,000	$521	$876,983	$11,399		$888,903	$3,626,628
DERMATOLOGY	$679,069	$233,889	$912,958	$18,135	$22,999	($9,637)	$120,277	$151,774	$867,732
MAYO 4 SURG	$1,029,350		$1,029,350	$96,796	$49,886	$37,870	$38,312	$222,864	$1,036,487
CUHCC	$2,200,000	$150,000	$2,350,000	$4,895	$1,280	$14,139	$31,692	$52,006	$398,005
MASONIC HOSP	$835,000	$800,000	$1,635,000	$314,905	$369,428	$142,965	$240,915	$1,068,213	$1,601,490
COMPUTER UPGRADE	$850,000		$850,000	--	--		$0	$0	$0
NEURORADIOLOGY UPGRADE	$909,000		$909,000	--	--		$0	$0	--
MISC. CAPITAL EXPEND.					$24,398	$1,295	$8,270	$33,963	$33,963
TOTAL	$10,102,419	$1,183,889	$11,286,308	$435,252	$1,344,974	$198,031	$738,975	$2,717,232	$7,863,814

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 18, 1990

TO: Members, Board of Governors

FROM: Greg Hart

SUBJECT: Heart Cath Expansion

At the August meeting of the Board we presented a proposal for expansion of the Cardiac Catheterization Laboratory. The project involves the addition of a fourth procedure room. The proposal presented earlier is attached.

The estimated cost for the project, as presented earlier, was $2,800,000. Several variations to facility remodeling are still being considered. The estimates for these variations range from $2,640,000 to $2,990,000. Given the growing volume in the Lab, we would ask for Board approval to proceed with the project this month, using the higher ($2.99 million) cost estimate. We will report back to the Board on final project cost when remodeling plans are finalized and bids are received.

Thank you for your attention to this project. We look forward to answering any questions you may have.

GH/kj

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%

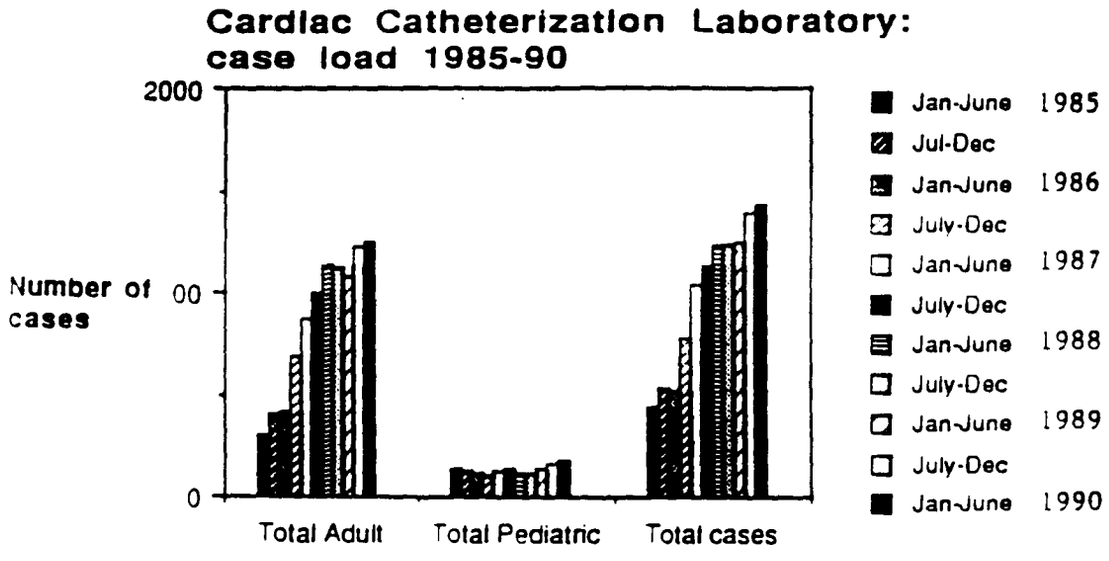
Cardiac Catheterization Laboratory:
case load 1985-90
2000
00
0
Number of cases
Total Adult
Total Pediatric
Total cases
Jan-June 1985
Jul-Dec
Jan-June 1986
July-Dec
Jan-June 1987
July-Dec
Jan-June 1988
July-Dec
Jan-June 1989
July-Dec
Jan-June 1990

Figure 1

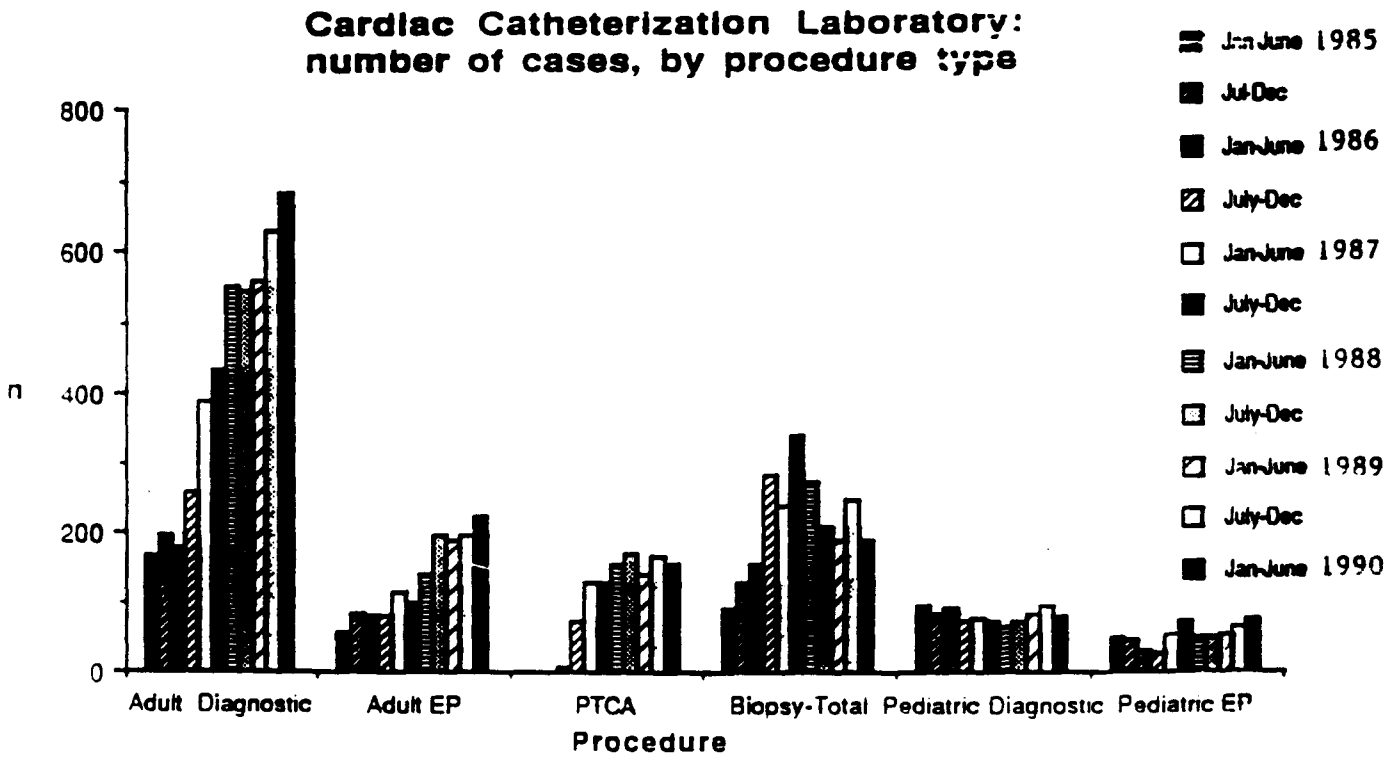
Cardiac Catheterization Laboratory:
number of cases, by procedure type
n
800
600
400
200
0
Adult Diagnostic
Adult EP
PTCA
Biopsy-Total
Pediatric Diagnostic
Pediatric EP
Procedure
Jan-June 1985
Jul-Dec
Jan-June 1986
July-Dec
Jan-June 1987
July-Dec
Jan-June 1988
July-Dec
Jan-June 1989
July-Dec
Jan-June 1990

Figure 2

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review: October 18, 1990
Finance Committee Review: October 24, 1990
Board of Governors Review: October 24, 1990

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Frontal Plane Image Chain Upgrade
Heart Cath Lab: Room 3

PURCHASE PRICE: $110,000

DESCRIPTION:

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

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

In early 1989, CGR was purchased by General Electric (GE). GE has developed an upgraded camera, image intensifier, and TV monitor to improve the fluoroscopic image quality for the CGR equipment. The Board was notified of the intent to purchase this upgrade for Room 2 in February 1990. Installation of this upgrade in that room has resulted in the image quality improvement promised by the vendor. Consequently, the decision has been made to purchase the same upgrade for the other room in which angioplasty procedures are performed, Heart Cath 3.

Submitted By: _____
Title: Associate Director

Approved By: _____
Title: Senior Associate Director

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review: October 18, 1990
Finance Committee Review: October 24, 1990
Board of Governors Review: October 24, 1990

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Image Processing Workstation for CT Section
Image Processing Workstation for MRI Section

PURCHASE PRICE: $120,000 each

DESCRIPTION:

Manipulation of the digital images acquired from CT and MRI procedures to improve clarity, obtain multi-angle views, etc. is becoming an indispensable component of image interpretation and usage. Recently, image processing and computer graphics techniques have been combined to enable three-dimensional (3-D) displays. These 3-D images are being utilized to improve detection and characterization of musculoskeletal disorders, guide reconstructive surgery, and aid in the planning for surgical implantation of prosthetic devises. 3-D display of soft tissue structures such as tumors and blood vessels is also being refined.

Extensive image manipulation requires a powerful microcomputer and specially designed software. To eliminate interference with performance of processes, vendors are developing these capabilities on independent computer workstations. While the techniques for CT and MRI image manipulation are similar, the computer software required for each modality is unique. At present, the best quality workstations available in the marketplace are usable for only one modality. Consequently, the Diagnostic Radiology Department intends to purchase one workstation equipped to process CT and another for MRI images.

Submitted By: [signature] Title: Associate Director

Approved By: [signature] Title: Senior Associate Director

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
August 29, 1990

MINUTES

ATTENDANCE:

Present:	Jerry Meilahn, Chair Robert Dickler Clifford Fearing Nellie Johnson David Lentz Margaret Matalamaki Roger Paschke Vic Vikmanis
Not Present:	Edward Ciriacy, M.D. Elwin Fraley, M.D.
Staff:	Greg Hart Teri Holberg Nels Larson Shannon Lorbiecki Helen Pitt
Guest:	Robert Wilson, M.D.

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on August 29, 1990 at 10:10 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the July 25, 1990 meeting as written.

JULY 1, 1990 THROUGH JULY 31, 1990 FINANCIALS:

Mr. Fearing reported to the Finance Committee the month of July inpatient admissions totaled 1,631, which was 138 above budget; average length of stay was 8.1 days; patient days totaled 12,687, which were 601 days above budget. The July average daily census was 410, which was above the budgeted level of 390. Clinic visits for the month of July were reported to be 11.0% over budget.

The Hospital's year-to-date Statement of Operations showed revenues over expenses by $2,299,862 a favorable variance of $2,730,450. Mr. Fearing stated ancillary revenue was 6.0% above budget and operating expenditures through July were reported to be 4.1% below budget.

Lastly, Mr. Fearing reported as of July 31 the balance of accounts receivable totaled $89,991,945 and represented 94.9 days of revenue outstanding.

GROUP INVESTMENT POOL:

Mr. Fearing stated that in March 1989 it was necessary to close out the trustee held Unit J construction accounts held by the First National Bank to comply with Treasury regulations. The remaining proceeds from the 1982 Bonds, totalling approximately $21,000,000 were placed in a special investment by the University of Minnesota on a temporary basis. Since then the investment has increased to approximately $24,000,000. To comply with Regent investment policies other investment options have been considered, those being the Temporary Investment Pool (TIP) and the Group Income Pool (GIP). TIP has no risk to principal and presently yields 7.8%. GIP has a general interest rate of 8.5%, with an overall rate of return over the last five years of 10%, but since it is invested primarily in bonds it has market risk.

After discussing the options with Mr. Roger Paschke, Mr. Fearing reported it was decided to diversify the Hospital's portfolio and place the $24,000,000 in the GIP over a graduated time frame between August and December of 1990.

CARDIAC CATHETERIZATION LAB EXPANSION:

Mr. Greg Hart presented to the Committee, for information, a proposal to add one additional angiographic room to the Cardiac Catheterization Lab. The estimated cost of the project is $2,800,000.

Mr. Hart stated the Cardiac Catheterization Lab currently has a utilization rate of 98% for the two angiographic rooms and a 86% utilization rate for the non-angiographic room. The volume has increased from 1,200 cases per year in 1985 to a present count of approximately 3,000 cases per year. Mr. Hart stated additional growth is expected to come from an increase in pediatric cardiology, patients in the Cardiac Transplant Program, and in electrophysiologic studies. The proposed angiographic room will assist with the current volume of cases and this anticipated growth.

Mr. Hart stated the projected has been included in the Hospital's long-range capital plan for a number of years. The new unit is projected to be operational in spring of 1991.

The proposal will be brought before the Committee in October for approval.

RENEWAL PROJECT REVIEW UPDATE:

Based on information previously presented to the Committee, Mr. Hart reported over the next ten years the capital plan will be reduced by $50,000,000. A direction in which non-Renewal Projects capital expenditures are reduced by $20,000,000 and the renewal project by $30,000,000 are described. New options for the renewal project are now being considered because of the $30,000,000

reduction, bringing the amount to be spent on the project to $35,000,000. The alternative which appears most likely involves vertical addition on Unit J, primarily for Inpatient Psychiatry. The floor would be built around the existing cooling towers to reduce overall cost and reduce operational disruption. The cost of this building addition would be approximately $16,000,000, with an additional $19,000,000 spent on upgrading other programs that were to have new or remodeled facilities in the Renewal Project. The difficulties with this alternative at this point is that the project would not include a shell floor in Unit J, and space improvements would not occur with a number of departments that were included in the original Unit J expansion option.

Mr. Hart stated a more definitive recommendation will be presented to the Board later this year.

UNION ORGANIZING ACTIVITY:

Mr. Hart reported to the Committee that two groups of employees throughout the University, supervisory and clerical, had submitted petitions to the Bureau of Mediation Services to call for union elections. Elections will occur for the supervisory unit in late September and early October and results will be known in early October. An election date had not be scheduled for the clerical unit. Mr. Hart will continue to keep the Committee informed of the union elections.

There being no further discussion, the August 29, 1990 meeting was adjourned at 11:25 P.M.

Respectfully submitted,

Teri Holberg

Teri Holberg
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 24, 1990

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1990 through September 30, 1990**

The Hospital's operations for the month of September reflect 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 September, inpatient admissions totaled 1,431 which was 5 below budgeted admissions of 1,436. Our overall average length of stay for the month was 8.3 days. Patient days for September totaled 12,009 and were 740 days above budget. The most significant areas in which admissions were above budget were in Medicine, Ophthalmology, Gynecology, and Adult Psych. These increases were offset by declines in Orthopedics, Pedicatrics, and Urology.

To recap our year-to-date inpatient census:

	1989-90 Actual	1990-91 Budget	1990-91 Actual	Variance	% Var
Admissions	4,780	4,517	4,734	217	4.8
Patient Days	38,477	35,815	37,784	1,969	5.5
Avg Length of Stay	8.0	7.9	7.9	0.0	0.0
Avg Daily Census	418.2	389.2	410.7	21.5	5.5
Percent Occupancy	71.7	67.5	71.5	4.0	5.9

OUTPATIENT CENSUS: Clinic visits for the month of September totaled 21,326 which was 92, or 0.4%, more than budgeted visits of 21,234. Visits were significantly above budget in Adult Psych, Radiation Therapy, Emergency Room, and Endoscopy. Family Practice, Ophthalmology, Orthopedic, and Pediatrics reported visits significantly below budgeted levels. Community University Health Care Center (CUHCC) visits for the month of September totaled 4,257 which was 237, or 5.9%, above budgeted visits of 4,020, while Home Health visits of 718 for the month were 204, or 22.6%, under budgeted visits of 922.

To recap our year-to-date outpatient census:

	1989-90 Actual	1990-91 Budget	1990-91 Actual	Variance	% Var
Clinic Visits	69,104	67,018	70,293	3,275	4.9
CUHCC Visits	13,095	13,331	12,684	(647)	(4.9)
HHA Visits	2,809	2,829	2,461	(368)	(13.0)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows revenues over expenses by $7,117,333, a favorable variance of $5,872,389. Patient care charges through September totaled $90,421,011, which was 4.2% over budget. Routine revenue was 3.6% above budget and reflects our favorable inpatient census variance.

Ancillary revenue was $2,729,077 above budget (4.4%) and primarily reflected the favorable variance in both inpatient and outpatient census. Inpatient ancillary revenue averaged $9,825 per admission compared to the budgeted average of $9,810 per admission. Outpatient revenue per clinic visit averaged $257 compared to the budgeted average of $262.

Operating expenditures through September totaled $71,987,840 and were $1,080,106 (1.5%) below budgeted levels of $73,067,946. 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 September 30, 1990, totaled $92,348,210 and represented 91.0 days of revenue outstanding. The overall increase in our patient receivables in September of 0.4 days occurred primarily in Commercial Insurance and State Health Plan.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels for September. 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 SEPTEMBER 30, 1990

	1990-91 Budgeted	1990-91 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$86,798,765	$90,421,011	$3,622,246	4.2%
Deductions from Charges	21,634,074	20,982,599	(651,475)	-3.0%
Other Operating Revenue	2,578,630	2,770,089	191,459	7.4%
Total Operating Revenue	67,743,321	72,208,501	4,465,180	6.6%
Total Expenditures	73,067,946	71,987,840	(1,080,106)	-1.5%
Net Operating Revenue	(5,324,625)	220,661	5,545,286	104.1%
Non-Operating Revenue and Expenses	6,569,569	6,896,672	327,103	5.0%
Revenue Over/Under Expense	$1,244,944	$7,117,333	$5,872,389	

	1990-91 Budgeted	1990-91 Actual	Variance Over/-Under Budget	Variance %
Admissions	4,517	4,734	217	4.8%
Patient Days	35,815	37,784	1,969	5.5%
Average Daily Census	389.2	410.7	21.5	5.5%
Average Length of Stay	7.9	7.9	0.0	0.0%
Percentage Occupancy	67.5	71.5	4.0	5.9%
Outpatient Clinic Visits	67,018	70,293	3,275	4.9%

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 18, 1990

TO: Members, Board of Governors

FROM: Greg Hart

SUBJECT: 1990-91 Capital Budget

You may recall that we have not yet asked for Board approval of the 1990-91 capital budget, given the reassessment of the long-range capital plan. We would request approval of the annual capital budget this month.

In August, the Board endorsed a general approach to the reassessment which called for a $20 million reduction in "non-Renewal Project" capital expenditures through 1998. This reduction was to include both major equipment purchases (greater than $600,000) and the annual capital budgets.

The original capital plan projected an $8,550,000 annual capital budget for 1990-91. We are recommending that this figure be revised to $7,000,000. A summary departmental breakdown of the recommended $7,000,000 budget is attached.

As you know, the Board must explicitly approve major capital projects during the year, in addition to the annual capital budget. At this point we foresee bringing the following projects for approval during the year:

Project	Approximate Cost
Replacement CT Scanner	$1,200,000
Replacement Linear Accelerator	2,100,000
Computer Upgrade	1,518,000
Neuroradiology Upgrade	1,809,000
Heart Cath Expansion	2,800,000
CV Radiology	800,000
Practice Acquisition	5,973,000
Bone Marrow/ICU Reconfiguration	700,000

Thank you for your consideration of this recommendation.

GH/kj

attachment

Long-Range Capital Plan Summary

Previously Projected Expenditures	
- Major Projects	$ 70,251,000
- Annual Capital Budgets	102,279,000
- Total	$172,530,000
Targeted Reduction	<$20,000,000>
New Projected Expenditures	$152,530,000
- Major projects Target	61,050,000
- Annual Budget Target	91,480,000

Annual Capital Budget Projection

	Budget	Rollforward	Total
1989	4,232,000	2,398,000	6,630,000
1990	3,222,000	2,692,000	5,914,000
1991	7,000,000	6,225,000	13,225,000
1992	7,511,000	-0-	7,511,000
1993	8,200,000	-0-	8,200,000
1994	8,800,000	-0-	8,800,000
1995	9,400,000	-0-	9,400,000
1996	10,000,000	-0-	10,000,000
1997	10,600,000	-0-	10,600,000
1998	11,200,000	-0-	11,200,000
			91,480,000

Capital Budget Allocation

Fiscal year 1990-91

Equipment	
Ambulatory Care	$ 320,000
Cardio-Respiratory	800,000
Diagnostic Radiology	1,240,000
Information Services	600,000
Laboratories	950,000
Materials Services	400,000
Medical Records	35,000
Nursing	180,000
Operating Rooms	530,000
Radiation Therapy	9,000
Biomedical Engineering	12,000
CCTV	45,000
Communications Center	13,000
Environmental Services	40,000
Finance	31,000
Healthcare Network	180,000
Infection Control	5,100
Maintenance and Operations	6,500
Pharmacy	12,000
Protection Services	1,000
Rehabilitation	34,000
Social Work	17,000
Patient Transport	9,000
	$5,469,600
Unallocated	200,000
Total Equipment	$5,669,600

Remodeling

Projects Over $50,000

Labs - Outpatient Lab Expansion	$ 145,000
Therapeutic Radiology - Hyperthermia	41,000
Dialysis - Water Supply	56,000
Same Day Admit	100,000
Eye Clinic	63,000
Orthopaedic Clinic	75,000
	$ 480,000
Remodeling Support	$ 148,000
Projects $5,000 - $50,000	$ 417,400
Projects Less Than $5,000	$ 285,000
Total Remodeling	$1,330,400
Total Capital Budget	$7,000,000

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 17, 1990

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - First Quarter
Fiscal Year 1990-91

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the first quarter of 1990-91 is $508,950.28 represented by 1,651 accounts. Bad debt recoveries during the period amounted to $61,885.06 (43 accounts) leaving a net charge-off of $447,065.22.

The net bad debts of $447,065.22 for the quarter were 0.50% of gross charges. This compares to a budgeted level of bad debts of 0.90% ($781,177).

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 first quarter.

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

CPF:slw

Attachments

UMHC Patient Accounting

Bad Debt Statistics: July 1990 through September 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	$36,331.63	89	$189,573.36	15	$225,904.99	104
Bad Debt (702) Charity Care	$10,221.61	29	$35,139.40	6	$45,361.01	35
Total	$46,553.24	118	$224,712.76	21	$271,266.00	139
Recoveries	($30.00)	2	($13,705.62)	2	($13,735.62)	4
Net Total	$46,523.24	118 *	$211,007.14	21 *	$257,530.38	139 *
Outpatient						
Bad Debt (701) Write-Offs	$147,937.94	1268	$40,831.52	8	$188,769.46	1276
Bad Debt (702) Write-Offs	$21,607.43	134	$10,954.66	1	$32,562.09	135
Total	$169,545.37	1402	$51,786.18	9	$221,331.55	1411
Recoveries	($4,322.79)	37	($43,826.65)	2	($48,149.44)	39
Net Total	$165,222.58	1402 *	$7,959.53	9 *	$173,182.11	1411 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	$184,269.57	1357	$230,404.88	23	$414,674.45	1380
Bad Debt (702) Charity Care	$31,829.04	163	$46,094.06	7	$77,923.10	170
Total	$216,098.61	1520	$276,498.94	30	$492,597.55	1550
Recoveries	($4,352.79)	39	($57,532.27)	4	($61,885.06)	43
Total Net Bad Debt	$211,745.82	1520 *	$218,966.67	30 *	$430,712.49	1550 *
Dollars Budgeted					$781,177.00	

* Net total of accounts does not include recoveries.

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UMHC Patient Accounting

Bad Debt Statistics: July 1990 through September 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	$814.63	24	$28,479.28	60	$7,037.72	5	$30,775.59	9	$158,797.77	6	$225,904.99	104
Bad Debt (702) Charity Care	$256.74	7	$8,959.37	21	$1,005.50	1	$24,250.91	5	$10,888.49	1	$45,361.01	35
Total	$1,071.37	31	$37,438.65	81	$8,043.22	6	$55,026.50	14	$169,686.26	7	$271,266.00	139
Recoveries	($30.00)	2					($3,620.83)	1	($10,084.79)	1	($13,735.62)	4
Net Total	$1,041.37	31 *	$37,438.65	81 *	$8,043.22	6 *	$51,405.67	14 *	$159,601.47	7 *	$257,530.38	139 *
Outpatient												
Bad Debt (701) Write-Offs	$27,056.54	812	$116,274.53	453	$4,606.87	3	$30,535.22	7	$10,296.30	1	$188,769.46	1276
Bad Debt (702) Write-Offs	$3,075.16	76	$16,336.39	56	$2,195.88	2			$10,954.66	1	$32,562.09	135
Total	$30,131.70	888	$132,610.92	509	$6,802.75	5	$30,535.22	7	$21,250.96	2	$221,331.55	1411
Recoveries	($660.54)	31	($2,496.25)	5	($1,166.00)	1	($2,490.13)	1	($41,336.52)	1	($48,149.44)	39
Net Total	$29,471.16	888 *	$130,114.67	509 *	$5,636.75	5 *	$28,045.09	7 *	($20,085.56)	2 *	$173,182.11	1411 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	$27,871.17	836	$144,753.81	513	$11,644.59	8	$61,310.81	16	$169,094.07	7	$414,674.45	1380
Bad Debt (702) Charity Care	$3,331.90	83	$25,295.76	77	$3,201.38	3	$24,250.91	5	$21,843.15	2	$77,923.10	170
Total	$31,203.07	919	$170,049.57	590	$14,845.97	11	$85,561.72	21	$190,937.22	9	$492,597.55	1550
Recoveries	($690.54)	33	($2,496.25)	5	($1,166.00)	1	($6,110.96)	2	($51,421.31)	2	($61,885.06)	43
Total Net Bad Debt	$30,512.53	919 *	$167,553.32	590 *	$13,679.97	11 *	$79,450.76	21 *	$139,515.91	9 *	$430,712.49	1550 *
Dollars Budgeted											$781,177.00	

* Net total of accounts does not include recoveries.

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UMHC Patient Accounting

Bad Debt Statistics: July 1990 through September 1990
In two ranges of account size

	Under $2000	# of Accounts	Over $2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Medicare Bad Debt (710)	$9,758.88	21	$0.00	0	$9,758.88	21
Recoveries	$0.00	0	$0.00	0	$0.00	0
Net Total	$9,758.88	21 •	$0.00	0 •	$9,758.88	21 •
Outpatient						
Medicare Bad Debt (710)	$6,593.85	80	$0.00	0	$6,593.85	80
Recoveries	$0.00	0	$0.00	0	$0.00	0
Net Total	$6,593.85	80 •	$0.00	0 •	$6,593.85	80 •
Total IP and OP Bad Debt						
Medicare Bad Debt (710)	$16,352.73	101	$0.00	0	$16,352.73	101
Recoveries	$0.00	0	$0.00	0	$0.00	0
Total Net Bad Debt	**$16,352.73**	**101** •	**$0.00**	**0** •	**$16,352.73**	**101** •

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UMHC Patient Accounting

Bad Debt Statistics: July 1990 through September 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												
Medicare Bad Debt (710)	$114.08	2	$8,529.20	18	$1,115.60	1					$9,758.88	21
Recoveries											$0.00	0
Net Total	$114.08	2 *	$8,529.20	18 *	$1,115.60	1 *	$0.00	0 *	$0.00	0 *	$9,758.88	21 *
Outpatient												
Medicare Bad Debt (710)	$2,046.99	65	$4,546.86	15							$6,593.85	80
Recoveries											$0.00	0
Net Total	$2,046.99	65 *	$4,546.86	15 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$6,593.85	80 *
Total IP and OP Bad Debt												
Medicare Bad Debt (710)	$2,161.07	67	$13,076.06	33	$1,115.60	1	$0.00	0	$0.00	0	$16,352.73	101
Recoveries	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Total Net Bad Debt	**$2,161.07**	**67 ***	**$13,076.06**	**33 ***	**$1,115.60**	**1 ***	**$0.00**	**0 ***	**$0.00**	**0 ***	**$16,352.73**	**101 ***

* Net total of accounts does not include recoveries.

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UMHC Patient Accounting

Bad Debt Statistics: First Quarter and Year-to-Date, Fiscal Year 1991
By State

State	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Alabama			0.00	0
Alaska	244.00	1	244.00	1
Arizona	363.40	4	363.40	4
Arkansas			0.00	0
California	3,594.01	20	3,594.01	20
Colorado	569.80	4	569.80	4
Connecticut	298.96	1	298.96	1
Delaware			0.00	0
Dist. of Colombia			0.00	0
Florida	4,297.71	3	4,297.71	3
Georgia			0.00	0
Hawaii			0.00	0
Idaho			0.00	0
Illinois	8,770.35	18	8,770.35	18
Indiana	22.00	1	22.00	1
Iowa	546.43	6	546.43	6
Kansas	122.85	3	122.85	3
Kentucky			0.00	0
Louisiana	28.29	2	28.29	2
Maine			0.00	0
Maryland	19,322.83	1	19,322.83	1
Massachusetts	599.80	1	599.80	1
Michigan	2,590.06	10	2,590.06	10
Minnesota	289,093.50	1,395	289,093.50	1,395
Mississippi			0.00	0
Missouri	485.91	6	485.91	6
Montana	3,076.96	1	3,076.96	1
Nebraska	210.04	2	210.04	2
Nevada			0.00	0
New Hampshire			0.00	0
New Jersey	0.90	1	0.90	1
New Mexico			0.00	0
New York	2,673.04	14	2,673.04	14
North Carolina			0.00	0
North Dakota	6,591.48	18	6,591.48	18
Ohio	2,894.38	8	2,894.38	8

UMHC Patient Accounting

Bad Debt Statistics: First Quarter and Year-to-Date, Fiscal Year 1991
By State

State	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Oklahoma			0.00	0
Oregon	96,618.49	39	96,618.49	39
Pennsylvania	57.97	2	57.97	2
Puerto Rico			0.00	0
Rhode Island			0.00	0
South Carolina			0.00	0
South Dakota	18,833.57	33	18,833.57	33
Tennessee			0.00	0
Texas	2,158.20	4	2,158.20	4
Utah			0.00	0
Vermont			0.00	0
Virginia			0.00	0
Washington	76.00	1	76.00	1
West Virginia			0.00	0
Wisconsin	13,649.23	44	13,649.23	44
Wyoming			0.00	0
Out-of-Country	525.75	3	525.75	3
Total	478,315.91	1,646	478,315.91	1,646
Medicare Bad Debt*	(16,352.73)	(101)	(16,352.73)	(101)
Legal Settlements	18,129.96	3	18,129.96	3
Bad Debt Agcy Und $50			0.00	0
Bad Debt - Med NC Chgs	12,504.41	2	12,504.41	2
Grand Total	492,597.55	1,550	492,597.55	1,550
Recoveries	(61,885.06)	43	(61,885.06)	43
Net Total	430,712.49	1,550	430,712.49	1,550

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

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UMHC Patient Accounting
Bad Debt Statistics: First Quarter and Year-to-Date, Fiscal Year 1991
By Service

Admitting Service	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Anesthesiology			0.00	0
Clinical Research			0.00	0
Dentistry	463.09	2	463.09	2
Dermatology			0.00	0
Family Practice			0.00	0
OB	133.70	1	133.70	1
NB			0.00	0
GYN	3,649.27	2	3,649.27	2
GYN-Oncology	21,627.72	10	21,627.72	10
Lab Medicine & Pathology			0.00	0
Medicine-Blue	930.02	3	930.02	3
Green	594.88	4	594.88	4
Masonic (Onc)	5,868.48	8	5,868.48	8
Purple			0.00	0
Red A	672.70	1	672.70	1
Red B			0.00	0
Rose A	18,946.12	6	18,946.12	6
Rose B			0.00	0
White A	6,155.73	8	6,155.73	8
White B	1,726.71	4	1,726.71	4
White C			0.00	0
Yellow A	1,556.42	3	1,556.42	3
Yellow B	1,187.60	3	1,187.60	3
Neurology	4,105.47	2	4,105.47	2
Neuro-epilepsy			0.00	0
Neurosurgery	13,940.04	8	13,940.04	8
New Born-General	835.35	2	835.35	2
Obstetrics-General	2,214.70	3	2,214.70	3
-Midwife			0.00	0
Ophthalmology	3,375.23	8	3,375.23	8
Orthopaedic Surgery	1,824.67	6	1,824.67	6
Otolaryngology	3,980.55	5	3,980.55	5
Pediatrics-General	14,260.09	10	14,260.09	10
Dentistry			0.00	0
Dermatology			0.00	0
Neonatology			0.00	0
Neurology	370.18	2	370.18	2
Neurosurgery			0.00	0

UMHC Patient Accounting

Bad Debt Statistics: First Quarter and Year-to-Date, Fiscal Year 1991
By Service

Admitting Service	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Opthalmology	82.40	1	82.40	1
Orthopaedics	275.96	1	275.96	1
Otolaryngology			0.00	0
Pulmonary	324.20	1	324.20	1
Surgery Green	2,402.03	2	2,402.03	2
Surgery Orange			0.00	0
Surg. Transplant	687.61	2	687.61	2
Urology	78.00	1	78.00	1
Physical Med. & Rehab.			0.00	0
Psychiatry-Child	793.47	2	793.47	2
-Adult	30,498.01	8	30,498.01	8
Radiology			0.00	0
Surgery-Blue	115,549.12	10	115,549.12	10
Orange	1,930.20	3	1,930.20	3
Purple	3,409.35	6	3,409.35	6
Red	3,609.56	12	3,609.56	12
White	1,622.14	4	1,622.14	4
Therapeutic Radiology			0.00	0
Urology	11,344.11	6	11,344.11	6
Unknown			0.00	0
Outpatient	197,291.03	1,486	197,291.03	1,486
Total	478,315.91	1646	478,315.91	1646
Medicare Bad Debt*	(16,352.73)	(101)	(16,352.73)	(101)
Legal Settlements	18,129.96	3	18,129.96	3
Bad Debt Agcy Und $50			0.00	0
Bad Debt - Med NC Chgs	12,504.41	2	12,504.41	2
Grand Total	492,597.55	1,550	492,597.55	1,550
Recoveries	(61,885.06)	43	(61,885.06)	43
Net Total	430,712.49	1,550	430,712.49	1,550

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

MHTC

Metro Hospital Trustee Council

THE METRO HOSPITAL TRUSTEE COUNCIL CORDIALLY INVITES ITS MEMBERS AND TWIN CITIES HOSPITAL ADMINISTRATORS TO ATTEND A DINNER FORUM ON:

THE FUTURE OF HOSPITALS' TAX-EXEMPT STATUS

Major new developments regarding hospitals' tax-exempt status are occurring on both the federal and state levels.

On the federal level, a May 1990 report by the General Accounting Office questions nonprofit hospitals' commitment to providing charity care and recommends that Congress link tax exemptions to a specific level of charity care. Congressman Edward Roybal plans to do just that with legislation expected to be introduced this fall.

On the state scene, several major court cases in Pennsylvania impose new judicially derived criteria on hospitals' continued access to tax exemptions.

Will these developments affect Minnesota hospitals?

What should hospitals strategic response be?

Speakers:

JOSEPH LETNAUNCHYN
Vice President, Finance and Continuing Care
Hospital Association of Pennsylvania
will discuss recent developments in Pennsylvania

TIM ECKELS
Project Manager, Lewin/ICF, Washington, D.C.
will discuss the new GAO report, Rep. Roybal's bill, and how hospitals can construct a "social accountability" budget.

Wednesday, November 7, 1990
5:30 P.M. - 9:00 P.M.
Whitney Hotel, 150 Portland, Minneapolis

Registration Fee: $50

6425 Nicollet Avenue South • Suite 320 B • Minneapolis, Minnesota 55423 • 612/869-1909

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

DATE: October 18, 1990

TO: The Board of Governors

FROM: Sally Huntington,
Interim Co-Director, Quality Assurance Services

SUBJECT: Approval of UMHC Quality Assurance Plan

Attached is a draft of the UMHC Quality Assurance Program's Organizational Plan. This plan has been approved by the Quality Assurance Steering Committee, Medical Staff-Hospital Council, and Joint Conference Committee. It is now referred for your review and approval. This plan was last reviewed and approved in 1987.

A summary of the most important elements of this plan follows:

- **Purpose of the Program** - To provide for coordination, and to enhance, where necessary, quality and appropriateness monitoring and evaluation activities.

- **Authority** - Overall responsibility and authority lies with the Governing Board which delegates authority, through the Medical Staff-Hospital Council and Quality Assurance Steering Committee, to medical staff, hospital departments and standing committees.

- **Coordination** - The three coordinating mechanisms include the Quality Assurance Steering Committee, the Support Services Subcommittee, and Quality Assurance Services.

  (1) The Steering Committee advises the Medical Staff-Hospital Council as to directions to be taken to improve UMHC quality assurance and utilization review systems.

  (2) The Support Services Subcommittee advises the Steering Committee on support services quality assurance activities and seeks to increase accountability for the QA process in support service departments.

  (3) Quality Assurance Services acts as a central coordinating resource and provides specialized staff support for the quality assurance process.

- **Program Components** - Important components include monitoring and evaluation by several committees of the Medical Staff-Hospital Council, by the clinical departments/divisions, and by the clinical support departments. Each is described in more detail in the plan (see pages 4 through 6).

- **Data Sources** - A variety of data sources are utilized to properly evaluate patient care including, for example, committee findings, clinical department findings, and outside agency reports.

- **Confidentiality** - All quality assurance information is considered confidential and not discoverable or submissable. The hospital confidentiality policy is referenced.

- **Program Evaluation** - The program shall be formally reviewed by the Steering Committee, with input from other individuals, committees and departments, at least annually.

A draft of this plan was submitted to the Joint Commission in August. Approval is recommended before the survey in November.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

DATE: October 18, 1990

TO: Board of Governors

FROM: Carol Miles Letourneau CMV
Interim Co-Director, Quality Assurance Services

SUBJECT: Approval of the UMHC Utilization Review Plan

Attached is the UMHC Utilization Review Plan which was originally approved in 1987 and was recently revised and reapproved by the Quality Assurance Steering Committee and Medical Staff-Hospital Council.

This document is essentially unchanged from the 1987 version with the following exceptions:

Concurrent Review Process (Appendices A and B)

- The PRO has established specific review requirements that must be fulfilled before a Hospital Issued Notice of Noncoverage (HINN) may be issued to a patient. (Pages 6-7.)

- The PRO Criteria for Inpatient Hospital Level of Care are attached (Appendix B). These criteria are currently used by the Quality Assurance Staff on all admissions regardless of paysource. They are widely accepted as the most specific and thorough criteria available and are used as screening guidelines by the Quality Assurance Staff to determine if a patient requires inpatient hospitalization. Different criteria are available for screening adults, pediatrics, psychiatry and rehabilitation.

- A proposed list of peer review physicians for each service is outlined on page 8. These physicians may be asked by the Quality Assurance Staff to review cases of questionably inappropriate utilization. If the peer review physician agrees that the patient's continued stay is inappropriate, they may be asked to discuss this issue with the attending physician. Although peer review has always been included in the Utilization Review/Concurrent Review Plan, specific physicians have not been designated for this role. Physicians identified on the list are either members of the Quality Assurance Steering Committee and/or Quality Assurance Liaisons.

- The desired outcome of incorporating peer review physicians into the concurrent review process is to increase the medical staffs awareness of inappropriate utilization not to issue large numbers of hospital denials. In the past, hospital issued denials have been very rare.

This plan is to be reviewed annually and approved by the Quality Assurance Steering Committee, the Medical Staff Hospital Council, and the Board of Governor through the Joint Conference Committee.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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October 11 1990

TO: Members, Board of Governors

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

SUBJECT: Proposed Revisions to the Bylaws, Rules and Regulations of the Medical and Dental Staff and Application Forms

The Bylaws Committee has completed its review of the Bylaws, Rules and regulations of the Medical and Dental Staff in their entirety. Also reviewed were the Medical and Dental Staff and Specified Professional Personnel-Psychology Staff application forms.

Enclosed are the complete documents including all changes and a summary of significant revisions for your consideration. Underlining indicates additions to existing language. ~~Strike-outs~~ indicate deletions from existing language.

These changes were endorsed by the Joint Conference Committee on October 10. We are asking for your approval of the changes on October 24.

Thank you.

RM/cf
Enclosures