THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

OCTOBER 23, 1991

TABLE OF CONTENTS

*** Other Items ***

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
OCTOBER 23, 1991
2:30 P.M.
555 DIEHL HALL

AGENDA

I.	Approval of the September 26, 1991 Minutes	Approval
II.	Chairman's Report	Information
	-Ms. Kristine Johnson	
III.	Hospital Director's Report	Information
	-Mr. Robert Dickler	
IV.	Special Presentation: George Adams, M.D.	Information
	-Professor & Head Department of Otolaryngology	
V.	Committee Reports	
	A. Consent Items	
	Planning and Development Committee	
	1. Quarterly Capital Expenditure Report	Information
	2. Quarterly Purchasing Report	Approval
	3. Development Office Update	Information
	Finance Committee	
	1. First Quarter, 1991-92 Bad Debts	Approval
	B. Joint Conference Committee	
	-Mr. George Heenan	
	1. Medical Staff-Hospital Council Report:	
	o Policy 16.4: Making Decisions to Forego Cardiopulmonary Resuscitation	Approval
	o Amendment to Rules and Regulations of the Medical and Dental Staff	Approval

2. Quality Assurance Plan — Approval

C. Planning and Development Committee

-Mr. Robert Nickoloff

1. Interstate Medical Center Proposal — Approval

D. Finance Committee

-Mr. Jerry Meilahn

1. September 30, 1991 Financial Statements — Information

2. 1990-91 Year End Financials — Information

VII. Other Business

VIII. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

September 26, 1991

Call To Order

Ms. Kristine Johnson called the September 26, 1991 meeting of the Board of Governors to order at 3:40 p.m. at Riverwood Conference Center, Monticello, Minnesota.

Attendance

Present:
David Brown, M.D.
Robert Dickler
Michael Dougherty
Phyllis Ellis
Bob Erickson
George Heenan
Kris Johnson
Nellie Johnson
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
J.E. Meilahn
Robert Nickoloff
Barbara O'Grady
Trudy Ohnsorg
Cherie Perlmutter
Roby Thompson, M.D.

Not Present:
Leonard Bienias
Jerry Olson

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the July 24, 1991 meeting as submitted.

Consent Agenda

A motion was seconded and passed to approve items on the consent agenda which consisted of:

a. Credentials Committee Recommendations

b. Appointment of Medical Staff-Hospital Council Committee Chairman

b. Major Capital Expenditure: Outpatient Laboratory Remodeling

c. Major Capital Expenditure: Replacement of Disk System for UNISYS A15 and A9 Computers

Finance Committee Report

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospitals's Statement of Operations for the period July 1, 1991 through August 31, 1991 shows revenues over expenses by $632,000, an unfavorable variance of $2,353,000. Patient care charges through August totaled $63,037,000, which was 5.6% under budget.

Mr. Fearing reported inpatient admissions for August totaled 1,552 which was 130 below budgeted admissions of 1,682. Overall average length of stay for the month was 7.1 days. Outpatient clinic visits for the month of August totaled 27,897 which was 4,107, or 12.8%, less than budgeted visits of 32,004.

The Hospital has limited filling of vacant positions at this time. The Baord discussed the level of FTEs which can be supported at current volume levels.

The members of the Board asked about the impact of the lower than budgeted census levels on the capital plan, in general, and the Renewal Project, specifically. Mr. Dickler indicated that planning continues for the Renewal Project but bids have not been released. The Board seconded and passed a motion that management staff should make the decision whether bids will be released prior to the next Board meeting. However, no bids should be awarded until the Board has considered the issue further and reached a more definitive conclusion.

Planning and Development Committee Report

Mr. Robert Nickoloff called on Mr. Robert Dickler to report on the Interstate Medical Center acquisition. Interstate Medical Center (IMC) is a multiple specialty clinic of twenty-eight physicians, and related staff, which operates primarily out of a facility in Red Wing, Minnesota. IMC also owns a clinic building in Elsworth, Wisconsin, and has satellite office space in Zumbrota, Minnesota. IMC is the only major clinic in Red Wing and is the major physician provider in this geographic area. This item is for information and will be presented for endorsement at the October Board of Governors meeting.

Adjournment

There being no further business, the September 26, 1991 business meeting of the Board of Governors was adjourned at 4:45 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 16, 1991

TO: Members of the Board of Governors

FROM: Shannon Lorbiecki
Secretary to the Board of Governors

We are pleased to welcome Dr. George Adams as our enrichment speaker this month. George is Professor and Head of the Otolaryngology Department.

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

CURRICULUM VITAE

George L. Adams, M.D.

Date and Place of Birth: February 8, 1941, Philadelphia, PA
Marital Status: Married Donna Lee Fletcher, 4/1/67
Three sons: Brett, Jay and Eric, born in Edina, MN

Education

Abington High School 1955-1958

Penn State University, B.S. degree 1958-1962
Phi Kappa Sigma Fraternity
Alpha Epsilon Delta (Pre-Med Honor Society)

Jefferson Medical College, M.D. 1962-1966

Nu Sigma Nu Fraternity: rush chairman, scholarship chairman, steward
Kappa Beta Phi Social Fraternity
Class Chairman, Alumni Association 1966-present

President, Freshman Class
President, Sophomore Class
President, Junior Class
President, Senior Class

Student Council, four years; athletic chairman; student health and welfare committee; housing committee; SAMA Pre-Med day (chairman); 1966 Clinic (yearbook) sales manager

Richard W. Foster Prize (given to outstanding student selected by the college)

S. MacCuen Smith Memorial Prize (for recognition in the field of otolaryngology, honorable mention)

Lange Medical Publications Prize (selected for outstanding extra-curricular achievement)

Research Clerkship: The effects of "G" on pulmonary arterial shunts, Aeronautical Medical Acceleration Laboratory, Johnsville, PA 1963

Clinical Clerkships:
U.S.N.H., Philadelphia 1964
U.S.N.H., Great Lakes, IL 1965

Internship (straight medical) Evanston Hospital, Evanston IL 1966-1967

National Boards Parts I, II, III

General Surgery Residency, Minneapolis V.A. Hospital 1967-1968

Residency in Otolaryngology, University of Minnesota 1968-1971

American Board of Otolaryngology 1971

License, Minnesota #021010-4

Military Service
U.S.N.R. Ensign 1915 program 1962-1971
U.S.N.H. Long Beach, California 1971-1973
Letter of Commendation, Outstanding Military Physician 1973

Employment

Professor and Head, Department of Otolaryngology University of Minnesota, Minneapolis, MN	1990-present
Interim Head, Department of Otolaryngology, University of Minnesota, Minneapolis, MN	1989-1990
Associate Head, Department of Otolaryngology, University of Minnesota, Minneapolis, MN	1988-1989
Associate Professor, Department of Otolaryngology University of Minnesota, Minneapolis, MN	1980-1990
Assistant Professor, Department of Otolaryngology University of Minnesota, Minneapolis, MN	1973-1980
Staff, University of Minnesota Hospital, Minneapolis, MN	1973-present
Staff, Veterans Administration Hospital, Minneapolis, MN	1973-present
Staff, Ridges/Fairview Hospital, Burnsville, MN	1984-1985
Staff, Children's Hospital, Minneapolis, MN	1973-1985
Staff, Eitel Hospital, Minneapolis, MN	1973-1985
Consultant, Nicollet Clinic, Minneapolis & Burnsville, MN	1973-1985

Professional and Scientific Societies

American Academy of Facial Plastic and Reconstructive Surgery, Fellow	September, 1986
American Academy of Otolaryngology	
Pan-American Broncho-Esophagological Society	1980-present
American College of Surgeons, Fellow	October, 1984
American Laryngological, Rhinological, and Otological Society (The Triological Society) - applied for membership	
American Medical Association	
American Society for Head and Neck Surgery	1987-present
Deafness Research Foundation	
Hennepin County Medical Society	
Minnesota Academy of Otolaryngology	
Minnesota State Medical Association	
Society of Military Otolaryngologists	
Society of University Otolaryngologists	1981-present

American Academy of Otolaryngology

Task Force, Preparation of New Materials, Continuing Education in Otolaryngology	1974-1978
Selected for Honors Award, New Orleans, LA	October, 1982
Continuing Education, Self-Instruction Packages	1978-1983
Editor, Patient-of-the-Month Program 1) osteoradionecrosis of the mandible, treatment 2) management of spontaneous CSF otorrhea	1981-1984
Annual Course: Mandibular Reconstruction with Drs. Maisel, Hilger and Foster	1981-1985
Mini-Seminar: Prospective Studies in Head and Neck Oncology with Drs. Lowry, Fee, Schuller, Jacobs, and Pajak	1985-1986
Member of the Board of Governors, Representing the State of Minnesota	1985-1987
Official State Legislative Coordinator for Minnesota	1986-1988

American Medical Association

Physician's Recognition Award in Continuing Medical Education	1984 & 1988

Minnesota Academy of Otolaryngology

Program Chair	1984-1985
President	1984-1986
Council Member	1981-1988
Representative, MMA Interspecialty Council	1985-1987
Representative, Foundation for Health Care Evaluation (Regional Peer Review)	1986-1987
Chairman, Legislative Committee	1987-1989

American Academy of Facial, Plastic and Reconstructive Surgery
Instructor in Laboratory and Guest Speaker:
Zygomatic Fractures 1977, 1980, 1988
Orbital Floor Fractures 1980
Fractures of the Maxilla and Zygoma 1984
Principles of Midfacial Fracture Care, St. Paul 1984
Instructor, Course on Maxillofacial Trauma 1977, 1980, 1985
Facial Plastic Surgery Contact at the University of Minnesota 1987

National Cancer Institute
Head and Neck Steering Committee, Eastern
Cooperative Oncology Group (ECOG) 1978-present
Associate Chairman, Head and Neck Cancer Committee, ECOG 1981-1984
Chairman-Elect, Head and Neck Cancer Committee, ECOG 1984
Co-Chairman, Head and Neck Committee, ECOG 1984-1987, 1989-1991
Head and Neck Intergroup Research Team
Utah Jan 1983
Washington Oct 1983
Executive Committee, Head and Neck Intergroup
National Cancer Institute 1984-present
Member, NCI Research Team (representing ECOG)
Consultant, Southwest Oncology Group, Head and Neck Committee
San Antonio, TX February 1984

Current Ongoing Protocols
Regional Director, NCI/ECOG Prospective Study on Combined Surgery, Chemotherapy, and Postoperative Radiation Therapy for Advanced Head and Neck Cancer.

Co-Chair (with Dr. M. Oken, Dr. R. Haselow, Chair), EST 3-06 (1981): Phase III, Simultaneous Cis-Platinum and Radiation Therapy Compared with Standard Radiation Therapy in the Treatment of Unresectable Squamous or Undifferentiated Carcinoma of the Head and Neck.

Principal Investigator (with Dr. Ronald McGlennon): Use of Ribavirin in management of laryngeal papillomatosis, 1991.

Co-Chair (with Drs. M. Oken, R. Haselow, and T. Grage), Study of Beta-Interferon for Advanced Recurrent Squamous Cell Carcinoma of the Head and Neck Preoperative Chemotherapy with Cis-Platinum, Methotrexate, and Bleomycin for Advanced Stage III and IV Carcinoma of the Head and Neck.

Surgical Chairman, ECOG Study on Combined Use of Chemotherapy and Radiation Therapy in Operable Carcinoma of the Head and Neck.

Coordinator (with Drs. Taylor, Murthy, and Haselow), EST P-C385 (1985): Pilot Study for the Evaluation of Simultaneous Cisplatin/5-FU Infusion Chemotherapy and Limited Radiation Therapy in Regionally Recurrent Head and Neck Cancer.

Chairman, Study of Effects of Alpha N1 Interferon in the Treatment of Juvenile Papillomatosis of the Larynx, Upper Midwest Section.

Coordinator in the Northwest Region, Study of Interferon for Juvenile Laryngeal Papillomas.

Member, Surgical Quality Assurance Committee for Review of Protocols of Surgery/Chemotherapy/Postoperative Radiation Therapy.

Member (with Drs. Davidson, Medina and Vaughn), Combined VA Study Committee for the Management of the N0 Neck.

Member (with Drs. Terence Davidson, Daniel Karp, and Kelvin Lee), Cooperative Study in the Veterans Administration for Head and Neck Cancer Registry. October 1988. VA Project Grant approved but not funded.

Administrative Responsibilities

Chairman, Search Committee for Head, Department of Obstetrics-Gynecology, University of Minnesota	1991-present
Head, Department of Otolaryngology, University of Minnesota	1990-present
Acting Chief, Division of Otolaryngology, Minneapolis VA Medical Center	1990-present
Interim Head, Department of Otolaryngology University of Minnesota	1989-1990
Member, Operating Room Committee, University of Minnesota Hospital	1989-present
Member, Council of Clinical Chiefs, University of Minnesota Hospital	1989-present
Member, University of Minnesota Clinical Associates Directors	1989-present
Member, Search Committee for Chairman of Medical Oncology, University of Minnesota	1989-1990
Director of Clinical Services, Department of Otolaryngology, University of Minnesota	1988-present
Chairman, Clinical Executive Policy Council, Department of Otolaryngology, University of Minnesota	1988-present
Associate Head of the Department of Otolaryngology, University of Minnesota	1988-1989
Chairman, Search Committee for Otolaryngologist-Head and Neck Surgeon, Minneapolis VA Medical Center and Department of Otolaryngology, University of Minnesota	1988-1989
Coordinator, Interdisciplinary Head and Neck Tumor Conference, University of Minnesota Hospital	1988
Chairman, Laser Safety Committee, University of Minnesota Hospital	1987-present
Editorial Board, Colleagues of the Medical Staff, a publication ofthe University of Minnesota Hospital	1987-present
Chairman, Search Committee for Pediatric Otolaryngologist Department of Otolaryngology, University of Minnesota	1987-1988
Planning and Marketing Committee, University of Minnesota Hospital	1986-present
Medical Staff-Hospital Council, University of Minnesota Hospital	1986-present
Otologist, Cochlear Implant Program, University of Minnesota Hospitals	1986-present
Coordinator, weekly Otology Conference, Minneapolis V.A. Hospital	1986-1987
Quality Assurance Committee, University of Minnesota Hospital	1987
Cost Evaluation Committee, University of Minnesota Hospital	
Clinical Oncology Task Force, University of Minnesota Hospital	1985-present
Search Committee, Department of Prosthodontics, University of Minnesota	1985
Chairman, Search Committee for Neurotologist, Department of Otolaryngology, University of Minnesota	1985-1986
Associate Member, Graduate School Faculty, University of Minnesota	1981-present
Tissue and Procedure Review Committee, University of Minnesota Hospital	1979-present
Coordinator, Otolaryngology Head and Neck Tumor Clinic, Minneapolis V.A. Hospital	1973-present
Adviser to Medical Students	1973-present
Coordinator, Year Two Medical Student Teaching, Department of Otolaryngology, University of Minnesota	1973-present
Coordinator, Year Four Medical Student Teaching, Department of Otolaryngology, University of Minnesota	1973-1988
Sub-Committee on Student Examinations, University of Minnesota Hospital	
Coordinator, Graduate Student Teaching Conferences, Department of Otolaryngology, University of Minnesota (year-round, weekly conferences)	1973-1988

Community Activities

Stewardship and Finance Committee, Oak Grove Presbyterian Church	1982-1988
Board Member, Bloomington Gymnastics Club; Meet Director	1982-1983

Meet Director, Minnesota Academy of Gymnastics 1983-1985
Coordinator of District Four, USGF Boys Gymnastics Meet,
Williams Arena, University of Minnesota May, 1985
Parents' Board, X-Boat Sailors, Lake Minnetonka

Competitive Sports
Sailing
E Scow Racing Fleet
Minnetonka Yacht Club
Inland Lake Yachting Association
National E Scow Association
Cross-Country Skiing
Birkebiener (30 km race, top 40% of men in age group)

Non-Competitive Sports
Jogging (10 mi/wk)
Tennis

PUBLICATIONS

Textbooks Edited

Fundamentals of Otolaryngology, Sixth Edition, Adams GL, Boies LR Jr, Hilger P. Philadelphia: W.B. Saunders, 1989.

Fundamentals of Otolaryngology, Fifth Edition, Adams GL, Boies LR Jr, Paparella MM. Philadelphia: W.B. Saunders, 1978.

Head and Neck Cancer: Clinical Decisions and Management Principles. McQuarrie D, Adams GL, Shons A, Browne G. Chicago: Yearbook Medical Publishers, 1986.

Chapters

1. Adams GL: Diseases of the Salivary Glands. In Adams GL, Boies LR Jr, Paparella MM (eds): Fundamentals of Otolaryngology, 5th edn. Philadelphia: W.B. Saunders, 1978, pp. 494-508.

2. Adams GL, Mathog RH, Maisel RH: Special Examinations in Otolaryngology. In Adams GL, Boies LR Jr, Paparella MM (eds): Fundamentals of Otolaryngology, 5 edn. Philadelphia: W.B. Saunders Company, 1978, pp. 28-64.

3. Pollak K, Adams GL, Boies LR Jr: Diseases of the Nose. In Adams GL, Boies LR Jr, Paparella MM (eds): Fundamentals of Otolaryngology, 5 edn. Philadelphia: W.B. Saunders Company, 1978, pp. 325-392.

4. Duvall AJ, Adams GL, Smith DG, Berlinger NT: Malignant Tumors of the Head and Neck. In Adams GL, Boies LR Jr, Paparella MM (eds): Fundamentals of Otolaryngology, 5 edn. Philadelphia: W.B. Saunders Company, 1978, pp. 625-660.

5. Adams GL: Infections of the Head and Neck. In Drage CW (ed): Respiratory Medicine. New York: Academic Press, 1982, pp 1-11.

6. Adams GL: Cancer of the Maxilla. In Gates G (ed): Current Therapy in Otolaryngology. St. Louis: B.C. Decker, Inc. through C.V. Mosby, Ontario, 1984.

7. Adams GL, Maisel R, Hilger P: Mandibular Reconstruction. In Gates G (ed): Current Therapy in Otolaryngology. St. Louis: B.C. Decker, Inc. through C.V. Mosby, Ontario, 1984.

8. Adams GL, McQuarrie DG, Rao Y: Cervical Lymphatics: Decisions and Variations in Managing Existing or Potential Cervical Lymph Node Metastases. In McQuarrie D, Adams GL, Shons A, Browne G (eds.): Head and Neck Cancer: Clinical Decisions and Management Principles. Chicago: Year Book Medical Publishers, 1985.

9. Adams GL: Cancer of the Oropharynx. In McQuarrie D, Adams GL, Shons A, Browne G (eds.): Head and Neck Cancer: Clinical Decisions and Management Principles. Chicago: Year Book Medical Publishers, 1985.

10. Adams GL: Malignant Tumors of the Paranasal Sinuses and Nasal Cavity. In McQuarrie D, Adams GL, Shons A, Browne G (eds.): Head and Neck Cancer: Clinical Decisions and Management Principles. Chicago: Year Book Medical Publishers, 1985.

11. Adams GL: Cancers Involving the Middle Ear and Temporal Bone. In McQuarrie D, Adams GL, Shons A, Browne G (eds.): Head and Neck Cancer: Clinical Decisions and Management Principles. Chicago: Year Book Medical Publishers, 1985.

12. Adams GL: Decisions and Management of Metastatic Cancer with an Unknown Primary Site. In McQuarrie D, Adams GL, Shons A, Browne G (eds.): Head and Neck Cancer: Clinical Decisions and Management Principles. Chicago: Year Book

Medical Publishers, 1985.

13. Adams GL: Carcinoma of the Paranasal Sinuses. In Gates G (ed): Current Therapy in Otolaryngology, Vol. 3. St. Louis: B.C. Decker, Inc. through C.V. Mosby, Ontario, 1986.

14. Adams GL: Surgical Infections of the Head and Neck. In Howard, Simmons RL (eds): Surgical Infectious Diseases, 2nd ed. New York: Appleton-Century-Crofts, 1987.

15. Adams GL: Malignant Tumors of the Nose and Paranasal Sinuses. In Kagan AR, Miles J (eds.): Head and Neck Oncology: Clinical Management. Elmsford, NY: Pergamon Press Inc., May, 1989, pp. 26-43.

16. Grage TB, Wesen CA, Adams GL: Free Bowel Autograft for Replacement of Cervical Esophagus and Pharynx. In Najarian JS, Delaney, JP: Progress in Gastrointestinal Surgery. Chicago: Year Book Medical Publishers, June, 1989, pp. 128-139.

17. Adams GL: Management of Carotid Artery Rupture. In: Gates GA: Current Therapy in Otolaryngology-Head and Neck Surgery, Vol 4. Philadelphia: B.C. Decker Inc., 1989.

18. Paparella MM, Adams GL, Levine SC: Diseases of the Middle Ear and Mastoid. In Adams GL, Boies LR Jr, Hilger P (eds.): Fundamentals of Otolaryngology, 6th ed. Philadelphia: W.B. Saunders, 1989, pp. 90-122.

19. Adams GL: Disorders of the Salivary Glands. In Adams GL, Boies LR Jr, Hilger P (eds.): Fundamentals of Otolaryngology, 6th ed. Philadelphia: W.B. Saunders, 1989, pp. 317-331.

20. Adams GL: Diseases of the Nasopharynx and Oropharynx. In Adams GL, Boies LR Jr, Hilger P (eds.): Fundamentals of Otolaryngology, 6th ed. Philadelphia: W.B. Saunders, 1989, pp. 332-369.

21. Adams GL: Malignant Tumors of the Head and Neck. In Adams GL, Boies LR Jr, Hilger P (eds.): Fundamentals of Otolaryngology, 6th ed. Philadelphia: W.B. Saunders, 1989, pp. 443-470.

22. Haselow RE, Warshaw MG, Oken MM, Adams GL, Aughey JL, Cooper JS, Schuller DE, Jacobs CD: Radiation alone versus radiation with weekly low dose cis-platinum in unresectable cancer of the head and neck. In Fee WE, Goepfert H, Johns ME, Strong EW, Ward PH: Head and Neck Cancer, Vol 2: Proceedings of the International Conference. Philadelphia: B.C. Decker Inc., 1990, pp. 279-281.

23. Adams GL: Complications of tracheostomy. In Cerra FB (ed): Perspectives in Critical Care, 1990. pp. 105-123.

24. Adams GL: Malignant Neoplasms of the Hypopharynx. In Cummings CW, Fredrickson JM, Harker LA, Krause CJ, Schuller DE: Otolaryngology-Head and Neck Surgery, second edition (in production), 1991.

Articles

1. Adams GL, Duvall AJ III: Adenocarcinoma of the head and neck. Arch Otolaryngol 93:261-270, 1971.

2. Adams GL, Paparella M, El Fiky F: Primary and metastatic tumors of the temporal bone. Laryngoscope 81:1273-1285, 1971.

3. Rontal E, Adams GL, Boies LR Jr: Cysts in the floor of the mouth. Minn Med 54:829-831, 1971.

4. Duvall AJ III, Adams GL, Pollak K, Charyulu K: Squamous cell carcinoma of the head and neck. Minn Med 56:480-491, 1973.

5. Adams GL, Duvall AJ III, Smith D, Pollak K: Malignant tumors of the paranasal sinuses. Minn Med 57:562-568, 1974.

6. Wurman L, Adams GL, Meyerhoff W: Carcinoma of the lip. Am J Surg 130:470-474, 1975.

7. Berlinger N, Tsakraklides V, Adams GL, Pollak K, Yang M, Good R: Prognostic significance of lymph node histology in patients with squamous cell carcinoma of the larynx, pharynx, or oral cavity. Laryngoscope 86:792-803, 1976.

8. Adams GL, Nelms CR: Complicated mandibular fractures. Otolaryngol Clin North Am 9:453-464, 1976.

9. Berlinger N, Adams GL: Immunologic assessment of regional lymph node histology in relation to survival in head and neck carcinoma. Cancer 37:697-705, 1976.

10. Oliviera C, Roth J, Adams GL: Oncocytic lesions of the larynx. Laryngoscope 87:1718, 1977.

11. Jung TTK, Adams GL: Dysphagia in laryngectomized patients. Otolaryngol Head Neck Surg 88:25-33, 1980.

12. Adams GL, Hilger P: Cystic fibrosis. Arch Otolaryngol 106 (2): 127-133, 1980.

13. Giordano A, Brady D, Foster C, Adams GL: Particulate cancellous marrow crib graft reconstruction of mandibular defects. Laryngoscope 90 (12):2027-2036, 1980.

14. Berlinger N, Koutroupas S, Adams GL, Maisel R: Patterns of involvement of the temporal bone in metastatic and systemic malignancy. Laryngoscope 90:619-627, 1980.

15. Adams GL, Goycoolea M, Foster C, Dehner L, Anderson R: Parotid lipomatosis in a 2-month-old child. Otolaryngol Head Neck Surg 89:402-405, 1981.

16. Giordano A, Adams GL, Boies L, Meyerhoff W: Current management of esophageal foreign bodies. Arch Otolaryngol 107:249-251, 1981.

17. Shrewsbury D, Adams GL, Duvall AJ III, Maisel R, Haselow R: Carcinoma of the tonsillar region: A comparison of radiation therapy with combined preoperative radiation and surgery. Otolaryngol Head Neck Surg 89:979-985, 1981.

18. Haselow R, Adams GL, Oken M, Goudsmit A, Lerner H, Marsh J: Simultaneous cis-platinum (DDP) and radiation therapy (RT) for locally advanced unresectable head and neck cancer. ASCO Abstracts, Clinical Trials: Head and Neck. March, 1982, C-780.

19. Adams GL: Mandibular reconstruction: External fixation. Otolaryngol Head

Neck Surg 90:583-584, 1982.

20. Adams GL, McCoid G, Weisbeski D: Cerebrospinal fluid otorrhea presenting as serous otitis media. Minn Med 65:410-415, 1982.

21. Adams GL, Haselow R: Oral and pharyngeal cancer: Early diagnosis for optimal treatment (Part I). Hospital Medicine (February): 173-185, 1983. [Illustrations reprinted as: Clinical highlights: Some examples of common oral malignancies, in Hospital Medicine (August): 143, 1986, as well as in a foreign edition of Medicine Illustrated.]

22. Adams GL, Haselow R: Oral and pharyngeal cancer: Early diagnosis for optimal treatment (Part II). Hospital Medicine (March):241-252, 1983. [Illustrations reprinted as: Clinical highlights: Classification of oropharyngeal tumors, in Hospital Medicine (January):37, 1987, as well as in a foreign edition of Medicine Illustrated.]

23. Giordano A, Ewing S, Adams GL, Maisel R: Laryngeal pseudosarcoma. Laryngoscope 93:735-740, 1983.

24. Maisel R, Liston S, Adams GL: Complications of pectoralis myocutaneous flaps. Laryngoscope 93:928-930, 1983.

25. Maisel R, Hilger P, Adams GL, Giordano A: Reconstruction of the mandible. Laryngoscope 93:1122-1126, 1983.

26. Maisel R, Adams GL: Osteomyocutaneous reconstruction of the oral cavity. Arch Otolaryngol 109:731-734, 1983.

27. Giordano A, Cohen J, Adams GL: Pharyngocutaneous fistula after laryngeal surgery: the role of the barium swallow. Otolaryngol Head Neck Surg 92:19-23, 1984.

28. Rothstein J, Adams GL, Galliani C, Elliott G: Relapsing polychondritis in a 30-month-old child. Otolaryngol Head Neck Surg 93:680-683, 1985.

29. Hilger P, Adams GL: Mandibular reconstruction with the A-O plate. Arch Otolaryngol 111:469-471, 1985.

30. Griebie M, Adams GL: Clostridium difficile colitis following head and neck surgery: Report of cases. Arch Otolaryngol 111:550-553, 1985.

31. Adams GL, Griebie M: Role of the CO2 laser in the management of localized carcinoma of the oral cavity: Emphasis on second primary malignancies. Minn Med:285-289, April 1985.

32. Porto DP, Adams GL, Foster C: Emergency management of carotid artery rupture. Am J Otolaryngol 7:213-217, 1986.

33. Adams GL: Diagnosis and management of midfacial fractures. Consultant 27(10): 1987.

34. Porto DP, Wick MR, Ewing SL, Adams GL: Neuroendocrine carcinoma of the larynx. Am J Otolaryngol 9:97-104, 1987.

35. Griebie M, Adams GL: "Emergency" laryngectomy and stomal recurrence. Laryngoscope 97:1020-1024, 1987.

36. Jacobs JL, Adams GL: Current results and future directions of clinical trials in head and neck cancer. Insights in Otolaryngology 3(5):1988.

37. Aden KK, Adams GL, Niehans , Abdel-Fattah, HMMI: Adenosquamous cell carcinoma of the larynx and hypopharynx with five new case presentations. Transactions Amer Laryngol Assoc 109:216-221, 1988.

38. Odland R, Adams GL: Pneumothorax as a Complication of Tracheoesophageal Voice Prosthesis Use. Annals of Otology, Rhinology, and Laryngology 97:537-541, 1988.

39. Adams GL: Treatment of Head and Neck Cancer with Combined Modalities. Investigative Radiology 24:562-567, 1989.

40. Kimberley BP, Nelson DA, Levine SC, Adams GL, Lee A, Scheller L: Cochlear implant hearing performance at the University of Minnesota. Journal of Otolaryngology (Canada) 18(1):24-27, 1989.

41. Abdel-Fattah H, Adams GL, Wick, MR: Hemangiopericytoma of the Maxillary Sinus and Skull Base. Head & Neck, 12:77-83, 1990..

42. Clayman GL, Adams GL: Permanent tracheostomy with cervical lipectomy. Laryngoscope 100(4):422-424, 1990.

43. Larson JT, Adams GL, Abdel-Fattah H: Survival statistics for multiple primaries in head and neck cancer. Otolaryngol Head Neck Surg 103(1):14-24, 1990.

44. Harada T, Juhn SK, Adams GL: Lysozyme concentrations in middle ear effusion and serum from children and adults with otitis media. Archives of Otolaryngology-Head and Neck Surgery 116:54-56, 1990.

45. Chipps BE, McClurg FL Jr., Friedman EM, Adams, GL: Respiratory papillomas: presentation before six months. Pediatric Pulmonology 9:125-130, 1990.

46. Clayman GL, Adams GL: Modifications of the mandibular swing for preservation of occlusion and function. Head and Neck 13:102-106, 1991.

47. Clayman GL, Adams GL, Paugh D, Koopman CF: Intracranial complications of paranasal sinusitis--a combined institutional review. Laryngoscope 101(3):234-239, 1991.

48. Malone BN, Adams GL, Ewing SL: Inverting papilloma associated with verrucous carcinoma of the maxilla. Submitted for publication.

49. Smith RW, Adams GL, Vance JC: Metastatic basal cell carcinoma: A report of two cases. Submitted for publication.

50. Anderson CB, Adams GL, Neglia JP: Tracheostomy in the management of bone marrow transplant patients. Submitted for publication to Otolaryngology-Head and Neck Surgery, 1990.

51. Adelstein D, Adams G, Wagner H Jr, Lynch E, Haselow R: Simultaneous radiatio therapy and chemotherapy with 5-fluorouracil and cisplatin for locally unresectable squamous cell head and neck cancer: An Eastern Cooperative Oncology Group pilot study. Submitted for publication to ASCO Abstracts, 1991

Video Tapes, Audio Tapes

1. Adams GL: Disorders of the throat. Continuing Education for Pharmacists, State of Minnesota, 1975.

2. Adams GL: Dysphagia and lumps in the throat. Audio-Digest 27 (25): July, 1979.

3. Adams GL: Ear, nose and throat (ENT) problems in children. Audio-Digest 31 (20):May 23, 1983.

4. Adams GL: Current management of carotid artery rupture. Audio-Digest 18 (9):May 16, 1985.

5. Adams GL: Oral cancer update. Minnesota Dental Association 1989 Star of the North Meeting, April 17, 1989.

6. Adams GL: Surgical infections involving head and neck. ACS Clinitapes CC89-PG16, October 16, 1989.

Presentations

1. Adams GL: "Tumors of the parotid gland," "Carcinoma of the head and neck," "Tonsillectomy and adenoidectomy." Family Practice Update and Review, University of Minnesota, February 1973.

2. Adams GL: Laryngeal Injury Workshop. Maxillofacial Trauma CME Course. University of Minnesota, September 1973.

3. Adams GL: Prosthodontic Graduate Course, "Cancer of the head and neck." University of Minnesota, April 1975, 1976, 1977, 1978.

4. Berlinger N, Tsakraklides V, Adams GL, Pollak K, Yang M, Good R: Prognostic significance of lymph node histology in patients with squamous cell carcinoma of the larynx, pharynx, or oral cavity. Presented at the Triological Society Meeting, Atlanta, GA, April 1975.

5. Adams GL: Detection and management of recurrent laryngeal cancer, Mayo Clinic, Rochester, MN, June 17, 1975.

6. Adams GL: Salivary gland disease. Practical Otolaryngology CME Course, University of Minnesota, Minneapolis, MN, February 23, 1976.

7. Adams GL: Cancer of the head and neck, Western Wisconsin Medical Society, Eau Claire, WI, April, 1976.

8. Adams GL: Current concepts in thoracic disease: Evaluation of hoarseness. Presented by the University of Minnesota, March 24-26, 1977.

9. Adams GL: Maxillo-facial trauma. Sponsored by the University of Minnesota and the American Academy of Facial, Plastic and Reconstructive Surgery, St. Paul Ramsey Hospital, April 11-17, 1977.

10. Adams GL: Continuing Medical Education for Pharmacists (Tape presentation for community events), throughout 1978.

11. Adams GL: Oncocytic lesions of the larynx, Southern Section of the Triological Society, New Orleans, LA, January 10, 1978.

12. Adams GL: Salivary gland disease. Practical Otolaryngology CME Course, University of Minnesota, Minneapolis, MN, February 20-21, 1978.

13. Adams GL: Causes of sore throat and oral lesions and head and neck tumors. Curriculum of General Internal Medicine Residents, Veterans Administration Hospital, Minneapolis, MN, March 16, 1978.

14. Adams GL: Head and neck oncology (steering committee meeting), Madison, WI, May 4, 1978.

15. Adams GL: Head and neck cancer. Tri-State Otolaryngologic Society, L'hotel de France, Bloomington, MN, August 22, 1978.

16. Adams GL: Head and neck cancer. Medical Conference, St. Cloud, MN, August 26, 1978.

17. Adams GL: Dysphagia in laryngectomized patients. American Academy of Ophthalmology and Otolaryngology, Las Vegas, NV, September 11-13, 1978.

18. Adams GL: Management of oral and skin lesions. Maxillofacial Trauma CME Course, Hennepin County Medical Center, Minneapolis, MN, October 13, 1978.

19. Adams GL: Causes of sore throat, oral lesions, and head and neck tumors. Curriculum of General Internal Medicine Residents, Veterans Administration

Medical Center, Minneapolis, MN, November 2, 1978.

20. Adams GL: Management of head and neck cancer with preoperative radiation, Eastern Cooperative Oncology Group, Boston, MA, November 13, 1978.

21. Adams GL: Dysphagia and lumps in the throat. Practical Otolaryngology CME Course, University of Minnesota, Minneapolis, MN, February 18, 1978.

22. Adams GL: Disorders of the parotid gland. Practical Otolaryngology CME Course, University of Minnesota, Minneapolis, MN, February 20-21, 1979.

23. Adams GL: Metastatic carcinoma of the temporal bone. Triological Meeting, Los Angeles, CA, April, 1979.

24. Adams GL: Mandibular reconstruction with titanium mesh graft and otogenous bone marrow. American Academy of Facial, Plastic and Reconstructive Surgery, New Orleans, LA, April 27, 1979.

25. Adams GL: Combined modalities in treatment of head and neck cancer, University of Minnesota, Minneapolis, MN, June 18, 1979.

26. Adams GL: Multidisciplinary management of head and neck cancer. American Cancer Society, Graduate Education Course. University of Minnesota, June 1979.

27. Adams GL: Infections of the head and neck. Pulmonary Disease Course, University of Minnesota, Minneapolis, MN, January, 1980.

28. Adams GL: Current concepts in head and neck cancer. Practical Ear, Nose and Throat Course, Bloomington, MN, February 8-9, 1980.

29. Adams GL: Maxillo-facial trauma. Sponsored by the American Academy of Facial, Plastic, and Reconstructive Surgery. University of Minnesota, May 14-15, 1980.

30. Adams GL: Tonsillectomy and adenoidectomy. Practical Ear, Nose and Throat Course, L'hotel de France, Bloomington, MN, February 8-9, 1980.

31. Adams GL: Fractures of the zygoma. Maxillofacial Trauma Course, American Academy of Facial, Plastic, and Reconstructive Surgery, University of Minnesota, St. Paul, MN, May 16-18, 1980.

32. Adams GL: Carcinoma of the tonsil: Combined radiation and surgery compared to full course radiation therapy in advanced cancer. American Academy of Otolaryngology, Anaheim, CA, September 27-October 1, 1980.

33. Adams GL: Lipomatosis of the parotid gland in a two-month-old child. American Academy of Otolaryngology, Anaheim, CA, September 27-October 1, 1980.

34. Adams GL: Multi-stage treatment and reconstruction of the facial gunshot patient. American Academy of Otolaryngology, Anaheim, CA, September 27-October 1, 1980.

35. Adams GL, Giordano A, Cohen J: Esophagram following laryngectomy. Minnesota Academy of Otolaryngology, December 13, 1980.

36. Adams GL: Tonsillectomy and adenoidectomy. Otolaryngology Update, Minneapolis, MN, February, 1981.

37. Adams GL: Adenocarcinoma of the head and neck. Presented at the Minnesota Head and Neck Oncology Program, University of Minnesota, Minneapolis, MN, March 1981.

38. Szachowicz E, Gudbrandsson F, Adams GL: The unknown primary carcinoma. Presented at the Minnesota Academy of Ophthalmology and Otolaryngology, December,

1981.

39. Adams GL, Maisel R, Hilger P: Gunshot wounds of the face, Presented at the American Academy of Otolaryngology, 1979-80-81.

40. Adams GL, et al.: Mandibular reconstruction. Presented at the American Academy of Otolaryngology, 1981-present.

41. Adams GL: Foreign body management. Presented at the Family Practice Update, Office Management in ENT. University of Minnesota, Minneapolis, MN, February 26-27, 1982.

42. Adams GL: Infants and children: Common ENT problems. Presented at the Family Practice Update, Office Management in ENT. University of Minnesota, Minneapolis, MN, February 26-27, 1982.

43. Adams GL, Ryu D: Large extracranial meningioma. Poster, presented at the American Academy of Otolaryngology-Head and Neck Surgery, September, 1982.

44. Adams GL (poster): Meningioma presenting as a parapharyngeal space mass. Presented at the American Academy of Otolaryngology, New Orleans, LA, October, 1982.

45. Giordano A, Cohen J, Adams GL: Pharyngocutaneous fistula after laryngeal surgery: The role of the barium swallow. Presented at the Academy of Otolaryngology-Head and Neck Surgery (Research Forum) New Orleans, October 17, 1982.

46. ElGabri T, Adams GL: Simultaneous carcinoma of the head, neck and lung. Presented at the Minnesota Academy of Otolaryngology-Head and Neck Surgery, December, 1982.

47. Adams GL, Berlinger N, Cohen J, Ayre T: Sinusitis in bone marrow transplant patients. Presented at the Minnesota Academy of Otolaryngology-Head and Neck Surgery, December, 1982.

48. Adams GL: Infants and children: Common ENT problems. Family Practice Update, Continuing Medical Education, Minneapolis, MN, February, 1983.

49. Adams GL: Combined modalities in the treatment of head and neck surgeries. Presented to the Grand Forks Medical Society, Grand Forks, N.D., March 16, 1983.

50. Rothstein J, Adams GL, Galliani C, Elliott G: Relapsing polychondritis in a 30-month-old child. Presented at the American Academy of Otolaryngology-Head and Neck Surgery, Anaheim, 1983.

51. Adams GL: Combined modality in the treatment of head and neck cancer: Implications for the pathologist. Presented to the E. T. Bell Fall Pathology Symposium: Current Concepts in Head and Neck cancer, University of Minnesota, November 4, 1983.

52. Adams GL: Cancer of the head and neck: Treatment with combined modalities. Presented to the Society of Oral Surgeons, Cable, WI, February 18, 1984.

53. Adams GL: Recognition of recurrent cancer of the larynx. Mayo Clinic Symposium on Laryngectomies, 1984.

54. Adams GL, Hilger P: Mandibular reconstruction. Presented to the Society for Plastic and Reconstructive Surgery, Palm Beach, FL, 1984.

55. Adams GL, Hilger P: Mandibular reconstruction with the synthese bar. Presented to the Triological Society, May, 1984, Palm Beach, FL.

56. Adams GL: Recognition of recurrent cancer of the larynx. A poster presentation to the American Academy of Otolaryngology-Head and Neck Surgery, Las Vegas, NV, September, 1984.

57. Moreano A, Adams GL: Malignant fibrous histiocytoma. Presented at the American Academy of Otolaryngology, Las Vegas, NV, September, 1984.

58. Adams GL: Midfacial fractures. Presented at the Maxillofacial Trauma Course, University of MN Continuing Medical Eduction, October 12, 1984.

59. Griebie M, Adams GL: Prophylactic antibiotics and complications in head and neck surgery. Minnesota Academy of Ophthalmology and Otolaryngology, December 1984.

60. Adams GL: Combined modalities in the treatment of head and neck cancer. University of Minnesota Department of Oral Surgery, November 15, 1984.

61. Porto D, Adams GL, Foster C: Current management of carotid artery blowouts. Midsection Meeting of the Triological Society, January, 1985, Rochester, MN.

62. Adams GL: University of Minnesota experience with chemotherapy, radiation therapy, and surgery. Presented at the Continuing Medical Education Conference on Radiation Therapy: Current Concepts in Radiation Therapy, May 24, 1985.

63. Adams GL: Combined therapy in the treatment of head and neck cancer. Presented at the Department of Radiation Therapy Update, University of Minnesota, June, 1985.

64. Porto D, Adams GL, Ewing S: Neuroectodermal pharyngeal carcinoma of the larynx. Presented at the American Academy of Otolaryngology Meeting, Atlanta, GA, October, 1985.

65. Agarwal S, Adams GL: Epidermal cyst of the maxilla. A poster presentation at the American Academy of Otolaryngology-Head and Neck Surgery, Atlanta, GA, October, 1985.

66. Malone B, Adams GL, Ewing S: Inverting papilloma with synchronous verrucous carcinoma of the maxilla. A poster presentation at the American Academy of Otolaryngology-Head and Neck Surgery, Atlanta, GA, October, 1985.

67. Biel M, Adams GL, Liston S, Johnson B: Neck swellings in trumpet players. A poster presentation at the American Academy of Otolaryngology-Head and Neck Surgery, Atlanta, GA, October, 1985.

68. Adams GL: Examination of the ear. Bloomington School Nurses Association, January, 1986.

69. Lowry L, Pajak T, Schuller D, Adams GL, Fee W: Prospective studies on head and neck cancer. A miniseminar at the American Academy of Otolaryngology-Head and Neck Surgery, San Antonio, TX, September, 1986.

70. Adams GL: Multiple modalities in the treatment of head and neck cancers. Presented at the Minnesota Tumor Registrars Association Fall Workshop, Minneapolis Veterans' Administration Medical Center, October, 1986.

71. Adams GL: Common childhood ENT problems. Presented at Office Management of Ear, Nose and Throat, a seminar offered by Continuing Medical Education, University of Minnesota, October, 1986.

72. Adams GL: Peritonsillar abscess and deep neck infections. Presented at Office Management of Ear, Nose and Throat, a seminar offered by Continuing Medical Education, University of Minnesota, October, 1986.

73. Griebie M, Adams GL: "Emergency" laryngectomy and stomal recurrence. Presented at the Midsection Meeting of the Triological Society, Cleveland, OH, January, 1987.

74. Adams GL: Medical and physical aspects of the resurrection. Presented to the Bloomington Clergy Association, Bloomington, MN, March, 1987.

75. Adams GL: Preliminary results, study on combined radiation therapy and cisplatinum for inoperable squamous cell carcinoma of the head and neck. Presented to the Intergroup of ECOG, Philadelphia, PA, July 1987.

76. Adams GL: Update on prospective head and neck cancer studies. Presented to the American Academy of Otolaryngology, Chicago, IL, September 1987.

77. Adams GL: Preliminary results of Protocol 2382: Inoperable head and neck cancer. Presented to ECOG, Clearwater, FL, November, 1987.

78. Aden KK, Adams GL: Adenosquamous carcinoma of the larynx and hypopharynx. Presented to the American Laryngological Society, Palm Beach, FL, April, 1988.

79. Odland RM, Adams GL: Pneumothorax as a complication of tracheoesophageal voice prosthesis use. Presented to the American Broncho-Esophagological Society, Palm Beach, FL, April, 1988.

80. Adams GL: Fractures of the Zygomatic Malar Complex. Presentation at Maxillofacial Trauma CME Course, University of Minnesota, June 3, 1988.

81. Kimberley BP, Scheller L, Adams GL, Nelson DA, Lee A, Levine S: Cochlear implant hearing performance at the University of Minnesota. Presented at the Annual Meeting of the Canadian Society of Otolaryngology-Head and Neck Surgery, Vancouver, British Columbia, June, 1988

82. Adams GL, Abdel-Fattah H: Hemangiopericytoma of the head and neck. Presented to the Second International Head and Neck Cancer Symposium, Boston, MA, August, 1988.

83. Adams GL: Clinical Correlation and Anatomy of the Ear. Lecture to medical student anatomy course, University of Minnesota, August 26, 1988.

84. Larson J, Adams GL: The incidence and significance of second primary malignancies in patients with head and neck cancer. Presentation at AAO-HNS Annual Meeting, Washington DC, September, 1988.

85. Fee W, Schuller D, Lowry D, Jacobs J, Adams G: Prospective Trials in Head and Neck Cancer Treatment. Panel presentation, AAO-HNS, Washington DC, September, 1988.

86. Adams GL: Use of the CO2 Laser for Cancer of the Oral Cavity. Presentation at Laser Surgery in Otolaryngology CME Course, University of Minnesota, November, 1988.

87. Adams GL: Malignancies of temporal bone and skull base. Alexandria International Conference on Otological Disorders, Friendship Society of Otolaryngology, Alexandria, EGYPT, April 3, 1989.

88. Adams GL: Cochlear implant program in Minnesota. Alexandria International Conference on Otological Disorders, Friendship Society of Otolaryngology, Alexandria, EGYPT, April 4, 1989.

89. Adams GL: Oral and pharyngeal cancer: treatment with combined modalities. Minnesota Dental Association Star of the North Meeting, April 17, 1989.

90. Adams GL: Case Presentations. "Current Concepts in Radiation Therapy" CME Course, University of Minnesota, May, 1989.

91. Adams GL: Current status of Head and Neck Intergroup Prospective Protocols, General Session presentation at Eastern Cooperative Oncology Group meeting, Atlanta, June 13, 1989.

92. Adams GL: Current prospective head and neck protocols. Surgical Committee presentation, Eastern Cooperative Oncology Group meeting, Atlanta, June 13, 1989.

93. Adams GL: Unresectable studies--proposed phase III replacement. Head and Neck InterGroup Steering Committee presentation, Eastern Cooperative Oncology Group meeting, Atlanta, June 14, 1989.

94. Adams GL: Surgical infections involving the head and neck. (Postgraduate course No. 16: Head and Neck Surgery for the General Surgeon.) 75th Annual Clinical Congress of the American College of Surgeons, Atlanta, Georgia, October 16, 1989.

95. Akale D, Adams GL, Leonard A, Goodale R, Hulbert J, Zachary M: University of Minnesota Laser Program: Combined use of laser with standard surgical techniques. Educational display at 75th Annual Clinical Congress of the American College of Surgeons, Atlanta, Georgia, October 1989.

96. Clayman GL, Adams GL, Paugh D, Koopmann CF: Intracranial complications of paranasal sinusitis--a combined institutional approach. Western Section Meeting, Triological Society, Pebble Beach California, January 7, 1990.

97. Adams GL: Indications for Tonsillectomy and Adenoidectomy. Medical Update 1990, Department of Surgery and Office of Continuing Medical Education, University of Minnesota; Fort Lauderdale, Florida, March 1990.

98. Adams GL: Complications of Sinusitis. Medical Update 1990, Department of Surgery and Office of Continuing Medical Education, University of Minnesota; Fort Lauderdale, Florida, March 1990.

99. Adams GL: Cochlear Implant Update. Medical Update 1990, Department of Surgery and Office of Continuing Medical Education, University of Minnesota; Fort Lauderdale, Florida, March 1990.

100. Adams GL: Cancer of the Oral Cavity. Medical Update 1990, Department of Surgery and Office of Continuing Medical Education, University of Minnesota; Fort Lauderdale, Florida, March 1990.

101. Adams GL: Management of Sinusitis and Nasal Polyps. 48th Annual Course in Allergy and Clinical Immunology, Department of Medicine and Office of Continuing Medical Education, University of Minnesota, April 20, 1990.

102. Adams GL: Use of the Laser in the Oral Cavity. Applied Laser Surgery in Otolaryngology. Departments of Otolaryngology and Dermatology and Office of Continuing Medical Education, University of Minnesota, April 21, 1990.

103. Anderson CB, Adams GL, Neglia JP: Tracheostomy in Bone Marrow Transplant Patients. American Broncho-Esophagological Association Meeting, Palm Beach, Florida, May 2, 1990.

104. Adams GL: Upper Airway Problems in Children. Twin Cities Pediatric Chest Conference, University of Minnesota, June 6, 1990.

105. Cross DS, Juhn SK, Adams GL: Role of Variable Prostaglandin Metabolites Mediating Immune Response in Squamous Cell Carcinoma of the Head and Neck. 94th Annual Meeting of the American Academy of Otolaryngology-Head and Neck Surgery, September 10, 1990.

106. Adams GL: Sinusitis. Surgery-Medical clinics for Family Practice. Department of Surgery, University of Minnesota, Grand View Lodge, Brainerd, September 15, 1990.

107. Adams GL: Current Prospective Trials in Head and Neck Cancer. Immunobiology: Head and Neck Cancer, 1990. Department of Otolaryngology and Office of Continuing Medical Education, University of Minnesota, Minneapolis, September 22, 1990.

108. Adams GL: Surgical Treatment of Dysphagia. Third International Otolaryngology Symposium, Innsbruck, Austria, September 26, 1990.

109. Adams GL: Parotid Disease (panel discussion). Third International Otolaryngology Symposium, Innsbruck, Austria, September 27, 1990.

110. Adams GL: Airway Assessment and Management in the Trauma Patient. Department of Oral and Maxillofacial Surgery, University of Minnesota, October 25, 1990.

111. Adams GL: Otolaryngology. Laser Nurse Seminar and Workshop, University of Minnesota, February 8, 1991.

112. Adams GL: Anesthesia . Laser Nurse Seminar and Workshop, University of Minnesota, February 8, 1991.

113. Cross DS, Platt JL, Juhn SK, Bach FH, Adams GL: Enhancement of Tumor Infiltrating Lymphocyte Response in Squamous Cell Carcinoma of the Head and Neck using a Prostaglandin Synthesis Inhibitor. Presented at the American Society of Head and Neck Surgery 32nd Annual Meeting, April, 1991.

UNIVERSI . OF MINNESOTA HOSPITAL AND CLINIC "PRELIMIN. .Y"

CAPITAL EXPENDITURES

7-1-90 THRU 06-30-91

RECURRING EQUIP & REMOD	BUDGET	ROLLFORWARD FROM 6-30-90	TOTAL	12-MONTH BUDGET	12-MONTH ROLLFORWARD	TOTAL	90-91 ACTUAL	89-90 ROLLFORWARD	TOTAL
EQUIPMENT PURCHASES									
90-91 BUDGET	$5,669,600		$5,669,600	$5,669,600		$5,669,600	$2,880,425	$0	$2,880,425
ROLLFORWARD		$6,224,875	$6,224,875		$6,224,875	$6,224,875	$0	$2,746,423	$2,746,423
	$5,669,600	$6,224,875	$11,894,475	$5,669,600	$6,224,875	$11,894,475	$2,880,425	$2,746,423	$5,626,848
REMODELING PROJECTS	$1,330,400		$1,330,400	$1,330,400		$1,330,400	$374,216	$669,469	$1,043,685
	$7,000,000	$6,224,875	$13,224,875	$7,000,000	$6,224,875	$13,224,875	$3,254,641	$3,415,892	$6,670,533
PRINCIPLE PAYMENTS									
LAB CHEMICAL ANALIZERS	$116,158		$116,158			$116,158			$107,881
CT SCANNER	$207,000		$207,000			$207,000			$207,000
COMPUTER EQUIP	$174,891		$174,891			$174,891			$174,889
MRI 2	$429,579		$429,579			$429,579			$429,579
	$927,628		$927,628			$927,628			$919,349
TOTAL:	$7,927,628		$14,152,503			$14,152,503			$7,589,882
BOND PAYMENTS:	$2,345,000	(PAYMENTS MADE FEB. 1, 1991)							

CAPITAL PROJECTS:	UMHC FUNDS FROM RESERVES	ADDITIONAL FUNDS FROM OTHER SOURCES	TOTAL AUTHORIZED BUDGET	1st QUARTER EXPEND. 1990-91	2nd QUARTER EXPEND. 1990-91	3rd QUARTER EXPEND. 1990-91	4th QUARTER EXPEND. 1990-91	Y-T-D 1990-1991	CURRENT & PRIOR YEAR EXPENDITURES
(1) ARCHITECT FEES PH II					$171,179	$169,618	$174,513	$515,310	$814,819
(1) OFFSITE RELOC.							$10,516	$10,516	$10,516
(1) AUTOPSY			$415,000				$121,001	$121,001	$121,001
BMT/ICU 4F			$100,000				$85,736	$85,736	$85,736
BONE MARROW TRAN. EXP.			$220,000				$3,466	$3,466	$3,466
NEURO-ANGIOGRAPHY SYST			$1,900,000				$30,000	$30,000	$30,000
DERMATOLOGY	$679,069	$233,889	$912,958		$2,180			$2,180	$869,912
CUHCC	$2,200,000	$150,000	$2,350,000	$58,887	$284,700	$829,812	$507,523	$1,680,922	$2,078,927
MAYO 4 SURG	$1,029,350		$1,029,350			$6,892		$6,892	$1,043,379
MASONIC HOSP	$835,000	$800,000	$1,635,000		$29,299	$38,778		$68,077	$1,669,567
COMPUTER UPGRADE	$850,000		$850,000		$348,969	$80,816	$150,316	$580,101	$580,101
C.T. SCANNER	$1,217,000		$1,217,000		$968,000	$242,000		$1,210,000	$1,210,000
CARDIOVASCULAR RAD.	$863,000		$863,000		$689,939		$170,416	$860,355	$860,355
LABS COMPUTER SYST. EXP.	$306,000		$306,000			$253,950		$253,950	$253,950
HEART CATH ROOM	$3,100,000		$3,100,000			$13,109		$13,109	$13,109
TOTAL	$11,079,419	$1,183,889	$14,898,308	$58,887	$2,494,266	$1,634,975	$1,253,487	$5,441,615	$9,644,838

1.) THESE PROJECT COSTS ARE BUDGETED FOR IN THE $37.62 MILLION RENOVATION PROJECT.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 16, 1991

TO: Members, Board of Governors

FROM: Greg Hart

RE: Quarterly Purchasing Report

Attached please find the quarterly purchasing report for the period April - June, 1991. The report will be reviewed at the October Committee meeting. Following the review we will be seeking endorsement of the report.

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

/gs

attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF APRIL - JUNE 1991

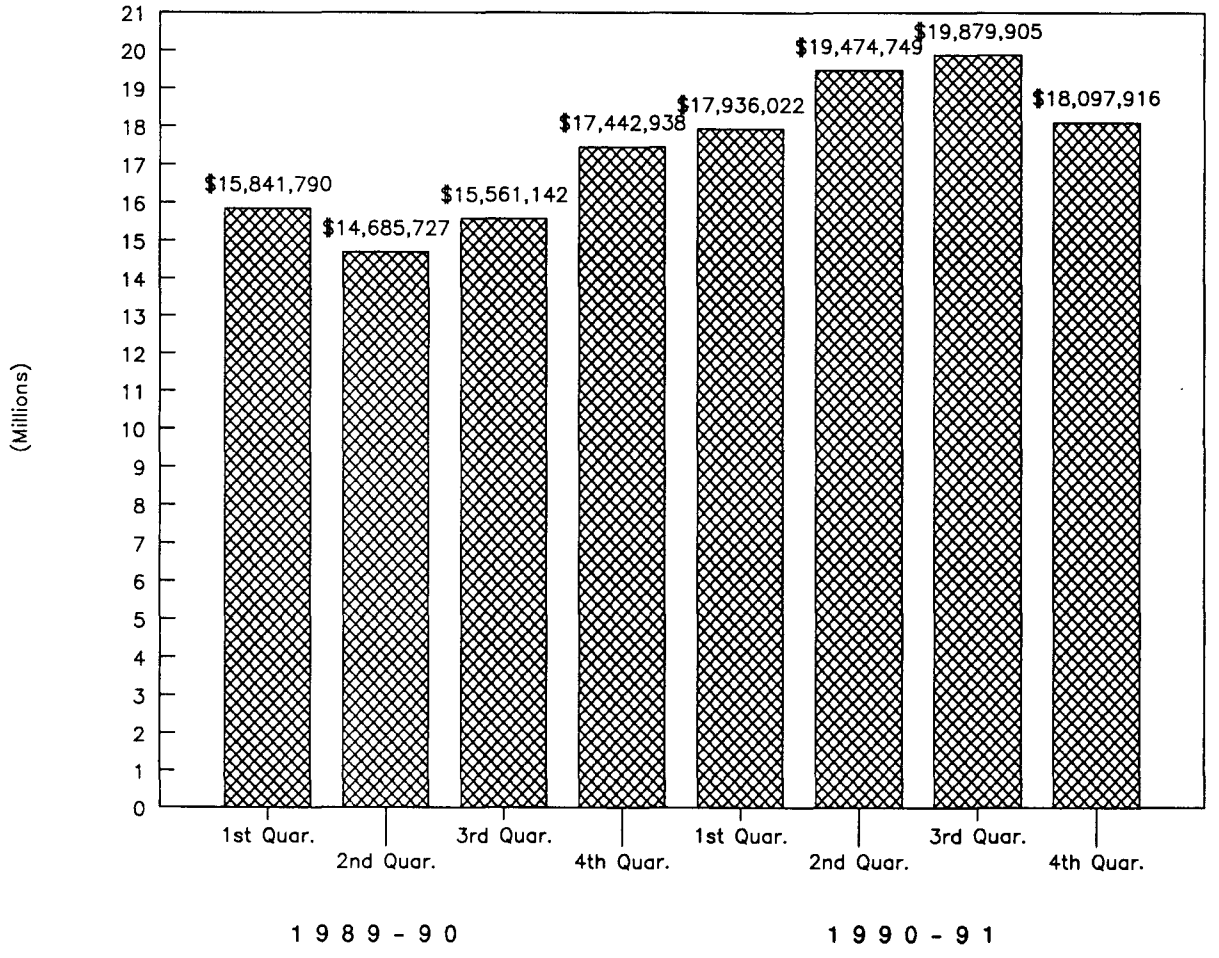
I. PURCHASE ORDER ACTIVITY

II. AWARDS TO OTHER THAN APPARENT LOW BIDDER

III. SOLE SOURCE ACTIVITY

IV. VENDOR APPEALS

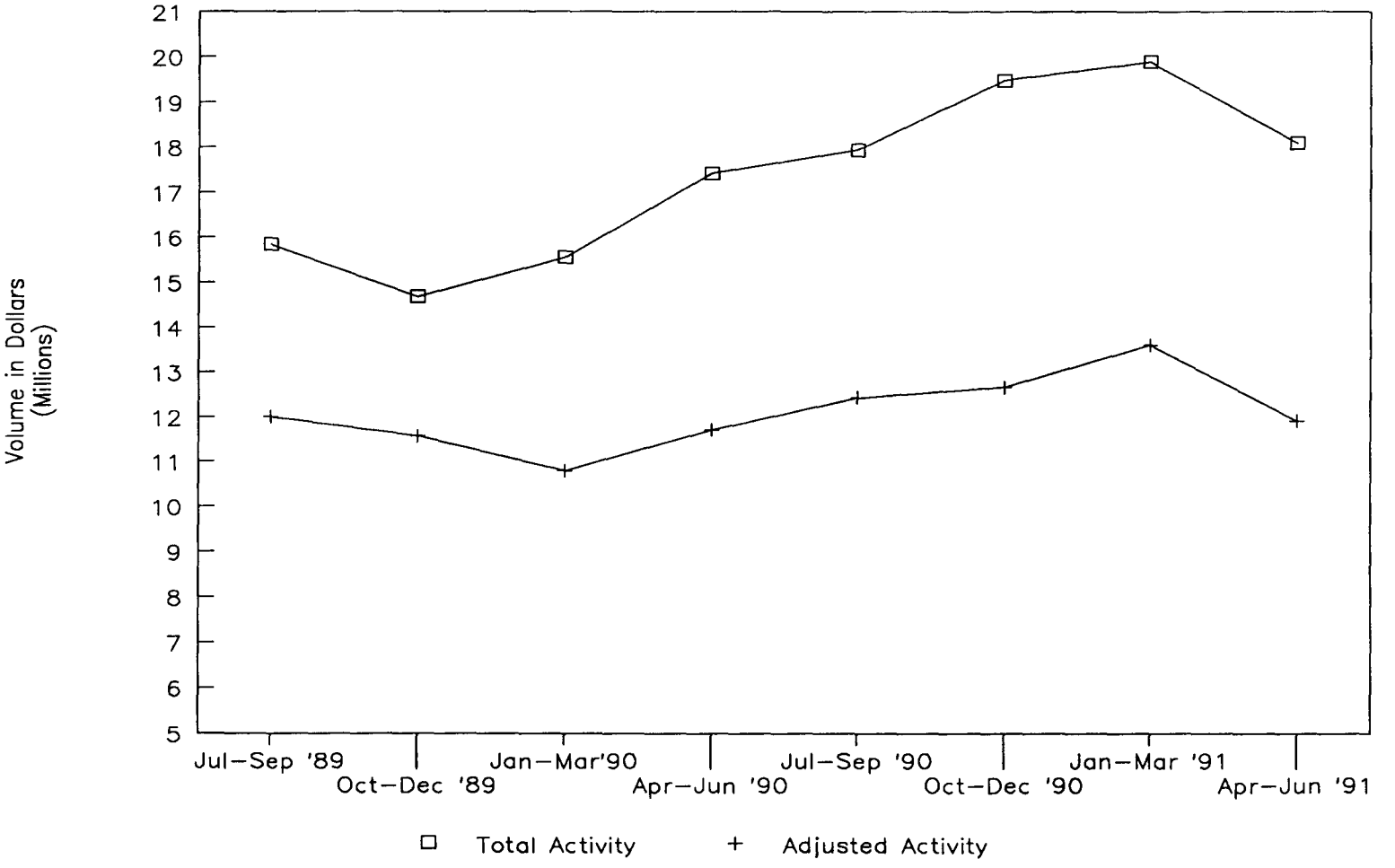
PURCHASE ORDER ACTIVITY



FOURTH QUARTER, FISCAL YEAR 1990–91, ACTIVITY:

	NUMBER	VALUE
PURCHASE ORDERS	9028	$16,746,605.12
OTHER PAYMENTS	524	$894,633.21
CONFIRMING ORDERS	384	$456,677.17
TOTAL THIS QUARTER	9,936	$18,097,915.50

ADJUSTED PURCHASING ACTIVITY



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

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	RT Circuit	North Star Medical $ 15,624.00	Medical Oxygen $ 17,850.00	Materials
		The available patient wye ports for carbon dioxide sampling were not acceptable because the resulting position of the 3 way stopcock created a potential hazard of becoming disconnected.		
2.	Dialyzer	Central Medical $ 60,336.00 Fresinius $ 54,720.00	Cobe $ 71,856.00	Materials
		The dialyzer was difficult to prime, required excessive time to complete dialysis, caused excessive clotting of blood, and did not meet Uf rate specification.		
3.	Video Equipment	Concept $ 22,610.00 Karl Storz $ 23,443.00	Dyonics $ 24,185.00	O.R.
		The specification for millimeter and degree size of the arthroscope and cannula were not met exactly which is critical for TMJ surgery.		
4.	Surgical Towels	E & I $ 10,272.00 Medline $ 10,200.00 Menard $ 10,119.99	Standard Textile $ 10,464.00	Materials
		Towels were too linty and shrunk excessively.		

5.	Transport Monitor	International Medical $ 18,577.50	Narco Medical $ 20,000.00	Cardiopulmonary
		Monitor is too heavy for carrying.		
6.	Huber Point Needles	Medix $ 13,006.50 Marquette $ 21,037.05	Pharmacia $ 28,275.00	Materials
		Needles are siliconized which makes them easier to unintentionally displace.		
		Burron $ 21,771.75	Pharmacia $ 28,275.00	
		Wings are small and smooth making them difficult to grip and remove. The side port is too short and the needle cover is awkwardly designed, increasing the risk of needle sticks.		

III. SOLE SOURCE–$5,000 and Over

	VENDOR	CONTRACT/ P.O. #	VALUE	DEPT.	PRODUCT
	Datascope	H100188	$22,500.00	Cardio–Resp	Intra–Aortic Balloon Pump
	Medical Specialties	H100102	$11,700.00	Cardio–Resp	Trace Monitors
	Medical Specialities	H110886	$11,850.00	Cardio–Resp	Ventilators & Gas Monitor Rental
	Kin Incorporated	H100080	$33,838.00	Labs	Autopsy Chamber
	Curtin Matheson	91–355	Open	Labs	Hematology Reagents
	Applied Biosystems	H116405	$36,000.00	Labs	Nucleic Acid Purification System
	Applied Biosystems	91–400	Open	Labs	Reagents
	Shandon	H100112	$13,440.00	Labs	Autopsy Table
	Cardio Methics	H100115	$28,750.00	Labs	Blood Flow Velocity Monitoring System
	Robbins Scientific	91–357	Open	Labs	HLA Cell Prep
	Coulter Source	H100199	$10,445.25	Labs	Analyzer, Micro–Processor
	Wampole Laboratories	H110864	$42,954.96	Labs	Microbial Equipment
	Bard	H432722	$9,205.00	M.S./CSP	Electrode Catheters
	Dictaphone	H100101	$6,234.00	Med. Rec.	Dictation Stations
	Rauland Borg	H100167	$13,548.00	Nursing	Nurse Call System
	Hoffman Surgical	H116569	$15,225.00	Nursing	Mobile Incubator System
	Pentax	H100161	$6,500.00	Outpatient	Gastroscope
	Roho	H110945	$15,120.00	O.R.	Surgery Table Mattress Rental
*	Gore	91–412	$56,834.00	O.R.	Grafts
	3M	91–414	Open	O.R.	Orthopedic Staples
	Impra	91–411	$9,325.00	O.R.	Grafts
	S.I.A.	91–413	$19,960.00	O.R.	Grafts
	Medtronic	91–406	Open	O.R.	Drug Delivery Pumps
	Roho	H116573	$6,116.00	O.R.	Surgery Table Mattress Rental
	Stryker Corporation	H115614	$5,131.00	O.R.	Micro Oscillation Saw
*	Construction Spec.	H100078	$50,140.00	O.R.	Rails & Guards
	Medtronic	H115625	$5,400.00	O.R.	External Pacemakers
	Premier Anterior Sys.	H116081	$34,480.00	O.R.	Instruments
	Key Functional Assessment	H116079	$25,166.00	P.M.& R.	Functional Assessment System
*	ATL	H100196	$99,900.00	Radiology	Ultrasound Upgrade
	3M Imaging	H100140	$31,788.00	Radiology	Laser Printer System
	TOTAL		$621,550.21		

* Over $50,000

IV. VENDOR APPEALS

1. VENDOR NAME/DOLLAR AMOUNT: Baxter/$77,500.00
   NATURE OF PURCHASE: Sequential Compression Devices
   INTENDED VENDOR/DOLLAR AMOUNT: Kendall/$87,500.00

   REASON FOR APPEAL:

   Product was found to be unacceptable because the therapy offered was intermittent rather than sequential compression as specified, and not considered equivalent. Vendor responded with numerous clinical studies which have been referred to medical staff for opinions as to whether the therapy warrants evaluation.

   STATUS: Pending.

2. VENDOR NAME/DOLLAR AMOUNT: Baxter/$1,117.25
   NATURE OF PURCHASE: Electrodes
   INTENDED VENDOR/DOLLAR AMOUNT: AMI/$528.99
   Lectec/$650.00

   REASON FOR APPEAL:

   Product was found unacceptable because the electrodes were packaged in threes, not singles, as specified. Vendor contended that the gel on their electrodes would not dry out once a package was opened and should therefore be equivalent to a single pack. Upon re-evaluation the product has still been found unacceptable because of the packaging. The potential cost savings of $80.00 does not warrant the administrative costs of switching stocking and issuing units, and would be negated by increased waste because opened packages in patients rooms would not be returned to stock upon discharge of the patient.

   STATUS: Award is pending final notification of Baxter.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 16, 1991

TO: Members, Board of Governors

FROM: Fred Bertschinger

SUBJECT: Development Office Quarterly Report

Attached for your information are summary reports of activities and donations received during the fourth quarter of FY 1991, totals for FY 1991, and summaries for the first quarter of FY 1992.

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

Contributions Received
UMHC Development Office
FY 1991

	I 7-9/90	II 10-12/90	III 1-3/91	IV 4-6/91	**Totals**
Patients Fund	$1,916	$2,044	$1,807	$2,916	**$8,683**
Transplant Asst Fund	1,830	3,442	34,541	4,317	**44,130**
Variety Club Pldg	4,460	20,565	554,177	385	**579,587**
Other Funds	138,148	119,534	119,009	237,944	**614,635**
Totals to Funds	$146,354	$145,585	$709,534	245,562	$1,247,035

Goal = $1,050,000

Irrevocable Future Gifts	0	2	0	0	2
Revocable Future Gifts	2	0	0	0	2

Contributions Received
UMHC Development Office
FY 1992

	I 7-9/91	II 10-12/91	III 1-3/92	IV 4-6/92	Totals	Goals
Patients Fund	$2,199				$2,199	$9,000
Transplant Asst Fund	7,454				7,454	46,000
Variety Club Pldg	189,300				189,300	700,000
Other Funds	200,516				200,516	445,000
Totals	$399,469				$399,469	$1,200,000

Irrevocable Future Gifts	0	4
Revocable Future Gifts	0	4

UMHC Development Office
FY 1992

Production Goals by Sources

		Goal
1.	Current Giving	
	A. New Former Patients - Mail	$ 2,000
	B. Lybunts and Pybunts - Mail and Phone	25,000
	C. Special Events	20,000
	D. Annual Campaign - Internal; Mail	20,000
	E. CWA Local 7200/US WEST Campaign	33,000
	F. Shelter Fund Project	5,000
	G. Peds Audio Project	10,000
	H. Chaplaincy Campaign	100,000
	I. Variety Club	350,000
	J. Tribute	35,000
	K. Bequests	400,000
II.	Deferred	
	A. Trusts, insurance, etc.	200,000
	Total	$1,200,000

UNIVERSITY OF MINNESOTA
TWIN CITIES

Development Office
The University of Minnesota Hospital and Clinic
Box 612 UMHC
Harvard Street at East River Parkway
Minneapolis, Minnesota 55455

Activities and Events
UMHC Development Office
FY 1991

1990

August 9	Begin first of six luncheons and tours for solicitors for the CWA Local 7200/U.S. West Charity Project.
September 8	Donor recognition event hosted by Bob and Sue Dickler - tour and dinner at UMHC followed by Gopher football game.
September 13	Kick-off for CWA Local 7200/U.S. West United Way and UMHC Transplant Assistance Fund Campaign. Goals of $30,000 and new organ donors.
October 17	U of M President's Club Annual Dinner Meeting.
November 4	Gopher Exhibition Basketball Game to benefit Child/Family Life.
November 15	Philanthropy Day recognition for Dr. Neal Gault and Genevieve Stelberg.
November 25	Annual Report To Donors - FY 1990 mailed.
December 3	Employee/Staff Annual Campaign solicitation mailed.
December 6	GIFT-ED, a U of M Foundation publication, mailed to major donors, administrators, department heads, and friends.

1991

January 16	CWA Local 7200/US West check presentation for the Transplant Assistance Fund. $30,000, plus $5,022 in matching gifts from the US West Foundation.
January 21	National Association for Hospital Development Region VII meeting with national president at Fairview.
January 28	Variety Club Childrens Hospital Pledge Advisory Committee meeting to approve 1991 allocations.

February 4	University and related organizations Development Officers for children's programs - meeting for coordination and joint project.
February 16	Minneapolis Commodores Chorus annual concert to benefit U of M for heart research. Expect $6,500.
March 25	Begin direct mail portion of Annual Campaign solicitation of former donors. Done in conjunction with U of M Development Office-Current Giving Department. Telemarketing to begin May 20.
April 28	Variety Club's Affair of the Heart annual benefit event.
May 7	MN Alumni Association Annual Meeting featuring August Wilson. We hosted 16 donors and friends.
May 15	Sigma Chi Derby Days to benefit Child and Family Life Services.
May 20	Begin telemarketing for previous donors.
June 17	CWA Local 7200/US WEST, Transplant Assistance Fund Campaign, "Head Start Kickoff".
June 27	UMHC Turtle Derby to benefit Child and Family Life Services.

Activities and Events
UMHC Development Office
FY 1992

1992

July 1	Begin preparation of articles and reports for the Annual Report to Donors.
July 10	CWA Local 7200/US WEST Direct, Transplant Assistance Fund Campaign, Kickoff.
July 30	Plan for Childrens Audio Arts project.
August 1	Begin CWA Local 7200/US WEST solicitors tours and luncheons.
August 28	Plan new efforts for solicitation of prospects and former donors by University of Minnesota Foundations Annual Giving Staff.
September 10	CWA Local 7200/US WEST, Transplant Assistance Fund Kickoff.
September 13	Mark Skogquist Memorial Golf Tournament to benefit leukemia research.
October 1	Commodores Chorus Recognition Luncheon and presentation of check for $6,300 for special heart research equipment.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 17, 1991

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - First Quarter
Fiscal Year 1991-92

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the first quarter of 1991-92 is $620,793.22 represented by 2,160 accounts. Bad debt recoveries during the period amounted to $10,650.66 (44 accounts) leaving a net charge-off of $610,142.56.

The net bad debts of $610,142.56 for the quarter were 0.67% of gross charges. This compares to a budgeted level of bad debts of 0.79% ($772,558).

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 Hospital Billing Department

Bad Debt Statistics July 1991 through September 1991
in five ranges of account size

	Less Than $100	# of Accounts	$100 – $999	# of Accounts	$1000 – $1999	# of Accounts	$2000 – $9,999	# of Accounts	$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	$1,015.57	28	$29,147.37	67	$15,611.58	11	129,330.52	32	$10,546.55	1	$185,651.59	139
Bad Debt (702) Charity Care	$120.68	3	$7,316.42	15	$2,782.72	2	$33,692.81	10	$45,108.18	3	$89,020.81	33
Total	$1,136.25	31	$36,463.79	82	$18,394.30	13	$163,023.33	42	$55,654.73	4	$274,672.40	172
Recoveries	($5.88)	1	($911.80)	1			($7,062.96)	1			($7,980.64)	3
Net Total	$1,130.37	31 *	$35,551.99	82 *	$18,394.30	13 *	$155,960.37	42 *	$55,654.73	4 *	$266,691.76	172 *
Outpatient												
Bad Debt (701) Write-Offs	$43,061.27	1133	$155,202.93	606	$39,045.68	27	$31,888.66	10			$269,198.54	1776
Bad Debt (702) Write-Offs	$3,555.22	83	$34,621.78	107	$22,358.28	16	$16,387.00	6			$76,922.28	212
Total	$46,616.49	1216	$189,824.71	713	$61,403.96	43	$48,275.66	16	$0.00	0	$346,120.82	1988
Recoveries	($1,081.05)	37	($1,588.97)	4							($2,670.02)	41
Net Total	$45,535.44	1216 *	$188,235.74	713 *	$61,403.96	43 *	$48,275.66	16 *	$0.00	0 *	$343,450.80	1988 *
Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	$44,076.84	1161	$184,350.30	673	$54,657.26	38	$161,219.18	42	$10,546.55	1	$454,850.13	1915
Bad Debt (702) Charity Care	$3,675.90	86	$41,938.20	122	$25,141.00	18	$50,079.81	16	$45,108.18	3	$165,943.09	245
Total	$47,752.74	1247	$226,288.50	795	$79,798.26	56	$211,298.99	58	$55,654.73	4	$620,793.22	2160
Recoveries	($1,086.93)	38	($2,500.77)	5	$0.00	0	($7,062.96)	1	$0.00	0	($10,650.66)	44
Total Net Bad Debt	**$46,665.81**	**1247 ***	**$223,787.73**	**795 ***	**$79,798.26**	**56 ***	**$204,236.03**	**58 ***	**$55,654.73**	**4 ***	[illegible]	**2160 ***
Dollars Budgeted											[illegible]	

* Net total of accounts does not include recoveries.

C:\WKDATA\RPT\BD\QTR1-92.WK1 jmb

UMHC Hospital Billing Department

Bad Debt Statistics July 1991 through September 1991
in the ranges of account size

	Under $2000	# of Accounts	Over $2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Bad Debt (701) Write - Offs	$45,774.52	106	$139,877.07	33	$185,651.59	139
Bad Debt (702) Charity Care	$10,219.82	20	$78,800.99	13	$89,020.81	33
Total	$55,994.34	126	$218,678.06	46	$274,672.40	172
Recoveries	($917.68)	2	($7,062.96)	1	($7,980.64)	3
Net Total	$55,076.66	126 *	$211,615.10	46 *	$266,691.76	172 *
Outpatient						
Bad Debt (701) Write - Offs	$237,309.88	1766	$31,888.66	10	$269,198.54	1776
Bad Debt (702) Write - Offs	$60,535.28	206	$16,387.00	6	$76,922.28	212
Total	$297,845.16	1972	$48,275.66	16	$346,120.82	1988
Recoveries	($2,670.02)	41	$0.00	0	($2,670.02)	41
Net Total	$295,175.14	1972 *	$48,275.66	16 *	$343,450.80	1988 *
Total IP and OP Bad Debt						
Bad Debt (701) Write- offs	$283,084.40	1872	$171,765.73	43	$454,850.13	1915
Bad Debt (702) Charity Care	$70,755.10	226	$95,187.99	19	$165,943.09	245
Total	$353,839.50	2098	$266,953.72	62	$620,793.22	2160
Recoveries	($3,587.70)	43	($7,062.96)	1	($10,650.66)	44
Total Net Bad Debt	$350,251.80	2098 *	$259,890.76	62 *	[illegible]	2160 *
Dollars Budgeted					[illegible]	

* Net total of accounts does not include recoveries.

C:\WKDATA\RPT\BD\QTR1 92 WK1 jmb

UMHC Hospital Billing Department

Bad Debt Statistical — **July 1991 through September 1991**

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)											$0.00	0
Recoveries											$0.00	0
Net Total	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *
Outpatient												
Medicare Bad Debt (710)	$221.45	14	$731.95	3							$953.40	17
Recoveries											$0.00	0
Net Total	$221.45	14 *	$731.95	3 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$953.40	17 *
Total IP and OP Bad Debt												
Medicare Bad Debt (710)	$221.45	14	$731.95	3	$0.00	0	$0.00	0	$0.00	0	$953.40	17
Recoveries	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Total Net Bad Debt	**$221.45**	**14 ***	**$731.95**	**3 ***	**$0.00**	**0 ***	**$0.00**	**0 ***	**$0.00**	**0 ***	**$953.40**	**17 ***

* Net total of accounts does not include recoveries.

C:\WKDATA\RPT\BD\QTR1 - 92.WK1 jmb

UMHC Hospital Billing Department

	Under $2000	# of Accounts	Over $2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Medicare Bad Debt (710)	$0.00	0	$0.00	0	$0.00	0
Recoveries	$0.00	0	$0.00	0	$0.00	0
Net Total	$0.00	0 *	$0.00	0 *	$0.00	0 *
Outpatient						
Medicare Bad Debt (710)	$953.40	17	$0.00	0	$953.40	17
Recoveries	$0.00	0	$0.00	0	$0.00	0
Net Total	$953.40	17 *	$0.00	0 *	$953.40	17 *
Total IP and OP Bad Debt						
Medicare Bad Debt (710)	$953.40	17	$0.00	0	$953.40	17
Recoveries	$0.00	0	$0.00	0	$0.00	0
Total Net Bad Debt	**$953.40**	**17 ***	**$0.00**	**0 ***	**$953.40**	**17 ***

C:\WKDATA\RPT\BD\QTR1 92 WK1 jmb

UMHC-Hospital Billing Department

Bad Debt Statistics — First Quarter and Year-to-Date, Fiscal Year 1992

By State

State	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Alabama			0.00	0
Alaska			0.00	0
Arizona	4,756.97	7	4,756.97	7
Arkansas	11.27	1	11.27	1
California	1,044.31	3	1,044.31	3
Colorado	129.91	3	129.91	3
Connecticut	1,077.77	1	1,077.77	1
Delaware			0.00	0
Dist. of Colombia	3,843.02	3	3,843.02	3
Florida	4,975.26	20	4,975.26	20
Georgia			0.00	0
Hawaii			0.00	0
Idaho			0.00	0
Illinois	3,022.71	13	3,022.71	13
Indiana			0.00	0
Iowa	1,624.71	10	1,624.71	10
Kansas	340.30	1	340.30	1
Kentucky	25.00	1	25.00	1
Louisiana			0.00	0
Maine			0.00	0
Maryland	82.20	1	82.20	1
Massachusetts	110.39	1	110.39	1
Michigan	2,593.73	37	2,593.73	37
Minnesota	428,003.61	1,767	428,003.61	1,767
Mississippi			0.00	0
Missouri	287.47	1	287.47	1
Montana	2,992.58	6	2,992.58	6
Nebraska	456.50	3	456.50	3
Nevada	172.00	2	172.00	2
New Hampshire			0.00	0
New Jersey	2,640.27	2	2,640.27	2
New Mexico			0.00	0
New York	3,892.47	15	3,892.47	15
North Carolina	170.40	2	170.40	2
North Dakota	19,130.06	13	19,130.06	13
Ohio	43.00	1	43.00	1
Oklahoma	645.55	2	645.55	2
Oregon			0.00	0
Pennsylvania	2,882.83	5	2,882.83	5
Puerto Rico			0.00	0
Rhode Island			0.00	0

UMHC Hospital Billing Department

Bad Debt Summary - First Quarter and Year-to-Date, Fiscal Year 1992

By State

State	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
South Carolina	996.00	1	996.00	1
South Dakota	55,914.48	70	55,914.48	70
Tennessee			0.00	0
Texas	1,170.54	6	1,170.54	6
Utah	3,323.12	1	3,323.12	1
Vermont			0.00	0
Virginia	2,076.40	8	2,076.40	8
Washington	4,245.91	5	4,245.91	5
West Virginia	137.19	1	137.19	1
Wisconsin	53,849.22	134	53,849.22	134
Wyoming	327.56	5	327.56	5
Out-of-Country	5,314.32	19	5,314.32	19
Total	612,309.03	2,171	612,309.03	2,171
Medicare Bad Debt*	(953.40)	(17)	(953.40)	(17)
Legal Settlements	8,942.36	3	8,942.36	3
Bad Debt Agcy Und $50	46.88	1	46.88	1
Bad Debt - Med NC Chgs	448.35	2	448.35	2
Grand Total	620,793.22	2,160	620,793.22	2,160
Recoveries	(10,650.66)	44	(10,650.66)	44
Net Total	**610,142.56**	**2,160**	**610,142.56**	**2,160**

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

C:\123\RPT\BD\ST-Q1-92.WK1 jmb

UMHC Hospital Billing Department

Bad Debt Statistics — First Quarter and Year-to-Date, Fiscal Year 1992

By Service

Admitting Service	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Anesthesiology			0.00	0
Clinical Research	2,076.06	2	2,076.06	2
Dentistry	28.93	1	28.93	1
Dermatology			0.00	0
Family Practice			0.00	0
OB			0.00	0
NB			0.00	0
GYN	950.55	2	950.55	2
GYN-Oncology	10,583.74	8	10,583.74	8
Lab Medicine & Pathology			0.00	0
Medicine-Blue	14,106.11	5	14,106.11	5
Green	3,716.41	1	3,716.41	1
Masonic (Onc)	10,819.43	12	10,819.43	12
Purple			0.00	0
Red A	993.17	3	993.17	3
Red B			0.00	0
Rose A	25,260.99	6	25,260.99	6
Rose B			0.00	0
White A	3,888.73	5	3,888.73	5
White B	8,907.34	9	8,907.34	9
White C	469.32	2	469.32	2
Yellow A	8,541.15	5	8,541.15	5
Yellow B	7,346.77	5	7,346.77	5
Neurology	4,564.01	2	4,564.01	2
Neuro-epilepsy			0.00	0
Neurosurgery	15,738.15	3	15,738.15	3
New Born-General	1,004.38	4	1,004.38	4
Obstetrics-General	8,317.29	11	8,317.29	11
-Midwife			0.00	0
Ophthalmology	8,060.80	5	8,060.80	5
Orthopaedic Surgery	17,505.01	14	17,505.01	14
Otolaryngology	4,213.60	6	4,213.60	6
Pediatrics-General	44,434.91	22	44,434.91	22
Dentistry			0.00	0
Dermatology			0.00	0
Gastro-Intestinal	356.64	1	356.64	1
Hematology Oncology	1026.5	1	1,026.50	1
Neonatology	24,001.27	3	24,001.27	3
Neurology			0.00	0
Neurosurgery	6,266.35	2	6,266.35	2
Opthalmology	2,831.50	2	2,831.50	2
Orthopaedics			0.00	0

UMHC Hospital Billing Department

Bad Debt Summary – First Quarter and Year-to-Date, Fiscal Year 1992

By Service

Admitting Service	First Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Otolaryngology	324.50	1	324.50	1
Pulmonary	1,049.43	1	1,049.43	1
Surgery Green			0.00	0
Surgery Orange			0.00	0
Surg. Transplant	33.40	1	33.40	1
Urology	2,051.59	1	2,051.59	1
Physical Med. & Rehab.			0.00	0
Psychiatry-Child			0.00	0
-Adult	12,756.75	12	12,756.75	12
Radiology			0.00	0
Surgery-Blue	2,548.52	5	2,548.52	5
Orange	1,363.20	1	1,363.20	1
Purple	7,571.61	4	7,571.61	4
Red	7,862.55	1	7,862.55	1
White	1,843.67	1	1,843.67	1
Therapeutic Radiology			0.00	0
Urology	1,258.07	2	1,258.07	2
Unknown			0.00	0
Outpatient	337,636.63	1,999	337,636.63	1,999
Total	612,309.03	2171	612,309.03	2171
Medicare Bad Debt*	(953.40)	(17)	(953.40)	(17)
Legal Settlements	8,942.36	3	8,942.36	3
Bad Debt Agcy Und $50	46.88	1	46.88	1
Bad Debt - Med NC Chgs	448.35	2	448.35	2
Grand Total	620,793.22	2,160	620,793.22	2,160
Recoveries	(10,650.66)	44	(10,650.66)	44
Net Total	**610,142.56**	**2,160**	**610,142.56**	**2,160**

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

MINUTES
Joint Conference Committee
Board of Governors
October 9, 1991

Attendance:	Present:	Debbie Day, M.D. Amos Deinard, M.D. Robert Dickler Phyllis Ellis Barbara O'Grady
	Absent:	George Heenan Robert Maxwell, M.D. Gerald Olson Richard Price, M.D.
	Staff:	Giles Caver Keith Dunder Shannon Lorbiecki

CALL TO ORDER

Ms. Barbara O'Grady called the meeting to order at 4:37 p.m.

APPROVAL OF MEETING MINUTES

The minutes of the September 11, 1991 meeting were approved as submitted.

SPECIAL PRESENTATION

Ms. Anne Doyle made a presentation regarding the Outcomes Management Project at the Park Nicollet Medical Foundation. Ms. Doyle is vice president for strategic development at the Foundation, a research and educational entity operated by Park Nicollet Medical Center.

The Outcomes Management Project was established in January 1990 to better record and evaluate medical outcomes data. The intent is to use data to improve quality of care and control costs for the benefit of all customers, including patients, physicians, and payors. To date, the Project has involved three clinical areas, including total hip replacement, cataract surgery, and rheumatology. Future areas of study include breast cancer and mental health.

QUALITY ASSURANCE PLAN

Mr. Robert Dickler presented the Quality Assurance Steering Committee Task Force Report. The report will guide attempts to better assess and improve quality of care. It will also communicate the Hospital and Clinic's commitment to a more progressive quality assurance program for the benefit of patients, physicians, payors, and regulatory bodies such as the JCAHO.

Mr. Dickler stated the report had been presented to and endorsed by the Council of Clinical Chiefs on September 24, 1991.

The Joint Conference Committee endorsed the recommendations of the Quality Assurance Plan.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT -
POLICY 16.4: MAKING DECISIONS TO FOREGO CARDIOPULMONARY RESUSCITATION

Dr. Frank Cerra presented revisions to Policy 16.4, or Resuscitation of the Hospitalized Patient. The first revision provides additional focus to cardiopulmonary resuscitation and better distinguishes it from other treatments. The second revision provides improved definition to the decision making process and the roles of the patient and physician.

Dr. Cerra stated the policy revisions had been presented to and endorsed by the Medical Staff-Hospital Council on October 8, 1991. Moreover, the Council will now address the implementation and quality assurance of the revisions.

The Joint Conference Committee endorsed the recommended revisions to Policy 16.4

MEDICAL STAFF-HOSPITAL COUNCIL REPORT -
AMENDMENT TO RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

Mr. Robert Dickler presented an amendment to Section VII-G of the Rules and Regulations of the Medical and Dental Staff, or Resuscitation of Hospitalized Patients. As with the revisions to Policy 16.4, this amendment provides improved definition to the decision making process and the roles of the patient and physician as they relate to cardiopulmonary resuscitation.

Mr. Dickler stated the amendment had been presented to and endorsed by the Medical Staff-Hospital Council on October 8, 1991.

The Joint Conference Committee endorsed the recommended amendment to Section VII-G of the Rules and Regulations of the Medical and Dental Staff.

CLINICAL CHIEFS REPORT

Mr. Robert Dickler presented the Clinical Chiefs Report. Mr. Dickler stated the Council of Clinical Chiefs had discussed the Board of Governors' September retreat at its last meeting.

The Council of Clinical Chiefs also continued discussion related to restructuring its meetings. There is a desire to make the meetings "more businesslike and productive."

ADJOURNMENT

There being no further business, the Joint Conference Committee meeting was adjourned at 6:00 p.m.

Respectfully submitted,

Giles Caver
Administrative Fellow

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 17, 1991

TO: Board of Governors

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

SUBJECT: Revision-Policy 16.4, Resuscitation of the Hospitalized Patient
Revision-Rules and Regulations of the Medical and Dental Staff

The Medical Staff-Hospital Council on October 8 and the Joint Conference Committee on October 9 have endorsed the attached revision to Policy 16.4, Resuscitation of the Hospitalized Patient, and revision to the Rules and Regulations of the Medical Staff, Section VII. Medical/Legal, G. Resuscitation of Hospitalized Patients. Underlining in the Rules and Regulations indicates additions to existing language. ~~Strike-outs~~ indicate deletions from existing language.

I am forwarding these recommendations to you for your review and approval on October 23. If you should have any questions, please feel free to call on me.

Thank you.

REM/cf
Attachment

Proposed Revision
October 9, 1991

Policy 16.4 Making Decisions to Forgo Cardiopulmonary Resuscitation

Purpose

This policy and procedure is adopted to assist patients, their representatives, and staff in making and implementing decisions to forgo cardiopulmonary resuscitation (CPR). Because CPR must not be delayed to be successful, CPR is always initiated unless an order not to perform CPR is written in the medical record.

Definitions

Cardiopulmonary Resuscitation (CPR): CPR is the attempt to restore cardiac and/or respiratory function following a cardiac and/or respiratory arrest, and includes any or all of the following: closed-chest cardiac compression, manually or mechanically assisted ventilation, and electrical defibrillation.

"No CPR": "No CPR" is the order written in the medical record when resuscitation efforts as defined above will not be undertaken. It does **not** limit the use of mechanical ventilation outside of the arrest situation, suctioning, the Heimlich maneuver, vasopressors, or other medical, surgical or nursing measures. For guidelines about forgoing other life-sustaining treatment, including intubation outside the situation of cardiopulmonary arrests see UMHC Policy 4.7, "Making Patient Care Decisions to Forgo Life Sustaining Treatment."

Competency: Competency is the ability to understand, reflect upon, and reiterate the medical situation, including the consequences of agreeing to or forgoing CPR. Competency is presumed in the absence of impaired judgment and is usually determined by the attending physician. The physician may consult other health care providers or persons who know the patient in assessing competency.

Patient Representative: A patient representative is the person who acts on behalf of the incompetent patient. The appropriate representative for an adult is determined in the following order: the health care proxy if the patient has a valid living will; the legal guardian with responsibility for healthcare decisions; the spouse; an adult daughter or son; either parent; an adult sibling; other close family members; a close personal friend. In the case of a minor, the child's parents or legal guardian may represent the patient.

Reasons for a "No CPR" Order

As with any intervention, the physician should first determine whether CPR is medically indicated for a given patient. If medically indicated, the competent patient decides if he or she desires CPR. In the following circumstances, a "no CPR" order will be written:

1. *Explicit refusal by a competent patient.*
A competent adult has the moral and legal right to refuse any medical intervention, including CPR, regardless of the underlying illness or prognosis. Physicians may not force unwanted interventions on competent patients who decline such interventions.

2. *Inferred refusal on behalf of an incompetent patient.*
When a patient is incompetent, the patient's representative shall make decisions regarding CPR in consultation with the physician, based on the patient's wishes as evidenced by previous statements (such as a living will), actions, and religious or philosophic beliefs. If the patient's wishes are not known, the patient's representative shall make the decision based on the patient's best interests.

3. *Attending-Physician determination that CPR is not medically indicated.*

There are clinical situations in which attempts at cardiopulmonary resuscitation are not medically indicated, and, in these situations, physicians should not offer CPR. Determining if attempts at CPR are medically indicated for a given patient is a complex clinical judgment to be made by the attending physician working with members of the health care team, and may include assessing:

a) the probability of immediate and short term survival of the patient after CPR given available data for similar patients,
b) the immediacy or inevitability of death from the patient's underlying disease despite initially successful CPR, and/or
c) the duration of cardiac arrest prior to initiation of CPR.

Procedures

1. In the absence of a "no CPR" order, efforts at CPR will be undertaken.

2. *Communicating a "no CPR" decision:*

a. If a patient (or patient's representative, if the patient is incompetent) decides to forgo CPR, the physician shall write a progress note explaining the factors that went into the decision and who was involved in the decision making. A "no CPR" order shall be written. The House Officer writing a "no CPR" order must document that the attending physician participated in the decision process and is in agreement. The attending physician must cosign the progress note and order within 24 hours.

b. When CPR is not medically indicated, the attending physician must explain the basis for this decision to the competent patient **before** writing the order. The attending physician must then write the "no CPR" order (this determination must be made by the attending physician). If the patient is not competent, reasonable efforts to explain this judgement to the patient's representative must be made. The attending physician must document in the progress notes why CPR is not medically indicated and specify who

has been informed of this decision. Please refer to procedure 7 of this policy in the situation where concerns or conflicts occur regarding CPR status. Until a dispute is resolved, the patient's wishes will be followed.

c. The physician shall communicate the decision to the primary or charge nurse.

3. *Terminating CPR:*

Similarly, the determination during cardiopulmonary resuscitation that further efforts should be abandoned is a clinical judgment to be made by the resuscitating physician.

4. *Decisions to forgo other treatment:*

A decision to forgo CPR may be compatible with receiving other aggressive interventions, including transfer to the ICU. A "no CPR" order refers only to the act of cardiopulmonary resuscitation in the setting of an arrest.

Decisions to forgo other treatment must be specifically stated (see policy 4.7). If foregoing other life sustaining treatment increases the likelihood of cardiopulmonary arrest, the physician is obligated to address CPR status.

5. *Reviewing a "no CPR" decision:*

A "no CPR" decision must be reviewed periodically, particularly if the patient's medical condition changes significantly or if the patient is considering a medical intervention which poses a significant risk of cardiopulmonary arrest (e.g. dialysis, pulmonary angiogram). Those responsible for making a "no CPR" decision may rescind it at any time.

6. *"No CPR" orders under special circumstances:*

a. *On readmission:* "No CPR" orders must be rewritten at the time of readmission, with a reference to the date of the original progress note describing how the decision was made.

b. *On transfer from an outside institution:* A "no CPR" order from an outside institution is not automatically honored at UMHC and should be reevaluated and discussed as appropriate upon admission to UMHC.

c. *In the emergency room:* "No CPR" orders may be written in the emergency room by the emergency staff physician, for the same reasons and following the same procedure as outlined above.

d. *On transfer between services within the hospital:* Upon transfer, a "No CPR" order must be rewritten in the medical record documenting continuing or discontinuing the "No CPR" order.

7. *Concerns or conflicts about CPR status:*

Concerns or conflicts among the patient's physicians, nurses, family, and/or the patient may be resolved by consultation with the Patient Relations Department or Biomedical Ethics Committee. If a patient and/or family disagrees about a "no CPR" status on the basis of physician judgement that CPR is not medically indicated, a second opinion from another attending physician may be sought. Until a dispute is resolved, the patient's wishes will be followed. Conflicts regarding CPR status seldom, if ever, need to be referred to the judicial system. If this process is contemplated the Hospital Attorney's Office shall be contacted.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	NURSING
VOL.: II	POLICY NUMBER:
EFFECTIVE:	September 14,
REVISION:	7/79,7/82,2/83, 5/85,10/87,2/88
REVIEWED:	10/78,80,82,84,8

SUBJECT: Resuscitation of the Hospitalized Patient

SOURCE: Biomedical Ethics Committee
Medical Staff-Hospital Council

POLICY

The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexp death. The University of Minnesota Hospital and Clinic recognizes that it is consistent with sound medical practice not to attempt cardiopulmonary resuscita in certain situations, such as in cases of irreversible illness where death is unexpected, where prolonged cardiac arrest dictates the futility of resuscitati efforts, or during the period of the initial and confirmatory examination to determine brain death. The patient and/or the patient representative(s) and th staff physician who is primarily responsible for the care of the patient and th has appropriate knowledge of the patient's medical condition, are the persons w should make the decision that cardiopulmonary resuscitation is contraindicated. This decision, of course, may be based on consultation with other professionals differences of opinion occur among the decision-makers, additional hospital resources should be consulted. A decision not to resuscitate a patient in the of cardiac or respiratory arrest is to be made and implemented as indicated in following guidelines.

GUIDELINES

1. CONSENT

   a. When the patient is competent,* the decision not to resuscitate will be reached consensually** by the patient and physician. This must be fully documented in the medical record.

   b. When the patient is judged to be incompetent, this decision not to resuscitate will be reached consensually** by the physician and the following patient representative(s) in order of priority: legally appoir guardian, spouse, adult children, parent(s), adult brother or sister or relatives (aunts, uncles, cousins) or close personal friend. This must b fully documented in the medical record.

APPROVED:	DATE: 2/27/88
TITLE: Hospital Director / Chief of Staff	

c. In those very rare instances in which the capacity of an otherwise competent* patient to be involved in making the decision not to resusc is questioned, the attending physician shall convene a care conference before a decision is made consensually** by the patient representative and the physician without direct patient involvement. The conference s include but not be limited to the house staff, nursing personnel and m involve members of the Biomedical Ethics Committee, psychiatry, psycho or other involved health care providers as appropriate. The basis for decision must be fully documented in the medical record.

d. If a physician and a competent* patient disagree, or, in the case of incompetency, the physician and the patient representative(s), are in disagreement about the resuscitation decision, a "Do Not Resuscitate" will not be written. Staff, patients, and/or the patient representati may seek consultation from the Biomedical Ethics Committee in the even disagreement.

e. If the patient is incompetent and there appears to be no appropriate p representative(s), this order may be written only upon consultation wi legal counsel.

f. No exception to this consent process will be recognized.

2. DOCUMENTATION

a. Physician's Order. The physician shall communicate the decision not tc resuscitate in the form of a written order. A staff physician or resic shall write this order. The resident physician who writes a "Do Not Resuscitate" order shall document on the progress notes that the staff physician has been consulted and agrees with the "Do Not Resuscitate" c

The written physician order shall be entered on the patient's order she One of the following orders should be used to convey the decision that cardiopulmonary resuscitation is inappropriate: "Do Not Attempt to Resuscitate", "Do Not Resuscitate", "Resuscitation is Contraindicated", the abbreviation "DNR". The order should include a reference to the physician's progress notes in the patient's medical record (for example Not Resuscitate - Progress Note 2/1/88"). The "Do Not Resuscitate" ord may be transcribed/implemented prior to the countersignature of the pro note by the appropriate staff physician.

b. Charting.

1) The physician shall make an entry in the patient's progress notes, including a statement of why resuscitation efforts are inappropriate that the decision has been discussed with the patient and/or patient representative(s). The appropriate staff physician will counter sig progress notes as soon as possible.

2) If the decision has not been discussed with the patient, the reasons this must be included and the consent process described in the medic records.

3) A "Do Not Resuscitate" order will only be transcribed/implemented if progress note in the patient's medical record has been written by th physician indicating a discussion with either the patient or his or representative(s), or legal counsel has occurred.

3. PROCEDURE IF ORDER DOES NOT APPEAR IN THE CHART. If both the order and the related progress notes do not appear in the chart, when an arrest occurs, nursing personnel will initiate resuscitation measures immediately in every case.

4. RE-EVALUATION. The decision that resuscitation should not be initiated must reviewed periodically with the patient, and always readdressed if the medica situation under which the resuscitation decision was made has significantly changed. This discussion should be documented in the progress notes of the patient's medical record by the physician and countersigned by the appropria staff physician as soon as possible. The order may be rescinded at any time

5. PROCEDURE ON READMISSION OR CHANGE OF SERVICE. For patients for whom a "Do Resuscitate" order has previously been written by a UMHC physician, a "Do No Resuscitate" order will be rewritten by the staff physician or resident for patient on every readmission, admission to a service from the Emergency Room change of service. The rewritten order should include a reference to the physician progress note written when the order was initially discussed with patient. (For example: Do Not Resuscitate - Progress note 2/1/88). If the order was written by a physician in another facility or if the patient's med condition has changed the order will be re-evaluated in accord with Section A previously written "Do Not Resuscitate" order will be valid on change of service until the new service has reviewed and continued or discontinued the order.

6. OTHER THERAPEUTIC CARE. A "Do Not Resuscitate" or similar order is compati with maximal therapeutic care. The patient may be receiving vigorous suppo all other therapeutic modalities and yet justifiably be considered a proper subject for the "Do Not Resuscitate" order.

* Competency may be presumed in the absence of any impairment of judgement. A patient with some impairment may still be competent to make this decision i patient has the capacity to understand, reflect upon, and reiterate the med situation, including the consequences of a deci[illegible] not to resuscitate and consequences of a decision to resuscitate. Psych[illegible]y ma[illegible] be consulted if competency is in question.

** Consensual agreement means that a discussion between the patient and/or fami and the physician has occurred, and that an understanding exists with regarc the process of dying and the procedures and treatment to be undertaken, or r undertaken, at the time of that event.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

Section VII. Medical/Legal

G. Resuscitation of Hospitalized Patients.

It is consistent with sound medical practice not to attempt cardiopulmonary resuscitation in certain situations, such as in cases of irreversible illness where death is not unexpected, or where prolonged cardiac arrest dictates the futility of resuscitation efforts. The attending or other staff physician who is primarily responsible for the care of a hospitalized patient may make the decision that cardiopulmonary resuscitation is contraindicated for the patient. ~~This decision may be finalized only after proper consultation and consent of the patient, or in proper circumstances, the patient's family (see Policy 16.4).~~ The decision to forgo cardiopulmonary resuscitation shall be made and implemented in accord with UMHC Policy 16.4

QUALITY ASSURANCE STEERING COMMITTEE TASK FORCE REPORT

August 1991

Task Force Members: David Dunn, M.D., Ph.D., Co-Chair
Greg Hart, Co-Chair
Paul Abramowitz, Pharm.D.
Amos Deinard, M.D.
Ian Gilmour, M.D.
David Hunter, M.D.
Sally Huntington, R.N., M.P.H.
MaryJo Kreitzer, R.N., Ph.D.
Carol Letourneau, R.N.
Ted Thompson, M.D.
Leo Twiggs, M.D.
Kathy Wilde, R.N.

EXECUTIVE SUMMARY

Following a successful 1990 JCAHO survey, the UMHC Quality Assurance Steering Committee recognized a unique opportunity to establish future directions which not only meet the requirements of external regulatory agencies, but more importantly, promote both historical and newly identified internal objectives for improved patient care and enhanced competitiveness. The Quality Assurance Steering Committee work group appointed to examine these issues reviewed national and local initiatives related to outcomes measurement, healthcare applications of continuous quality improvement, the increase in data-driven competitiveness, and the strengths and weaknesses of current UMHC quality assurance programs. These discussions focused in particular on the need for our quality assurance activities to have more clinical relevance, and the potential for integration of quality assurance with clincial research. The work group concluded the potential for integration of aspects of clinical research, outcomes measurement, quality improvement, and data useful for marketing and contract negotiation appears high, and that such integration should shape our future quality assurance programs. Ten recommendations were developed:

1) UMHC should make its quality assurance programs more clinically relevant by better integrating the clinical research activities of the medical staff with the Hospital's quality assurance programs and by promoting publication of findings in a manner that will influence clinical practice.

2) In order to truly impact the many aspects of patient care, UMHC's quality assurance activities should become more interdisciplinary, both at the physician-to-physician level and between physicians and other hospital departments.

3) The Quality Assurance Steering Committee should direct departmental and programmatic quality assurance activities toward clinical relevance and opportunities for patient care improvement, and should actively assess the effectiveness of actions taken.

4) UMHC should appoint a physician to its administrative staff (Senior Associate Director of Medical Affairs) to work with Medical Staff leadership, Hospital Administration, the Health Sciences, and Medical School in guiding future quality assurance activities.

5) UMHC should continue to "fine-tune" certain aspects of the quality assurance program to assure ongoing compliance with JCAHO standards.

6) The Quality Assurance Steering Committee should be restructured to support implementation of the recommendations in this document.

7) UMHC should enhance its level of expertise and participation in outcome assessment studies on a selected basis, and seek to upgrade the level of research quality in such studies. UMHC should promote participation in cost-effectiveness evaluations.

8) UMHC should utilize outcomes data more effectively in marketing and contract negotiation, and should incorporate outcomes and other "customer-focused" data desired by third party payors into the quality assurance program.

9) UMHC should develop a continuous quality improvement program uniquely appropriate to the University of Minnesota health care environment.

10) Consistent with the philosophy of continuous quality improvement, UMHC should develop quality assurance indicators which reflect the priorities of both internal and external customers, and utilize a quality management process which focuses on improving quality from that perspective.

The work group believes a program based on these recommendations will provide for improved patient care, be relevant to UMHC clinicians, produce data which enhances UMHC competitiveness, and be responsive to changes in the national and local healthcare community. Specific action steps for these recommendations, as well as additional background information, can be found in the text of the full Task Force report.

INTRODUCTION

Physicians and other health care professionals have since the beginning of medicine attempted to evaluate the therapeutic effectiveness of their health care practices. With the 1990s the health care community has entered an era of unprecedented growth in activity directed at the assessment of outcomes and the analysis of the effectiveness of various therapies.[1] We are seeing increased interest in clinical outcomes; increasing national focus on cost-containment; increasing competitiveness, including a desire by business and insurors to enter into cooperative relationships with providers; and the emergence of healthcare applications of "total quality management" or "continuous quality improvement" from the business environment.

Historically University of Minnesota physicians and other health care professionals have contributed to patient care improvement through clinical research, and to the development of innovative and patient-focused improvements in health care systems. The University of Minnesota Hospitals and Clinic (UMHC) has been, and increasingly will be, challenged to respond to health care industry and external regulatory and reimbursement challenges.

Following a successful 1990 JCAHO survey, the UMHC Quality Assurance Steering Committee recognized a unique opportunity to establish future directions for quality assurance activities which not only meet the requirements of external regulatory agencies but, more importantly, promote our own objectives for improved patient care and competitiveness.

The Quality Assurance Steering Committee work group appointed to examine these issues met four times during the spring of 1991. The group discussed outcome evaluation initiatives with Harry Wetzler, M.D., Senior Scientist, Interstudy, and Anne Doyle, Vice

President, Strategic Development, Park Nicollet Medical Foundation; viewed and discussed a "Total Quality Management" videotape prepared by Paul Batalden, M.D., Vice President, Hospital Corporation of America; and reviewed current UMHC quality assurance activities, particularly focusing on clinical relevance and interdisciplinary integration.

The following document, prepared by the work group, describes local and national efforts to promote outcome measurement; presents an introduction to the management philosophy called "continuous quality improvement"; and, within the context of these and other developments, describes the strengths and weaknesses of current UMHC quality assurance programs. The document concludes with ten recommendations to guide development of a clinically relevant and institutionally coordinated quality improvement program which will improve UMHC's competitiveness and its quality of care.

OUTCOMES AND EFFECTIVENESS MEASUREMENT

Outcomes measurement assesses the results of care provided. Outcomes may be compared to a given standard, may be compared between similar programs or institutions, may be used to separate what works from what does not, and may seek to find optimal "value." Few topics have captured the imagination of the health care community, especially the payor community, more in recent years than outcomes measurement.[2]

Arnold Epstein, M.D., Harvard Medical School, believes at least three factors have contributed to the increased emphasis on outcome measurement: (1) the need for cost-containment and the concern for resulting compromises in quality of care, (2) increased competition with the knowledge that price alone is an inadequate basis of comparison and, (3) research by John Wennberg and others which documents substantial geographic

differences in the frequency of use of various medical procedures.[1]

Proponents of outcomes and effectiveness research expect that analysis of pooled clinical and functional status data will increase our understanding of the effectiveness of different interventions, provide additional information for decision making by physicians and patients, and aid in the development of standards to guide physicians and third-party payors in optimizing the use of resources. Further, outcome data may become an essential component of provider-purchaser contract negotiations. Taulbee predicts purchasers of health care will expect providers to use solid, objective data to demonstrate "value," defined as quality or outcome divided by cost.[3] Walter McClure suggests that the "buy right" stategy (comparisons of quality and cost among providers) will provide important incentives leading to true marketplace reform.[4]

In response to the growing demand, several professional societies, private corporations, the federal government, and JCAHO, among others, have initiated outcomes-oriented data-gathering efforts. Examples follow:

United HealthCare, a national healthcare management company, has undertaken a two-year, $1.2 million study funded by 12 pharmaceutical companies. The study focuses on the outcomes of alternative hypertension and coronary artery disease treatments among UHC enrollees.[5]

The **American Medical Association (AMA),** in cooperation with the Rand Corporation and the eleven-university Academic Medical Center Consortium, is working on outcome projects that will be used to develop practice parameters for physicians.[6] In August 1990, the AMA reported completed practice parameters for 47 topics and announced the intention to develop 136 additional topics. It should be noted that, even with the AMA's

involvement, practice parameter development remains controversial: the development process is time consuming and expensive; some question whether guidelines can allow for patient preferences; consensus guidelines on the same topic developed by different panels of experts often do not agree; and the promulgation and enforcement of guidelines may be focused only on decreasing inappropriate care rather than on increasing access to beneficial procedures.[1]

In 1989 the **federal government** created the Agency for Health Care Policy and Research (AHCPR) to highlight a new emphasis on medical effectiveness research. AHCPR reports directly to the Secretary of Health and Human Services and is at the same level as the Food and Drug Administration and the Centers for Disease Control. This agency has funding capability of nearly $100 million. The AHCPR initially supported four major outcomes measurement projects: cataracts, myocardial infarction, prostatism, and back pain. Other projects with smaller funding included total knee replacement, chronic ischemic heart disease, peripheral vascular disease, colon cancer, and biliary disease. With congressional authorizations through 1994 providing for increases up to $185 million, AHCPR intends to expand to include other investigator-initiated assessment projects, controlled trials and prospective studies, data development and maintenance, and demonstration of the effectiveness of the research products.[7] Specific funding opportunities and study findings are described in a monthly AHCPR publication "Research Outcomes." Recent issues include a request for proposals related to disseminating research information, findings related to endarterectomy, a listing of 46 continuing Medical Treatment Effectiveness Program research projects, and a listing of newly funded studies.

Beginning in 1987 **JCAHO** convened eight expert Task Forces to develop sets of clinical performance measures for use in a national hospital performance database. Comparative data "will assist hospitals in prioritizing quality improvement activities

and will be incorporated into an outcome-oriented performance monitoring system for the JCAHO accreditation process."[8] Examples of specialties selected include cardiovascular services, trauma, obstetrics, medical oncology, and anesthesia services. Examples of quality indicators developed by the Task Forces include term infants admitted to an ICU within 24 hours of delivery and death during or within 48 hours of anesthesia administration.

Numerous other outcome databases and multi-hospital evaluations have been initiated. Examples include (1) The Quality Measurement and Management Project managed by the Hospital Research and Educational Trust, the research and development affiliate of the American Hospital Association. Main purposes include helping participating hospitals respond to growing demands for data from purchasers, regulators and consumers; and bringing together hospitals, purchasers, regulators, and consumers to develop approaches to quality monitoring and management.[9] (2) A Connecticut Hospital Association project which utilizes discharge abstract data from 26 of the 38 acute general hospitals in the state. Each hospital is provided with predicted, risk adjusted outcome rates which can be compared to statewide rates.[10] (3) Several outcomes projects which use sets of survey instruments developed by the Minneapolis-based nonprofit health policy research organization, Interstudy. The "Outcomes Management System" (OMS) seeks to build an "ongoing observational study into routine medical care by systematically assessing, tracking, and analyzing health outcomes."[11] Information tracked over time includes common demographics, a diagnosis-specific clinical data set, patient satisfaction, and patient-reported quality of life/functional status information. One of the primary goals is development of a national repository for pooling data from providers. Participating providers will "own" the data set and be charged with maintaining the integrity of the database and facilitating appropriate use. In the spring of 1991 Interstudy reported that 75 healthcare organizations were

collecting data on approximately 15,000 patients. Projects of particular interest include six diverse clinics piloting OMS through the American Group Practice Consortium (Park Nicollet is participating); and an Employer/Insuror Consortium seeking to track angina, asthma, and low back pain (employers include General Motors and AT&T, insurors include Blue Cross/Blue Shield of Illinois).

Though outcomes measurement is in its infancy, some conclusions can be drawn at this point: outcomes and therapy effectiveness measurement is an increasingly important competitive tool; needs to be focused to be clincially valid; is in early stages of development; is expensive to implement and maintain; and provides opportunities for research funding. If misapplied, outcomes data can harm tertiary medical centers. If correctly applied, outcomes data can be an effective competitive and quality improvement tool. UMHC cannot disregard the growing trends in outcomes measurement.

CONTINUOUS QUALITY IMPROVEMENT (CQI)

Adding "value" to products and services through quality improvement may be a new concept for health care providers but it is not to many other industries. When U.S. automakers in the 1970s began losing market share to Japan, American industrialists began to examine the work of W. Edwards Deming and his contemporary Joseph M. Juran. Since the end of World War II Deming and Juran had been working with the Japanese to improve production processes using scientific methods of system analysis. By the 1980s many U.S. companies such as the Ford Motor Company, General Motors, and Xerox adopted continuous quality improvement as a management philosophy. More recently, hundreds of hospitals across the country have become involved in CQI primarily through the efforts of the National Demonstration Project on Quality Improvement in Health Care. The Project is funded by the John A. Hartford Foundation and the Harvard Community Health Plan.

Reflecting this interest in applying industrial quality management techniques to health care, JCAHO plans over the next five years to revise its accreditation standards to assure integration of certain CQI processes. Additionally, industrial purchasers of healthcare such as Honeywell have indicated they prefer to negotiate with providers who practice CQI. John Burns, M.D., Honeywell's Vice President, Health Management: "the role of business is to directly contract with groups who are willing to hold themselves to the existing standards of the medical literature, adopt continuous quality improvement process, and measure outcomes."[3] Further, Blue Cross/Blue Shield of Minnesota has indicated one of the "requirements" for providers to participate as a center of excellence will be selection of one or two mutually agreed upon CQI projects (probably including the use of a functional status outcome instrument).[12]

While Deming and Juran take somewhat different approaches to quality improvement both have the same underlying principle: quality evaluation must change from strictly end product inspection to the analysis and fine tuning of production processes.[3] In this system quality is the end result of a complex and continuous interaction of people and support systems.[13] In fact, Deming estimates that 85% of improvement opportunity relates to systemic factors while 15% relates to the performance of people.[14]

A comparison of quality improvement and traditional quality assurance shows that both use objective data and follow-up evaluations to assess the effectiveness of actions. There are, however, significant differences:[15,16]

Quality Assurance	Continuous Quality Improvement
Inspection oriented (Detection)	Prevention oriented
Focuses on people	Focuses on improving the process
Focuses on the exceptions, the tails of the curve	Is aware of exceptions but works to move the whole curve
Correction of special causes (a piece of equipment)	Correction of common causes (systems)
Involves primarily clinical areas	Is hospital-wide in that every member of the team contributes to patient satisfaction
Individual department focus	Team focus
Responsibility of the few	Responsibility of the many
Leadership may not be vested	Leadership actively leads
Problem solving by authority	Problem solving at all levels
JCAHO the primary customer	Patient is primary customer. Others include physicians, nurses, third party payors, referral sources.

In sum, continuous quality improvment is a management system which focuses on customer-oriented problems; uses front line work groups and disciplined analysis techniques; and advocates the "no matter how well you do you can always do better" philosophy.

Hospitals have generally approached CQI by initiating evaluation of a system which affects many "customers," for example patients, physicians, and hospital staff. Projects may be targeted by "competitive benchmarking" which uses comparative data from other institutions; or by customer satisfaction, where anyone receiving a direct output is viewed as a customer. Examples of projects selected include evaluations of the admission process and operating room utilization including delays and scheduling inefficiencies. Further, because systems usually involve many employees functioning as a coordinated team, and because all aspects of the system may not initially be well understood, group collaboration and data analysis are stressed.

Interdisciplinary project teams identify relevant data and utilize quantitative analytical techniques to identify possible cause and effect and to show variability. Recommendations for process improvement are developed and re-evaluation is planned.

Although CQI projects to date have focused primarily on management issues, Brent James, M.D., Intermountain Healthcare, has observed that applying CQI to clinical issues is a logical extension of much that is done in the clinical setting: diagnosing/searching for probable causes, testing intervention theories, and evaluating results.[17]

Review of results reported to date reveals that CQI in the hospital setting is in the developmental stage, that the healthcare model may ultimately differ from the industrial model, and that outcome evaluations and CQI are both compatible and complementary. Some examples: (1) The University of Michigan Hospital initiated several projects including an evaluation of the admissions process to reduce waiting time and a process study of operating room throughput. Michigan received the Healthcare Forum/Witt National Award for Commitment to Quality in 1990 (the healthcare equivalent of the Malcolm Baldrige National Quality Award) and continues a commitment to CQI. (2) Intermountain

Healthcare targeted antibiotic use and deep wound infections. While data showed prophylactic antibiotic choices were appropriate, they also revealed that in 27% of cases antibiotics were given before the optimal time while in 36% they were given after. The process was examined and modifications made with a reduction in the rate of deep wound infections.[18] (3) The neonatal unit at Rush Presbyterian was interested in the effect of body position on x-ray evaluation of endotracheal tube placement. Initially, 49% of films identified a concern with endotracheal tube placement due to body rotation. The process was analyzed by an interdisciplinary team and several interventions were implemented with a decrease to 27%. Additional interventions were planned.[19] (4) Intermountain Healthcare initiated a comparative study of length of stay and charges for transurethral prostatectomy discharges from four hospitals. Even with severity adjustment, a high degree of variability in length of stay was identified between the four hospitals and between attending physicians. The first goal was to try to reduce the variability, the second to decrease the overall mean. Analysis of several variables identified that removal of more tissue during the first OR procedure seemed to be related to a decreased rate of return to the operating room, and that physicians with a shorter length of stay more consistently used the same day admit surgery program and thorough pre-operative patient teaching. No data on the interventions designed or the effectiveness of the effort were provided.[18] 5) West Paces Ferry Hospital established a team to evaluate factors contributing to a 22% C-section rate. Data were collected to describe the frequency and timing of events leading up to C-section. Examination of the reasons for C-section revealed that a surprisingly high proportion of C-sections were performed at the patient's request. There was also a need to clarify the definitions of "failure to progress" and "cephalopelvic disproportion" for further data collection. The patient education process was revised and clarified definitions were circulated to physicians. The overall rate decreased to 17.8% ($p<0.001$).[20]

In summary, continuous quality improvement is in the developmental stages in healthcare, has a strong customer focus, is becoming increasingly important to purchasers of care, and has been more frequently applied to patient service departments and systems than to true clinical issues.

EVALUATION OF UMHC QUALITY ASSURANCE PROGRAMS

UMHC quality assurance efforts have been primarily directed towards achieving compliance with external regulations, struggling to catch up with JCAHO standards and responding to requests from the local PRO and third party payors. The UMHC Quality Assurance Steering Committee would now like to go beyond compliance with regulations and develop a program which not only meets the requirements of external agencies but, more importantly, promotes our own patient care and competitive objectives. Following is a description of the current status of some elements of our quality assurance program.

Outcomes and Effectiveness Measurement - As noted earlier, clinicians affiliated with the University of Minnesota have in the past contributed to the frontiers of clinical research. Although it might be expected that clinical research would include an outcome component, the extent to which UMHC clinicians are currently involved in formal outcome studies is generally unknown. Following is a description of two known outcome evaluations.

The University of Minnesota and 17 similar centers are participating in a quality assessment system which analyzes the results of inpatient care of children with cardiac anomalies. The Pediatric Cardiac Care Consortium quantitatively analyzes outcomes, provides comparative feedback while preserving confidentiality, and seeks improvements in care through physician

education. Data published in the June 1990 issue of Minnesota Medicine included between-hospital comparisons of case mix adjusted mortality rates and length of stay. The program continues to expand with authors citing low cost, useful data, research potential, and physician leadership being the keys of success.[21]

UMHC is also participating in an outcome study funded by the John A. Hartford Foundation and coordinated by the Healthcare Education and Research Foundation. The Minnesota Clinical Comparison and Assessment Project (MCCAP) has established the following mission: to determine whether carefully formulated internal medical management programs, involving regular feedback to physicians of precise and reliable data comparing their clinical performance with both predetermined clinical guidelines and the experience of their colleagues will improve the effectiveness and efficiency of care provided in Minnesota hospitals. In the first phase of the project two diagnoses (simple MI and pediatric asthma) and three procedures (cholecystectomy, total hip replacement, cesarean section) are being studied. Clinical guidelines for each group are developed by clinicians from the community prior to the initiation of data collection. Clinical data are abstracted from the medical record and the patients are interviewed to obtain information on functional status and quality of life both before and six months after procedures when appropriate. Analysis of data will begin in spring of 1992.

Although some UMHC clinicians have observed that quality assurance data may target areas with research potential, research has generally been considered unrelated to quality assurance. The potential for mutually beneficial integration of clinical research, outcomes measurement, quality assurance, and data useful for marketing and contract negotiation would appear high. How can quality assurance data be designed to contribute to research and publication efforts thus becoming more clinically

and academically relevant? How can aspects of clinical research be integrated into quality assurance? How can cost or utilization information be integrated? How can long-term outcome or patient evaluation of quality of life be integrated? What can be done to promote UMHC participation in outcomes research funding opportunities? How can research and quality assurance contribute data useful in marketing and contract negotiation?

These questions suggest that achieving the goal of mutually beneficial integration potentially requires several actions including (1) increased communication and cooperation with other divisions of the Health Sciences, including the Center for Health Services Research; (2) increased data management resources including expertise in study design, statistics, and computer support; and (3) evaluation of the risks and benefits of participation in specific comparative outcome studies.

Continuous quality improvement - UMHC has initiated systems evaluations which are very similar to CQI projects reported in the literature. For example: two significant medication errors occurred on one pediatric intensive care unit in one weekend. The unit recognised the incidents involved systems which served the other pediatric intensive care unit and together they initiated a joint evaluation. An interdisciplinary ad-hoc group examined the processes involved and initiated recommendations which affected physician, nursing and Pharmacy participants. Similarities between this example and reported CQI projects include analysis of an issue affecting many customers, a (pediatric medication) system/process evaluation, and the interdisiplinary project team.

Other CQI projects have been initiated by the Resource Utilization Task Forces appointed to evaluate ancillary utilization and length of stay. These projects have involved interdisciplinary teams, investigated issues identified by "customers" on the team as well as external "customers," and used

data to clarify processes and identify common factors. Examples of projects include: (1) a concurrent study to evaluate the extent to which open-ended physician orders were unnecessarily carried forward; (2) a chart review to clarify factors contributing to increased/variable length of stay for a specific patient population; and (3) a study to evaluate a specific service's Operating Room processes including delays in moving patients through the system and scheduling inefficiencies.

Even though such evaluations have been initiated, UMHC has not typically described them as CQI projects, has not employed some of the traditional aspects of CQI such as the involvement of front line personnel in work groups, and has not developed a formal position on continuous quality improvement which can be communicated to employees and external agencies.

UMHC conducts satisfaction surveys for at least two important customer groups: patients and referring physicians. Survey information, however, is not consistently integrated into departmental quality assurance discussions, may not be viewed through the CQI lens which suggests there is always room for improvement, and may not lead to development of customer-driven indicators for continued evaluation. Internal customers such as physicians or nurses are not surveyed.

UMHC does not have an organized method of identifying and participating in appropriate "benchmarking" activities. As a result UMHC may find itself a reactor instead of an initiator. For example, participation in JCAHO comparative data development may offer opportunities to critique the value of the process as well as to begin to understand what the comparative data will mean to UMHC clinical programs.

Finally, even though UMHC has initiated several projects with CQI components, and even though other components could be added, CQI, in its purest form, may be perceived by some as the evangelistic

trend-of-the year and therefore a questionable fit with UMHC culture.

Compliance with external regulations - The November 1990 JCAHO survey confirmed UMHC had made great progress in improving quality assurance programs. As stated earlier this leaves UMHC in a position of strength and provides an opportunity to build on and improve the structure developed for monitoring and evaluation.

Forums for the discussion of quality assurance issues have been established for 33 clinical services/divisions, the intensive care units, and the clinical support services. While some services/departments have implemented clinically relevant and productive programs, others have participated reluctantly, viewing this as a wasteful process driven only by the JCAHO and Hospital Administration. While some have responded to identified concerns with productive interventions, others have essentially refused to acknowledge that opportunities for improvement exist. Incentives to promote participation have not been developed.

The Quality Assurance Steering Committee has provided valuable direction and support during program development. Until the November 1990 survey, QASC evaluation of hospital quality assurance programs emphasized structure and process: Does the department have indicators? thresholds? and documented conclusions etc? Evaluations should now begin to include examination of indicators for clinical relevance and an expectation of response to significant issues. In the past most hospital programs were reviewed by the full committee. Given the number of programs needing evaluation, the size and composition of the committee, the time constraints of committee members, and the varied backgrounds of participating clinicians, in-depth and focused reviews were not easily accomplished.

Multidisciplinary quality assurance evaluations occur on the intensive care units, and for patient populations served by Psychiatry, Pediatric Cardiology, Pediatric Nephrology, Pediatric Hematology-Oncology, Obstetrics/Gynecology, and Radiology. Quality assurance programs in other areas do not generally cross departmental boundaries even when departmental indicators have interdisciplinary implications which would benefit from interdisciplinary discussion.

Other standards requiring attention to assure compliance at the next JCAHO survey include improved definition of risk management systems, improved integration of quality assurance information from Medical Staff-Hospital Council Committees, use of key quality assurance information in the credentialling process, and significant improvements in Ambulatory Care quality assurance including development of indicators which evaluate clinical performance and outcomes.

In summary, UMHC has a good foundation upon which to build: clinical research is a vital part of the academic environment, elements of continuous quality improvement already exist, and the value of multidisciplinary discussions is not disputed. The need for improvement is equally clear: clinical relevance must be enhanced, outcome data are essential for marketing and contract negotiation, and both internal and external customers must be considered. The following ten recommendations are designed to promote development of a clinically relevant and institutionally coordinated quality improvement program which will improve UMHC's competitiveness.

RECOMMENDATIONS

1) **UMHC should make its quality assurance programs more clinically relevant by better integrating the clinical research activities of the medical staff with the Hospital's quality assurance programs and by promoting publication of findings in a manner which will influence clinical practice.** Approaches might include:

   - o identification of existing research which can be included in the quality assurance process
   - o selection of indicators which contribute directly to research efforts or target opportunities for future research
   - o providing data management support including expertise in study design, statistical analysis, and computer support
   - o use of publications such as "Colleagues" to communicate positive results, for example, improved patient care or successful use of outcome data in contract negotiation
   - o provide departments with examples of model UMHC programs. For example, Radiology has developed an interdisciplinary, clinically relevant process which creates opportunities for publication.

2) **In order to truly impact the many aspects of patient care, UMHC's quality assurance activities should become more interdisciplinary, both at the physician-to-physician level and between physicians and other hospital departments.**

   A. Identify patient groupings, for example by diagnosis, procedure, or product line, where interdisciplinary coordination is key. Establish teams, including departments such as Nursing, Cardio-Respiratory, or Pharmacy as appropriate, to develop interdisciplinary indicators and meet regularly for review. Targeted groups might include:

   - o Cardiology/Cardiovascular Thoracic Surgery/Interventional Cardiology
   - o Obstetrics/Neonatal ICU
   - o Surgery/Anesthesia/Radiology/SICU

   B. Initiate two interdisciplinary quality improvement projects as noted in recommendation 9.

3) **The Quality Assurance Steering Committee should direct departmental and programmatic quality assurance activities toward clinical relevance and opportunities for patient care improvement, and should actively assess the effectiveness of actions taken.** Quality Assurance Steering Committee annual review should include evaluation of indicators for clinical relevance, and assessment of the appropriateness and effectiveness of actions taken. Other approaches might include:

- o sending representatives from the Steering Committee to departmental/service meetings to provide informal feedback on indicator selection and the review process.
- o development of a referral process to communicate and evaluate concerns identified between annual reviews.

4) **UMHC should appoint a physician to its administrative staff (Senior Associate Director of Medical Affairs) to work with Medical Staff leadership, Hospital Administration, the Health Sciences, and Medical School in guiding future quality assurance activities.**

- o function as an ombudsman to educate and gain support
- o assist with establishing priorities, transforming these recommendations into a strategic plan and action
- o identify and implement incentives to promote participation in activities that affect patient care
- o function as a negotiator and arbitrator

5) **UMHC should continue to "fine-tune" certain aspects of the quality assurance program to assure ongoing compliance with JCAHO standards.**

- o integrate quality assurance information from Medical Staff-Hospital Council Committees and Risk Management systems into departmental/service quality assurance review. Work with Committee leadership to select priority information and determine the best approach.
- o identify key hospital-wide indicators to be tracked for credentialling purposes. Work with the Credentials Committee to establish guidelines. For example, incorporation of a severity rating system based on peer review, with documentation of corrective actions and planned follow-up.
- o develop quality assurance programs for Ambulatory Care. Work with the Outpatient Committee and Outpatient Administration.

6) **The Quality Assurance Steering Committee should be restructured to support implementation of the recommendations in this document.**

- o consider a Steering Committee with a smaller, more multidisciplinary membership, which meets quarterly, and has primarily an oversight role
- o consider establishing subcommittees to evaluate the programs of assigned departments/services and provide reports to the full committee. Subcommittees might be based on clinically related patient groupings or targeted interdisiplinary teams; might meet every other month; might choose to send representatives to department/service meetings; and might be charged with assuring significant issues are addressed or referred to the full committee. One subcommittee should focus on development of Ambulatory Care quality assurance programs.

7) **UMHC should enhance its level of expertise and participation in outcome assessment studies on a selected basis, and seek to upgrade the level of research quality in such studies. UMHC should promote participation in cost-effectiveness evaluations.**

- o continue participation in MCCAP studies
- o identify and communicate research funding opportunities for outcomes assessment studies
- o encourage Center for Health Services Research involvement, particularly for applications to agencies like the AHCPR
- o assess national and regional databases to determine if UMHC should participate and/or take the lead. Include a review of potential risks and benefits of specific studies so that UMHC will not be placed at a disadvantage.
- o provide data management support including expertise in study design, statistical analysis, and computer support
- o initiate an outcomes assessment pilot, including patient feedback on functional status and quality of life, for a carefully defined group of patients. Consider populations with existing clinical databases or populations where quality of life information may be useful for marketing (for example, seeking third party payor center of excellence status). Consider also a blinded comparative study to evaluate the effect of patient functional status feedback.

8) **UMHC should utilize outcomes data more effectively in marketing and contract negotiation, and should incorporate outcomes and other "customer-focused" data desired by third party payors into the quality assurance program.**

- o work with individuals involved in marketing and contract negotiation to identify and incorporate indicators of interest to third party payors

9) **UMHC should develop a continuous quality improvement program uniquely appropriate to the University of Minnesota health care environment.**

- o identify existing activities which utilize CQI techniques and communicate successful results
- o select two system-wide issues for interdisciplinary team analysis. Examples might include communication with referring physicians and the effects of this communication on referral patterns, Operating Room systems, customer satisfaction in the clinics.
- o seek to educate and gain the support of individuals at all levels. Begin with those involved in existing/new projects. Include everyone from top leadership to the front line.
- o assure compliance with JCAHO standards related to CQI

10) **Consistent with the philosophy of continuous quality improvement, UMHC should develop quality assurance indicators which reflect the priorities of both internal and external customers, and utilize a quality management process which focuses on improving quality from that perspective.**

- o each department/service should ask its internal and external customers for suggestions of appropriate indicators. Referring physicians should be one of the external customers.

REFERENCES

1. Epstein AM. The Outcomes Movement - Will It Get Us Where We Want to Go? The New England Journal of Medicine July 1990; 323(4):266-270.

2. Geigle R, Jones SB. Outcomes Measurement: A Report From the Front. Inquiry Spring 1990; 27:7-13.

3. Taulbee P. Outcomes Management: Buying Value and Cutting Costs. Business and Health March 1991; 28-39.

4. Inglehart JK. Competition and the Pursuit of Quality: A Conversation with Walter McClure. Health Aff (Millwood) 1988; 7(1):79-90.

5. Marcinko T. Outcomes Management: Medicine Under the Microscope. Managed Care Insights (Parke-Davis Newsletter) Fall 1990; 1(3):12-16.

6. American Medical Association, Office of Quality Assurance. QA Practice Parameters Update August 1990.

7. Salive ME, Mayfield JA, Weissman NW. U.S. Department of Health and Human Services, Agency for Health Care Policy and Research. Patient Outcomes Research Teams and the Agency for Health Care Policy and Research. HSR: Health Services Research December 1990; 25(5):697-708.

8. Marder RJ. Development and Testing of a National Standardized Set of Obstetrical Care Performance Indicators: The JCAHO Experience. Abstract of Paper Presented at the International Society for Quality Assurance In Health Care's Eighth International Symposium (May 29 - June 1, 1991).

9. Longo D. Measuring Quality in Multi-Hospital Systems: The Quality Measurement and Management Project. Abstract of Paper Presented at the International Society for Quality Assurance In Health Care's Eighth International Symposium (May 29 - June 1, 1991).

10. Smits HL, Lynch JT, Goldberg AJ. Towards Excellence in Care: Voluntary Collaboration Among Hospitals in Developing Clinical Indicators. Abstract of Paper Presented at the International Society for Quality Assurance In Health Care's Eighth International Symposium (May 29 - June 1, 1991).

11. Ellwood PM. Shattuck Lecture - Outcomes Management, A Technology of Patient Experience. New England Journal of Medicine 1988; 318:1549-1556.

12. Stump MA, Blue Cross/Blue Shield of Minnesota. Verbal communication at InterStudy's OMS: Gaining Momentum Conference (May 8-10, 1991).

13. Merry MD. Total Quality Management for Physicians: Translating the New Paradigm. Quality Review Bulletin March 1990; 101-105.

14. Walton M. The Deming Management Method. New York: The Putnam Publishing Group 1986.

15. Schiff LP, Smith M, Feather H, McPhail V, Fainter J, Buchanan D. The Opportunities of Quality Improvement Compared to the Traditional Quality Assurance Program. Abstract of Paper Presented at the Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

16. Weaver CG, Appel F. Integrating Quality Assurance and Quality Improvement. Abstract of Paper Presented at the Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

17. Kralovec OJ, James B. Obtaining Physician Commitment and Medical Results in the Quality Improvement Process. Abstract of Paper Presented at the Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

18. Kralovec OJ. Obtaining Physician Commitment and Medical Results in the Quality Improvement Process. Author's Notes from Presentation at the Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

19. Address at Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

20. McEachern JE, Schiff L, Hallum A. A Quality Improvement Approach with a Cross Functional Team to Lower C-Section Rates. Abstract of Paper Presented at the Society for Health Systems/Healthcare Information and Management Systems Society's 1990 Conference: Quest for Quality and Productivity in Health Services (September 24-25, 1990).

21. Moller JH, Borbas C, Hagler DJ, McKay CJ, Stone FM. Demonstrated Value of a Physician-Directed Quality Assessment System. Minnesota Medicine June 1990; 73:26-32.

MINUTES
Planning and Development Committee
Board of Governors
October 14, 1991

CALL TO ORDER

Acting Chairman Johnson called the October 14, 1991 meeting of the Planning and Development Committee to order at 12:09 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present:	Leonard Bienias Robert Dickler Greg Hart Nellie Johnson Trudy Ohnsorg Ted Thompson, M.D.
	Absent:	Clint Hewitt William Jacott, M.D. Peter Lynch, M.D. Robert Nickoloff
	Staff:	Fred Bertschinger Giles Caver Cliff Fearing

APPROVAL OF MEETING MINUTES

The minutes of the July 18, 1991 meeting were approved as submitted.

INTERSTATE MEDICAL CENTER PROPOSAL

Mr. Cliff Fearing presented a proposal to purchase the facilities and practice of Interstate Medical Center (IMC), Red Wing, Minnesota, for a total acquisition cost of $9,074,600. The structure of the proposed acquisition and the financial basis for the purchase price were again reviewed with the Committee.

The new corporation's board of directors will consist of six members. Three members will be physicians who practice at IMC, and three members will be representatives from the Hospital.

A motion to endorse the purchase of Interstate Medical Center was seconded and passed unanimously. The Committee recommendation will be forwarded to the Board of Governors, whose recommendation will be sent to the Board of Regents for consideration in November and December.

QUARTERLY CAPITAL EXPENDITURE REPORT

Mr. Greg Hart presented the Quarterly Capital Expenditure Report. During Fiscal Year 1991, the Hospital spent $6,926,872 on recurring equipment and remodelling and $919,349 on principle payments. Sources of funding included monies budgeted for Fiscal Year 1991 and monies "rolled forward" from Fiscal Year 1990. The Hospital also spent $6,251,628 on capital projects.

QUARTERLY PURCHASING REPORT

Mr. Mark Koenig presented the Quarterly Purchasing Report for April-June 1991. Total purchase order activity was $18,097,915. This amount is down from the two prior quarters.

Mr. Koenig presented six "purchase awards to other than low bidder" ($10,000 or more). The Hospital also made a number of sole source purchases, including three in excess of $50,000. Mr. Koenig noted two vendor appeals.

A motion to endorse the Quarterly Purchasing Report was seconded and passed unanimously.

DEVELOPMENT OFFICE UPDATE

Mr. Fred Bertschinger presented the Development Office Quarterly Report for April-June 1991. Total contributions received amounted to $245,562. During Fiscal Year 1991, total contributions received amounted to $1,247,035, well in excess of the goal of $1,050,000.

The budgeted goal for Fiscal Year 1992 is $1,200,000. Mr. Bertschinger stated this year's goal is below last year's actual because bequests constitute a significant amount and are quite variable.

A motion to endorse the Development Office Quarterly Report was seconded and passed unanimously.

LITHOTRIPSY UPDATE

Mr. Greg Hart provided an update regarding the mobile lithotripsy program. Due to difficulties experienced with the machine vendor, an alternative approach to the program has been developed. The Hospital will first continue leasing a machine from the vendor on a short term basis. Second, the Hospital may begin leasing a machine from an Alabama hospital for a three to six month period. Third, the Hospital may place its current on-site machine in a van, thus using it both on-site for Hospital patients and off-site at other hospitals. The net financial impact of this approach compared to the prior lease arrangement is positive.

The Committee will continue to receive updates regarding Mobile Lithotripsy.

MOBILE CATH UPDATE

Mr. Greg Hart provided an update regarding the possible purchase or lease of a mobile cardiac catheterization laboratory. The Hospital is discussing a possible joint venture with two other hospital systems, one of which may bring its cardiologists in as joint venture partners. The status of the mobile cath marketplace was again discussed, and it was noted that our affiliates in Northern Minnesota remain very interested in this service.

The Committee will continue to receive updates regarding Mobile Cath, and will be asked to approve a definitive business plan and structure later this year.

RIVERSIDE MEDICAL CENTER

Mr. Greg Hart provided an update regarding service relocation discussions with Riverside Medical Center. A jointly-retained consultant recommended that Obstetrics and the Neonatal Intensive Care Unit be relocated to Riverside.

Mr. Hart indicated discussions among the Hospital, Riverside, and involved physicians are proceeding well. A more detailed financial analysis is now being considered. It is anticipated that a conclusion for these discussions will be presented to the Board in late 1991 or early 1992.

The Committee will continue to receive updates regarding Riverside Medical Center negotiations.

UMCA UPDATE

Dr. Ted Thompson presented an update regarding the Hospital's activities with UMCA. The Hospital and UMCA are attempting to identify where University physicians practice when not at the Hospital. Medica referrals, or the lack thereof, are also of interest. Finally, the Hospital and UMCA continue to pursue interdepartmental issues, including billing.

The Committee will continue to receive updates regarding UMCA.

OTHER BUSINESS

Mr. Robert Dickler provided an update regarding strategic planning. The "request for proposal" has been disseminated to various consulting firms, and Mr. Dickler has appointed a task force to provide ongoing assistance to whichever firm is selected. The intent is to formally begin the planning effort by year end and to complete the process by August or September 1992.

The Committee will continue to receive updates regarding the strategic planning process.

ADJOURNMENT

There being no further business, a motion for adjournment was seconded and passed at 1:02 p.m.

Respectfully submitted,

Giles Caver
Administrative Fellow

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 17, 1991

TO: Board of Governors

FROM: Robert Dickler
Hospital Director

SUBJECT: Acquisition of Red Wing Medical Center

I am writing to you at this time to request that you approve UMHC acquiring the Interstate Medical Center (IMC) physician practice in Red Wing, Minnesota. It is our intent to make this presentation to you for information during the retreat on September 26 and 27, 1991. We will seek your endorsement of this proposal at the October Board of Governors meeting.

Should you approve this proposal, we will request the Board of Regents approval during November and December.

While the actual acquisition documents are still being developed, the expected future structure of IMC will be a new nonprofit corporation.

The price for the acquisition is $9,074,600 subject to adjustment for any issues discovered during the due diligence process.

We request that you review the attached proposal so we can answer any of your questions at the retreat, or as usual you may call either Mr. Fearing or myself at 626-0966 or 626-5003 if you have questions or concerns.

RD:sw

Attachment

PROPOSAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ACQUISITION OF

INTERSTATE MEDICAL CENTER
RED WING, MINNESOTA

(Much of the following are excerpts from the Bylaws and Articles of Incorporation of the New Corporation.)

Existing Physician Practice Description:

Interstate Medical Center (IMC) is a multiple specialty clinic of twenty-eight physicians, and related staff, which operates primarily out of a facility in Red Wing, Minnesota. IMC also owns a clinic building in Elsworth, Wisconsin, and has satellite office space in Zumbrota, Minnesota. IMC is the only major clinic in Red Wing and is the major physician provider in this geographic area.

IMC is a healthy and viable clinic with a patient volume of approximately 150,000 patient encounters per year. It's yearly gross revenues are approximately $14 million, and it has demonstrated a consistent pattern of growth over the last several years.

The Red Wing facility consists of two buildings, containing a total of approximately 42,000 gross square feet, and parking space for 205 cars. The main clinic building is twenty years old and consists of two floors of about 16,000 gross square feet each. The therapy building, which is about five years old, also houses storage. The Elsworth facility was constructed in 1984, and comprises approximately 3,000 gross square feet.

New Corporation:

The name of the new corporation will continue to be Interstate Medical Center. We are proposing, with concurrence of our legal counsel, that the new organization be established as a non-profit organization and seek tax exempt status from the Internal Revenue Service. It is our belief that this type of organizational structure best fits the mission of the University and the new organization.

Mission of New Corporation:

The mission of the corporation will be to engage in, and assist and contribute to, the support of charitable, scientific, and educational activities and projects, within the meaning of Section 501(c)(3) of the Internal Revenue Code.

In support of the mission, the main activities of the corporation shall include:

A. To operate a multi-specialty medical clinic providing health care services and promoting health in Red Wing, Minnesota and the surrounding areas.

B. To operate programs for medical education including medical residency and continuing medical education, as well as community health education and specialty outreach programs.

C. To engage in clinical research and scientific investigation related to health and medicine.

D. To do any and all other acts and things, and to exercise any and all other rights and powers which may be necessary, advisable, desirable or expedient in the accomplishment of any of the foregoing purposes.

Corporate Authority:

The corporation shall have authority to do any and all acts and things and carry on and conduct all other activities as may be necessary, advisable, desirable or expedient to accomplish its purposes, to the full extent permitted by the laws of the State of Minnesota.

All activities of the corporation shall be carried on, and all of its funds shall be used and applied exclusively for, the purposes for which this corporation was organized.

No part of the net earnings of the corporation shall inure to the benefit of any member, officer, director or any other individual (except that reasonable compensation may be paid for services rendered to or for the corporation in furtherance of one or more of its purposes, and except that individuals may benefit from grants, and similar payments or contributions made for the purposes for which this corporation was organized, in furtherance of the purposes of the corporation).

No substantial part of the activities of the corporation shall be the carrying on for propaganda or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign on behalf of any candidate for public office, by publishing or distributing statements or otherwise.

The corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code.

The corporation shall not afford pecuniary gain or profit, incidentally or otherwise, to its members or its employees.

This corporation will be formed under Chapter 317A of Minnesota Statutes.

Governance:

Sole Member -

The sole member of the corporation shall be the Regents of the University of Minnesota, a corporation established and operating in accordance with Minnesota Statutes, Section 158. The rights and obligations of the sole member shall be fulfilled by the University of Minnesota Hospital and Clinic, by and through its Board of Governors and management.

Notwithstanding anything to the contrary herein, the sole member shall reserve and retain certain powers to manage the affairs of the corporation. No action may be taken by the corporation inconsistent with the mission of the corporation, nor shall any amendment to such corporate purposes occur, without the specific written approval of the sole member.

In addition, the sole member shall be notified of any proposal for the Corporation to enter into a provider agreement with any third party payor, and the Corporation shall not enter into any such provider agreement without the approval of the sole member; provided, that the sole member may only withhold such approval if the terms of the proposed agreement materially conflict with the mission or corporate purposes of the University of Minnesota Hospital and Clinic.

The Corporation's annual budget shall be formulated for the purpose of maintaining first-rate medical clinic, education and research programs. All revenues generated by the Corporation shall be devoted to the maintenance of its programs and other corporate operations. The annual operating and capital budgets shall be formulated by the Board of Directors or its designee and shall be approved in writing by the Board of Directors not later than the end of the first month of the new fiscal year to which the budget applies. Subsequent to such approval, the annual budget shall be submitted for approval to the sole member and shall be subject to the written approval of such member.

The prior written consent of the sole member shall also be required for:

A. Any merger, consolidation, or substantial transfer of the property of the corporation to any other entity; or

B. Any modification or amendment of the corporate capital or operating budget in excess of $50,000 or in excess in the aggregate of 10% of the budget; or

C. Any action that might, in the reasonable judgement of the member, jeopardize the non-profit status of the corporation.

The University of Minnesota Hospital and Clinic shall not be removed as a member of the Board. In addition, the sole member of the corporation shall have the sole vote on or in respect of any matter on which members of the corporation have the right to vote under law, the Articles of Incorporation or Corporation Bylaws. The sole member may not voluntarily or involuntarily transfer or assign its membership or any right arising therefrom, except to another entity controlled by the University of Minnesota and acceptable to the majority of the Board of Directors of the corporation. Consent of the Board of Directors shall not be unreasonably withheld.

In the event of liquidation, dissolution or winding up of the corporation, whether voluntary or involuntary or by operation of law, the remaining property and assets of the corporation, after provision has been made for the payment of debts, obligations and liabilities of the corporation in accordance with M.S.A. 317A.701 et seq., shall be distributed to the University of Minnesota.

Finally, no amendment to the Articles of Incorporation may be made which has material impact on the powers reserved to the sole member.

Board of Directors -

The management of the corporation shall be vested in a Board of Directors, subject to the reservation of certain powers for the sole member. The number of directors shall be fixed by the Bylaws of the corporation, and may be altered by amending the Bylaws.

The first Board of Directors shall consist of two classes of directors. Three directors shall be the "University Directors". The Board of Governors of the University of Minnesota Hospital and Clinic shall appoint the University Directors based on recommendation of the Hospital Director.

The remaining three directors shall be the "Physician Directors". The physicians shall appoint the Physician Directors by election of the entire physician group.

The term of office of the members of the first Board of Directors shall be for the periods of 1, 2, or 3 years for University and Physician Directors. Each such director shall hold office until the end of the term of his or her office or until his or her successor has been elected and qualified.

Except as provided otherwise in the Articles of Incorporation of the corporation, the business and affairs of the corporation shall be managed by or under the direction of the Board of Directors.

Each director, except members of the first Board of Directors, whose terms of office are specified in the Articles of Incorporation of the corporation, shall serve for a three year term and until his or her successor is elected and qualified.

Any director may resign at any time by giving written notice to the Secretary. Such resignation shall take effect without acceptance upon receipt of the notice, unless a later date is specified in the notice.

Vacancies in the Board of Directors shall be filled by a new appointment or election, as the case may be, as set forth in the Bylaws. A person so elected to fill a vacancy shall serve as a director for the remainder of the term whose vacancy has been filled, and until his or her successor has been elected and qualified.

Any Physician Director may be removed at any time by a majority vote of the physicians eligible to vote for a Physician Director. Any University Director may be removed at any time by the University. Any Physician Director shall be removed as a director of the corporation should he or she cease employment with the corporation. In such circumstances, either the presiding officer of the Board or the corporation's President shall provide immediate written notice of such removal, which removal shall be effective upon the earlier or either (i) the date the notice is received; or (ii) the date the director to be removed ceases employment with the corporation.

A majority of the directors currently holding office shall constitute a quorum for the transaction of business, except under no circumstances shall a quorum be deemed to exist if fewer than two Physician Directors and two University Directors are present. In the absence of a quorum, a majority of the directors present may adjourn a meeting from time to time until a quorum is present, provided, that notice of a meeting's adjournment by less than a quorum of directors shall be provided to the absent directors. Except as otherwise required by law or the Bylaws, the acts of a majority of the directors present at a duly held meeting shall be the acts of the Board of Directors; provided, that if fewer than six directors are present at a meeting, a unanimous action by the directors shall be required for the Board of Directors to act.

If the Board is unable to reach a decision on an issue because of a deadlock and such deadlock continues for a period of 90 days then mediation shall be mandatory upon the written request of any Director. If such deadlock is not resolved by mediation, the Directors may agree to submit the issue to binding arbitration by a mutually agreeable arbitrator. If a deadlock is not resolved by mediation and is not submitted to binding arbitration, any Director may ask a court of competent jurisdiction to resolve the issues.

Bylaw Amendments. The power to adopt, amend, or repeal the Bylaws is vested in the Board of Directors, provided, that no amendment shall be made to the Bylaws which has a material impact on the reservation of powers to the sole member. Any amendment to the Articles of Incorporation or Bylaw changes must be approved by 3/4 of the members of the Board of Directors.

Board Meetings:

The Board of Directors shall hold an annual meeting for the purpose of electing officers and transacting any other business coming before it. The Board may hold such other meetings as it may from time to time determine. The meetings shall be held at any place within or without the State of Minnesota that the Board may designate. Absent such designation, Board meetings shall be held at the registered office of the corporation. The President or any director may call a special Board meeting.

An action required or permitted to be taken at a Board meeting may be taken by written action signed by all of the directors.

Directors shall receive no compensation, but may be reimbursed for reasonable expenses as shall be determined from time to time by resolution of the Board of Directors. Nothing herein shall be construed to preclude any director from serving this corporation in any other capacity and receiving proper compensation therefor.

At either the annual meeting or a special meeting, the Board of Directors shall consider the annual budget for the corporation. At least ten days prior to such meeting all directors shall be provided with the proposed annual budget, as approved by the Physician's Committee. Such meetings shall occur at least 30 days prior to the commencement of the fiscal year of the corporation for which the budget is proposed. Simultaneous with the delivery of the proposed budget to the directors, such budget shall also be delivered to the member.

The following matters shall require specific approval by the Board of Directors:

A. Non-budgeted capital expenditures of more than $50,000;

B. The merger or consolidation of the corporation with, or transfer of more than 25% of the assets of the corporation to, any entity;

C. The incurring or guaranteeing by the corporation of indebtedness in excess of $50,000 in aggregate during any fiscal year, as defined in generally accepted accounting principles to include notes, bonds, debentures, capital leases and otherwise, except purchase money indebtedness incurred in connection with the purchase or construction of a capital asset included in the budget and except indebtedness incurred by the corporation's drawing down on any line of credit approved by the Board of Directors;

D. The purchasing or acquiring by the corporation of stock or other securities or evidences of indebtedness, or the making of loans or advances to, or any investment in, any corporation, partnership or other entity, except for the regular investment of funds (in accordance with the corporation's investment policies) including, without limitation, clinic revenues and employee benefit plan funds, and except for investments in joint ventures in the amount of $25,000 or less.

E. The adoption or termination of any lease for space or equipment with annual costs in excess of $50,000.

F. The Board shall be informed of, but need not approve, termination of the employment of any physician.

G. Grants or gifts in excess of $5,000.

Officers:

The corporation shall have at least two natural persons exercising the functions of the office of President and Treasurer. The Board of Directors may elect or appoint such other officers or agents as it deems necessary, each of who shall have the powers, rights, duties and responsibilities set forth in these Bylaws unless otherwise determined by the Board. Any of the offices or functions of those offices may be held by the same person. Officers shall receive no compensation, but may be reimbursed for reasonable expenses as determined from time to time by resolution of the Board.

At the annual meeting of the Board of Directors, the Board shall elect officers, who shall hold office until their successors are elected and qualified; provided, however, that any officer may be removed with or without cause by the affirmative vote of the directors in accordance with the Bylaws (without prejudice, however, to any contract rights of such officer).

Any officer may resign at any time by giving written notice to the corporation. The resignation is effective without acceptance when notice is given to the corporation, unless a later date is specified in the notice.

If a vacancy in any office of the corporation occurs for any reason, such vacancy may, or in the case of a vacancy in the office of President or Treasurer shall, be filled for the unexpired part of the term by the Board of Directors.

126.

President. Unless provided otherwise by a resolution adopted by the Board of Directors, the President shall (a) be the chief executive officer of the corporation, and have general active management of the business of the corporation; (b) preside at all meetings of the Board and of the members; (c) see that all orders and resolutions of the Board are carried into effect; (d) sign and deliver in the name of the corporation any deeds, mortgages, bonds, contracts or other instruments pertaining to the business of the corporation, except in cases in which the authority to sign and deliver is required by law to be exercised by another person or is expressly delegated by the Articles, the Bylaws or the Board to some other officer or agent of the corporation; (e) maintain records of and certify proceedings of the Board and Members; and (f) perform such other duties as may from time to time be prescribed by the Board.

Treasurer. Unless provided otherwise by a resolution adopted by the Board of Directors, the Treasurer shall (a) keep accurate financial records for the corporation; (b) deposit all monies, drafts and checks in the name of and to the credit of the corporation in such banks and depositories as the Board of Directors shall designate from time to time; (c) endorse for deposit all notes, checks and drafts received by the corporation as ordered by the Board, making proper vouchers therefor; (d) disburse corporate funds and issue checks and drafts in the name of the corporation, as ordered by the Board; (e) render to the President and the Board of Directors, whenever requested, an account of all of his or her transactions as Treasurer and of the financial condition of the corporation; and (f) perform such other duties as may be prescribed by the Board of Directors or the President from time to time.

Secretary. The Secretary shall, unless otherwise determined by the Board, be secretary of and attend all meetings of members and Board of Directors, and record the proceedings of such meetings in the minute book of the corporation and, whenever necessary, certify such proceedings. The Secretary shall give proper notice of meetings to members and directors and shall perform such other duties as may be prescribed by the Board of Directors or the President from time to time.

Vice President. Each Vice President shall have such powers and shall perform such duties as may be specified in the Bylaws or prescribed by the Board of Directors. In the event of absence or disability of the President, the Board of Directors may designate a Vie President or Vice Presidents to succeed to the power and duties of the President.

Other Officers. Any other officers appointed by the Board of Directors shall perform such duties and be responsible for such functions as the Board of Directors may prescribe.

Delegation. Unless prohibited by a resolution by the Board of Directors, an officer elected or appointed by the Board may delegate in writing some or all of the duties and powers of his or her office to other persons.

Physicians' Committee:

The Board of Directors shall establish a Physicians' Committee which shall have and exercise the authority of the Board in the day-to-day management of the business of the corporation, including, without limitation, the following matters:

A. Determination of physician work schedules, call coverage schedules, vacation and leave schedules, staffing, and all issues of a similar nature relating directly to the performance of work and services by physicians employed at the corporation.

B. Determination of compensation for professional employees, including salaries, bonuses, insurance and other welfare benefits, retirement and other similar benefit plans, and all other aspects of compensation for professional employees of the corporation. In establishing compensation for professional employees of the corporation, the Physicians' Committee shall refer to salary ranges of similarly situated practitioners in comparable clinics which shall be prepared by the corporation's outside accountants. Compensation for professional employees of the clinic shall be competitive with comparable group practices, so as to permit the corporation to retain its professional staff, but shall not exceed a reasonable level of compensation. In accordance with the purposes of the corporation as set forth in its Articles of Incorporation, the compensation system shall not be used as a device to distribute the net profits of the corporation to its professional employees. No action shall be taken by the Physicians' Committee as to compensation that might reasonably be anticipated to jeopardize the tax-exempt status of the Corporation. Compensation and benefit programs must be fully reflected and approved in the annual budget.

C. All other matters respecting the management and operation of the corporation except those powers retained by the sole member and except as the Board of Directors may otherwise determine by specific resolution adopted by such Board.

The Physicians' Committee shall be composed of the three Physician Directors serving as members of the Board of Directors and three or more additional physicians practicing medicine as employees of Interstate Medical Center.

The Physicians' Committee may, from time to time, appoint such other committees as it may deem proper, and may prescribe the functions and membership of such other committees. The Physicians' Committee shall at all times be subject to the control and direction of the Board.

The degree of local control over the governance and management of the Corporation is intended to maintain the local influence over the medical practice of the Red Wing area and reduce the operating inefficiencies and increased costs that would be associated with direct University control. The separate corporation also allows the University to be isolated for malpractice actions, retirement and other liabilities of the physicians and employees of IMC.

The fiscal year of the corporation shall be established by the Board of Directors.

The corporation shall indemnify such persons, for such expenses and liabilities, in such manner, under such circumstances, and to such extent, as permitted by Minnesota Statutes.

The corporation shall not enter into contracts or transactions between the corporation or a related corporation and a director or member of the Physicians' Committee of the corporation or between the corporation and an organization in which a director or member of the Physicians' Committee of the corporation is a director, officer or legal representative or has a material financial interest, except in accord with the provisions of Minnesota Statutes.

Purchase Price:

The purchase price of IMC that has been agreed to is an aggregate $9,074,600 subject to change due to new property or equipment acquisitions or any errors or omissions or other issues affecting the purchase price discovered during the due diligence process. Of this amount, $3,596,600 is directed toward the real property and other assets. Real estate and equipment appraisals have been received which support the $3,596,000 purchase price. UMHC will loan the new corporation the funds to purchase these assets from existing IMC. The new corporation will in turn repay UMHC for the real estate and other assets. $5,478,000 is directed toward the purchase of the goodwill and ongoing business value of the clinic, and will be paid out over the course of eight years. The reasonableness of this component of the price was confirmed by an independent accounting firm. The total present value payment of this transaction is $7,759,000 since the payment for the practice is made over eight years. These payments are also contingent upon the physicians remaining with the clinic over the eight year period.

All of these parameters have been reviewed by external consulting and legal firms experienced in the legal and financial issues related to the acquisition of a practice. These efforts have indicated that the aggregate purchase price proposed is within the fair market value of the practice and that the structure and purposes of the acquisition are consistent with the current understanding and interpretations of relevant laws and regulations.

Other:

The University of Minnesota Hospital and Clinic has - throughout it's history - served as a statewide and regional resource. The types of relationships which UMHC and the University have developed with outstate communities has continually evolved over this period of time to both reflect and initiate changes in health care delivery.

The acquisition of IMC provides a significant opportunity for the University and UMHC to geographically expand the base of medical operations, and provide greater opportunities for education, research, and service to the Greater Minnesota community and the Red Wing region. By this acquisition, UMHC will gain a secure relationship with a viable out-state provider. We expect to very quickly expand the residency program in Pediatrics to place residents in Red Wing, and as other departments develop relationships with IMC, further residency arrangements will be instituted. We expect that the relationship with the Rural Physician Apprenticeship Program (RPAP) will be reinforced and potentially expanded. The IMC patient population will be incorporated into appropriate research activity, allowing the expansion of research protocols. We also envision that this

relationship will permit the potential development of protocols and models related to rural health care and expansion of community education and continuing medical education involving a geographic region where this opportunity has not previously existed. These types of changes will, of necessity, take place over a number of years and require the existence of a secure relationship to foster their development.

The Board structure of three physicians and three University directors was negotiated in concert with the sole member retained powers. We believe that the sole member retained powers are adequate to assure that the corporation is acting in the best interest of the University, and at the same time a three to three Board membership provides equal opportunity for maintaining a joint interest in the new corporation's programmatic financial viability.

The purchase of IMC has been discussed with local business leaders and the local Hospital Board. State legislators from the area have been briefed on this issue and we have had numerous discussions with our clinical leadership and faculty. To our knowledge, there is no vocal opposition to this acquisition.

The purchase of IMC will not increase the malpractice exposure to RUMINCO since IMC is a separate corporation and not insured by RUMINCO. In addition, with three members of the Hospital on the IMC Board, Quality Assurance issues can be overseen.

As an investment, the final negotiated price will allow UMHC to provide a return on investment of approximately our historical rate of return on the short term investment portfolio. It will also provide us with education and research opportunities that would not be available should we not proceed.

We hope this proposal provides you the basis for understanding the presentation we will provide during the retreat. As always, should you have any questions or concerns, please contact me or Mr. Fearing at 626-5003 or 626-0966 respectively.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 23, 1991

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1991 through September 30, 1991**

The Hospital's operations for the month of September reflect inpatient admissions and days, and outpatient clinic visit activity below budget. Similarly, both ancillary revenue and routine revenue are below budgeted levels.

INPATIENT CENSUS: For the month of September, inpatient admissions totaled 1,343 which was 152 below budgeted admissions of 1,495. Our overall average length of stay for the month was 8.1 days. Patient days for September totaled 10,515 and were 1,609 days below budget. The areas in which admissions were most significantly below budget were Gynecology, Pediatrics, and Ophthalmology.

OUTPATIENT CENSUS: Outpatient encounters (including CUHCC and Home Health) for the month of September totaled 26,067 which was 1,627, or 5.9%, less than budgeted encounters of 27,694. Encounters were below budget in virtually all clinical areas with the most significant decreases in Radiation Therapy, OB/GYN, Medicine, Adult Psych, Child Psych, Surgery, Otolaryngology, and Dermatology. Family Practice and Home Health visits were over budgeted levels for September.

From what we've been able to identify, our declines in census appear to be the result of several factors, including changes in medical staff in some clinical services, a shortage of available organs for transplant, and increased competition from other metropolitan hospitals.

To recap our census:

Monthly Data						YTD Data				
90/91 Actual	91/92 Budget	91/92 Actual	Variance	% Var		90/91 Actual	91/92 Budget	91/92 Actual	Variance	% Var
1,431	1,495	1,343	(152)	(10.2)	Admissions	4,734	4,777	4,535	(242)	(5.1)
12,099	12,124	10,515	(1,609)	(13.3)	Patient Days	37,784	38,406	35,235	(3,171)	(8.3)
8.3	8.1	8.1	0.0	0.0	Avg Length of Stay	8.0	8.0	7.7	(0.3)	(3.8)
400.3	404.1	350.5	(53.6)	(13.3)	Avg Daily Census	410.7	417.4	383.0	(34.4)	(8.2)
69.7	70.2	61.7	(8.5)	(12.1)	Percent Occupancy	71.5	72.5	67.3	(5.2)	(7.2)
26,301	27,694	26,067	(1,627)	(5.9)	Outpt Encounters	85,438	88,554	85,166	(3,388)	(3.8)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses being greater than revenues by $1,069,000, an unfavorable variance of $4,431,000. Patient care charges through September totaled $90,791,000, which was 6.7% under budget.

Routine revenue was $2,864,000 (10.1%) below budget and ancillary revenue was $3,645,000 (5.3%) below budget and reflects both our unfavorable inpatient and outpatient census variance.

Deductions from charges totaled $25,059,000, which was $1,063,000 (4.4%) over budgeted deductions of $23,996,000. Billing adjustments are $896,000 (27.6%) over budget. These relate primarily to greater than anticipated discounts granted for prompt payment of billed charges, and significant decreases in reimbursement under our VA contracts. The governmental contractual adjustment for the period ending September 30, 1991, is $193,000 (1.5%) over budget, and is attributed to our Medicare census being greater than budgeted levels. HMO/PPO discounts have a slightly favorable variance (-0.8%) as a result of higher than anticipated reimbursement for the Blue Cross AWARE contract.

Operating expenditures through September totaled $75,597,000 and were $3,811,000 (4.8%) below budgeted levels of $79,408,000. The overall favorable variance is primarily due to lower patient related costs (medical supplies and services and blood) and anticipated expenses not yet incurred.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of September 30, 1991, totaled $95,051,000 and represented 92.0 days of revenue outstanding. The overall decrease in our patient receivables in September of 2.2 days was reflected in decreases in Commercial Insurance, Minnesota Medical Assistance, and Minnesota Comprehensive Health Act (MCHA) contracts.

CONCLUSION: The Hospital's overall operating position shows a loss for the month and year-to-date. We continue to work towards identifying and evaluating ways of attracting and retaining more of the healthcare market, while at the same time keeping our expenditure levels in line with our revenues.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO SEPTEMBER 30, 1991

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	$97,300,000	$90,791,000	($6,509,000)	-6.7%
Deductions From Revenue	23,996,000	25,059,000	1,063,000	4.4%
Net Patient Service Revenue	73,304,000	65,732,000	(7,572,000)	-10.3%
Other Operating Revenue				
Appropriation & Support	3,345,000	3,256,000	(89,000)	-2.7%
Other Revenue	3,000,000	2,850,000	(150,000)	-5.0%
Total Other Revenue	6,345,000	6,106,000	(239,000)	-3.8%
Total Revenue From Operations	79,649,000	71,838,000	(7,811,000)	-9.8%
Operating Expenses:				
Salaries	31,228,000	30,863,000	(365,000)	-1.2%
Fringe Benefits	7,649,000	7,540,000	(109,000)	-1.4%
Contract Compensation	4,994,000	4,964,000	(30,000)	-0.6%
Supplies And Services	18,296,000	16,829,000	(1,467,000)	-8.0%
Utilities And Maintenance	3,033,000	2,977,000	(56,000)	-1.8%
General Supplies & Expense	5,385,000	3,826,000	(1,559,000)	-29.0%
Insurance	483,000	482,000	(1,000)	-0.2%
Depreciation & Amortization	4,673,000	4,461,000	(212,000)	-4.5%
Interest	2,894,000	2,872,000	(22,000)	-0.8%
Provision For Uncollectibles	773,000	783,000	10,000	1.3%
Total Operating Expenses	79,408,000	75,597,000	(3,811,000)	-4.8%
Net Revenue From Operations	241,000	(3,759,000)	(4,000,000)	
Nonoperating Gains: Investment Income	3,120,000	2,690,000	(430,000)	-13.8%
Revenue And Gains In Excess Of Expense	$3,361,000	($1,069,000)	($4,430,000)	

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	4,777	4,535	(242)	-5.1%
Patient Days	38,406	35,235	(3,171)	-8.3%
Average Length Of Stay	8.0	7.7	(0.3)	-3.8%
Average Daily Census	417.4	383.0	(34.4)	-8.2%
Percentage Occupancy	72.5	67.3	(5.2)	-7.2%
Outpatient Encounters	88,554	85,166	(3,388)	-3.8%

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 23, 1991

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Report of Operations for the Period
July 1, 1990 through June 30, 1991

The 1990-91 fiscal year for University of Minnesota Hospital and Clinic has shown a decline in inpatient admissions for the third straight year. At the same time, however, we experienced an increase in our outpatient clinic visits over prior year levels. Below is a brief summary of major factors which have contributed to our 1990-91 financial position.

Inpatient Census: Admissions for the 1990-91 fiscal year totaled 18,161 compared to 18,331 for the previous year, a decrease of 170, or (0.9%). Patient days for the year totaled 145,665, down by 1,819 (1.2%) from 147,484 days in 1989-90. The hospital overall average length of stay remained at 8.0 days in the current year.

We budgeted for a decline in our inpatient census levels in 1990/91 which was consistent with industry trends. However, we experienced smaller declines than anticipated in both inpatient admissions and patient days. While admissions in many areas decreased from the prior year or remained fairly constant, Medicine, Neurosurgery, and Neurology showed significant increases. The continuing expansion of existing programs, such as cardiology and wound-healing, resulted in increases in Medicine. The increases in Neurology and Neurosurgery can be attributed to the hiring of new faculty.

To recap our inpatient census for the 1990-91 fiscal year:

	1989-90 Actual	1990-91 Budget	1990-91 Actual	Variance	% Var
Admissions	18,331	17,350	18,161	811	4.7
Avg. Lgth. of Stay	8.0	8.0	8.0	0.0	0.0
Patient Days	147,484	137,800	145,665	7,865	5.7
Percent Occupancy	69.6	65.1	69.3	4.2	6.5
Avg. Daily Census	404.1	377.5	399.1	21.6	5.7

Outpatient Census: The Hospital's outpatient clinic census showed an increase from the 1989-90 levels, going from 270,756 visits in 1989-90 to 277,036 in 1990-91. This represents a 2.3% increase over the prior year levels and a 5.3% increase (14,036) over the budgeted 1990-91 total of 263,000. The increase in clinic census occurred in most clinical areas with the major increases occurring in Adult Psych, Medical Endoscopy, Emergency Room, Family Practice, and Dentistry. Clinic areas that experienced significant decreases in activity included Child Psych, Dermatology, Surgery, and Psychology.

To recap our outpatient census for the 1990-91 fiscal year:

	1989-90 Actual	1990-91 Budget	1990-91 Actual	Variance	% Var
Clinic Visits	270,756	263,000	277,036	14,036	5.3
CUHCC Visits	53,062	53,112	50,009	(3,103)	(5.8)
HHA Visits	11,255	11,222	11,489	267	2.4

Operations - Revenue: Patient care revenue for the 1990-91 fiscal year totaled $350,983,714 and is an increase of $31,158,617 (9.7%) over the 1989-90 fiscal year. The increase in revenue is approximately $15,978,700 above budget and results in an overall favorable variance of 4.8%. This overall variance is due primarily to greater than anticipated admissions and outpatient visits.

Routine revenue totaled $100,218,939, and represents a favorable variance of approximately $4,211,900. Ancillary service revenue totaled $250,764,775, and was approximately $11,766,800 (4.9%) above budget. The overall ancillary variance is almost entirely due to the increased census levels; the utilization level per inpatient was actually lower than anticipated while outpatient utilization was higher. Inpatient ancillary revenue per admission averaged $9,770 compared to the budgeted average of $9,810. Outpatient revenue per clinic visit averaged $265 compared to the budgeted average of $262. Nearly all ancillary areas experienced revenues above budget, with the greatest increases occurring in the clinical labs and the blood bank, pharmacy, diagnostic radiology, central sterile processing, and the operating rooms. In addition to the climb in census levels, other factors impacted these increases. The expansion of the cardiology, wound-healing, and

hemophilia programs caused increases in lab and blood revenues, changes in protocols to new and safer, more expensive drugs increased our pharmacy revenues, and strong efforts made to improve the quality and service of our MRI program enabled us to increase our market share, thereby increasing our revenues.

Deductions from Charges: Deductions from charges totaled $84,654,000 for the fiscal year and represent an overall unfavorable variance of $4,171,000. The major portion of this variance is a $6,607,186 (33.2%) unfavorable variance in HMO/PPO contractual adjustments. About $2,055,100 of the variance relates to AWARE inpatient write-offs, and is primarily due to higher than expected charges per inpatient discharge. In addition, we experienced a significant increase in activity and deductions related to U-Care patients ($797,400) and our transplant contracts ($3,013,500).

The $3,254,100 (6.8%) favorable variance in governmental write-offs was due to several factors. We saw a $7,225,000 favorable variance in Medicare adjustments, $3,509,500 of which is related to better than expected Medicare payments for indirect medical education. The remaining variance for Medicare is a combination of factors including a reduction in charges per case, an increase in the case mix index, and an increase in the number of Medicare patients. Offsetting this favorable variance are unfavorable variances for the amortization of our deferred third party liability ($3,000,000), and for smaller governmental programs such as CHAMPUS and County Papers ($1,500,000).

Other Operating Revenue: Other operating revenue totaled $27,545,355 for the 1990-91 fiscal year, an increase of $576,794 (2.1%) over the prior year total of $26,968,561. The increase is $1,563,355 (6.0%) over the budgeted revenue of $25,982,000, and reflects significant favorable variances for interest income from bond proceeds, reference lab revenue, food services, and professional fees.

Operations - Expenditures: Operating expenses for the 1990-91 fiscal year totaled $294,090,900 and was an increase of $14,303,600 (5.1%) over the 1989-90 fiscal year. The increase in expense was approximately $3,772,900 over budget and resulted in an overall unfavorable variance of 1.3%. Most of this variance was associated with the increase in demand for patient services and unanticipated increases in our insurance costs.

Personnel costs (salaries and fringe benefits) were over budget by $1,584,900. The increased salary costs were the result of higher staffing levels. During the 1990-91 fiscal year we averaged 3,801 full-time equivalents (FTE's), which was an increase of 117 over the budgeted total of 3,684. The increase in staffing levels is largely attributed to the increased census levels experienced throughout the year, with patient-related services accounting for

91% of the FTE increase. The favorable variance in fringe benefit expenses is because of lower than anticipated increases in benefit rates effective January of 1991.

Supplies and expense directly related to patient care activities were $2,477,000 over budget in aggregate. Many of these expenses relate directly to the increase in ancillary revenues. They include such things as drugs, blood and blood derivatives, laboratory and medical supplies, laundry and food services, transplant activities, and temporary contracting of agency nurses.

Expenses related to buildings, building services, and equipment were $951,800 under budget. These costs include utilities, maintenance and repair, communications, building rental, and depreciation. The major decrease was seen in depreciation, and resulted primarily from delays in purchasing some capital items and delays in the upgrading or renovating of computer systems and ancillary departments (Heart Cath Lab, Neuroradiology rooms, etc.).

Insurance expense for 1990-91 totaled $2,246,895 and was $1,475,895 over budget. This unfavorable variance relates to our general and malpractice liability and is the result of several factors. We had anticipated that further reductions in premiums through retained earnings credits and retrospective premium adjustments beyond what we had received in prior years would be made, but they were not realized. In addition, we incurred unanticipated liabilities for the estimated cost of asserted claims and incidents not yet reported and for potential uninsured claims in excess of policy aggregate limits in prior years.

Finally, we experienced a net favorable variance in our general supply and expense categories totaling $814,000. The major portions of this variance relate to a $1,600,000 favorable variance due to no relocation expenses being incurred for departments originally thought to be impacted by the Renewal Project II, a $504,000 favorable variance in interest expense due to decreased rates on the variable rate bonds, and an unfavorable variance of $824,000 related to the unanticipated FICA payments and stipend increases for the residents.

Non-Operating Revenue: Non-operating revenues totaled $12,282,856 in 1990-91 and represent a favorable variance from budget of $2,370,900. The overall variance is mainly due to increased interest earnings on the reserve funds and the investments held by the trustee.

Accounts Receivable: The balance in patient accounts receivable as of June 30, 1991 totaled $95,679,101 and represents 94.9 days of revenue outstanding; this is an increase of 1.3 days and an increase of $9,973,443 from June 30, 1990. Much of the increase was seen in those payors that require diagnostic/DRG assignment. These would include Medicare, Minnesota Medical Assistance, and Blue Cross AWARE.

Capital Expenditures: During the 1990-91 fiscal year, UMHC expended $8,953,400 from hospital operating funds, $2,500,000 from our reserve funds, and $2,776,100 from the hospital plant and trustee funds for current year capital expenditures. The major components of our capital spending were: (1) $6,179,000 for recurring equipment, remodeling, and renovation, (2) $2,776,100 for major capital projects (Masonic III, MRI II, etc.), and (3) $5,274,400 in principal payments on debt and capital leases.

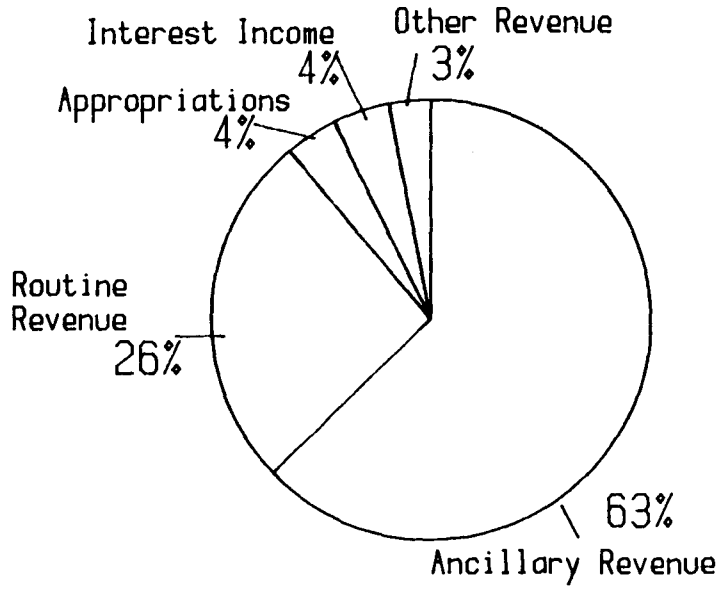
Conclusion: For the third straight year UMHC experienced a decline in our admission levels. At the same time, our average length of stay remained constant and our outpatient visits increased significantly. While a shift from inpatient activity to an outpatient venue is consistent with the industry, the continued decline in admissions is of concern. We must work towards not only retaining our share of the healthcare market, but expanding it in order to help maintain the integrity of UMHC's financial position.

UMHC continued to experience increasing pressure from third party payors as HMO's, insurance companies, and self-insured companies moved to contract for specific services, and more governmental agencies moved towards prospective payment systems. These activities are continuing to force UMHC, as well as other providers, away from fee-for-service pricing and toward negotiated fixed fee pricing. UMHC must keep working with the HMO's, PPO's, and other insurers to develop pricing strategies which will enhance our competitive position while enabling us to meet our financial goals and objectives.

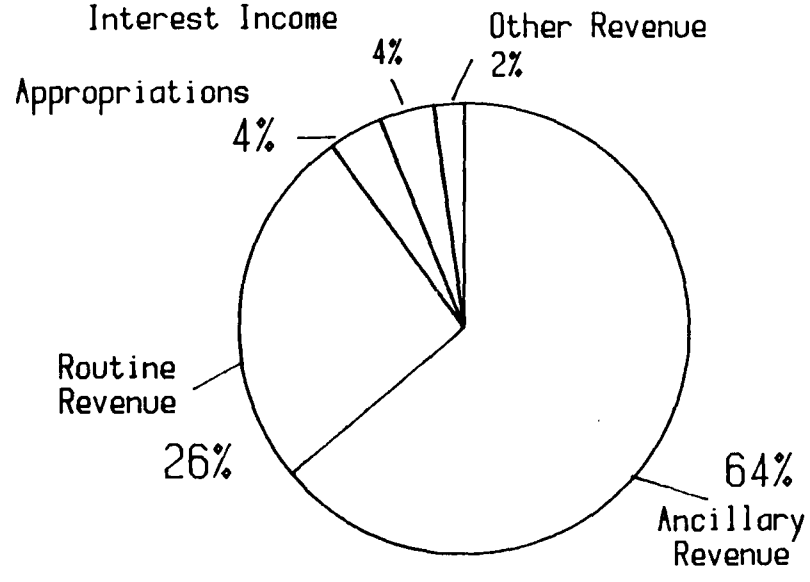
The competitive and cost conscious environment we are in will continue, and will challenge us to find new sources of revenue and ways to reduce costs. Over the past fiscal year, UMHC has continued its numerous efforts aimed at reducing costs, increasing efficiency and productivity, and minimizing the number of unnecessary or duplicative procedures performed while maintaining a high quality of patient care. We initiated discussion with other parties and healthcare providers to establish affiliations or joint ventures. We are exploring new avenues for market penetration, and program diversification and expansion in order to continue to sustain UMHC's mission of patient service, education, and research.

University of Minnesota Hospital and Clinic

89/90 Revenue Summary

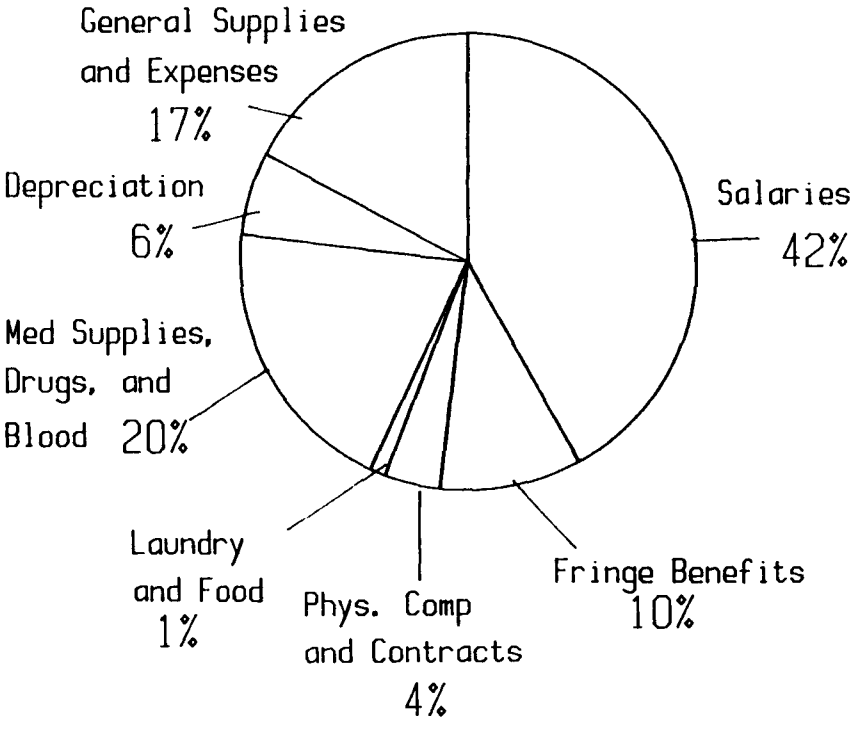


90/91 Revenue Summary

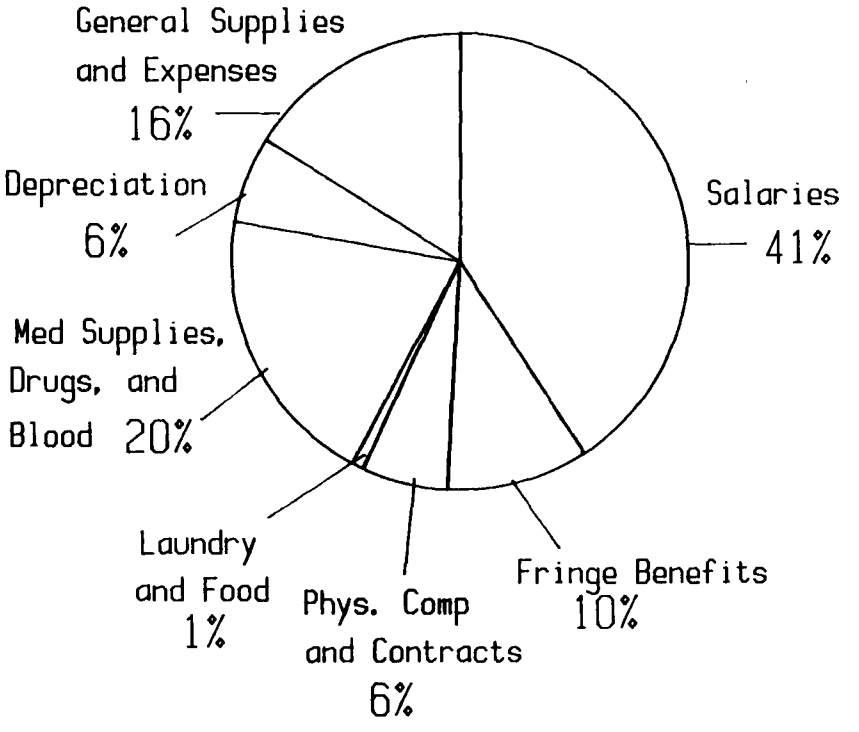


University of Minnesota Hospital and Clinic

89/90 Expense Summary



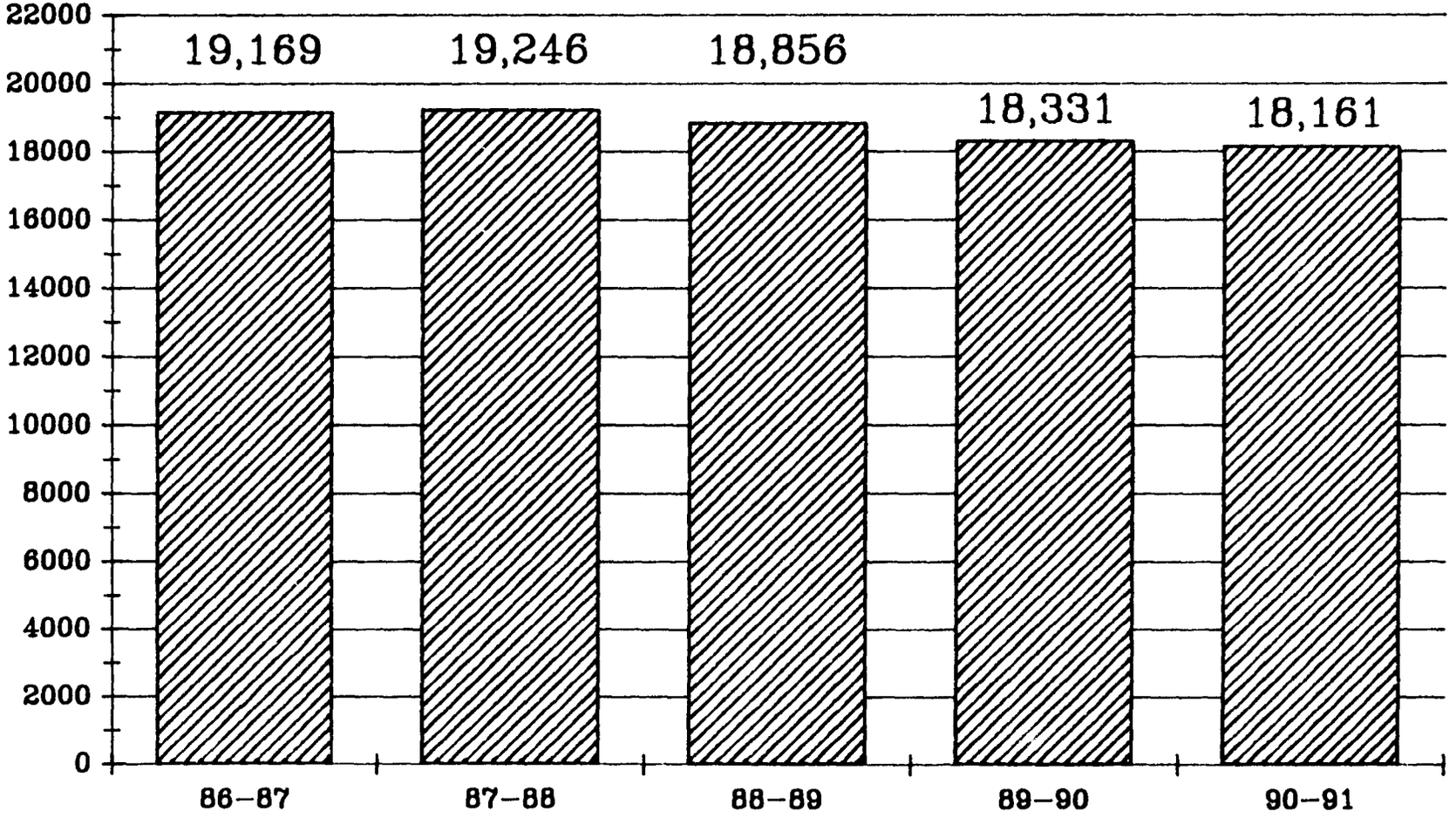
90/91 Expense Summary



University of Minnesota Hospital and Clinic

Admissions

1986–87 through 1990–91



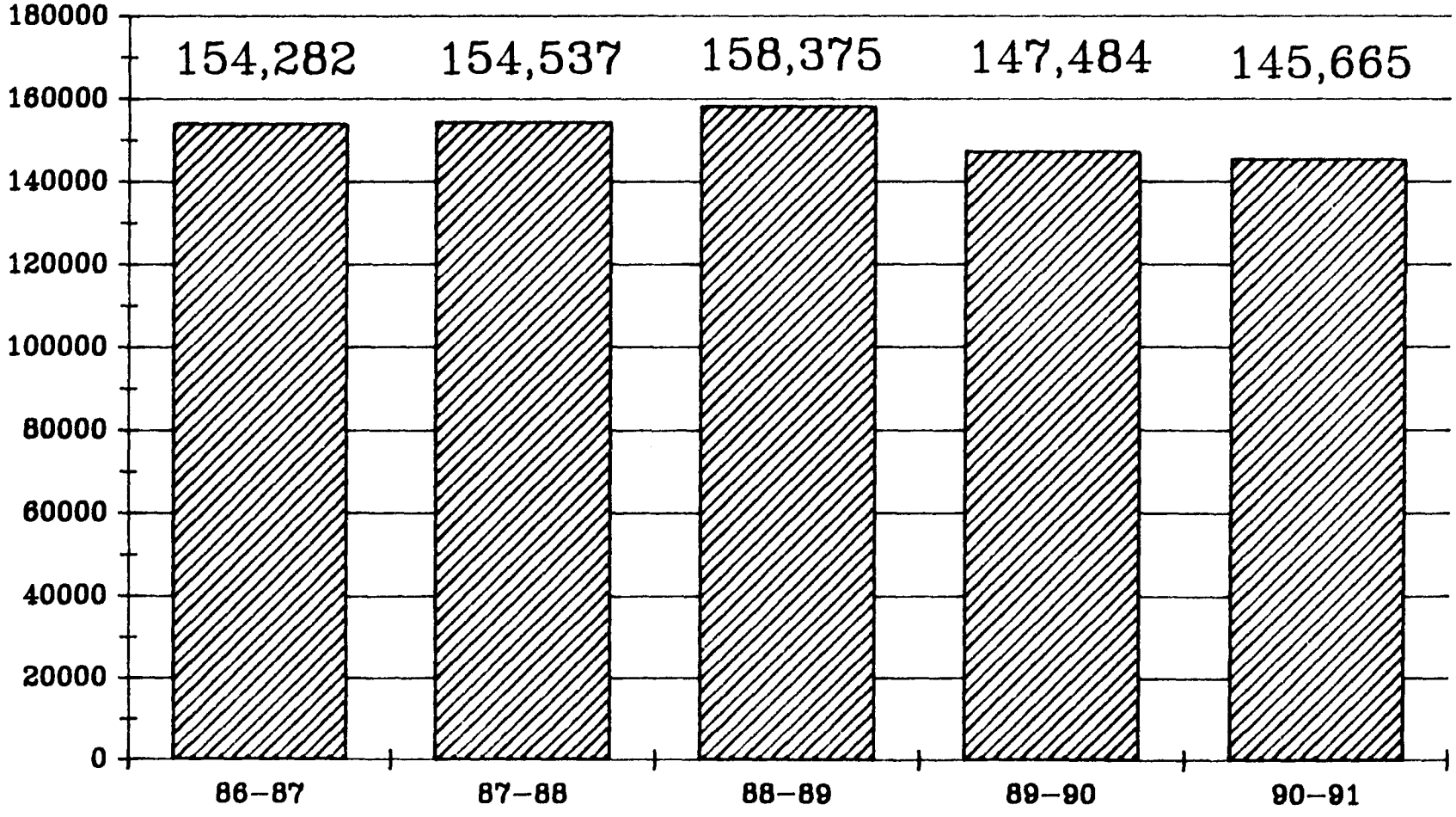
University of Minnesota Hospital & Clinic
Inpatient Admissions by Clinical Service
For Fiscal Years 1986-87 through 1990-91

Admissions	1986-87	1987-88	1988-89	1989-90	1990-91
Clinical Research	482	434	416	360	361
Dentistry	70	56	47	39	66
Dermatology	23	24	32	21	13
Family Practice	27	27	24	26	36
Gynecology	1,476	1,336	1,249	1,477	1,330
Medicine	3,981	4,354	4,660	4,226	4,462
Neurology	431	367	357	294	359
Neurosurgery	878	898	937	946	1,027
Newborn	346	345	354	358	349
Obstetrics	594	575	586	560	552
Ophthalmology	990	968	574	443	464
Orthopedics	1,020	1,193	1,205	1,107	1,116
Otolaryngology	459	447	415	403	412
Pediatrics	3,322	3,080	3,024	3,314	3,122
PM & R	163	173	206	206	192
Psychiatry - Adult	783	827	854	824	806
Psychiatry - Child	90	95	91	56	76
Surgery	2,931	3,093	2,960	2,956	2,831
Urology	1,099	943	839	688	557
Other	4	11	26	27	30
Total	19,169	19,246	18,856	18,331	18,161

University of Minnesota Hospital and Clinic

Patient Days

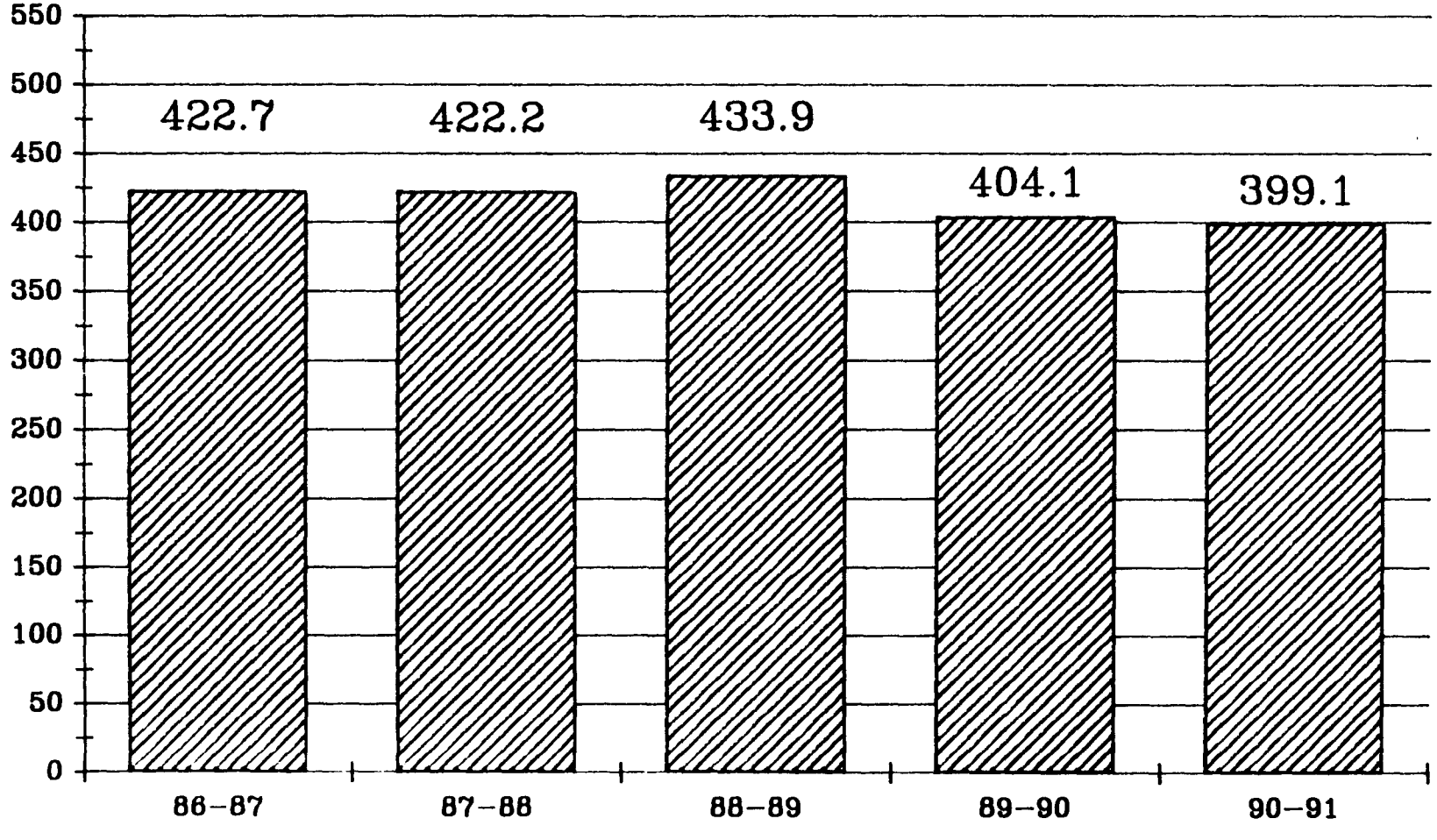
1986–87 through 1990–91



University of Minnesota Hospital and Clinic

Average Daily Census

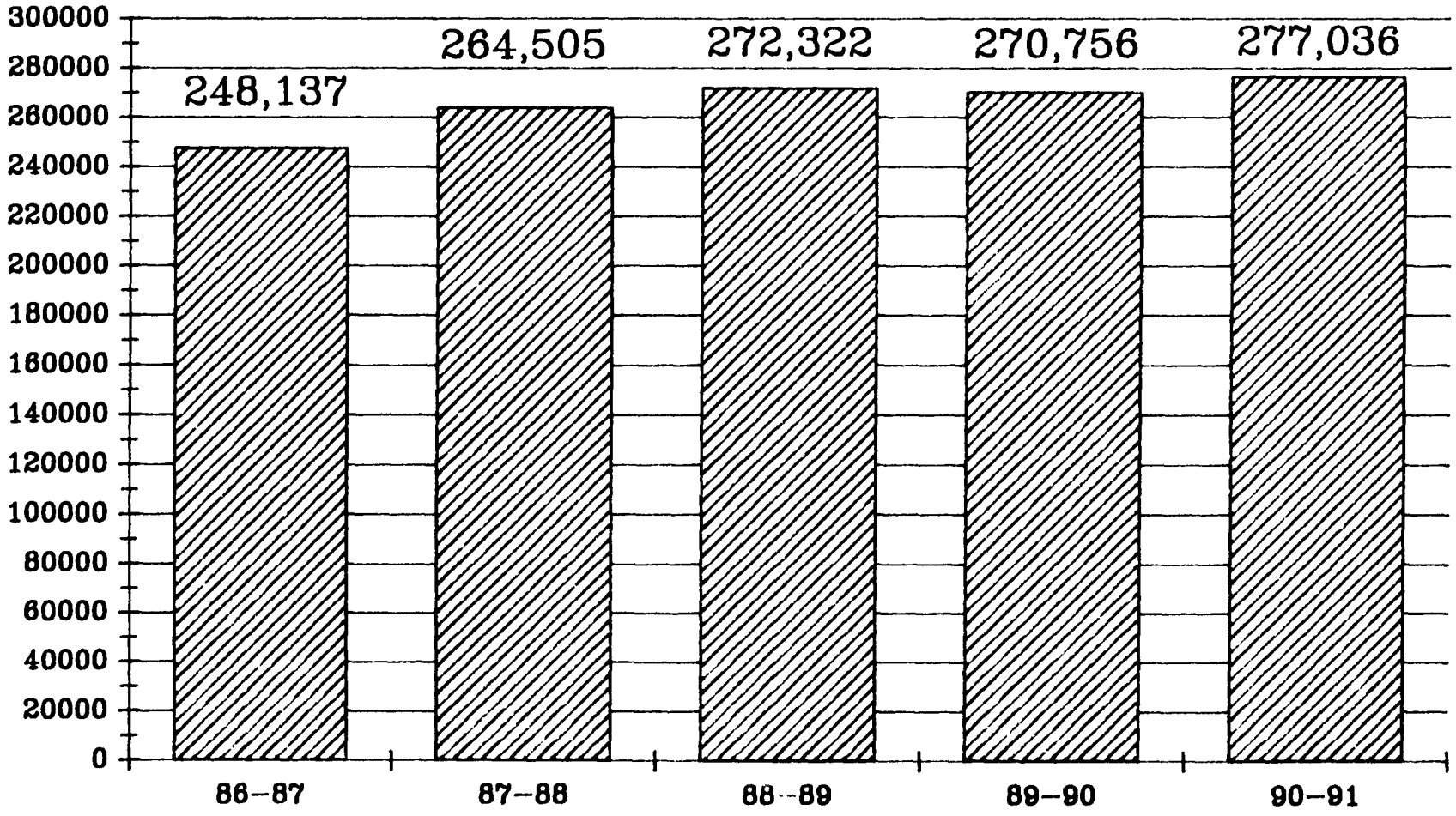
1986–87 through 1990–91



University of Minnesota Hospital and Clinic

Outpatient Clinic Visits

1986–87 through 1990–91

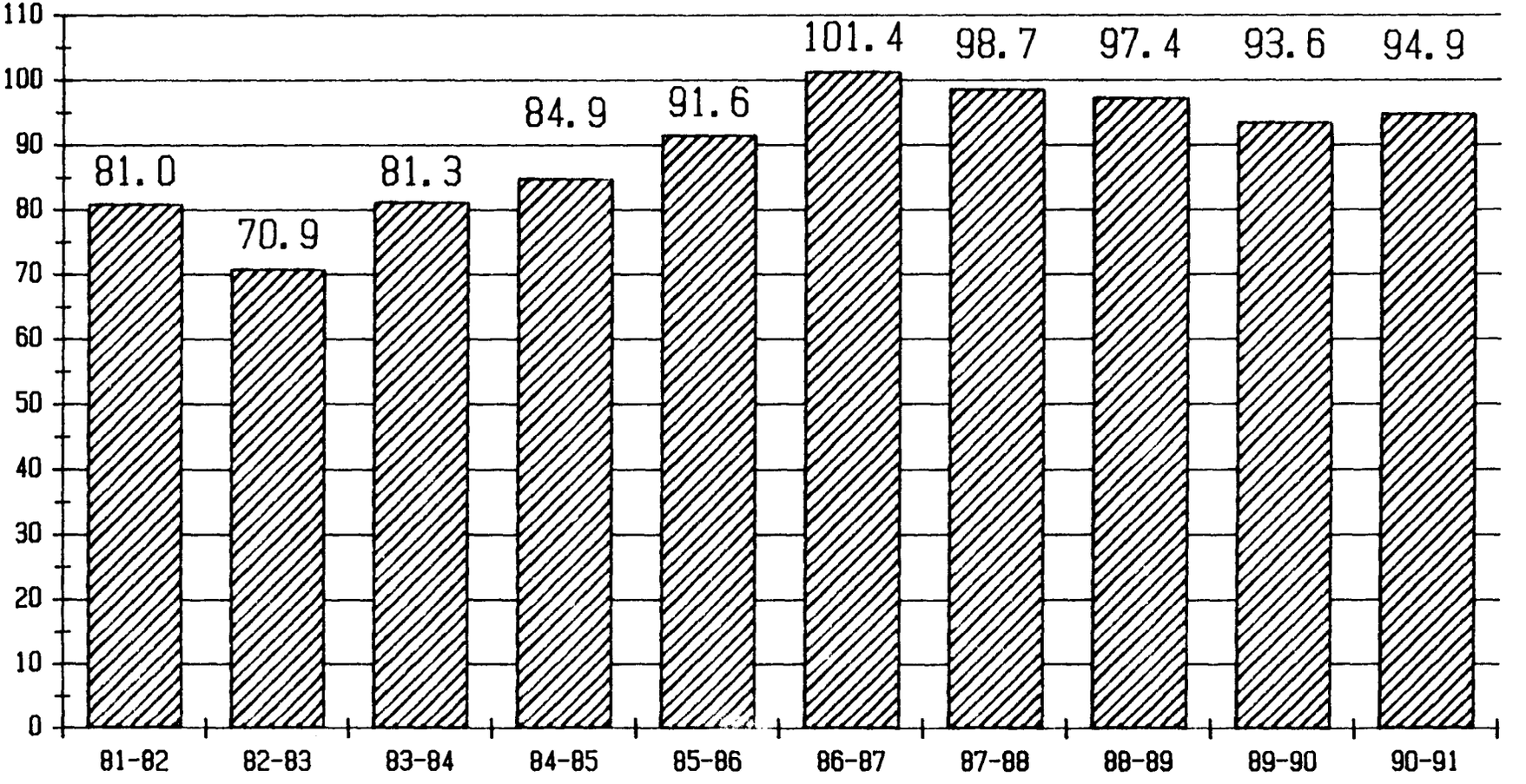


University of Minnesota Hospital & Clinic
Outpatient Clinic Visits by Clinical Services
For Fiscal Years 1986-87 through 1990-91

Clinic Visits	1986-87	1987-88	1988-89	1989-90	1990-91
Ambulatory Surgery	3,750	3,631	3,030	2,777	2,710
Dentistry	4,102	5,270	5,524	3,759	4,747
Dermatology	13,517	13,854	16,313	15,721	15,426
Emergency Room	16,119	15,401	16,938	19,300	20,677
Family Practice	8,970	9,882	11,646	11,196	12,123
Gynecology	17,328	17,886	15,127	13,939	13,563
Medicine	38,623	45,400	49,859	51,985	54,272
Neurology	4,667	4,595	4,569	4,987	5,962
Neurosurgery	3,373	3,982	3,991	4,099	3,998
Obstetrics	2,303	2,595	2,429	2,194	2,003
Ophthalmology	25,526	26,905	23,576	22,382	21,260
Orthopedics	15,187	16,640	19,337	18,508	18,458
Otolaryngology	10,651	9,985	9,758	10,368	11,381
Pediatrics	14,593	14,600	15,547	15,967	15,969
PM & R	1,512	2,039	2,102	1,833	1,620
Psychiatry	24,793	24,405	26,368	24,881	27,055
Clinical Psych	3,173	4,215	4,182	4,923	4,531
Radiation Therapy	16,728	18,953	17,487	18,349	17,992
Surgery	14,041	14,731	15,458	15,433	15,825
Urology	9,181	9,536	9,081	8,155	7,464
Total	248,137	264,505	272,322	270,756	277,036

University of Minnesota Hospital and Clinic

Revenue Days in Accounts Receivable
1981–82 through 1990–91



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SOURCE OF RECEIPTS

1986 TO 1991

	1986		1987		1988		1989		1990		1991	
	Amount in 1000s	% of Total	Amount in 1000s	% of Total	Amount in 1000s	% of Total	Amount in 1000s	% of Total	Amount in 1000s	% of Total	Amount in 1000s	% of Total
MEDICARE	$39,984	20.5%	$44,949	19.7%	$47,513	18.2%	$48,456	17.2%	$52,809	17.5%	$60,594	19.1%
MEDICAL ASSISTANCE & FEDERAL CRIPPLED CHILDREN	12,181	6.2%	19,526	8.6%	26,883	10.3%	27,333	9.7%	28,647	9.5%	26,639	8.4%
BLUE CROSS	18,185	9.3%	28,578	12.5%	28,385	10.9%	25,153	8.9%	27,803	9.2%	30,052	9.5%
OTHER COMMERCIAL INSURANCE	78,602	40.2%	89,312	39.2%	93,167	35.7%	102,214	36.3%	112,407	37.2%	116,218	36.7%
HMO	N/A	N/A	N/A	N/A	12,556	4.8%	18,606	6.6%	17,959	5.9%	19,044	6.0%
PATIENT LIABILITY	9,288	4.8%	9,817	4.3%	8,657	3.3%	11,229	4.0%	11,942	4.0%	10,666	3.4%
MISC. AGENCY ACCOUNTS	10,144	5.2%	9,182	4.0%	11,488	4.4%	15,552	5.5%	15,777	5.2%	18,034	5.7%
COUNTY	1,318	0.7%	825	0.4%	735	0.3%	961	0.3%	868	0.3%	1,448	0.5%
STUDENT HEALTH SERVICE	12	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COLLECTION AGENCIES	729	0.4%	811	0.4%	776	0.3%	628	0.2%	659	0.2%	581	0.2%
OTHER	261	0.1%	810	0.4%	885	0.3%	3,301	1.2%	260	0.1%	864	0.3%
REFUNDS	(3,340)	−1.7%	(4,860)	−2.1%	(4,925)	−1.9%	(5,651)	−2.0%	(5,843)	−1.9%	(7,254)	−2.3%
SUBTOTAL: PATIENT CARE RECEIPTS	167,364	85.6%	198,950	87.4%	226,120	86.7%	247,782	88.1%	263,288	87.1%	276,887	87.4%
APPROPRIATIONS AND SUPPORT	13,106	6.7%	13,860	6.1%	14,409	5.5%	14,877	5.3%	15,491	5.1%	16,015	5.1%
INVESTMENT INCOME	9,756	5.0%	8,771	3.9%	12,044	4.6%	10,922	3.9%	12,958	4.3%	13,911	4.4%
OTHER INCOME	5,201	2.7%	6,145	2.7%	8,302	3.2%	7,725	2.7%	10,573	3.5%	9,903	3.1%
	$195,427	100.0%	$227,726	100.0%	$260,875	100.0%	$281,306	100.0%	$302,310	100.0%	$316,715	100.0%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1990 TO JUNE 30, 1991

	1989-90 Actual	1990-91 Budgeted	1990-91 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	$319,825,000	$335,005,000	$350,984,000	$15,979,000	4.8%
Deductions From Revenue	72,977,000	80,483,000	84,654,000	4,171,000	5.2%
Net Patient Service Revenue	246,848,000	254,522,000	266,330,000	11,808,000	4.6%
Other Operating Revenue					
Appropriation & Support	15,491,000	15,976,000	16,015,000	39,000	0.2%
Other Revenue	11,478,000	10,006,000	11,530,000	1,524,000	15.2%
Total Other Revenue	26,969,000	25,982,000	27,545,000	1,563,000	6.0%
Total Revenue From Operations	273,817,000	280,504,000	293,875,000	13,371,000	4.8%
Operating Expenses:					
Salaries	115,225,000	118,374,000	120,762,000	2,388,000	2.0%
Fringe Benefits	27,310,000	28,671,000	27,867,000	(804,000)	-2.8%
Contract Compensation	11,549,000	17,104,000	18,572,000	1,468,000	8.6%
Supplies And Services	58,022,000	59,989,000	62,555,000	2,566,000	4.3%
Utilities And Maintenance	10,887,000	11,170,000	11,454,000	284,000	2.5%
General Supplies & Expense	21,529,000	18,989,000	17,179,000	(1,810,000)	-9.5%
Insurance	903,000	771,000	2,247,000	1,476,000	
Depreciation & Amortization	17,931,000	19,628,000	18,509,000	(1,119,000)	-5.7%
Interest	12,527,000	12,607,000	12,103,000	(504,000)	-4.0%
Provision For Uncollectibles	3,905,000	3,015,000	2,843,000	(172,000)	-5
Total Operating Expenses	279,788,000	290,318,000	294,091,000	3,773,000	1
Net Revenue From Operations	(5,971,000)	(9,814,000)	(216,000)	9,598,000	-97.8%
Nonoperating Gains: Investment Income	12,543,000	9,912,000	12,283,000	2,371,000	23.9%
Revenue And Gains In Excess Of Expense	$6,572,000	$98,000	$12,067,000	$11,969,000	

	1989-90 Actual	1990-91 Budgeted	1990-91 Actual	Variance Over/(Under) Budget	Variance %
Admissions	18,331	17,350	18,161	811	4.7%
Patient Days	147,484	137,800	145,665	7,865	5.7%
Average Length Of Stay	8.0	8.0	8.0	0.0	0.0%
Average Daily Census	404.1	377.5	399.1	21.6	5.7%
Percentage Occupancy	69.6	65.1	69.3	4.2	6.5%
Outpatient Encounters	270,667	263,000	277,036	14,036	5

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
BALANCE SHEETS

JUNE 30, 1991 AND JUNE 30, 1990

ASSETS	06/30/91	6/30/90
CURRENT ASSETS		
Operating Cash	$13,611,000	$7,452,000
Reserve Cash- Third Party Payable	21,246,000	16,337,000
Reserve Cash- Current Indebtedness	5,721,000	7,240,000
Accounts Receivable		
Patient Receivables	95,679,000	85,706,000
Other Receivables	1,795,000	1,116,000
Third Party Receivable	2,145,000	2,471,000
Appropriation Receivable	1,325,000	1,281,000
	100,944,000	90,574,000
Less Allowances for Losses in Collection	(7,805,000)	(7,441,000)
Less Allowances for Discounts to Third Party Payors	(24,620,000)	(20,215,000)
	68,519,000	62,918,000
Inventories of Drugs & Supplies	4,723,000	4,574,000
Prepaid Expenses	1,061,000	636,000
TOTAL CURRENT ASSETS	$114,881,000	$99,157,000
ASSETS WHOSE USE IS LIMITED		
Board Designated Assets Available for Assignment		
Cash & Investments	$44,819,000	$74,397,000
Accrued Interest	148,000	320,000
	44,967,000	74,717,000
Cash & Invest for Debt Service	13,000,000	13,000,000
Cash & Invest for Working Capital	16,000,000	16,000,000
TOTAL	$73,967,000	$103,717,000
PROPERTY, PLANT, & EQUIPMENT		
Land, Buildings & Improvements	$191,909,000	$188,293,000
Equipment	98,495,000	90,989,000
	290,404,000	279,282,000
Less Accumulated Depreciation	(133,650,000)	(116,252,000)
	156,754,000	163,030,000
Construction in Progress	5,581,000	4,382,000
TOTAL PROPERTY, PLANT, & EQUIPMENT	162,335,000	167,412,000
Assigned Cash & Investments for Construction/Equipment	45,136,000	8,546,000
TOTAL	$207,471,000	$175,958,000
INVESTMENTS HELD BY BOND TRUSTEE	$19,108,000	$20,306,000
OTHER ASSETS		
Deferred Third Party Reimbursement	$6,404,000	$7,071,000
Deferred Debt Expense	1,009,000	1,093,000
Deposits and Other	374,000	350,000
TOTAL	$7,787,000	$8,514,000
TOTAL ASSETS	$423,214,000	$407,652,000
RESTRICTED ASSETS		
Cash and Investments	$7,416,000	$6,874,000

LIABILITIES AND FUND BALANCES	06/30/91	6/30/90
CURRENT LIABILITIES		
Accounts Payable	$11,539,000	$12,238,000
Payable to Third Party Contr. Payors	18,431,000	13,522,000
Salaries, Wages and Payroll Taxes	9,833,000	9,243,000
Accrued Vacation	9,233,000	8,530,000
Accrued Professional Fees and Physician Compensation	2,171,000	1,217,000
Contracts Payable	522,000	492,000
Construction Retainages	307,000	121,000
Interest Payable	4,684,000	4,971,000
Current Portion of Long-Term Debt	3,157,000	3,020,000
Promissory Notes Payable	0	1,300,000
TOTAL CURRENT LIABILITIES	$59,877,000	$54,654,000
LONG-TERM DEBT, LESS CURRENT PORTION	$165,282,000	$168,167,000
UNRESTRICTED FUND BALANCE	$198,055,000	$184,831,000
TOTAL LIABILITIES & FUND BALANCE	$423,214,000	$407,652,000
RESTRICTED FUND BALANCES		
Endowment Funds	$2,553,000	$2,432,000
Gift Funds	4,863,000	4,442,000
	$7,416,000	$6,874,000

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

CASH FLOW

FOR THE PERIOD JULY 1, 1990 TO JUNE 30, 1991

OPERATING ACTIVITIES AND NONOPERATING REVENUES:	
Excess of operating revenues over operating expenses:	($216,000)
Noncash revenues and expenses included in operating activity:	
Depreciation and amortization	$19,309,000
Unreimbursed University G & A services	$196,000
Provision for uncollectible accounts	$2,843,000
Change in patient receivable and other receivables	($8,771,000)
Change in due from third party reimbursement program	$327,000
Change in due to third party reimbursement programs	$4,908,000
Change in accounts payable	($276,000)
Change in accrued expenses	$1,569,000
Other, net	($412,000)
Net cash provided by operating activities	$19,477,000
Nonoperating revenues	$12,283,000
Net cash provided by operating activities and nonoperating revenues	$31,760,000
INVESTING ACTIVITIES:	
Acquisition of property, plant and equipment	($12,411,000)
Funds transferred from other sources	$410,000
Cash outflows for Property & Plant	($12,001,000)
Increase in assets whose use is limited	($5,642,000)
Net cash used in investing activities	($17,643,000)
FINANCING ACTIVITIES:	
Repayment of long-term debt	($2,345,000)
Repayment of notes payable	($2,224,000)
	($4,569,000)
Increase in cash and equivalents	$9,548,000
Cash and cash equivalents at June 30, 1990	$31,029,000
Cash and equivalents at June 30, 1991	$40,577,000

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF CHANGES IN FUND BALANCE

FOR THE PERIOD JULY 1, 1990 THROUGH JUNE 30, 1991

	UNRESTRICTED GENERAL	RESTRICTED SPECIFIC	RESTRICTED ENDOWMENT
Beginning Balance	$184,831,000	$4,442,000	$2,432,000
Additions:			
Total Revenue over Expense	$12,067,000		
Unreimbursed University G & A Services	$197,000		
Adjustment to Shared Buildings	$550,000		
Transfer to finance property and and equipment additions	$410,000	($410,000)	
Gifts, grants and bequests		$988,000	
Investment Income		$298,000	$295,000
Deductions:			
Disbursements		($455,000)	($2,000)
Transfer University portion of McMahon Trust Fund			($172,000)
	$198,055,000	$4,863,000	$2,553,000

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD DESIGNATED FUND ACTIVITY
07/01/90 THROUGH 06/30/91

	Unassigned	Assigned	Totals
Balance at 07/01/90	$103,717,337	$8,545,989	$112,263,326
Interest Income on Reserves and Bond Proceeds	11,494,800	0	11,494,800
Dermatology Loan Payment	14,143	0	14,143
Transfer from Restricted Funds	400,000	0	400,000
Transfer from Unassigned Board Cash to Assigned Cash:			
Autopsy	(365,000)	365,000	0
Temp. Psychology	(100,000)	100,000	0
Rehab. Satellites	(240,000)	240,000	0
Heart Cath Room	(3,100,000)	3,100,000	0
Bone Marrow Transplant	(220,000)	220,000	0
BMT/ICU 4F	(100,000)	100,000	0
Labs Computer Systems	(306,000)	306,000	0
OB Temporary	(120,000)	120,000	0
Architect & Engineer Fee Phase II	(400,000)	400,000	0
Neuroangiography System	(991,000)	991,000	0
Computer Upgrade	(30,000)	30,000	0
All-purpose Plant Funds	(22,208)	22,208	0
Phase II Renovation - Remaining Budget	(35,665,000)	35,665,000	0
	(41,659,208)	41,659,208	0
Transfer from Operations for Equipment Reserve	0	3,963,213	3,963,213
Expenditures Against Equipment Roll Forward Reserve	0	(3,602,825)	(3,602,825)
Cash Expenditures Against Plant Funds	0	(5,429,035)	(5,429,035)
Balance at 06/30/91	$73,967,072	$45,136,550	$119,103,622

BOARD OF GOVERNORS ANNUAL RETREAT

September 26-27, 1991

Riverwood Conference Center
Monticello, Minnesota

SUMMARY

Thursday Morning

Chairman Kristine Johnson welcomed everyone to the Retreat and thanked them for attending. Chairman Johnson introduced Dr. Roby Thompson who is beginning a three year term as Chair of the Council of Chiefs of Clinical Services.

Strategic Planning--Introduction and Background

Mr. Robert Dickler set the stage for the Board of Governors discussion of strategic planning. He presented several definitions of a strategic planning process. Consideration of mission is essential in the strategic planning process. The Board was asked to review the overall intent and philosophy of the Hospital's mission statement.

Over the past few years, the Hospital has worked within a strategic issues orientation rather than a formal strategic planning process. The reason for formalizing a process now are that the plan will include the Hospital, the Medical School and the Clinical Departments; there is growing consensus that a plan is needed; we plan to consider what we should be doing within the context of who we want to be; and there is a growing urgency for more central vision in the clinical program arena.

Mr. Dickler presented statistics which showed that both admissions and marketshare have declined for the past several years.

The question to be addressed by the strategic planning process is -- how can UMHC maintain and/or achieve adequate volume and diversity of activity to meet the core needs of the University's educational and research programs while maintaining the Hospital's financial viability and clinical department income generating capacity? Mr. Dickler specifically asked the Board to consider the Hospital's mission, the issues to be included in the strategic planning process, and the role of the Board of Governors in the strategic planning process.

Perspectives on the Current Status of UMHC

Ms. Cherie Perlmutter, Interim Vice President for Health Sciences

Ms. Perlmutter indicated that she is very anxious for the key parties in provision of clinical care to develop greater consensus about future direction. UMHC is viewed by the State as its general hospital and the services to the outstate population is very important. Ms. Perlmutter

suggested that the Hospital take a long term view of its role in the State and as a resource for the training of health care professionals.

Dr. Robert Anderson, who will assume the position of Vice President for Health Sciences in early 1992 was introduced at this time and indicated that this strategic planning process will be important in developing consensus on future direction.

Perspectives on the Current Status of UMHC

Dr. David Brown, Dean, Medical School

Dr. Brown discussed the development of a dedicated University of Minnesota hospital. Currently, about 25 percent of the total medical school teaching is conducted at UMHC. Students consider their educational experiences at UMHC to be of high quality. Although the education and research missions of the Hospital are important, high quality care for their medical problems will continue to attract patients.

Dr. Brown indicated that he is anxious to participate in development of a strategic plan.

Perspectives on the Current Status of UMHC

Dr. Thomas Ferris, Chairman, Department of Medicine

The Department of Medicine is the largest department of the Medical School providing 25 percent of the undergraduate clerkship teaching as well as conducting a large graduate training program. Dr. Ferris indicated that teaching programs utilizing a number of training sites strengthens the programs and that it is research which differentiates UMHC from other hospitals in the Twin Cities.

Dr. Ferris indicated that it is the research program which distinguishes The University of Minnesota Hospital and Clinic from other hospitals in the region. The Department of Medicine has 87 full-time faculty members practicing at the University. Of these, 70 are primary investigator on an federally sponsored research project. Over $13 million is brought into the University by the Department of Medicine through their research program.

Dr. Ferris indicated that the Hospital could assist in development of clinical programs by provision of resources such as space and salary support.

Perspectives on the Current Status of UMHC

Dr. Leo Furcht, Chairman, Department of Lab Medicine

Dr. Furcht presented an overview of the Department of Laboratory Medicine and Pathology. The Department is very large with over 500 employees. The Department is in the top two programs in the country in terms of research funding. The Department is involved in both undergraduate laboratory technology training and in graduate training programs. The graduate medical education program includes about 40 residents. The two major divisions are Anatomic Pathology and Laboratory Medicine.

Recruitment of faculty in the Pathology area is very competitive. The Department is concerned that the number of surgical pathology specimens analyzed is too low to adequately train residents. The number of surgical pathology specimens is one indicator of a Hospital's activity levels. The number of specimens at UMHC is less than 10,000. This is much lower than most major academic medical centers. Lab Medicine and Pathology has numerous research programs which are also dependent upon the number of specimens received.

Dr. Furcht expressed concern about the erosion of volume and marketshare the Hospital has experienced over the past several years. The mix of patients and pressures on Departmental finances are also concerns.

Perspectives on the Current Status of UMHC

Dr. Roby Thompson, Chairman, Department of Orthopaedic Surgery

Dr. Thompson presented information on the status of the Orthopaedic Surgery Department. The Department has ten full-time faculty members, has a very strong research program, and accepts seven residents each year who train at six hospital sites. Dr. Thompson indicated that one hospital cannot meet the program's educational needs for exposure to a wide spectrum of orthopaedic diseases. The Orthopaedics Department has a full-time faculty member practicing at each training site. These faculty members are responsible for ensuring that the University program is not jeopardized by these relationships with outside hospitals.

Current Status of UMHC-General Board Discussion

The Board discussed the large number of faculty who practice at community hospitals and the impact of these relationships on the University. The role of the Board of Governors in a strategic planning process which encompasses the Medical School and Clinical Departments along with the Hospital was discussed.

Chairman Johnson asked the small groups to focus their discussion around three items:

1. The Hospital's mission statement.
2. The Board's role in the strategic planning process.
3. Specific priority areas which should be explored as part of the strategic planning process.

<u>Thursday Afternoon</u>

Small Group Discussion of Strategic Planning

Group I Report

On behalf of group I, Mr. George Heenan presented a summary of the group's discussion. The group recommends that the mission statement be considered in light of several specific issues and that it should also be more specific in terms of what the Hospital wants to be.

In the first major area, provision of high quality services, the group identified user friendliness of the University as a major issue. In support of education, the group discussed negative relationships with graduates of the Medical School and graduate medical education programs. Additional issues are relationships with referring physicians. In the area of cost-effectiveness, this is an area where significant steps still need to be taken. The Hospital needs to improve incentives for cost-effectiveness.

In terms of adequate volume of patient activity, the group discussed the need to consider each of the three missions, education, research and patient service, when determining what mix and level of volume is necessary. In terms of supporting research, the group felt that, although there are some issues with shortages of space and additional resources, the Hospital is rating pretty high.

Additional issues for consideration during the strategic planning process are the strategies which we must utilize to compete in this marketplace, and what criteria purchasers of health care will use to determine where they purchase health care (e.g. low cost versus high quality as only criterion).

The group recommends that the Board play an active role in goal setting for the strategic planning process and in measuring actual performance against these goals. The Board needs to be involved in some of the tough decision-making which will be necessary during this process.

Group II Report

On behalf of group II, Mr. Robert Nickoloff presented a summary of the group's discussions. The group identified a number of specific issues to be addressed during the strategic planning process including simulating a group practice model, deciding whether we will develop primary and secondary care or find other ways to insure an adequate flow of specialty patients, opening up the medical staff, improving physician networking and marketing to referring physicians, third party payers, and patients. The group thought that the security of the funding that the Hospital receives from the University should be considered in the strategic planning process. The group also identified a user-friendly atmosphere to payers, referring physicians, and patients as a critical strategic issue.

The group agreed that the Board should play an active role in the strategic planning process.

Group III Report

For group III, Dr. Leo Furcht presented the major issues identified by the group to be governance, establishing ground rules and maintaining an adequate volume and revenue stream. Additional critical issues are becoming a multi-site organization and relationships with other institutions.

The Hospital's mission statement should be modified slightly to emphasize fiscal soundness as well as cost-effective provision of care.

The group agreed with groups I and II that the Board should play key roles in the strategic planning process and in moving the Hospital from a reactive to a proactive focus.

General Board Discussion and Summary

The members present generally acknowledged the merit of a comprehensive strategic plan and the need for the Board to remain involved through the Planning and Development committee and the full Board. The Hospital's mission statement is generally viewed as acceptable in principle with some specific wording recommendations.

Specific issues recommended for the strategic planning process include a clearer view of our clinical priorities, clear definition of service area, resolution of issues which cross departmental lines and governance. The governance issue was the topic of the remainder of the retreat. The Board asked management staff to develop a summary of key issues to be addressed during the strategic planning process.

Mr. Dickler informed the Board that the Hospital will be looking for some outside assistance in establishing a strategic planning process. A request for proposal (RFP) for a consultant will be distributed in the near future.

Governance - Introduction and Background

Mr. Dickler briefly summarized the history of the Board of Governors. Governance has been raised as an issue by a number of Board members. Issues which should be considered in any restructuring include mission, governance and decision making, management structure and flexibility, economic flexibility and finance, politics and liability.

Friday Morning

Board Empowerment Discussion

Ms. Barbara O'Grady, Ms. Trudy Ohnsorg, and Ms. Margaret Matalamaki shared some information concerning Board empowerment which was discussed at a Minnesota Hospital Association Trustee Conference. Ms. O'Grady discussed characteristics of an effective Board member. Ms. Ohnsorg led a discussion on how the Board can work to enhance its effectiveness. Ms. Matalamaki discussed the role of medical staff members of the Board.

University Hospital Governance Structures--External Perspectives

Mr. Dickler introduced the two guest presenters. Mr. William Kerr has been with the University of California at San Francisco (UCSF) Hospital for over 20 years and has been the Hospital Director since 1977. The San Francisco area is the only metropolitan area in the country with a greater HMO penetration than the Twin Cities. The Hospital at UCSF does not have a governing board separate from the University Regents.

Ms. Alethea Caldwell is currently Director of the Department of Health Sciences for the State of Arizona and former President, University of Arizona Hospital. Ms. Caldwell was President at Arizona during the time period where a decision was made to legally separate the hospital from the University.

William Kerr

Mr. Kerr presented background information on the governance of UCSF hospital. The Board of Regents, consisting of 28 members, 8 of which are ex officio, govern all of the hospitals in the University of California system. A 430 bed community hospital, Mount Zion, has merged with the Hospital recently.

Current major issues facing the Hospital are State finances and care of the uninsured, space, manpower, and balancing the multiple missions of the Medical Center. The Hospital is involved in extensive contracting tailored to meet almost any demand. The Medical Center has a clinical practice organization which is empowered to set the contract terms and reimbursement levels. The clinical practice organization has also provided a vehicle for underwriting primary care and developing performance criteria for medical staff.

Governance and management issues the UCSF Hospital is facing include the relationship of the Mount Zion trustees and the amount of State involvement in Hospital governance. The Hospital does not have concerns with their ability to establish human resource policies, in purchasing and contracting, or in services purchased from the University. Maintaining integrity of the Hospital's reserves is a critical issue for UCSF Medical Center.

Aleathea Caldwell

Ms. Caldwell has worked with a number of governance models and encouraged the Board to focus on the governance issues to be addressed rather than a specific governance model. Ms. Caldwell was the CEO of the University of Arizona Hospital which in 1983 was a 300 bed tertiary care hospital which was poorly differentiated in a market with sophisticated community physicians. The environment was very competitive with excess bed capacity. Specific problems for the Hospital included inadequate volume for teaching programs, an inflexible budget since the Hospital was a line item in the State's budget, there was no incentive for productivity improvement, and the salary structure was unresponsive to the market. In summary, the Hospital was unable to manage itself or establish relationships with other providers and was losing money.

An outside firm made several recommendations to ensure that the Hospital would have sufficient volume and control over resources. The University administration played a leadership role in creating legislation which enabled the Hospital to be set up as a private not-for-profit corporation with a number of ties back to the University. The impact of legal separation at Arizona has been beneficial to everyone involved with the Health Sciences Center.

Ms. Caldwell recommended that the Board begin with the mission and principles which are important and consider a number of governance models.

University Hospital Governance Structures External Perspectives Discussion

The Board discussed clinical practice group structures. Mr. Kerr indicated that at UCSF all faculty practice primarily/exclusively at on-campus facilities. The practice group is able to negotiate binding agreements with third-party payers, including managed care programs; the practice group provides a mechanism for underwriting primary care and marketing; and the

practice group serves as mechanism for the clinical departments to challenge each other regarding their clinical activities. In 1983, UCSF was excluded from the Medi-Cal program. This short-term exclusion had a very dramatic impact on the Medical Center because 20 percent of its patients were Medicaid. This forced the institution to closely scrutinize their styles and patterns of practice. The decision making structure is very decentralized with a very limited committee structure, but the clinical departments work must more cooperatively than they did in the past.

Ms. Caldwell indicated that the legal separation at Arizona led to improved decision making because the number of people involved in decision making decreased and their roles were clarified. Inability to reach a decision could no longer be blamed on the University bureaucracy.

Board Discussion--Governance Options

The Board discussed the relationship of UMHC to the clinical departments and to the University. The Board of Governors has been given a high level of support and autonomy by the Board of Regents. The Board members would like to be more knowledgeable about the current process of problem identification and resolution and to achieve greater common understanding of the Board's role and responsibilities. Specific governance issues that all parties agreed need to be addressed are the financial structure of the Hospital (including University relations) and further autonomy in personnel matters.

Chairman Johnson and Vice-Chairman Lentz will work with Mr. Dickler to develop a draft work plan for the Board of Governors for the next year. Ms. Johnson thanked the retreat participants for attending and deliberating over these important issues facing the Hospital.

Liaison Trustee Briefing

American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone: 312.280 3555

TRUSTEES IN ADVOCACY

Our health care system is rapidly becoming an issue of national concern. Business, labor, the elderly, and other interest groups--including hospitals--are already shaping reform proposals designed to improve access and contain costs. Federal, state, and local governments are also vitally interested in health care, which is seen as consuming an ever-increasing amount of public resources as the uninsured and underinsured populations grow.

Keeping current on pending health care issues is challenging even to hospital executives, let alone to public officials who make decisions on a wide range of topics besides health care. To help hospitals serve their patients and communities, key governmental decision makers need to hear from local community leaders who understand and can articulate the health care viewpoint. Many local business and community leaders serve on hospital boards, and the experience and opinions of these informed individuals who represent their communities is of practical value to legislators. When it comes to grassroots advocacy, trustees have been a largely untapped resource, yet there is no better group than trustees to be the link between the community, hospital, and government. In this briefing, we will discuss why trustees should be advocates for their hospitals and communities, and how they can do so.

POLITICAL ADVOCACY DEFINED

In a general sense, political advocacy is educating and influencing elected and appointed government officials to support legislation and regulations favorable to a particular cause or to defeat or to repeal measures that are unfavorable to a cause. Political advocacy helps hospitals maintain or establish practices and policies that will facilitate the delivery of effective, high quality medical care and health services to patients. These objectives must be addressed at all levels of government--local, state, and national.

CRITICAL ISSUES FACING HOSPITALS

The federal budget deficit and decreased federal support to local governmental units has prompted all officials to seek new sources of revenue and new ways to save money. As a result, health care costs are under increasing scrutiny. Hospitals have been easy targets for budget cuts, because they can be viewed as monolithic, impersonal institutions, rather than as patient-centered places where people take care of the health of the community.

Issues of particular concern to hospitals that require grassroots advocacy efforts include: the annual debate over the federal Medicare budget, local and state challenges to hospital tax-exempt status and related charity-care legislation, improving access through Medicaid, outpatient payment reform, and medical malpractice liability, to name a few. In addition, business, labor, and government at all levels are beginning to address the issue of health care reform.

WHY TRUSTEES SHOULD BE INVOLVED

While national, state, and metropolitan hospital associations continue their professional efforts, coordinated actions of individual citizens with a local perspective, such as governing board members, are very effective in getting the health care message across to elected officials. Unlike a hospital chief executive officer (CEO) or association staff member who have vested interests in issues, voluntary trustees are viewed as citizen leaders. Governing board members are often company executives, business owners, auxilians, and leaders of civic or religious organizations, and they are respected in their communities. Trustees have credibility with elected and appointed officials and their opinions carry weight because they do not derive their living from the hospital, and they bring a community perspective to the issues.

Each trustee is a community representative and constituent, who has a right to be heard and to communicate with his or her elected and appointed officials. Elected officials, in particular, may need the support of trustees as much as trustees need the support of legislators. In a recent speech before the American Hospital Association Congress of Hospital Trustees, the Honorable Thomas J. Tauke, (R-IA), a former member of the U. S. House of Representatives, observed that given the range of issues, legislators and their staffs may not be fully informed about particular issues or may not be aware of the local impact of certain issues. In addition, Tauke noted that the median age of congressional staff members is under 24, and the average job tenure is 18 months.

The volume of issues, staff turnover, and inexperienced staff contribute to an information gap. Public officials and their staffs benefit from regular, informed communications on health care issues, and hospital governing board members can complement the information provided by national, state, and metropolitan hospital associations. Few are better qualified than trustees to inform officials about the ways local hospitals are struggling to meet the community health care needs of the 1990's with financial resource constraints.

Some trustees have an interest in political activities and a working relationship with their elected officials, while others may know them socially. These board members are in a position to take on expanded advocacy roles. Other trustees may be uneasy with the political process, but with a little encouragement and the right resources, can become advocates. Maine trustee and political advocate Brian Rines, Ph.D., has this opinion:

> I know that not every trustee is going to be comfortable lobbying in the legislature. On the other hand, that doesn't mean that when trustees run into their legislators at the local shopping center or social club, they can't talk with them about what's going on in health care.
> (Trustee, August 1990.)

HOW TRUSTEES CAN GET INVOLVED

"If you can make a phone call or write a letter, you can lobby," states the non-partisan group, Independent Sector, in its brochure on effective lobbying. It can be that simple. Armed with facts, anecdotes, and passion, trustees can advance the public policy agenda for hospitals and the patients they serve.

However, before talking with elected officials, trustees will want to be fully briefed on the issues and the message or policy position that needs to be communicated. It starts with the hospital--the CEO, the trustees, and the hospital's government relations director, if any, need to agree on a number of things, including: the issue or policy position to be raised; what hospital-specific data should be used to support the issue or position; and with which officials. The American Hospital Association and state and metropolitan hospital associations are good resources for this information and should be contacted before beginning any advocacy efforts. This is important because these associations have existing working relationships with government officials and also coordinate the grassroots activities of many hospitals. These organizations can provide background information about elected officials, such as their

interests, committee appointments, and specific issues they support or oppose. In addition, the associations will provide resources such as fact sheets on recommended positions so that all members of the hospital community will present a united front to their elected officials. By working in concert with these groups, trustees are "plugged in" and become part of the communications network.

Advocacy can employ a wide range of activities. Typical advocacy activities of trustees follow.

Letters Writing a letter is one of the most popular and effective ways to communicate with public officials. The letter should be brief and address one point, no longer than one page if possible, and written on personal or business stationery. Letters should include a statement describing the preferred position on the issue, a formal request for action and support, and facts, arguments, and anecdotes from the trustee's hospital that support the stated position.

Phone calls Phone calls to elected officials are valuable, but are best reserved for critical times when votes are about to be cast, regulations are about to be promulgated, or other executive actions are imminent, and immediate communication is required. When calling a public official, trustees should explain (or remind them) who they are, and then follow the same guidelines as for writing letters; brevity is important.

Visits with public officials Visits with public officials are an excellent way to get to know them and their key staff members, as well as to request support for an issue. Appointments for these visits should be made well in advance by contacting the official's scheduling or appointment secretary. Plan to be brief, since many meetings do not last more than 15 minutes. During the visit, trustees should state their viewpoint succinctly, personalize arguments and facts with specific, local examples, and formally request support for a position. Trustees may want to leave a fact or information sheet that states the preferred position and the requested action. If the trustee doesn't have the answer to a question asked by the public official or staff member, he or she should say so, promise to get back to the official with the information, and do so. Always follow up a visit with a thank-you note, restating the request and noting the date and time of the visit.

In addition to scheduling individual appointments, many state and metropolitan associations sponsor "Days at the Capitol" and assist in arranging group visits to various officials. Governing board members also are encouraged to attend the AHA Annual Membership Meeting, conducted every January in Washington, D.C. This meeting provides education on public policy issues and

focuses on advocacy. Each state delegation meets with many of their elected officials, and these visits are usually coordinated by state hospital association staff.

One more note on congressional visits: trustees should not underestimate the importance of the congressional staff. If the legislator is not available, trustees should state their case just as eagerly to the staff member who is on hand. Staff serve as key advisors and often help determine whether (or how) the official should support the trustee's position on the issue.

Hospital visits In consultation with hospital executives, trustees may want to invite their elected officials to visit the hospital between legislative sessions and especially during an election campaign. With the 1992 elections approaching, this is a particularly good time to consider hosting such an event. The guest can tour the emergency department, visit an outpatient support or counseling group, and see a demonstration of new technology.* The CEO and the board chairman (or a politically active trustee) can lead the tour, with the executive providing facts and figures, and the trustee emphasizing the patient and community benefit aspects of hospital operations. A hospital fact sheet should be provided after the visit. The fact sheet might include information on the hospital's programs and services, with such statistical information as how many people are employed by the hospital, the number of persons who received free care, and how many have benefitted from the latest technology acquisitions.

Thank-you letters An often overlooked but important follow-up activity is a brief note of appreciation, thanking the legislator (and staff) for his or her time and support on an issue. Trustees should use the letter as another opportunity to emphasize their position and let their legislator know that they are available as a resource on health care issues.

Also, it would be very useful if trustees called their metropolitan and state hospital associations and AHA after all advocacy contacts with public officials to report their results and update information on file.

Hospital Speakers Bureau Many hospitals have speakers' bureaus to provide hospital representatives for presentations at community events. Knowledgeable and articulate trustees could be included on the speakers bureaus' roster to discuss key issues of community concern. Building community support is essential to encourage public officials to address hospital concerns.

*A new AHA publication, "The Basics: Planning a Congressional Visit to Your Hospital," can be requested through state and metropolitan hospital associations.

Political Action Committees (PACs) Financial support of candidates' political campaigns is another form of effective advocacy. Federal and state PACs allow the hospital community to support candidates who are supportive of hospitals. Many state associations have their own PACs that accept contributions from trustees and then make contributions to candidates for state office.

CONCLUSION

There are significant consequences for hospitals when local, state, and federal governments implement legislation and regulations that affect patient care and services. Trustees serve hospitals in many capacities, and one critical role is as advocates for their hospitals. Governing board members who understand the political process, know the issues, are plugged into association networks, and can articulate the message that needs to be conveyed, are encouraged to participate. As volunteers and community leaders, trustees are in the best position to let their public officials know that hospitals are more than buildings of "bricks and mortar." They are vital community centers--serving patients, promoting the community's health, and employing local residents.

* * * * *

For additional activities or details on the suggestions described in this paper, please contact the American Hospital Association, Washington Office, 202/638-1100 or 800/424-4301, Capitol Place, Building III, 50 F Street, N.W., Washington, D.C., 20001, or your state or metropolitan hospital association.

REFERENCES

AHA Guide to Political Awareness, Politics and Health: What You Can Do. American Hospital Association. Washington, D.C., 1991.

Lobby? You? Independent Sector. Washington, D.C.

Derks, Steven M. Trustees and public policy. Trustee. December 1989; 16-17.

Hoium, Vernon. Tips for trustees on lobbying. Trustee. December 1989; 16.

"Hospital associations, political advocacy, and trustees." Trustee. August 1990; 6-8.

McEntee, Chris. Hospital trustees: natural allies in political advocacy. Trustee. June 1988; 13.

Smith, Lester E. Health care advocacy needs trustees. Trustee. October 1989; 22.

State of the Nation's Access to Hospital Services. American Hospital Association. Washington D.C. 1991.

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Board of Governors
Box 502
Harvard Street at East River Road
Minneapolis, Minnesota 55455

October 17, 1991

TO: Members of the Board of Governors

Leonard Bienias
David Brown, M.D.
Robert Dickler
Michael Dougherty
Phyllis Ellis
Robert Erickson
George Heenan
Kris Johnson
Nellie Johnson
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
Jerry Meilahn
Robert Nickoloff
Barbara O'Grady
Trudy Ohnsorg
Gerald Olson
Cherie Perlmutter
Roby Thompson, M.D.

Dear Governors:

Enclosed is an article from the October issues of Trustee which discussed hospital policy concerning forgoing life-sustaining treatment. I thought that the article might be of interest as you will be considering UMHC's "no CPR" policy at your meeting this month.

Sincerely,

Shannon Lorbiecki

Shannon Lorbiecki
Assistant Director
Secretary to the Board of Governors

SLL /gs

Easing passages: a hospital's policy on life-sustaining treatment

by Frank Sabatino

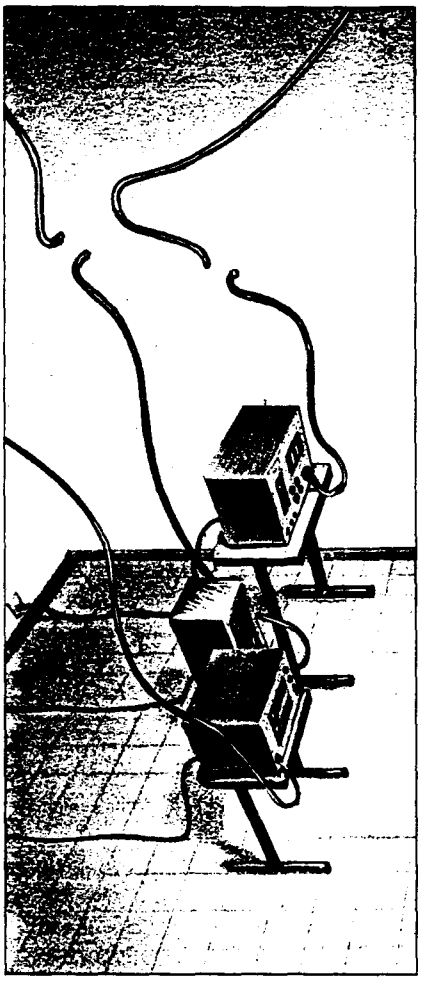
THE ISSUES SURROUNDING life choices are complex, soul-searching, and individual. Perhaps the best that institutions can do is to ensure that individuals' choices are informed, unrestricted, and respected.

On Feb. 27, 1991, the board of trustees of Yale–New Haven (CT) Hospital approved a policy entitled "Limiting Life-Sustaining Treatment," culminating a three-year policy development process. Its stated purpose is to determine when life-sustaining treatments or procedures should be initiated or terminated. The policy presumes care to include "total therapeutic support" for patients, and it attempts to provide objectives to guide providers in the management of individual patients.

Fenn

According to John Fenn, M.D., chief of staff of Yale–New Haven Hospital, a member of the board's medical committee, and an ex-officio member of the hospital's bioethics committee, which drafted the policy, "The key and core of the policy is the determination of goals for patient care. It forces care-givers to review with patients the goals of their treatment on an individual basis."

According to Fenn, who along with the hospital's director of legal affairs, Virginia Roddy, Esq., assisted the hospital's 10-member bioethics committee in drafting the policy, a team approach to the development of policies on such sensitive issues is advisable. Fenn notes that the new policy limiting life-sustaining treatment provides broader directives than the institution's do-not-resuscitate policy and incorporates that earlier policy into it.



He says that during the policy development process, the lead role was played by the institution's bioethics committee. But during the process, the policy was reviewed several times by the hospital's medical board (the institution's senior governing group of the medical staff) and by the board's medical committee (a board subcommittee of which Fenn is a member). Finally, it was presented to the full board for approval in February of this year.

"The protocol was much like that followed for appointments to the medical staff or other important decisions," Fenn says. Of the three-year development process, Fenn says, "Each word was carefully crafted, tortured and teased." He says emotional, philosophical and legal concerns dominated the board's review of the policy.

"We were carving out new territory, and there was some concern about our taking a leadership role," Fenn says. Questions that were raised by the full board included whether or not other such policies existed nationwide (they did not), whether the policy had been reviewed by hospital counsel (it had), and how the policy related to ultimate decisions and to patients.

"I believe there was general satisfaction and admiration for the work of the committee," says Fenn. To other boards interested in a similar undertaking, Fenn advises, "Have the courage to consider such issues and develop a policy for your own institution. I say 'have the courage' because not everyone will see the need for such a policy. But in retrospect, I must say the vast majority of the responses we've received concerning this policy are commendations."

Committee composition. At Yale–New Haven, the hospital's bioethics committee capitalizes on the broad

Frank Sabatino is senior correspondent for Trustee.

array of multitalented individuals within its membership. For instance, the committee is chaired by a psychiatrist with a law background and includes five other physicians, among them an internist, an oncologist and a general practitioner. (The other two physicians on the committee are a physician-ethicist who is chairman of the hospital's institutional review board, and the hospital's chaplain, who is also a clinical professor of pediatrics.)

The two nurses on the committee are the head of the hospital's nursing ethics committee (herself an oncology nurse) and the head nurse of the hospital's neurosurgery intensive care unit. Both nurses work closely with patients who have terminal illnesses.

The hospital's vice president of administration is a member of the committee, as is a social worker specializing in oncology.

Policy considerations. The Yale–New Haven policy addresses 12 general principles (see sidebar, this page).

The policy also includes definitions of key terms such as "advance directive," "terminally ill," "functional maintenance therapy," and "functional equilibrium." Perhaps most useful to providers is the policy's patient classification system, which provides a method to identify appropriate goals in the treatment of each patient.

Speaking about the committee's decision to include this classification system within the policy, chief-of-staff Fenn said, "We were troubled by the sometimes inappropriate allocation of resources to futile cases."

The policy defines three possible options for the primary goal in the management of a patient's treatment: achieving arrest, remission or cure of the basic disease process; maintaining the patient's functional equilibrium; and maximizing the patient's comfort as he or she is dying.

Howard V. Zonana, M.D., chairman of Yale–New Haven's bioethics committee, cautions, "Our goal was to make useful distinctions for providers in possible treatment options without being simplistic or reductionist. This is *not* a formula approach to patient management. The fiduciary responsibility that underlies the patient-physician relationship is emphasized in the policy."

12 principles of Yale–New Haven's new policy

Yale–New Haven Hospital's "Limiting Life-Sustaining Treatment" policy includes a statement of 12 general principles covering the following topics:

1. Limitation of treatments
2. Initiating and withdrawing treatments
3. The affect of limiting treatment on other treatment decisions
4. Decisions about fluids and nutrition
5. The key role of communication among those involved in treatment decisions
6. Patients' rights to be informed of diagnostic and therapeutic options
7. The weight assigned to advance directives
8. The role of competency in assessing patients' decisions
9. The rights of patients who lack decision-making capacity
10. Professionals' rights to participate in or to decline participation in treatment decisions
11. Lines of accountability within an institution and presumptions made about patients' families
12. Professionals' avoidance of judicial authorization to seek consensus regarding treatment plans

Procedures. Procedures to implement the policy cover physician responsibilities, registered nurse responsibilities, and the issue of cancellation of orders. According to Fenn, the procedures "reflect significant attention to a collaborative practice of medicine." He also notes that the procedures attempt to place "the patient in the ideal position to receive the best possible care."

The inclusion of a section on cancellation of orders is also important. Fenn says, "Sometimes things do change. It's unusual for there to be a reversal of a patient's course, but a policy needs to be flexible enough to recognize this possibility."

The policy indicates that a do-not-resuscitate order or a major limitation of functional maintenance therapy may be suspended or cancelled on the request of the patient or duly authorized member of the family. This section of the policy notes that the impetus for such cancellation may arise from either a change in prognosis for medical irreversibility of the patient's basic disease process or from the patient's or family's reconsideration of their preferences.

Fenn states that the policy attempts to force providers to "rethink sudden reversal of a well-thought-out plan of treatment." He also says that the policy vests responsibility for canceling a major limitation of functional maintenance therapies or a DNR order with a physician so as to prevent "hasty, illogical actions sometimes requested by a frantic family."

Management caveats. Institutions interested in tackling the thorny issues raised by Yale–New Haven's policy may be well-advised to recognize that the task is not an easy one.

Psychiatrist Zonana, who chairs the institution's bioethics committee, notes, "Our own committee was going for six or seven years before we addressed the issue of limiting life-sustaining treatment. We tried to develop a track record before we addressed this topic. For instance, our work in the management of AIDS patients helped develop this policy."

Zonana

Zonana encourages institutions to pay attention to the issues of nursing responsibilities in drafting any such policy. Especially in cases where patients enter an institution's door through an emergency department, nurses may have more exposure to the patient and his/her family than a physician, he says. Similarly, he says that HMOs with fairly high physician turnover rates may also suffer from a lack of long-standing physician/patient relationships and may well benefit from nurses' more intimate

(continued on page 21)

Washington Report *continued*

$2,000 if a physician practicing in its outpatient department referred a patient to a supplier with whom the hospital did not have an arrangement. And hospitals would have to reimburse the beneficiary for any copayment or deductible incurred.

Outside suppliers also could be fined if they wrongly bill Medicare rather than the hospital. To comply with the rules, hospitals would need to institute extensive billing and patient-tracking systems, said Marion Torchia, director of policy and government relations in the Healthcare Financial Management Association's (HFMA) office in Washington, DC. Their systems would have to link bills from independent suppliers to hospital encounters before Medicare could be billed.

Such systems could be costly, but Medicare would not compensate hospitals for the associated costs, noted AHA's Hodur.

Bundled bills also would slow hospitals' cash flow, predicted John Jurovich, vice president of finance for the Baton Rouge–based Louisiana Hospital Association. Hospitals would have to wait to bill Medicare for their services until bills from outside suppliers were received, he said.

Hospitals' cash flow also would slow down if patients did not go to an outside supplier when referred, HFMA's Torchia said. In these cases, a hospital's books would remain open while waiting to receive bills from outside suppliers, bills that may arrive six months later or not at all, she said.

The rules do not define the time frame within which related services initiated by the hospital encounter must be bundled in the initial bill.

The rules also do not spell out what would happen when an outside supplier charges the hospital more than Medicare reimburses.

AHA's Hodur said HCFA is examining that issue, which indicates that HCFA may modify the draft rule further.

Meanwhile, the AHA has urged its allied hospital associations and member hospitals to express their concerns to Congress and to request that HCFA delay publishing a final rule until Congress legislates a new outpatient-payment system. ■

Easing passages *continued*

knowledge of patients as they approach policy development on patient care issues.

Hospitals around the country are asking Yale–New Haven Hospital for copies of the policy, Fenn says. The policy has been printed in a brochure that is disseminated to nursing, medical and resident staffs, and an administrative manual is currently being produced. Once that is complete, it will be distributed to all patient care divisions.

According to Fenn, implementation has centered on working with the nursing staff, "the most stable part of our work force," he says. Since the policy was approved, its use has primarily been in response to troubling issues. Fenn hopes that eventually the policy will be used prospectively, which will make its use easier.

"The vast majority of patients fall into 'class A,' that is, the primary goal of their treatment is to achieve arrest, remission or cure of the basic disease process. It's unusual to have patients who require that life-sustaining treatment be limited." ■

Acknowledging the spirit—patients are more than bodies

"Failure to acknowledge the spiritual or psychological component of life is a big issue, an unspoken problem in medicine today." So says Christine K. Cassell, M.D., a geriatrician at the University of Chicago, Prizker School of Medicine.

In an essay in a September 1990 issue of the *New England Journal of Medicine* co-authored with Diane E. Meier, M.D., of the Mt. Sinai Medical Center, New York City, Cassell observed, "For many people the transcendent or spiritual meaning of life (and afterlife) creates a context in which death is not the enemy, and is in fact sometimes to be welcomed as an appropriate and timely end, either to a life fully lived or to a life cut short by the ravages of incurable disease."

Cassell

Interviewed recently by *Trustee*, Cassell said, "We have large debates about pain control in the treatment of the terminally ill, and how if we were only better at pain control we'd better meet patients' needs. In my experience, it's not always physical pain that's the patient's problem. Often, it's a spiritual pain.

"Our failure to acknowledge a spiritual dimension perpetuates our denial of death and often places the spiritual and psychological dimension in opposition to medical and technological issues.

"If providers can be more aware of this spiritual dimension, I also believe that they can derive more meaning from their work. Those who work with the chronically ill or with terminal illnesses often experience frustration simply because they believe that if they have failed to 'cure' a patient, they have been unsuccessful. But let's face it: approximately 80 percent of people do die in hospitals."

Yale–New Haven's enlightened policy on limiting life-sustaining treatment seems to acknowledge the role that technology has played in precipitating a reassessment of what some have called "the tyranny of cure-oriented medicine."

Yale–New Haven's policy says, "With the development of dramatic life-sustaining interventions in modern medicine, there has been the corresponding need to determine when these treatments or procedures should be initiated and terminated."

Howard V. Zonana, M.D., chairman of Yale–New Haven's bioethics committee, notes that the "help-and-heal" mission of medicine can be sacrificed to a strictly technologically oriented practice of medicine. Preferring not to speak against technology, he speaks of the need for "balance" in medicine. Zonana also notes that the lack of primary care physicians within many hospitals has exacerbated the problem.—F.S.

STRATEGIC PLANNING ISSUE SUMMARY
BOARD OF GOVERNORS RETREAT
SEPTEMBER. 1991

The Hospital, Medical School, and Clinical Departments need to develop a more commonly shared vision and more explicit and concrete goals and objectives to guide the fulfillment of the joint missions of education, research, and service.

The changes made over the past several years which have improved internal decision making processes' need further enhancement. Areas of primary emphasis include more effective ways to balance Hospital and Medical School priorities and the appropriate balance between departmental and institutional priorities.

Continuing changes in the broader health care delivery system have, and will, change the nature of the population served at the Hospital and within the inpatient and outpatient settings. Future plans must incorporate strategies for balancing on and off campus activities - including the role of UMHC in primary and secondary care. In addition, Hospital and medical staff relationships with other hospital systems, managed care organizations, and physician practices need to be re-evaluated and more focused.

The appropriate governance and organizational tructure for the Hospital, and other units of the Health Sciences Center, will continue to need reassessment and potential modification. Specific areas for near term review include human resource management and financial relationships.

The University; because of its size, complexity and history; is often perceived as a difficult environment for patients, physicians, and the public. While many of these factors have been effectively dealt with, there is a need to both continue to improve "user friendliness" and communicate those changes.

There is a continuing need to improve the efficiency and cost effectiveness of the Hospital and overall patient care process. These efforts must recognize the collateral importance for maintaining and improving the quality of patient care.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SUMMARY OF ADJUSTMENTS TO THE 1990–91 PRELIMINARY STATEMENT OF OPERATIONS

The preliminary 1990–91 Statement of Operations presented in July indicated that the net revenue over expense for the fiscal year was $12,086,819. At the time preliminary statements were issued in July, the University had not completed its year–end closing process. During the subsequent closing process, several adjustments were made which have changed the net revenue over expense to $12,067,026. The following is a summary of those adjustments.

Preliminary Revenue Over Expense	12,086,819
Subsequent Entries Resulting From University of Minnesota Final 6/30/91 Closing:	
Increase in Investment Income	112,111
Increase in Accounts Payable	(150,688)
Increase in Revenue from Operations	18,784
Independent Auditor Adjustments	–0–
Final Net Revenue Over Expense	12,067,026

Coopers &Lybrand

certified public accountants

REPORT OF INDEPENDENT ACCOUNTANTS

The Board of Regents
University of Minnesota:

We have audited the accompanying balance sheets of the University of Minnesota Hospital and Clinic (the Hospital) as of June 30, 1991 and 1990 and the related statements of revenue and expenses of general funds, changes in fund balances and cash flows of general funds for the years then ended. These financial statements are the responsibility of the Hospital's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Hospital as of June 30, 1991 and 1990 and the results of its operations and its cash flows of general funds for the years then ended in conformity with generally accepted accounting principles.

Coopers & Lybrand

Minneapolis, Minnesota
September 27, 1991

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BALANCE SHEETS

June 30, 1991 and 1990

ASSETS	1991	1990
General Funds		
Current assets:		
Cash and cash equivalents	$ 40,577,406	$ 23,649,189
Receivables:		
Patient services, net of allowances and uncollectible accounts of $31,623,000 in 1991 and $26,912,000 in 1990	74,262,474	69,450,219
State appropriations	1,325,527	1,281,378
Other	1,339,037	818,140
Inventories	4,722,753	4,573,855
Prepaid expenses and other	1,060,747	635,332
Total current assets	123,287,944	100,408,113
Assets whose use is limited:		
By board for property and equipment replacement and expansion	119,103,622	119,643,426
Under bond indenture agreement held by trustee	19,108,008	20,306,305
Total assets whose use is limited	138,211,630	139,949,731
Property and equipment, net	162,335,020	167,412,330
Other assets:		
Deferred third-party reimbursement, less current portion	5,737,885	6,624,547
Deferred financing costs	1,008,844	1,092,412
Other	373,707	350,016
Total other assets	7,120,436	8,066,975
	$430,955,030	$415,837,149
Restricted Funds		
Investments	7,416,416	6,873,680
	$ 7,416,416	$ 6,873,680

The accompanying notes are an integral part of the financial statements.

LIABILITIES AND FUND BALANCE	1991	1990
General Funds		
Current liabilities:		
Current maturities of long-term debt and capital lease obligations	$ 3,157,098	$ 4,320,342
Accounts payable	20,096,421	22,200,160
Due to University	4,021,484	2,403,012
Due to third-party payors	16,285,919	11,050,775
Accrued liabilities:		
Salaries, wages and employee benefits	19,066,792	17,772,025
Interest	4,683,732	4,971,131
Construction retainages	306,857	121,278
Total current liabilities	67,618,303	62,838,723
Long-term debt and capital lease obligations, less current maturities	165,282,084	168,167,333
Fund balance	198,054,643	184,831,093
	$430,955,030	$415,837,149
Restricted Funds		
Fund balances:		
Endowment funds	2,553,410	2,431,714
Specific purpose funds	4,863,006	4,441,966
	$ 7,416,416	$ 6,873,680

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

STATEMENTS OF REVENUE AND EXPENSES OF GENERAL FUNDS

for the years ended June 30, 1991 and 1990

	1991	1990
Net patient service revenue	$263,515,619	$242,942,760
State appropriations	16,014,519	15,490,602
Other revenue	11,502,390	11,292,905
Total operating revenue	291,032,528	269,726,267
Expenses:		
Salaries and benefits	158,688,787	151,026,322
Supplies and services	62,554,798	58,019,881
Depreciation and amortization	18,348,757	17,823,106
Physician and professional fees	14,755,816	12,458,572
Interest	12,102,997	12,527,264
Utilities and communications	6,034,581	6,103,409
Rentals	2,795,871	3,558,885
Allocation of University general and administrative services	296,493	282,374
Other	15,015,258	12,117,320
Total operating expenses	290,593,358	273,917,133
Income (loss) from operations	439,170	(4,190,866)
Nonoperating gain from investment income	11,627,856	10,763,360
Revenue and gain in excess of expenses	$ 12,067,026	$ 6,572,494

The accompanying notes are an integral part of the financial statements.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

STATEMENTS OF CHANGES IN FUND BALANCES

for the years ended June 30, 1991 and 1990

	1991		
		Donor Restricted Funds	
	General	Specific	Endowment
Balance at beginning of year	$184,831,093	$4,441,966	$2,431,714
Additions:			
Revenue and gain in excess of expenses	12,067,026		
Unreimbursed University general and administrative services	196,493		
Adjustments to Hospital-shared facilities	549,638		
Transfer to finance property and equipment additions	410,393	(410,393)	
Gifts, grants and bequests		987,878	
Investment income		298,478	295,666
Deductions:			
Transfer to other general fund revenue		(454,923)	(1,957)
Fund balance transfer to University			(172,013)
Balance at end of year	$198,054,643	$4,863,006	$2,553,410

The accompanying notes are an integral part of the financial statements.

1990		
	Donor Restricted Funds	
General	Specific	Endowment
$178,123,411	$3,289,413	$2,161,348
6,572,494		
190,707		
(318,065)		
312,546	(312,546)	
	1,787,199	65,607
	286,561	205,053
	(608,661)	(294)
(50,000)		
$184,831,093	$4,441,966	$2,431,714

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

STATEMENTS OF CASH FLOWS OF GENERAL FUNDS

for the years ended June 30, 1991 and 1990

	1991	1990
Cash flows from operating activities and gain:		
Revenue and gain in excess of expenses	$ 12,067,026	$ 6,572,494
Adjustments to reconcile revenue and gain in excess of expenses to net cash provided by operating activities and gain:		
Depreciation and amortization	18,348,757	17,823,106
Unreimbursed University general and administrative services	196,493	190,707
(Increase) decrease in receivables	(5,157,275)	3,878,224
(Decrease) increase in accounts payable	(485,267)	4,935,321
Increase in net amounts due to third-party payors	5,235,144	7,312,485
Increase in accrued liabilities	1,192,947	166,085
(Increase) decrease in inventories	(148,898)	354,411
(Increase) decrease in prepaid expenses and other assets	(425,415)	21,803
Decrease in deferred third-party reimbursement	666,636	666,636
Total adjustments	19,423,122	35,348,778
Net cash provided by operating activities and gain	31,490,148	41,921,272
Cash flows from investing activities:		
Purchase of property and equipment	(12,251,302)	(6,706,563)
Decrease (increase) in assets whose use is limited	1,738,101	(21,366,903)
Other	(23,691)	325,782
Net cash used by investing activities	(10,536,892)	(27,747,684)
Cash flows from financing activities:		
Transfer to University		(50,000)
Payments on long-term debt	(4,435,432)	(5,135,904)
Transfer of donor restricted funds to finance property additions	410,393	312,546
Net cash used by financing activities	(4,025,039)	(4,873,358)
Net increase in cash and cash equivalents	16,928,217	9,300,230
Cash and cash equivalents at beginning of year	23,649,189	14,348,959
Cash and cash equivalents at end of year	$ 40,577,406	$ 23,649,189

The accompanying notes are an integral part of the financial statements.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies:

ORGANIZATION:

The University of Minnesota Hospital and Clinic (the Hospital) is an accounting entity within the University of Minnesota (the University). The Board of Regents of the University has granted the Hospital Board of Governors the authority over matters involving patient care and medical staff affairs. The Hospital Board of Governors also has authority and provides policy review and recommendations in other areas of Hospital operations. The Board of Regents appoints members of the Hospital Board of Governors and retains authority for the Hospital's annual operating and capital budgets, appointment of the Hospital's General Director and approval of the Hospital's overall goals and objectives. The Hospital as a unit of the University is exempt from federal income taxes as an instrumentality of the State of Minnesota under Section 501(c)(3) of the Internal Revenue Code.

NET PATIENT SERVICE REVENUE:

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payors. Final settlements of estimated amounts are recorded in the period that they are determined.

STATEMENT OF REVENUE AND EXPENSES OF GENERAL FUNDS:

For purposes of display, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as revenues and expenses. Other transactions are reported as gains or losses.

DEFERRED FINANCING COSTS:

Debt issuance costs and bond discounts are deferred and amortized using the effective-interest method over the term of the related bond issue.

DONOR-RESTRICTED FUNDS:

Donor-restricted funds are used to differentiate resources, the use of which is restricted by donors or grantors from resources of general funds on which donors or grantors place no restriction or that arise as a result of the operation of the Hospital for its stated purposes. Restricted gifts and other restricted resources are recorded as additions to the appropriate restricted fund.

Continued

1. Summary of Significant Accounting Policies, continued:

DONOR-RESTRICTED FUNDS, continued:

Resources restricted by donors for property and equipment replacement and expansion are added to the general fund balance to the extent expended within the period.

Resources restricted by donors or grantors for specific operating purposes are reported in other revenue to the extent used within the period.

ASSETS WHOSE USE IS LIMITED:

Assets whose use is limited include assets set aside by the Hospital Board of Governors (Board) for property and equipment replacement and expansion, over which the Board retains control and may at its discretion subsequently use for other purposes, and assets held by trustees under bond indenture agreements.

INVENTORIES:

Inventories are stated at the lower of cost or market, with cost determined substantially on the first-in, first-out basis.

PROPERTY AND EQUIPMENT:

Property and equipment acquisitions are recorded at cost or, if donated, at fair value at the date of receipt. Upon sale or retirement of property and equipment, the cost and related accumulated depreciation and amortization are eliminated from the respective accounts and the resulting gain or loss is included in the statement of revenue and expenses. Depreciation and amortization is computed using the straight-line method based on the estimated useful lives of the related assets. Costs of repairs and maintenance are charged to expense as incurred, while cost of renewals and betterments are capitalized.

Adjustments to property and equipment, and related accumulated depreciation and amortization, allocated by the University pertaining to the Hospital's operations are determined annually based on the square footage of the University buildings occupied by the Hospital during the year. Allocation adjustments to property and equipment utilized by the Hospital are recorded through adjustments to the Hospital's general fund balance.

STATE APPROPRIATIONS:

The Hospital is appropriated state funds for general operating use. The appropriations are used primarily for operating expenses and are recorded on the accrual basis.

Continued

1. Summary of Significant Accounting Policies, continued:

CASH EQUIVALENTS, RESTRICTED INVESTMENTS AND INVESTMENT INCOME:

The Hospital participates in the University's centralized cash and investment program in which all cash and investments are managed by the University. Cash and cash equivalents and Board-designated cash and investments are invested in the University Temporary Investment Pool (TIP), Separately Invested Funds (SIF) and Consolidated Endowment Funds (CEF) which consist primarily of foreign and domestic commercial paper, money market mutual funds and short-term U.S. government and agency securities. Cash equivalents and assets whose use is limited by board for property and equipment replacement and expansion are valued at market. Assets whose use is limited under bond indenture agreement held by trustee consist primarily of specific money market mutual funds and securities issued by U.S. government agencies invested in CEF and held at cost, which approximates market.

The Hospital considers all cash equivalents to be investments in TIP as the guidelines of investments in TIP allow funds to be available within a short time frame.

The Hospital receives income from the University based on its share of units in the investment pools. Investment income on proceeds of borrowings held by trustee, to the extent not capitalized, is reported as other revenue. Investment income earned from all other funds is reported as nonoperating gains.

2. Net Patient Service Revenue:

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. A summary of the payment arrangements with major third-party payors and the components of net patient service revenue follows:

- Medicare - Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient nonacute services, certain outpatient services, and defined capital and medical education costs related

Continued

2. Net Patient Service Revenue, continued:

to Medicare beneficiaries are paid based on a cost reimbursement methodology. The Hospital is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Hospital. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through June 30, 1989 and settled through 1982.

- Medicaid - Inpatient and outpatient services rendered to Medicaid Assistance and General Assistance beneficiaries are paid at prospectively determined rates according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient capital costs are reimbursed at a tentative rate which is subject to final settlement based on a cost reimbursement methodology after audit. The Hospital's cost settlements have been settled through June 30, 1984.

- Blue Cross - Inpatient services rendered to Blue Cross and Blue Cross affiliate subscribers are reimbursed, on an interim basis, at prospectively determined rates per day of hospitalization. Interim outpatient services reimbursement is on either a fee-screen based level or on billed charges, depending upon the type of service provided. The prospectively determined inpatient per diem rates are subject to length-of-stay limitations and the outpatient billed charge reimbursement is subject to predetermined target rate limitations. Both the inpatient and outpatient limitations are effected as part of a year-end settlement process.

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Hospital under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined per diem rates.

Continued

3. Assets Whose Use is Limited:

The following is a summary of investments whose use is limited and the primary limitations on their use as of June 30, 1991 and 1990:

	1991	1990
By board for property and equipment replacement and expansion:		
Amounts invested in University TIP and CEF in 1991 and TIP and SIF in 1990	$119,103,622	$119,643,426
Under bond indenture agreement held by trustee:		
Sinking funds	$ 2,784,632	$ 3,936,069
Other funds	16,323,376	16,370,236
	$ 19,108,008	$ 20,306,305

4. Deferred Third-Party Reimbursement:

Costs related to losses on abandonment of construction plans were incurred in 1983. In addition, losses on advance refunding of revenue bonds were recognized in 1985 and 1986. A portion of the abandonment costs and the refunding losses is recoverable from Medicare in future years based on existing regulations. Estimated recoverable amounts have been recorded as deferred third-party reimbursement on the accompanying balance sheets and will be realized in varying annual amounts through 2012. Final Medicare regulations related to changes in capital cost reimbursement were enacted in 1991 and are expected to affect the realization of deferred third-party reimbursement. In anticipation of this, the Hospital has accrued $3,000,000 as of June 30, 1991 which is included in Due to third-party payors in the accompanying financial statements.

5. Property and Equipment:

The following is a summary of property and equipment as of June 30, 1991 and 1990:

	1991	1990
Land and land improvements	$ 3,130,702	$ 2,817,188
Buildings and fixed equipment	198,457,421	195,002,963
Major movable equipment	85,609,802	78,842,363
Construction in progress	5,580,792	4,182,454
Equipment under capital leases	3,206,346	2,819,407
	295,985,063	283,664,375
Less accumulated depreciation and amortization	133,650,043	116,252,045
	$162,335,020	$167,412,330

Continued

6. Long-Term Debt:

The following is a summary of long-term debt as of June 30, 1991 and 1990:

	1991	1990
General Obligation Refunding Bonds, Series 1986A, due in varying installments through February 1, 2011 with interest at 6.00% to 7.75% payable semiannually	$102,959,270	$105,168,143
The Hospital's portion of the University's variable rate demand bonds, Series 1985E, 1985F, 1985G, 1985H and 1985I, due in varying installments through October 1, 2017, at annual interest rates from 3.75% to 6.05% in 1991	62,971,365	62,971,365
Note payable at 5.13% due to the University in varying installments through 1991	71,575	1,578,575
Capital lease obligations at varying rates of imputed interest, collateralized by leased equipment with an amortized cost of $2,225,837 at June 30, 1991	2,436,972	2,769,592
	168,439,182	172,487,675
Less current maturities	3,157,098	4,320,342
	$165,282,084	$168,167,333

A summary of principal payments required on long-term debt in future years is as follows:

Year Ending June 30	
1992	$ 3,157,098
1993	3,391,593
1994	3,524,238
1995	3,663,176
1996	3,345,953
Later years	151,357,124
	$168,439,182

Continued

6. Long-Term Debt, continued:

The Hospital's long-term debt includes its share of the University's Variable Rate Demand Bonds, Series 1985E, 1985F, 1985G, 1985H and 1985I. The Hospital is indebted directly to the University for this amount and pays all principal and interest directly to the University as required under the terms of the bond indenture agreement. The Variable Rate Demand Bonds are subject to optional tender and mandatory tender by the bondholders in certain circumstances. The Hospital expects that tendered bonds will be resold to the public by a remarketing agent. To provide for the purchase of tendered bonds which are not remarketed, the University has entered into a credit agreement with a bank. The full faith and credit of the University is pledged for payment of principal and interest on the 1985 and 1986 Bonds. A portion of these bond proceeds were used to retire the Variable Rate Demand Bonds, Series 1985B, 1985C and 1985D. In prior years, the Variable Rate Demand Bonds, Series 1985B, 1985C and 1985D, were issued for the purpose of advance refunding of Series 1982 Term Bonds and Serial Bonds.

7. Pension Plan:

All employees of the Hospital meeting age and length of service requirements participate in civil service (Minnesota State Retirement System - MSRS) or faculty (University of Minnesota) pension plans (the plans). The plans require contributions by both the employer and employee. The Hospital's pension expense for the years ended June 30, 1991 and 1990, was $5,257,419 and $5,429,868, respectively, which includes amortization of prior service costs through 2012.

The Faculty Retirement Plan is a defined contribution plan and is fully funded. The MSRS statewide plan is a defined benefit plan and it covers employees of the State of Minnesota, school districts, counties, cities and other political subdivisions. The unfunded vested benefit liabilities of the MSRS plan are not actuarially segregated by employer unit. As of June 30, 1991, University employees represented approximately 28 percent of active plan participants in MSRS.

Continued

7. Pension Plan, continued:

At June 30, 1990, the date of the latest actuarial valuation, net assets available for benefits were $2,067,688,000 for the MSRS plan. The actuarial present value of accumulated plan benefits and amounts specifically applicable to the Hospital were not calculated.

8. Transactions Related to the University:

The Hospital has contracts with the University Medical School for the services and stipends of residents and medical school staff involved with direct patient care, in-service education and administrative duties within the Hospital. Total expense for such services and stipends for the years ended June 30, 1991 and 1990 were approximately $10,059,000 and $8,532,000, respectively.

The costs of certain general and administrative services provided to the Hospital by the University are accounted for as an operating expense of the Hospital. The Hospital has not been required to make a cash transfer to reimburse the University for the entire cost of these services. Unreimbursed University services were $196,493 and $190,707 in 1991 and 1990, respectively. Accordingly, the unreimbursed costs are shown as an addition to the general fund balance of the Hospital. The Hospital is charged by the University departments separate from the allocation of general and administrative services for services and supplies purchased from them. Additionally, the Hospital charges the University departments for services and supplies provided to them.

The University, including the Hospital, is self-insured for workers' compensation claims. The University has accrued approximately $35,000,000 at June 30, 1991 related to reported and unreported claims. The University requires that the Hospital make monthly payments to the University for the Hospital's estimated cost of workers' compensation benefits. The University currently has no plans to require payment beyond these scheduled monthly payments.

Continued

9. Commitments and Contingencies:

The Hospital has professional liability insurance coverage provided on a claims-made basis including provisions for retrospective premium adjustments. The coverage is provided through RUMINCO, Ltd., a wholly owned subsidiary of the University, which was principally established for the purpose of providing liability coverage for the University, including the Hospital. This policy provides coverage with a $1,000,000 per person claim limitation, $3,000,000 per occurrence claim limitation and $5,000,000 aggregate annual claim limitation. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims incurred but not reported (IBNR) during its term will be uninsured. The University has accrued approximately $1,800,000 for estimated IBNR claims related to the Hospital's professional liability coverage as of June 30, 1991. The University currently has no plans to require payment of this amount from the Hospital. Accordingly, no such accrual has been made in the Hospital's financial statements.

Insurance premiums to RUMINCO totaled $1,123,858 and $834,945 in 1991 and 1990, respectively. The Hospital received dividends of $655,000 and $1,965,000 in 1991 and 1990, respectively, from RUMINCO which were used to reduce insurance expense (included in other expenses) in the accompanying financial statements.

The Hospital contracts with the University for services of medical residents. The University's position is that medical residents are students for social security purposes and therefore had not collected social security taxes from these individuals or remitted to the Social Security Administration the employer's share of these taxes, prior to October 1, 1990. In August 1990, the University was notified by the Social Security Administration that it does not consider medical residents to be students for social security purposes. As of October 1, 1990, the University and the Hospital began collection of social security taxes from residents and remittance of both the employee and employer portions of these taxes to the Social Security Administration. These remittances are being paid under protest as the University contends that the assessment is inappropriate.

If the Social Security Administration's assessment is upheld, the University estimates it would owe approximately $5,000,000, excluding interest, in social security taxes for calendar years 1985 and 1986, representing both the employer and employee share. No assessments or claims have been made for years subsequent to 1986. The amount apportionable to the Hospital, if any, has not been determined. The University is vigorously contesting this assessment. No liability for these taxes has been recorded within these financial statements.

Continued

10. Supplemental Cash Flow Information:

	1991	1990
Cash paid for interest	$12,086,968	$12,428,248

Supplemental schedule of noncash investing and financing activities:

	1991	1990
Capital lease obligations incurred as a result of the Hospital entering into equipment leases	$386,939	$2,819,407
Adjustments to the general fund balance as a result of allocation of facilities shared with the University	$549,638	$ (318,065)

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

DECEMBER 18, 1991

THE HOLIDAY PARTY WILL BEGIN IMMEDIATELY AFTER
THE MEETING IN THE LIBRARY OF THE CAMPUS CLUB

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
DECEMBER 18, 1991
2:30 P.M.
EAST WING - CAMPUS CLUB

AGENDA

C. Joint Conference Committee

No items requiring Board deliberation.

D. Finance Committee

1. November 30, 1991 Financial Statements — Information

To be distributed at the Meeting

2. Labor Relations Update — Information

V. Other Business

VI. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

October 23, 1991

Call To Order

Mr. David Lentz called the October 23, 1991 meeting of the Board of Governors to order at 2:45 p.m. in 555 Diehl Hall.

Attendance

Present:
Leonard Bienias
David Brown, M.D.
Robert Dickler
Michael Dougherty
George Heenan
Kris Johnson
Nellie Johnson
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
Robert Nickoloff
Barbara O'Grady
Cherie Perlmutter

Not Present:
Michael Dougherty
George Heenan
Phyllis Ellis
Bob Erickson
Jerry Meilahn
Trudy Ohnsorg
Jerry Olson
Roby Thompson, M.D.

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the September 26, 1991 meeting as submitted.

Chairman's Report

Mr. Lentz briefly reviewed the Board of Governors retreat summary. The Board will be kept informed as the strategic planning process is developed.

Mr. Lentz informed the Board that the Holiday Reception will follow the December 18th Board meeting and encouraged all to attend.

Special Presentation: George Adams, M.D.

Mr. Robert Dickler introduced Dr. George Adams, Professor and Head of the Otolaryngology Department. Dr. Adams presented an overview of the Department of Otolarynogology.

The Board thanked Dr. Adams for his presentation.

Directors Report

Mr. Dickler reported that the census of the Hospital has been closer to the previous year through October.

Mr. Dickler handed out a strategic planning issue summary to the Board.

Mr. Dickler reported that the Shelter Fund Dinner and Dance on October 19, 1991 was well attended and a huge success, although the final amount raised has not been calculated.

Consent Agenda

A motion was seconded and passed to approve items on the consent agenda which consisted of:

a. Quarterly Capital Expenditure Report

b. Quarterly Purchasing Report

c. Development Office Update

d. First Quarter, 1991-92 Bad Debts

Joint Conference Committee

In Mr. Heenan's absence, Ms. Barbara O'Grady called on Dr. Robert Maxwell to present policy 16.4: Making Decisions to Forego Cardiopulmonary Resuscitation and the amendment to the Rules and Regulations of the Medical Dental Staff bylaws.

Dr. Maxwell presented revisions to Policy 16.4, Resuscitation of the Hospitalized Patient. Dr. Maxwell stated the policy revisions had been presented to and endorsed by the Medical Staff-Hospital Council and the Joint Conference Committee.

Dr. Maxwell presented an amendment to Section VII-G of the Rules and Regulations of the Medical and Dental Staff, or Resuscitation of Hospitalized Patients. As with the revisions of Policy 16.4, this amendment provides improved definition to the decision making process and the roles of the patient and physician as they relate to cardiopulmonary resuscitation.

The Board seconded and passed a motion to approve Policy 16.4 and the Rules and Regulations amendment.

Mr. Greg Hart presented the Quality Assurance Plan. Following a successful 1990 JCAHO survey, the UMHC /Quality Assurance Steering Committee recognized a unique opportunity to establish future directions which not only meet the requirements of external regulatory agencies, but more importantly, promote both historical and newly identified internal objectives for improved patient care and enhanced competitiveness.

The Board seconded and passed a motion to approve the Quality Assurance Plan.

Planning and Development Committee

Mr. Robert Nickoloff called on Mr. Cliff Fearing to report on Interstate Medical Center. Mr. Fearing asked the Board to approve the acquisition of Interstate Medical Center in Red Wing for $9,074,600.

After considerable discussion regarding the importance of this relationship to the Medical Center, the Board seconded and passed a motion to approve the purchase of Interstate Medical Center in Red Wing.

Finance Committee

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospitals's Statement of Operations for the period July 1, 1991 through September 30, 1991 shows expenses over revenues by $1,069,000, an unfavorable variance of $4,431,000. Patient care charges through August totaled $90,791,000, which was 6.7% under budget.

Mr. Fearing reported inpatient admissions for September totaled 1,343 which was 152 below budgeted admissions of 1,495. Overall average length of stay for the month was 8.1 days. Outpatient clinic visits for the month of September totaled 26,067 which was 1,627, or 5.9% less than budgeted visits of 27,694.

Mr. Fearing distributed copies of the Coopers and Lybrand Report on Financial Statements for the years ended June 30, 1991 and 1990. The audit revealed no material issues with the financial statements.

Adjournment

There being no further business, the October 23, 1991 business meeting of the Board of Governors was adjourned at 4:40 p.m. A non-public executive session of the Board of Governors was called at 4:45 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

MINUTES
Planning and Development Committee
Board of Governors
October 14, 1991

CALL TO ORDER

Acting Chairman Johnson called the October 14, 1991 meeting of the Planning and Development Committee to order at 12:09 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present:	Leonard Bienias Robert Dickler Greg Hart Nellie Johnson Trudy Ohnsorg Ted Thompson, M.D.
	Absent:	Clint Hewitt William Jacott, M.D. Peter Lynch, M.D. Robert Nickoloff
	Staff:	Fred Bertschinger Giles Caver Cliff Fearing

APPROVAL OF MEETING MINUTES

The minutes of the July 18, 1991 meeting were approved as submitted.

INTERSTATE MEDICAL CENTER PROPOSAL

Mr. Cliff Fearing presented a proposal to purchase the facilities and practice of Interstate Medical Center (IMC), Red Wing, Minnesota, for a total acquisition cost of $9,074,600. The structure of the proposed acquisition and the financial basis for the purchase price were again reviewed with the Committee.

The new corporation's board of directors will consist of six members. Three members will be physicians who practice at IMC, and three members will be representatives from the Hospital.

A motion to endorse the purchase of Interstate Medical Center was seconded and passed unanimously. The Committee recommendation will be forwarded to the Board of Governors, whose recommendation will be sent to the Board of Regents for consideration in November and December.

QUARTERLY CAPITAL EXPENDITURE REPORT

Mr. Greg Hart presented the Quarterly Capital Expenditure Report. During Fiscal Year 1991, the Hospital spent $6,926,872 on recurring equipment and remodelling and $919,349 on principle payments. Sources of funding included monies budgeted for Fiscal Year 1991 and monies "rolled forward" from Fiscal Year 1990. The Hospital also spent $6,251,628 on capital projects.

QUARTERLY PURCHASING REPORT

Mr. Mark Koenig presented the Quarterly Purchasing Report for April-June 1991. Total purchase order activity was $18,097,915. This amount is down from the two prior quarters.

Mr. Koenig presented six "purchase awards to other than low bidder" ($10,000 or more). The Hospital also made a number of sole source purchases, including three in excess of $50,000. Mr. Koenig noted two vendor appeals.

A motion to endorse the Quarterly Purchasing Report was seconded and passed unanimously.

DEVELOPMENT OFFICE UPDATE

Mr. Fred Bertschinger presented the Development Office Quarterly Report for April-June 1991. Total contributions received amounted to $245,562. During Fiscal Year 1991, total contributions received amounted to $1,247,035, well in excess of the goal of $1,050,000.

The budgeted goal for Fiscal Year 1992 is $1,200,000. Mr. Bertschinger stated this year's goal is below last year's actual because bequests constitute a significant amount and are quite variable.

A motion to endorse the Development Office Quarterly Report was seconded and passed unanimously.

LITHOTRIPSY UPDATE

Mr. Greg Hart provided an update regarding the mobile lithotripsy program. Due to difficulties experienced with the machine vendor, an alternative approach to the program has been developed. The Hospital will first continue leasing a machine from the vendor on a short term basis. Second, the Hospital may begin leasing a machine from an Alabama hospital for a three to six month period. Third, the Hospital may place its current on-site machine in a van, thus using it both on-site for Hospital patients and off-site at other hospitals. The net financial impact of this approach compared to the prior lease arrangement is positive.

The Committee will continue to receive updates regarding Mobile Lithotripsy.

MOBILE CATH UPDATE

Mr. Greg Hart provided an update regarding the possible purchase or lease of a mobile cardiac catheterization laboratory. The Hospital is discussing a possible joint venture with two other hospital systems, one of which may bring its cardiologists in as joint venture partners. The status of the mobile cath marketplace was again discussed, and it was noted that our affiliates in Northern Minnesota remain very interested in this service.

The Committee will continue to receive updates regarding Mobile Cath, and will be asked to approve a definitive business plan and structure later this year.

RIVERSIDE MEDICAL CENTER

Mr. Greg Hart provided an update regarding service relocation discussions with Riverside Medical Center. A jointly-retained consultant recommended that Obstetrics and the Neonatal Intensive Care Unit be relocated to Riverside.

Mr. Hart indicated discussions among the Hospital, Riverside, and involved physicians are proceeding well. A more detailed financial analysis is now being considered. It is anticipated that a conclusion for these discussions will be presented to the Board in late 1991 or early 1992.

The Committee will continue to receive updates regarding Riverside Medical Center negotiations.

UMCA UPDATE

Dr. Ted Thompson presented an update regarding the Hospital's activities with UMCA. The Hospital and UMCA are attempting to identify where University physicians practice when not at the Hospital. Medica referrals, or the lack thereof, are also of interest. Finally, the Hospital and UMCA continue to pursue interdepartmental issues, including billing.

The Committee will continue to receive updates regarding UMCA.

OTHER BUSINESS

Mr. Robert Dickler provided an update regarding strategic planning. The "request for proposal" has been disseminated to various consulting firms, and Mr. Dickler has appointed a task force to provide ongoing assistance to whichever firm is selected. The intent is to formally begin the planning effort by year end and to complete the process by August or September 1992.

The Committee will continue to receive updates regarding the strategic planning process.

ADJOURNMENT

There being no further business, a motion for adjournment was seconded and passed at 1:02 p.m.

Respectfully submitted,

Giles Caver
Administrative Fellow

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

December 11, 1991

TO: Members, Board of Governors

FROM: Greg Hart

RE: Quarterly Purchasing Report

Attached please find the quarterly purchasing report for the period July - September, 1991. The report will be reviewed at the December Committee meeting. Following the review we will be seeking approval of the report.

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

/gs

attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF JULY - SEPTEMBER 1991

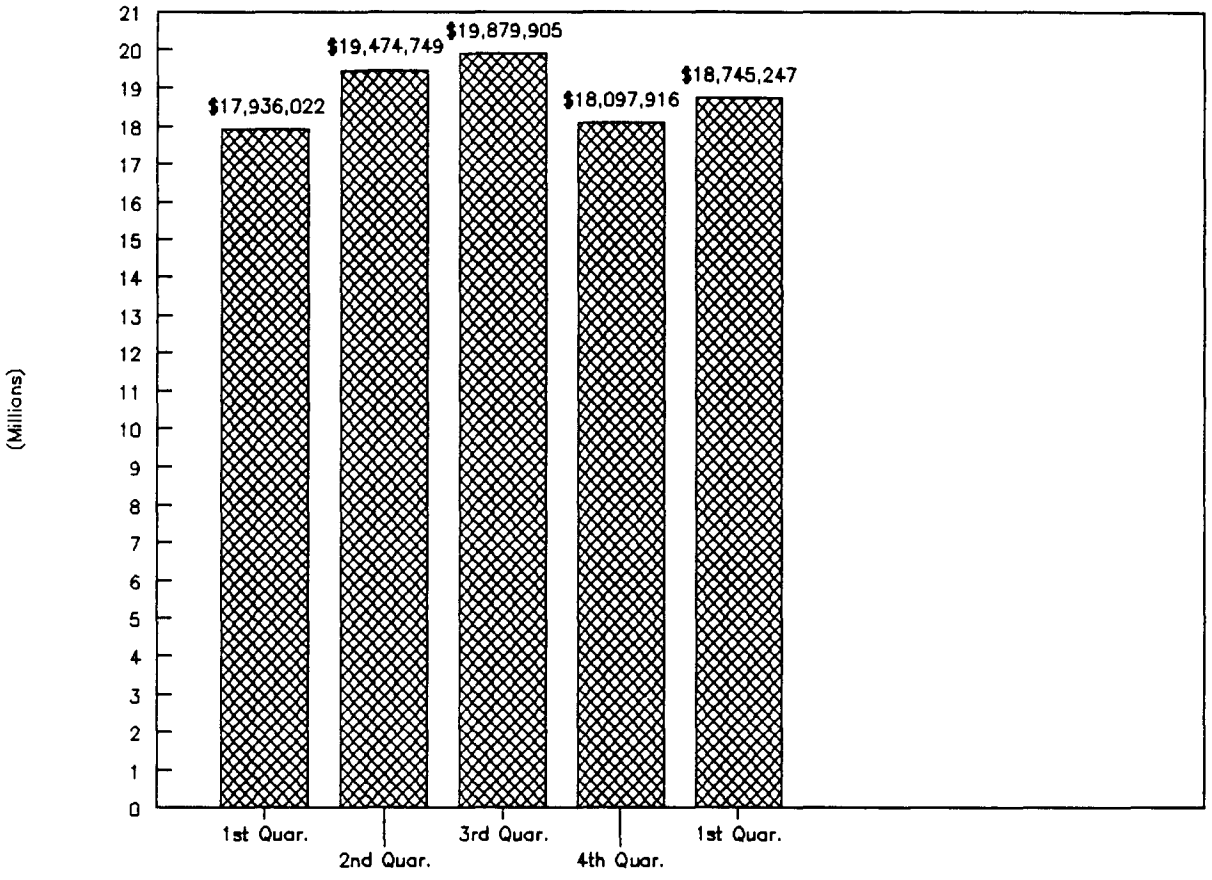
I. PURCHASE ORDER ACTIVITY

II. AWARDS TO OTHER THAN APPARENT LOW BIDDER

III. SOLE SOURCE ACTIVITY

IV. VENDOR APPEALS

PURCHASE ORDER ACTIVITY



FIRST QUARTER, FISCAL YEAR 1991-92, ACTIVITY:

	NUMBER	VALUE
PURCHASE ORDERS	8979	$16,582,557.12
OTHER PAYMENTS	358	$1,585,662.22
CONFIRMING ORDERS	361	$577,027.22
TOTAL THIS QUARTER	9,698	$18,745,246.56

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

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Thermometers, Oral & Rectal	Medix $ 12,650.00	Medline $ 16,247.20	Materials
		The thermometer container has no cap which raises a safety concern should the thermometer fall and break.		
2.	Introducers	Daig $ 45,416.00 Cook $ 56,646.20	Davol $ 60,825.00	Materials
		The introducer is ribbed which allows it to kink easily impeding the placement of the catheter, and it does not have the knife stripping technique allowing placement by one person.		
3.	Ziplock Bags	Co-Ordinated Pkg $ 10,150.48	Leslie Paper $ 10,917.49	Materials
		Bags are difficult to zip, and open easily under pressure.		
4.	Cath., Leonard Dual Lumen, 10 Fr.	Bio Instruments $ 22,880.00 Kolling $ 18,216.00	Davol $ 35,640.00	Materials
		The design of the catheter connection site carries a high probability of kinking.The clamping are slides, which could cause it to become lodged within the patient, and the cuff is too thick and easily frayed which could cause a granulation of the tissue. The hub is rough, decreasing patient comfort.		

5.	Subcutaneous Port w/Preconnect Large Venous Cath., Hickman	Bio Instruments $ 28,830.00 Kolling $ 25,575.00 Strato (Infusaid) $ 24,645.00	Davol $ 32,550.00	Materials
		The design of the port does not have a shape which enhances the septum target area making it difficult to inject into the port.		
		Strato (Lifeport) $ 26,505.00	Davol $ 32,550.00	
		The Lifeport style does not have an anti-kinking sleeve included on the port.		
6.	Subcutaneous Port w/Preconnect Small Venous Cath., Hickman	Strato (Infusaid) $ 8,215.00 Kolling $ 7,967.00	Davol $ 10,850.00	
		The design of the port does not have a shape which enhances the septum target area making it difficult to inject into the port.		
7.	Subcutaneous Port Port-a-Cath w/Unattached Ventricular Cath.	Bio Instruments $ 18,600.00	Davol $ 18,600.00	
		The Bio Instruments port does not have a shape which enhances the septum target area making it difficult to inject into the port.		
		Strato (Lifeport) $ 17,100.00	Davol $ 18,600.00	
		The Lifeport style does not have an anti-kinking sleeve included on the port.		

III. SOLE SOURCE–$5,000 and Over

	VENDOR	CONTRACT/ P.O. #	VALUE	DEPT.	PRODUCT
	Schneider	H118705	$5,700.00	Radiology	Wallstent
	Monarch Minnesota	91-502	$11,000.00	M.S.	Nutrition Flatware
	American Bio Products	H110963	$33,144.00	Labs	Reagent Kits
	C.R. Bard	H438307	$9,630.00	CSP	Catheters
	Danek	H100211	$14,620.00	O.R	TRSH Spinal System
	Concept	H118583	$6,350.00	O.R.	Video Printer & Transformer
	Cobe/Gambro Hospal	H118864	$23,590.00	Nursing	Bicarbmodules
	U.S. West	H114575	$12,561.60	Marketing	Advertising
	Johnson & Johnson	H441458	$6,360.00	Radiology	Stents
*	Surgical Lasers	H119469	$74,000.00	O.R.	Surgical Laser System
	Abbott Labs	H119327	$31,850.00	Labs	Parallel Processing Center
	Target Therapeutics	H119481	$21,115.00	Radiology	Tracker Catheters
	Haldeman Homme	H443868	$9,165.00	Facilities	Casework/Installation
	Interventional Therapeutics	H443909	$9,165.00	Radiology	Balloon Catheters
	Key Functional Assessment	H444060	$6,857.50	Rehab	Forms and Manuals
	American Society of Hospital Pharmacists	H119358	$6,450.00	Pharmacy	Formulary Text
	Midwest Surgical	H119349	$31,950.00	Amb. Surg.	Surgical Microscope
	Medical Graphics	H121327	$24,900.00	Labs	Cardiac Outpatient System
	TOTAL		$332,708.10		

* Over $50,000

IV. VENDOR APPEALS - No activity to report this quarter.

UNIVERSITY MINNESOTA HOSPITAL AND CLINIC

CAPITAL EXPENDITURES
7-1-91 THRU 09-30-91

RECURRING EQUIP & REMOD	BUDGET	ROLLFORWARD FROM 6-30-91	TOTAL	3-MONTH BUDGET	3-MONTH ROLLFORWARD	TOTAL	91-92 ACTUAL	90-91 ROLLFORWARD	TOTAL
EQUIPMENT PURCHASES									
91-92 BUDGET	$6,818,850		$6,818,850	$1,700,000		$1,700,000	$1,459,775	$0	$1,459,775
ROLLFORWARD		$4,871,763	$4,871,763		$1,220,000	$1,220,000	$0	$412,752	$412,752
	$6,818,850	$4,871,763	$11,690,613	$1,700,000	$1,220,000	$2,920,000	$1,459,775	$412,752	$1,872,527
REMODELING PROJECTS									
91-92 BUDGET	$1,692,150		[illegible]0	$423,000		$423,000	$35,541		$35,541
ROLLFORWARD		$1,446,000	[illegible],446,000		$361,000	$361,000		$311,810	$311,810
	$1,692,150	$1,446,000	$3,138,150	$423,000	$361,000	$784,000	$35,541	$311,810	$347,351
	$8,511,000	$6,317,763	$14,828,763	$2,123,000	$1,581,000	$3,704,000	$1,495,316	$724,562	$2,219,878
PRINCIPLE PAYMENTS									
LAB CHEMICAL ANALIZERS	$126,841		$126,841	$30,669		$30,669	$26,245		$26,245
CT SCANNER	$71,575		$71,575	$54,000		$54,000	$54,000		$54,000
COMPUTER EQUIP	$139,517		$139,517	$45,687		$45,687	$30,367		$30,367
MRI 2	$462,648		$462,648	$112,465		$112,465	$112,465		$112,465
	$800,581		$800,581	$242,821		$242,821	$223,077		$223,077
TOTAL:	$9,311,581		$15,629,344	$2,365,821		$3,946,821	$1,718,393		$2,442,955

BOND PAYMENTS: $2,490,000 (PAYMENTS DUE FEB. 1, 1992)

CAPITAL PROJECTS:	UMHC FUNDS FROM RESERVES	ADDITIONAL FUNDS FROM OTHER SOURCES	TOTAL AUTHORIZED BUDGET	1st QUARTER EXPEND. 1991-92	CURRENT & PRIOR YEAR(S) EXPENDITURES
(1) ARCHITECT FEES PH II				$104,166	$1,177,430
(1) OFFSITE RELOC.					$10,516
(1) AUTOPSY	$415,000		$415,000	$115,845	$298,960
(1) OB INPT. (TEMP)	$370,000		$370,000	$119,782	$273,011
BMT/CU 4F	$100,000		$100,000	$1,874	$87,610
BONE MARROW TRAN. EXP.	$220,000		$220,000	$8,900	$12,366
NEURO-ANGIOGRAPHY SYST	$1,900,000		$1,900,000	$1,345,114	$1,375,114
DERMATOLOGY	$679,069	$233,889	$912,958		$869,912
CUHCC	$1,800,000	$550,000	$2,350,000	$15,036	$2,238,070
MAYO 4 SURG	$1,029,350		$1,029,350		$1,043,379
MASONIC HOSP	$835,000	$800,000	$1,635,000		$1,655,933
COMPUTER UPGRADE	$850,000		$850,000	$28,338	$768,776
C.T. SCANNER	$1,217,000		$1,217,000		$1,210,000
CARDIOVASCULAR RAD.	$863,000		$863,000		$860,355
AF15 SOFTWARE LICENSE	$783,000		$783,000	$782,157	$782,157
UNIT J	see note #2			($29,480)	$22,312
LABS COMPUTER SYST. EXP.	$306,000		$306,000		$250,365
HEART CATH ROOM	$3,100,000		$3,100,000		$13,109
TOTAL	$14,467,419	$1,583,889	$16,051,308	$2,491,733	$12,949,376

1.) THESE PROJECT COSTS ARE BUDGETED FOR IN THE $37.62 MILLION RENOVATION PROJECT.
2.) THESE PROJECT COSTS ARE PART OF ORIGINAL UNIT J, FOR ARCHITECTUAL AND INSURANCE EXP.

MINUTES
Joint Conference Committee
Board of Governors
October 9, 1991

Attendance:	Present:	Debbie Day, M.D. Amos Deinard, M.D. Robert Dickler Phyllis Ellis Barbara O'Grady
	Absent:	George Heenan Robert Maxwell, M.D. Gerald Olson Richard Price, M.D.
	Staff:	Giles Caver Keith Dunder Shannon Lorbiecki

CALL TO ORDER

Ms. Barbara O'Grady called the meeting to order at 4:37 p.m.

APPROVAL OF MEETING MINUTES

The minutes of the September 11, 1991 meeting were approved as submitted.

SPECIAL PRESENTATION

Ms. Anne Doyle made a presentation regarding the Outcomes Management Project at the Park Nicollet Medical Foundation. Ms. Doyle is vice president for strategic development at the Foundation, a research and educational entity operated by Park Nicollet Medical Center.

The Outcomes Management Project was established in January 1990 to better record and evaluate medical outcomes data. The intent is to use data to improve quality of care and control costs for the benefit of all customers, including patients, physicians, and payors. To date, the Project has involved three clinical areas, including total hip replacement, cataract surgery, and rheumatology. Future areas of study include breast cancer and mental health.

QUALITY ASSURANCE PLAN

Mr. Robert Dickler presented the Quality Assurance Steering Committee Task Force Report. The report will guide attempts to better assess and improve quality of care. It will also communicate the Hospital and Clinic's commitment to a more progressive quality assurance program for the benefit of patients, physicians, payors, and regulatory bodies such as the JCAHO.

Mr. Dickler stated the report had been presented to and endorsed by the Council of Clinical Chiefs on September 24, 1991.

The Joint Conference Committee endorsed the recommendations of the Quality Assurance Plan.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT -
POLICY 16.4: MAKING DECISIONS TO FOREGO CARDIOPULMONARY RESUSCITATION

Dr. Frank Cerra presented revisions to Policy 16.4, or Resuscitation of the Hospitalized Patient. The first revision provides additional focus to cardiopulmonary resuscitation and better distinguishes it from other treatments. The second revision provides improved definition to the decision making process and the roles of the patient and physician.

Dr. Cerra stated the policy revisions had been presented to and endorsed by the Medical Staff-Hospital Council on October 8, 1991. Moreover, the Council will now address the implementation and quality assurance of the revisions.

The Joint Conference Committee endorsed the recommended revisions to Policy 16.4

MEDICAL STAFF-HOSPITAL COUNCIL REPORT -
AMENDMENT TO RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

Mr. Robert Dickler presented an amendment to Section VII-G of the Rules and Regulations of the Medical and Dental Staff, or Resuscitation of Hospitalized Patients. As with the revisions to Policy 16.4, this amendment provides improved definition to the decision making process and the roles of the patient and physician as they relate to cardiopulmonary resuscitation.

Mr. Dickler stated the amendment had been presented to and endorsed by the Medical Staff-Hospital Council on October 8, 1991.

The Joint Conference Committee endorsed the recommended amendment to Section VII-G of the Rules and Regulations of the Medical and Dental Staff.

CLINICAL CHIEFS REPORT

Mr. Robert Dickler presented the Clinical Chiefs Report. Mr. Dickler stated the Council of Clinical Chiefs had discussed the Board of Governors' September retreat at its last meeting.

The Council of Clinical Chiefs also continued discussion related to restructuring its meetings. There is a desire to make the meetings "more businesslike and productive."

ADJOURNMENT

There being no further business, the Joint Conference Committee meeting was adjourned at 6:00 p.m.

Respectfully submitted,

Giles Caver
Administrative Fellow

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

December 12, 1991

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 November 12 and December 10 and the Joint Conference Committee on December 11 have endorsed the attached Credentials Committee Reports and Recommendations.

I am forwarding these recommendations to you for your review and approval on December 18. If you should have any questions, please feel free to call on me.

REM/cf
Attachment

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

October 24, 1991

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby 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 Anesthesiology	Category
Chris H. Kehler	Attending Staff
Department of Laboratory Medicine and Pathology	
Janet S. Beneke	Attending Staff
Jose Jessurun	Attending Staff
Department of Medicine	
Stephen C. Battista	Attending Staff
Barbara C. Cahill	Attending Staff
Kathy Faber-Langendoen	Attending Staff
Melissa B. King	Attending Staff
Jane A. Little	Attending Staff
Eric L. Weinshel	Attending Staff
Department of Obstetrics and Gynecology	
Jeffrey M. Fowler	Attending Staff
June LaValleur	Attending Staff
Department of Ophthalmology	
Martha M. Wright	Attending Staff

Applications for Appointment to the Medical Staff and Requests for Clinical Privileges continued:

Department of Orthopedics

Kirkham B. Wood	Attending Staff

Department of Pediatrics

Michael S. Glock	Attending Staff
Anne M. Kelly	Attending Staff
John P. Perentesis	Attending Staff

Department of Radiology

Christopher E. Engeler	Attending Staff
Mary C. Foshager	Attending Staff
Steven E. Miltz-Miller	Attending Staff
Henry P. Thode	Attending Staff
Scott A. Wegryn	Attending Staff

Department of Surgery

Brett T. Gemlo	Clinical Staff
Warren V. Schubert	Clinical Staff

Department of Therapeutic Radiology

Paul W. Sperduto	Attending Staff

The following medical staff member has submitted an application and supporting documentation requesting the addition of clinical privileges. The Committee has reviewed and considered this request and hereby recommends approval.

Department of Neurosurgery	Category
Stephen J. Haines	Attending Staff

Add: CNS Endoscopy with lasers: Nd: YAG, KTP and CO_2

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 Anesthesiology	Category	Date Eligible
Calvin B. Cameron	Attending Staff	June 19, 1991

Recommendations for Regular Medical Staff Appointment continued:

Department of Dermatology		
Kenneth E. Bloom	Attending Staff	August 27, 1991
Department of Hospital Dentistry		
Rick L. Diehl	Attending Staff	June 19, 1991
Department of Laboratory Medicine and Pathology		
D. Ted Eastlund	Clinical Staff	August 27, 1991
Alejo Erice	Attending Staff	August 27, 1991
Department of Neurology		
Martha A. Fehr	Attending Staff	August 27, 1991
Christopher M. Gomez	Attending Staff	August 27, 1991
Randall T. Schapiro	Clinical Staff	June 19, 1991
Lawrence J. Schut	Clinical Staff	June 19, 1991
Department of Pediatrics		
Jane E. Crosson	Attending Staff	August 27, 1991
David F. Graft	Clincial Staff	August 27, 1991
Martha L. Spencer	Clinical Staff	August 27, 1991
Department of Radiology		
Daniel J. Loes	Clinical Staff	August 27, 1991
David E. Tubman	Clinical Staff	August 27, 1991
Department of Surgery		
Paul F. Gores	Attending Staff	August 27, 1991
Department of Therapeutic Radiology		
Larry R. Past	Clinical Staff	August 27, 1991
Department of Urology		
William D. Borkon	Clinical Staff	August 27, 1991

The following Specified Professional Personnel-Psychology Staff has applied for appointment to the psychology staff and has requested clinical privileges. The Committee hereby recommends approval of this applicant and her request for privileges.

Department of Pediatrics	Category
Glenace E. Edwall	Attending Staff

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

Department of Family Practice and Community Health	Category
Christopher L. Krogh	Attending Staff
Department of Medicine	
Lynn Burmeister	Attenidng Staff
James T. Lane	Attending Staff
Teresa C. McCarthy	Attending Staff
Gregory J. Path	Attending Staff
Department of Obstetrics and Gynecology	
Bruce A. Work	Attending Staff
Department of Psychiatry	
Robert M. Rose	Attending Staff
Department of Radiology	
Carolyn S. McDonald	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

December 3, 1991

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby 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 Medicine	Category
Leslie A. Couch	Attending Staff
David H. Ingbar	Attending Staff
Stephen C. Remole	Attending Staff
Department of Neurology	
Robert A. Gross	Attending Staff
Michael W. Risinger	Clinical Staff
Department of Orthopedics	
Garry M. Banks	Attending Staff
Denis R. Clohisy	Attending Staff
Department of Pediatrics	
Peter A. Blasco	Attending Staff
Harumi Jyonouchi	Attending Staff
Michael C. Vespasiano	Attending Staff
Department of Psychiatry	
Nancy C. Raymond	Attending Staff
Department of Radiology	
James F. Crowe	Attending Staff
Tore Detlie	Attending Staff

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

Department of Neurology	Category
Richard W. Price Add: administration of chemotherapy	Attending Staff
Department of Urology	
John C. Hulbert Add: laparoscopic nephrectomy	Attending Staff

Department of Medicine	Present Category	Requested Category
John R. Raines	Clinical Staff	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
Nelson L. Rhodus	Attending Staff	August 27, 1991
Department of Ophthalmology		
James E. Egbert	Attending Staff	August 27, 1991

The Committee recommends acceptance of the resignation of Medical Staff appointment from the following physician.

Department of Neurology	Category
Raul Cruz-Rodriguez	Clinical Staff

HB/cf

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
October 23, 1991

MINUTES

ATTENDANCE:

Present: Edward Ciriacy, M.D.
Robert Dickler
Michael Dougherty
Clifford Fearing
Leo Furcht, M.D.
David Lentz
Margaret Matalamaki
Vic Vikmanis

Staff: Giles Caver
Greg Hart
Nels Larson
Shannon Lorbiecki
Helen Pitt
Sharon Weiss

CALL TO ORDER:

The Finance Committee was called to order by Mr. David Lentz on October 23, 1991 at 12:30 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the July 24, 1991 meeting as written.

JULY 1, 1991 THROUGH SEPTEMBER 30, 1991 FINANCIALS:

Mr. Cliff Fearing reported to the Finance Committee the month of September inpatient admissions totaled 1,343, which was 152 below budget; average length of stay was 8.1 days; patient days totaled 10,515, which were 1,609 days below budget. The September average daily census was 351, which was below the budgeted level of 404. Clinic visits for the month of September were reported to be 5.9% under budget.

The Hospital's year-to-date Statement of Operations showed expenses being greater than revenues by $1,069,000, an unfavorable variance of $4,431,000. Gross patient revenue was 5.3% below budget and operating expenditures through September were reported to be 4.8% below budget.

As of June 30, the balance of accounts receivable totaled $95,051,000 and represented 92.0 days of revenue outstanding.

The Hospital's overall operating position shows a loss for the month and year-to-date.

1990-91 YEAR-END FINANCIAL STATEMENTS:

Mr. Fearing presented to the Committee for information the 1990-91 Financial Statement that was prepared by Coopers & Lybrand. At the time preliminary statements were issued in July, the University had not completed its year-end closing process. During the subsequent closing process, adjustments were made which changed the net revenue over expense by (19,793). Mr. Fearing reported that no audit adjustments made.

In reviewing the Hospital's analysis of the 1990-91 fiscal year, Mr. Fearing stated that the Hospital had a very financially successful year mainly due to the fact that there was an increase in volume by about 5% over what was budgeted and the expense base was kept at about 1% above budget for an overall favorable outcome.

FIRST QUARTER, 1991-92 BAD DEBTS:

Mr. Fearing reported the bad debts for the first quarter totaled $620,793.22 represented by 2,160 accounts. Receivables amount to $10,650.66, leaving a net charge-off of $610,142.56. This amount represents 0.67% of gross charges and compares to a budgeted level of 0.79%.

The Finance Committee seconded and passed a motion to endorse the First Quarter, 1991-92 Bad Debt report as submitted.

1990-91 YEAR-END CAPITAL EXPENDITURES REPORT:

Mr. Greg Hart presented to the Committee the 1990-91 Year-End Capital Expenditure Report for information only.

Mr. Hart reported that the actual capital expenditures for the year-to-date was $7M. Comparing that amount to the budgeted capital expenditures, the Hospital had underspent the capital budget by $6.3M.

INTERSTATE MEDICAL CENTER:

Mr. Fearing summarized for the Committee the appraised value as well as the projected future value of Interstate Medical Center.

Financial issues relating to the acquisition of this practice were reviewed by the Committee. The proposal for the purchase of Interstate Medical Center will be brought before the Board of Regents in November for information and again in December for action.

The Finance Committee seconded and passed a motion to endorse the acquisition of Interstate Medical Center.

LABOR RELATIONS UPDATE:

The Finance Committee officially went into an Executive Session on the matter of Labor Relations/Negotiations.

There being no further discussion, the October 23, 1991 meeting was adjourned at 2:00 P.M.

Respectfully submitted,

Sharon Weiss

Sharon Weiss
Recording Secretary

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review: December 9, 1991
Finance Committee Review: December 18, 1991
Board of Governors Review: December 18, 1991

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Digital Radiographic/Fluoroscopic System Replacement
Diagnostic Radiology: Pediatric Section

PURCHASE PRICE: $550,000

DESCRIPTION:

The GI/GU Section of Diagnostic Radiology has one room equipped with a radiographic/fluoroscopic machine and a digital imaging system selected specifically for imaging pediatric patients. When the radiographic/fluoroscopic machine was purchased in 1986, the vendor donated the digital imaging system (valued at $300,000) in return for UMHC's commitment to assist in developing and testing the digital imaging computer software. The quality of fluoroscopic images obtained with the lowest radiation exposures of any machine on the market coupled with the image manipulation capabilities anticipated with the digital system appeared to provide the most state-of-the-art selection available.

Unfortunately, the equipment has never met the original expectations. While the radiographic/fluoroscopic system does produce acceptable quality images with minimal radiation levels, lower total radiation exposure levels to patients have not been achieved because of longer exposure times caused by limitations in table movement and difficulties in controlling image intensifier movement during fluoroscopy procedures. While minimally acceptable digital images were initially achieved, the quality has deteriorated to unacceptable levels during the past two years. In addition, the equipment has required and continues to require frequent repair.

Repeated attempts by the vendor's local staff during the past five years and concentrated efforts by corporate staff in July and August to improve both the digital image quality and machine reliability to acceptable levels have had very limited success. Vendor personnel indicate that an additional expense of $150,000-175,000 should correct most of the remaining problems but will provide no guarantees. Given the age of the machine, the history of unsolved problems, and the fact that the vendor has ceased to market this type of equipment, the conclusion has been reached that the most prudent action is to replace the machine.

Purchase of this replacement equipment is included in the current year's capital budget.

Submitted By: Al Dees
Title: Assoc. Dir.

Approved By:
Title: Senior Associate Director

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Planning & Dev. Committee Review: December 9, 1991
Finance Committee Review: December 18, 1991
Board of Governors Review: December 18, 1991

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: 2 Tandem VLX Processors
(Phase 2 Upgrade of Clinical Laboratory Computer Systems)

PURCHASE PRICE: $149,800

DESCRIPTION:

The Clinical Laboratory Information System (CLIS) supports information processing and management related to test ordering, laboratory processing, analysis, data acquisition, verification, quality control and result reporting for over twenty laboratories located throughout UMHC. Computer support is provided 24 hours a day, 365 days a year, for a workload in the range of 1 million results per month. Updated cumulative summary reports are printed daily for inclusion in the medical record. The CLIS is interfaced to the Hospital Computer System, and the new EMTEK bedside care system, making laboratory results available to Patient Care Units within moments of test completion. Billing data is communicated daily.

The system was installed in 1987, with phase 1 of a planned upgrade occurring in 1990. Prior to this expansion, statistical data had shown that the Laboratory computer system was running with a two processor deficit for acceptable performance.

Computer system performance had stabilized at acceptable levels after the first upgrade. However, after the scheduled implementation of a number of applications, system statistics are now showing a 20% user response time degradation, with a number of additional applications still remaining on the installation schedule.

New versions of the operating system, and new laboratory and hospital applications planned for implementation in the coming year, are expected to increase the computer load by the equivalent of two additional central processing units (Tandem VLX processors). These additional system resources were proposed as a second phase of the planned system upgrade, and were included in capital budget requests for FY1991-92. The second phase was to be dependent upon thorough evaluation of performance data after installation and system runing with the phase 1 resources.

Expand the CLIS by adding two Tandem VLX processor modules with a total of 48 Megabytes of memory at a cost of $149,800. This cost is for reconditioned, Tandem maintenance certified, equipment which at this time can be obtained for about 40% of the retail list price for new equipment.

This project has been budgeted for 1991-92.

Submitted By: Al Dees
Title: Associate Director

Approved By: [signature]
Title: Senior Associate Director

PROPOSAL FOR REPLACEMENT OF 1.0 TESLA MAGNETIC RESONANCE IMAGER THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BACKGROUND

UMHC is currently operating two MRI units: a 1.0 Tesla machine which UMHC began leasing and operating in January 1985, and a 1.5 Tesla machine acquired in 1989.

The architecture of the 1.0 machine is no longer state-of-the-art. Due to the significantly improved image quality, throughput, and increased versatility obtained, 1.5 Tesla has replaced 1.0 Tesla as the dominant size for high field strength magnets in the marketplace. Consequently, the majority of the vendor's development resources are focused on 1.5 Tesla machines. No upgrades or enhancements for this 1.0 machine are available without incurring significant additional expense. Timely, reliable service is also more difficult to obtain because of a shortage of technicians with training and experience in the repair of this older architecture machine.

The limitations of the 1.0 Tesla machine mean that it is currently being used for only about 30% of the procedure load, and that percentage continues to decrease steadily. Newer, more sophisticated procedures, such as internal auditory canals, orbits, sella, and shoulders, cannot be performed on it. Consequently, those must all be done on the newer, 1.5 Tesla unit. Because of the significant improvement in image quality, some physicians routinely request or demand that procedures for their patients be done on the newer machine. Due to the inferior image quality obtained from the 1.0 Tesla machine and lengthy waiting times for the 1.5 Tesla machine, UMHC physicians are sending more than 20 patients per month to an external imaging center. The conclusion has been reached that the 1.0 Tesla machine is no longer worth the $28,650 monthly ($343,800 annual) lease cost.

UMHC's current 1.5 Tesla unit has a projected capability of supporting 3400 procedures annually when operated 16 hours per weekday and on an on-demand basis on weekends and holidays. UMHC's actual 1990-91 volume of 3661 exceeded that projected capability by 261 or 7.7%. The 1991-92 budgeted volume of 4022 exceeds it by 622 or 18.3%.

A survey of clinical chiefs and selected medical staff from Neurosurgery, Orthopaedics, Otolaryngology and Obstetrics/Gynecology indicates that if timely, 1.5 Tesla imaging service was available on-site for all procedures, the following additional volumes would materialize within the first year from new business and elimination of external referrals:

PROCEDURE	NO.
Brain	520-780
Extremities	52
Abdomen	156-208
Head	76
TOTAL	804-1116

These additions would increase the total annual procedure volume to a range of 4826-5138 or 41.9%-51.1% above the projected capability of UMHC's existing 1.5 Tesla unit.

The following alternatives for meeting this demand have been considered:

A. **Operate the existing 1.5 Tesla machine 24 hours per day on weekdays.**

This option would increase the projected capability of the machine to 4533 procedures. That would be sufficient capacity to handle the current volume but not the increases projected above. Wait times for exams would not be shortened and would likely increase.

This option would provide no on-site backup. When the machine needed repair or had to be shut down for software or hardware upgrading, CT would be the only on-site backup. While ambulatory patients could temporarily be routed to an off-site location, that is not a viable backup for inpatients.

Under this option a very high percentage of the machine's capacity would be required for direct patient care procedures. This would severely limit the amount of time available for pursuit of one of the radiologists' and hospital's missions--research, development, or adaptation of new MRI imaging or spectroscopy procedures for clinical usage.

Technologist and nurse staffing for night shift operation could probably be recruited with payment of premium salaries. However, it is unlikely that necessary staff radiologist and physicist coverage could be obtained.

B. **Contract with another hospital or imaging center for off-site service until UMHC's volume increases to a specific percentage of one machine's capacity (such as 167% or 5680 procedures).**

A survey of available capacity at other local 1.5 Tesla MRI installations has not been conducted. However, it is unlikely that a single site could be found which could take on 600 additional procedures immediately and up to 1700 additional procedures within a year, at least not without a long-term commitment from UMHC.

An off-site location would be usable only for ambulatory cases. To minimize the inconvenience factor for patients, transportation service between UMHC and the off-site location would have to be provided.

This option would provide no on-site backup. When UMHC's machine needed repair or needed to be shut down for software or hardware upgrading, CT would be the only on-site backup for inpatient cases and for ambulatory cases which could not be scheduled at the off-site location.

Under this option a very high percentage of the machine's capacity during day and evening shift hours would be required for direct patient care procedures. Consequently, the only time available for research, development, or adaptation of new MRI imaging or spectroscopy procedures for clinical usage would be during night shift hours. As the radiologists and physicists engaged in research and development must also be present during many of the hours when patient care procedures are being performed, their ability to conduct research and development during the night shift would be very limited. Therefore, pursuit of one of the faculty's and hospitals' missions would be severely restricted.

If the off-site entity would not agree to having UMHC radiologists oversee performance of and provide the interpretation for procedures completed there, this option would also deprive UMHC's radiologist staff of the professional revenue for those cases.

C. Purchase on-site, mobile service from an imaging service company until UMHC's volume reaches a specific percentage of one machine's capacity.

Due to environmental constraints, 1.0 Tesla is the largest machine available on a mobile basis. There are a few installations where a 1.5 Tesla machine has been placed in a trailer. However, these are fixed installations where a trailer was used because it was a significantly less expensive enclosure than a constructed building. Because this option would not provide access to a 1.5 Tesla machine, it is not viable.

D. Replace the existing 1.0 Tesla machine with a 1.5 Tesla unit on-site.

This option enables provision of all service to patients on-site, provides on-site 1.5 Tesla MRI backup, provides time and equipment for research and development with minimal impact on patient service, and retains all hospital and professional fee revenue at UMHC.

Based on examination of the pros and cons of each of these alternatives, the following action is proposed.

PROPOSAL

Replace the 1.0 Tesla MRI machine with a new, state-of-the-art machine with a magnet strength of 1.5 Tesla or greater.

PROJECTED COST

Equipment	$2,400,000
Installation	600,000

FINANCIAL ANALYSIS

The 1991-92 MRI revenue and expense budget is displayed in Section I of Attachment A. 4022 procedures resulting in gross charges of $4,032,918 are projected. Based on a present overall reimbursement level of 89.8%, $3,622,589 in net revenue is projected. $2,090,531 in expenses are projected to produce this revenue.

As displayed in Section II of Attachment A, the projected annual incremental cost resulting from installation of a replacement machine is $262,178. Based on the current 89.8% reimbursement rate, $291,958 in additional gross charges would be required to cover this additional cost. That translates to the need for an additional 292 procedures assuming the ratio of procedures with and without the administration of contrast media remains constant.

The first year increases projected with the availability of two 1.5 Tesla machines as detailed above would yield the following additional net revenue:

PROCEDURE	NO.	NET REVENUE
Brain		
Without Contrast	285-427	$247,177 - 370,332
With Contrast	235-353	222,109 - 333,636
Extremities		
Without Contrast	2	1,735
With Contrast	50	47,257
Abdomen		
Without Contrast	15-19	13,009 - 16,478
With Contrast	141-189	133,265 - 178,632
Head		
Without Contrast	33	28,621
With Contrast	43	40,641
TOTAL	804-1116	$733,814 - 1,017,332

The projected total range is 175-282% above the 292 additional procedures and $441,856 to $725,374 above the $291,958 in additional gross charges required to cover the incremental cost.

This acquisition is included in UMHC's capital plan for the 1991-92 fiscal year.

FINANCIAL ANALYSIS
REPLACEMENT OF MRI-I UNIT

ATTACHMENT A

I. CURRENT ANNUAL MRI OPERATING BUDGET (1991-92)

PROCEDURE VOLUME PROJECTIONS

PROCEDURE	WITHOUT CONTRAST	WITH CONTRAST	TOTAL
Brain	1013	1224	2237
Spinal Cord	750	427	1177
Extremities	278	9	287
Myocardium	5	0	5
Pelvis/Hips	121	0	121
Abdomen	68	7	75
Head	50	39	89
Chest	25	6	31
TOTALS	2310	1712	4022

REVENUE PROJECTIONS

PAYER	% OF TOTAL	GROSS CHARGES	% REIMB.	NET REVENUE
Agency	9.6%	$387,196	86.9%	$336,439
BC/AWARE	11.7%	$471,847	88.8%	$419,000
HMO	3.2%	$129,052	85.0%	$109,694
Commercial	12.5%	$504,110	100.0%	$504,110
Medicare	18.2%	$733,984	75.2%	$551,956
MA/GAMC	8.6%	$346,828	75.1%	$260,468
Self-pay	27.5%	$1,109,041	98.7%	$1,094,623
Other	8.7%	$350,860	98.7%	$346,299
TOTALS	100.0%	$4,032,918	89.8%	$3,622,589

EXPENSE PROJECTIONS

Salaries & Fringe Benefits	$313,891
Maintenance	$455,000
Depreciation/Lease Payments	
MRI-I (Lease @ $28,650/mo.)	$343,800
MRI-II (Equipment & Facility)	$557,617
Interest Expense	
MRI-II (Equipment & Facility)	$211,590
Consumable Supplies	$208,633
TOTAL	$2,090,531

II. MARGINAL ANNUAL COST OF MRI-I REPLACEMENT	
Salaries & Fringe Benefits	$83,099
Depreciation	
Equip. & Facil. less current lease	$24,906
Interest Expense (Equipment & Facility)	$131,395
Consumable Supplies	$22,778
TOTAL	$262,178
III. ANNUAL VOLUME INCREASE REQUIRED TO RECOVER MARGINAL COST	
Gross Charge Increase Required	
($262,178/.898)	$291,958
Volume Increase Required	
Procedures Without Contrast (57.4% @ $965.80)	174
Procedures With Contrast (42.6% @ $1052.50)	118
Total	292

BOARD OF GOVERNORS
NEW MEMBERS
January, 1992

Maria R. Gomez

Ms. Maria Gomez has been Director, Health Policy Analysis Team, Health Care Programs with the Minnesota Department of Human Services since March of 1991. She is responsible for enhancing the cost containment and quality assurance capabilities of the Department's Health Care Programs to improve the State's prudence in purchasing health care services. Prior to assuming her current position, Ms. Gomez has held a variety of positions within the Department of Human Services since 1976, most recently Assistant Commissioner of Health and Residential Programs.

Ms. Gomez received a B.A. in French and Spanish from the University of Miami, Coral Gables, Florida and a Master of Social Work from the University of Minnesota. A native of Cuba, Ms. Gomez is a citizen of the U.S.A. Her awards and honors include the 1991 Lloyd M. Short Merit Award for Distinguished Service in Public Affairs and the Outstanding Citizen of the Year Award in 1980 for work with refugees.

S. Albert Hanser

Mr. Albert Hanser is currently President of Hanrow Financial Group, a merchant banking company. Mr. Hanser was the President of F.B.S. Merchant Banking Group from its inception in 1984 until 1989. The F.B.S. Merchant Banking Group is the investment banking division of the First Bank System.

Mr. Hanser is a former Board of Governors member and Chair. He served as Chair of the Board of Governors from 1979 through 1981. In approving Mr. Hanser's term that began in January, 1986, the Board of Regents encouraged turnover in Board of Governors membership by mandating Mr. Hanser's retirement from the Board in December of 1988.

Mr. Hanser has been actively involved in the United Way, the Cancer Society's Investment Committee, and the Community resource Committee of the Citizen's League. He is a Director of the Minnesota Association of Public Teaching Hospitals (MAPTH), a former member of the LifeSpan, Inc. Board and a member of the Brown University Board of Advisors.

John Morrison

Mr. Morrison is Chairman of the Board and major shareholder in a group of 25 banks located in Minnesota, Wisconsin, Colorado and Montana as well as an industrial manufacturing company in California, a radio and television station in Wisconsin and Michigan. During the past twenty years, he has owned and operated 40 different companies of various sizes and in various industries throughout the U.S. and Europe. Mr. Morrison is chairman of the John & Susan Morrison Advisor Fund Foundation.

Kristine A. Zualkernan

Ms. Kristine Zualkernan is a second year student in the University of Minnesota Medical School. She received a B.S. degree in genetics and cell biology from the University of Minnesota in 1989.

While pursuing her Bachelor's degree Ms. Zualkernan held Research Assistant positions in the Departments of Neuropharmacology, Pediatrics, and Pediatric Nephrology. Following completion of her Bachelor's degree she spent a year as Senior Laboratory Technician in the Department of Veterinary Biology. Ms. Zualkernan has traveled extensively. She has spent time in Laos, China, Norway, Sri Lanka, and Thailand.

Since Medical School matriculation, Ms. Zualkernan has served as Co-chair of the Humanistic Health Committee; is Delegate, American Medical Association-Medical Student Section, Twin Cities Chapter; is the student representative to the Committee on Public Health and Preventive Medicine, Minnesota Medical Association.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

December 18, 1991

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1991 through November 30, 1991**

The Hospital's operations for the month of November reflect inpatient admissions and days, and outpatient clinic visit activity below budget. Similarly, both ancillary revenue and routine revenue are below budgeted levels.

INPATIENT CENSUS: For the month of November, inpatient admissions totaled 1,336 which was 179 below budgeted admissions of 1,515. Our overall average length of stay for the month was 8.1 days. Patient days for November totaled 11,588 and were 554 days below budget. The areas in which admissions were most significantly below budget were Gynecology, Pediatrics, Clinical Research, and Surgery. The areas in which admissions were significantly over budget were Neurosurgery and Orthopedics.

OUTPATIENT CENSUS: Outpatient encounters (including CUHCC and Home Health) for the month of November totaled 24,810 which was 3,026, or 10.9%, less than budgeted visits of 27,836. Almost all clinics were significantly under budget for the month of November, with the most marked decreases in Medicine, Orthopedics, Child Psych, and Radiation Therapy. Family Practice, Heart Cath Lab (encounters not budgeted), and Home Health visits were over budgeted levels for November.

We are continuing to analyze the factors which have resulted in our decline in census and are carefully monitoring the trend.

To recap our census:

Monthly Data						YTD Data				
90/91 Actual	91/92 Budget	91/92 Actual	Variance	% Var		90/91 Actual	91/92 Budget	91/92 Actual	Variance	% Var
1,527	1,515	1,336	(179)	(11.8)	Admissions	7,853	7,878	7,456	(422)	(5.4)
11,975	12,142	11,588	(554)	(4.6)	Patient Days	62,119	63,309	59,071	(4,238)	(6.7)
8.0	8.0	8.1	0.1	1.3	Avg Length of Stay	8.0	8.0	7.9	(0.1)	(1.3)
399.2	404.7	386.3	(18.4)	(4.6)	Avg Daily Census	406.0	413.7	386.1	(27.6)	(6.7)
69.1	70.3	67.7	(2.6)	(3.7)	Percent Occupancy	70.6	71.8	67.8	(4.0)	(5.6)
27,133	27,836	24,810	(3,026)	(10.9)	Outpt Encounters	142,847	146,924	141,522	(5,402)	(3.7)

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses being greater than revenues by $1,768,000, an unfavorable variance of $(6,532,000). Patient care charges through November totaled $153,042,000, which was 4.7% under budget.

Routine revenue was $3,298,000 (7.1%) below budget and ancillary revenue was $4,302,000 (3.8%) below budget and reflects both our unfavorable inpatient and outpatient census variance.

Deductions from charges totaled $42,812,000, which was $3,195,000 (8.1%) over budgeted deductions of $39,617,000. Billing adjustments were $429,000 (17.5%) over budget. These were related primarily to greater than anticipated discounts granted for prompt payment of billed charges. Contracts, previously combined with Billing Adjustments, were $706,000 (24.2%) over budget. These were a result of significant decreases in reimbursement under our VA contracts. The governmental contractual adjustment for the period ending November 30, 1991, was $1,502,000 (7.0%) over budget. Significant increases in the average charge per case resulted in increases in both the Medicare and Medicaid contractual allowances. Deductions from charges related to HMO/PPO discounts totaled $13,163,000 through November, which was $525,000 (4.2%), over budget. Again, the major factor in the variance was the increase in the average charge per patient.

Operating expenditures through November totaled $126,732,000 and were $5,186,000 (3.9%) below budgeted levels of $131,919,000. The overall favorable variance was primarily due to lower patient related costs (personnel, medical supplies and services, drugs and blood) and anticipated expenses not yet incurred.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of November 30, 1991, totaled $105,927,000 and represented 102.6 days of revenue outstanding. The overall increase in patient receivables in November of 6.8 days was reflected by an increase in Medicare, and Commercial Insurance.

CONCLUSION: The Hospital's overall operating position shows a monthly loss as well as year-to-date. While our census levels typically decline in November and December with the holiday periods, the decline this November was greater than we anticipated. Census levels for the first two weeks of December, however, are higher than anticipated. Given the variability we are experiencing through this period, we believe we should see to what level our census recovers in January and then take appropriate actions with regard to our expenditure base.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO NOVEMBER 30, 1991

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	$160,643,000	$153,042,000	($7,601,000)	-4.7%
Deductions From Revenue	39,617,000	42,812,000	3,195,000	8.1%
Net Patient Service Revenue	121,026,000	110,230,000	(10,796,000)	-8.9%
Other Operating Revenue				
Appropriation & Support	5,575,000	5,483,000	(92,000)	-1.7%
Other Revenue	5,014,000	4,913,000	(101,000)	-2.0%
Total Other Revenue	10,589,000	10,396,000	(193,000)	-1.8%
Total Revenue From Operations	131,615,000	120,626,000	(10,989,000)	-8.3%
Operating Expenses:				
Salaries	52,907,000	51,462,000	(1,445,000)	-2.7%
Fringe Benefits	12,886,000	12,524,000	(362,000)	-2.8%
Contract Compensation	8,325,000	8,390,000	65,000	0.8%
Supplies And Services	30,218,000	28,255,000	(1,963,000)	-6.5%
Utilities And Maintenance	4,876,000	5,115,000	239,000	4.9%
General Supplies & Expense	7,945,000	6,516,000	(1,429,000)	-18.0%
Insurance	780,000	776,000	(4,000)	-0.5%
Depreciation & Amortization	7,890,000	7,433,000	(457,000)	-5.8%
Interest	4,817,000	4,948,000	131,000	2.7%
Provision For Uncollectibles	1,275,000	1,313,000	38,000	3.0%
Total Operating Expenses	131,919,000	126,732,000	(5,187,000)	-3.9%
Net Revenue From Operations	(304,000)	(6,106,000)	(5,802,000)	
Nonoperating Gains: Investment Income	5,068,000	4,338,000	(730,000)	-14.4%
Revenue And Gains In Excess Of Expense	$4,764,000	($1,768,000)	($6,532,000)	

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	7,878	7,456	(422)	-5.4%
Patient Days	63,309	59,071	(4,238)	-6.7%
Average Length Of Stay	8.0	7.9	(0.1)	-1.3%
Average Daily Census	413.7	386.1	(27.6)	-6.7%
Percentage Occupancy	71.8	67.8	(4.0)	-5.6%
Outpatient Encounters	146,924	141,522	(5,402)	-3.7%