UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

July 3, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The July meeting of the Joint Conference Committee will be held on:

Wednesday, July 9, 1986
4:30 P.M.
8-106 University Hospital

The agenda and background materials for the meeting are enclosed. I will look forward to seeing you on Wednesday.

cc: Nancy Green
Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

May 8, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The May meeting of the Joint Conference Committee has been cancelled, given an absence of discussion or action items for the Committee agenda.

The next meeting of the Committee will be held on June 11, 1986, 4:30 P.M., in the Board Room in Unit J. The agenda for the June meeting will include the annual medical staff reappointments and an update on our quality assurance program.

cc: Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt

JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, July 9, 1986
4:30 P.M.
8-106 University Hospital

AGENDA

I.	Approval of Minutes	Approval
II.	Medical Staff-Hospital Council Report	Information
III.	"Patients First" Update Ms. Nancy Green	Information
IV.	Clinical Chief's Report	Information

MINUTES
JOINT CONFERENCE COMMITTEE
JUNE 11, 1986

ATTENDANCE: PRESENT:

Phyllis Ellis, Chair
George Heenan
James Moller, M.D.
Greg Hart

STAFF: Jan Halverson
Nancy Janda

GUESTS: Jan Brockway
Lois Kelly

I. Call to Order

The meeting was called to order at approximately 4:45 p.m.

II. Approval of Minutes

The minutes of the April 8, 1985 meeting of the Joint Conference Committee were approved as submitted.

III. Medical Staff Hospital Council Report

Dr. Moller indicated that the Medical Staff Hospital Council meeting consisted primarily of a review of the recommendations from the Credentials Committee, largely for purposes of reappointment of the medical staff. Dr. Moller discussed the Credentials Committee report and then recommended that reappointments, termination of medical staff appointments, regular medical staff appointments, addition and/or deletion of clinical privileges, changes in staff category, provisional medical staff appointments, and resignations from the medical staff be approved as recommended by the Credentials Committee and Medical Staff Hospital Council. The Joint Conference Committee acted to endorse the Credentials Committee report and recommendations.

Dr. Moller then provided the Joint Conference Committee with recommendations for Medical Staff Hospital Council Committee chairman. The Joint Conference Committee endorsed these recommended appointments.

Dr. Moller noted that Dr. Robert Maxwell had won the election for Vice Chief of staff and indicated that this appointment also requires Joint Conference Committee and full Board of Governors approval. The Joint Conference Committee endorsed the appointment of Dr. Robert Maxwell as Vice Chief of Staff.

Dr. Moller presented recommendations relative to the annual reappointments or appointments of the Chiefs of Clinical Services. He noted that Dr. William Thompson, Radiology; Dr. Peter Lynch, Dermatology; Dr. Roby Thompson, Physical Medicine and Rehabilitation; Dr. Alfred Michael, Pediatrics; and Dr. Bruce Work, OB/GYN are new Clinical Chiefs appointments. The Joint Conference Committee endorsed the recommended appointments.

In the course of these discussions, the Joint Conference Committee indicated that any insurance information received prior to the full Board of Governors meeting should be incorporated into the Credentials Committee recommendations.

IV. Quality Assurance Program Update

Ms. Jan Brockway presented an update on the Quality Assurance Program. She described the goals for 1986 and went through examples of data based monitoring tools which have developed and are being applied in clinical and hospital departments. Ms. Brockway also described the reporting form being used for follow-up on problems that are deemed to need attention. Mr. Heenan suggested that this form include identification of those parties with the authority to implement the follow-up actions.

Ms. Brockway also described the progress to date and the monitoring activities for Medical Staff committees, and indicated work on these monitoring tools will continue over the next several months, with an eye toward the next Joint Commission visit in late 1987.

V. Clinical Chiefs Report

Mr. Hart indicated that Dr. Duvall and Dr. Levitt were attending an UMCA Board meeting and he reported on recent Clinical Chiefs activities on their behalf. Recent meetings of the Chiefs have included a discussion of the Malpractice Insurance Task Force recommendations and management of the high census levels which have been experienced since the move to Unit J.

There being no further business, the meeting was adjourned at approximately 6:30 p.m.

Respectfully,

Gregory Hart
Senior Associate Director
Director of Operations

PATIENT RELATIONS

"Your Opinion Counts"

Six Month Summary

"Your Opinion Counts" surveys are mailed to all patients discharged from UMHC with the exception of those previously hospitalized within the past five months and those who have died. Return rate is based on those returned from that months mailing.

NOVEMBER -	1,100 mailed	
	249 returned	- 23%
DECEMBER	931 mailed	
	308 returned	- 33%
JANUARY	1,005 mailed	
	366 returned	- 36%
FEBRUARY	872 mailed	
	308 returned	- 35%
MARCH	1,009 mailed	
	367 returned	- 36%
APRIL	844 mailed	
	342 returned	- 41%

Approximately 1/3 of those returned request follow-up which involves various degrees of problem solving. Thank you letters are sent to those who provide us with complimentary feedback. Overall, patients and visitors are pleased with an opportunity to provide feedback and impressed with the follow-up.

"YOUR OPINION COUNTS"

Six Month Summary

	NOV. %	DEC. %	JAN. %	FEB. %	MAR. %	APR. %
I. General Information						
A. Reasons of choosing UMHC						
Physician's referral	43	40	47	50	49	48
Physician is here	23	21	27	24	24	26
University reputation	16	16	16	11	14	21
B. Average age of patient	36	39	35	?	?	?
	0-93	0-84	0-89	?	?	?
C. Gender						
Female	54	51	51	47	45	52
Male	46	49	42	53	55	48
II. Directions/Registration						
A. Parking difficulty	26	25	23	23	26	24
B. Directions difficulty	15	13	13	19	17	14
C. Reasonable admission time	90	92	99	97	97	92
D. Staff friendliness	99	97	99	97	97	99
III. Accomodations						
A. Room ready and clean	96	92	92	92	93	93
B. Room clean during stay	87	83	85	81	86	89
C. Disturbed by noise	36	38	35	41	39	36
IV. Food Service						
A. Proper temperature	67	71	71	71	72	75
B. Quality of food	74	74	80	78	76	74
C. Food choice satisfactory	83	85	87	88	80	79
D. Received food ordered	89	89	85	85	79	77
V. Physicians						
A. Medical staff introduction	91	94	92	93	93	96
B. Aware of teaching role	88	92	91	90	91	90
C. Positive effect of role	78	74	83	73	81	80
D. Care coordinated	89	91	89	88	90	90
E. Physicians courteous	96	96	97	96	95	99
VI. Diagnostic Procedures						
A. Diagnostic & lab explained	94	93	94	93	92	94
B. Results received	82	78	80	79	77	78
C. Delays in therapy	8	16	7	9	11	6
D. Delays in tests/xrays	18	21	20	17	18	17
E. Delays in surgery	18	20	19	22	21	21
VII. Nursing Staff						
A. Respond promptly	92	89	90	93	91	92
B. Courteous and caring	96	96	97	97	96	98
C. Questions answered	97	97	97	97	96	97
VIII. Hospital Staff						
A. General staff courteous	99	99	99	98	99	99

	Nov. %	Dec. %	Jan. %	Feb. %	Mar. %	Apr. %
IX. Discharge						
A. Received assistance	96	94	96	95	94	95
B. Received meds timely	93	86	90	91	89	90
C. D/c questions answered	93	95	95	94	95	96
X. Overall Impressions						
A. Treated in caring manner	97	96	95	95	95	98
B. Privacy respected	98	94	95	95	96	95
C. Would you choose UMHC again	96	94	93	93	93	95

STAFF SURVEY STATISTICS
APRIL,1986

TOTAL SURVEYS SENT = 4,690

PHYSICIANS	= 850	(18%)
GENERAL STAFF	= 2,370	(51%)
NURSING	= 1,470	(31%)

TOTAL SURVEY RETURNED = 1,302 (28%)

PHYSICIANS	= 304	(23%)
GENERAL STAFF	= 570	(44%)
NURSING	= 428	(33%)

AREA RESPONSE

PHYSICIANS	= 304/850	(36%)
GENERAL STAFF	= 570/2,370	(24%)
NURSING	= 428/1,470	(29%)

UHMC OVERALL SURVEY SUMMARY
(Adjusted Table)

	Almost Never	Sometimes	Generally	Almost Always	Average	Number of Responses
1. In general, the people who work at UMHC treat each other with courtesy and kindness.	21.0 1.7	188.0 14.8	643.0 50.6	418.0 32.9	3.148	1270
2. The UMHC employees are courteous and kind to patients.	5.0 0.4	81.0 6.6	491.0 40.2	644.0 52.7	3.453	1221
3. I see physicians being courteous and kind to patients.	10.0 0.9	166.0 14.5	620.0 54.1	351.0 30.6	3.144	1147
4. In my experience, employee concerns are responded to in a prompt and helpful manner.	152.0 12.7	507.0 42.4	398.0 33.3	139.0 11.6	2.438	1196
5. The people I work with find UMHC to be open to their ideas about courtesy and kindness to patients.	42.0 3.8	223.0 19.9	512.0 45.8	341.0 30.5	3.030	1118
6. The people I work with find UMHC to be open to ideas in general.	138.0 11.3	448.0 36.6	440.0 35.9	199.0 16.2	2.571	1225
7. Patients and visitors are encouraged to voice their concerns.	45.0 4.0	201.0 18.1	415.0 37.3	451.0 40.6	3.144	1112
8. UMHC is a place where courtesy and kindness to patients and visitors are top priorities.	115.0 9.5	343.0 28.4	463.0 38.4	285.0 23.6	2.761	1206
9. My co-workers and I at UMHC clearly understand the Hospitals' expectations of courtesy and kindness to patients and visitors.	48.0 4.0	148.0 12.3	449.0 37.2	561.0 46.5	3.263	1206
10. Management decisions that I am aware of are made with sensitivity to their effect on patients and visitors.	91.0 8.0	363.0 31.8	442.0 38.7	246.0 21.5	2.738	1142
11. Hospital employees are neat and professional in their dress.	65.0 5.1	412.0 32.4	590.0 46.4	204.0 16.1	2.734	1271
12. Physicians are neat and professional in their dress.	44.0 3.5	327.0 26.3	608.0 48.8	266.0 21.4	2.880	1245
13. It has been my experience that courtesy and kindness are rewarded at UMHC.	365.0 31.5	446.0 38.5	247.0 21.3	101.0 8.7	2.072	1159
14. I have seen that staff who are discourteous are reminded and confronted in constructive ways.	364.0 35.4	370.0 36.0	237.0 23.1	56.0 5.5	1.985	1027
15. I am proud to be a part of UMHC.	29.0 2.3	169.0 13.4	442.0 35.2	617.0 49.1	3.310	1257

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

June 20, 1986

Dear Colleague,

This fall we will be launching our new guest relations program called PATIENTS FIRST. The purpose of PATIENTS FIRST is to strengthen and renew the human element in our interaction with patients and one another. In these times of high technology, it's critical that the kindnesses, courtesy, consideration and compassion we give to patients, visitors and each other be superior.

This summer we will be working further on the development of PATIENTS FIRST and we need your help. We'd like you to please attend one of the "Think Tank" meetings scheduled for July 21, 22, and 23, 1986.

The objectives of these 90 minute meetings are:

1. to learn about your perspective and opinion about where we stand with guest relations now; our strong points, our weak points and obstacles that stand in the way of positive guest relations here.

2. to obtain your suggestions and ideas about what our guest relations needs to be in order to ensure its long lasting success.

There will be several such "Think Tank" meetings which will enable us to get a broad cross section of employees involved in the planning stages of our guest relations program, PATIENTS FIRST. Please discuss with your department head or supervisor about which "Think Tank" session will fit best into your work schedule. Your participation is of great importance to this program and we value your input. Attached is a schedule of "Think Tank" sessions. Please choose a session which fits your schedule and return by July 3rd. Your participation will be on paid time.

It is with the active involvement of University of Minnesota Hospital and Clinic staff that our program will be successful. Thank you for joining us in this very important and exciting project.

Sincerely,

C. Edward Schwartz
Hospital Director

PATIENTS FIRST

Think Tanks - Meeting Schedule

Monday, July 21, 1986		
8:30 - 10:00 a.m.	Dining Room II	-Supervisory Group
12:00 - 2:00 p.m.	Bridges Conference Room	-Department Heads
3:30 - 5:00 p.m.	Bridges Conference Room	-Employees
7:00 - 8:30 p.m.	Bridges Conference Room	-Employees
Tuesday, July 22, 1986		
7:30 - 9:00 a.m.	Dining Room II	-Residents
10:30 - 12:00 a.m.	Dining Room II	-Employees
3:00 - 4:30 p.m.	Bridges Conference Room	-Employees
Wednesday, July 23, 1986		
7:00 - 8:30 a.m.	Bridges Conference Room	-Attending Physicians
9:30 - 11:00 a.m.	Bridges Conference Room	-Administration
1:30 - 3:00 p.m.	Bridges Conference Room	-Employees

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

September 5, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The September meeting of the Joint Conference Committee will be held on:

Wednesday, September 10, 1986
4:30 P.M.
8-106 University Hospital

The agenda and background materials for the meeting are enclosed. Due to scheduling constraints we will be limiting the length of our meeting this month. Please expect that the business meeting will conclude about 5:30 p.m. As usual, dinner will be served at the conclusion of the meeting. All committee members and guests are most welcome to stay for supper. I will look forward to seeing you on Wednesday.

cc: David M. Brown, M.D.
Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Robert McCollister, M.D.
Barbara Tebbitt

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NOTE: The Medical School student survey results will be distributed at the meeting. Thank you.

JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, September 10, 1986
4:30 P.M.
8-106 University Hospital

AGENDA

I.	Approval of Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee/Medical Staff-Hospital Council Report and Recommendations	Endorsement
III.	Medical School Student Survey - David M. Brown, M.D. - Robert McCollister, M.D. - Nancy Raymond	Information
IV.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
July 9, 1986

ATTENDANCE: Present: Phyllis Ellis, Committee Chair
Dr. Jack Duvall
Dr. Seymour Levitt
Dr. Michael Popkin
Nancy Raymond

Absent: George Heenen
Nancy Janda
Dr. James Moller
C. Edward Schwartz

Staff: Nancy Green
Greg Hart
Jan Halverson
Barbara Tebbitt

CALL TO ORDER

The meeting was called to order at approximately 4:45 p.m.

APPROVAL OF MINUTES

The minutes of the June 11, 1986 meeting of the Joint Conference Committee were approved as submitted.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

There was no meeting of the Medical Staff-Hospital Council in July.

PATIENTS FIRST PROGRAM UPDATE

Ms. Nancy Green, coordinator of the Patients First program, provided the group with an update on the Hospital's guest relations efforts. She first reviewed a six month summary of the patient survey results. It was noted that the return rate on the survey continues to improve with consistent feedback

through April of 1986. Ms. Green indicated that we will need results through July to determine whether or not the opening of Unit J is affecting patient perceptions as reported through the survey instrument. Ms. Green also indicated that later this year there are plans to initiate a telephone survey of those who do not return the written survey.

The results of the staff survey on our "patients first" climate were then reviewed. Ms. Green also indicated that employee "think tanks" will be conducted late in July, through which additional ideas from employees relative to guest relations will be solicited. The patient survey results, the employee survey results, and the ideas generated from the think tanks will then be used to structure workshops, training programs, and other action items to be implemented in the fall. Ms. Green indicated that she would keep the Committee updated on the progress of the Patients First program.

CLINICAL CHIEFS REPORT

Dr. Levitt and Dr. Duvall reported that recent meetings of the Clinical Chiefs have included discussion of the house staff malpractice report recommendations, management of continued high census levels, and the discussions with Gillette Hospital. Mr. Hart then reviewed the status of the Gillette discussions and the group discussed the pros and cons of a potential relationship with Gillette.

There being no further business the meeting was adjourned at approximately 6:15 p.m.

Respectfully submitted,

Greg Hart

GH/kj

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

September 4, 1986

TO: Joint Conference Committee

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

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

The Credentials Committee of the Medical Staff-Hospital Council has transmitted two reports and recommendations to the Medical Staff-Hospital Council since July. The Medical Staff-Hospital Council approved the committee's recommendations at its August 12, 1986 meeting and will act on the committee's recommendations from its September meeting on September 9, 1986, a day prior to the next Joint Conference committee meeting. The attached report and recommendations has been combined to include recommendations approved in August by the Council and those to be acted upon at the meeting of September 9, 1986.

I am forwarding these recommendations to you for your review and consideration on September 10, 1986. A report will be made as to the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on September 24, 1986.

Thank you.

Attachments

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

September 4, 1986

TO: Joint Conference Committee

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

SUBJECT: Credentials Committee Report and Recommendations

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

Hospital Dentistry	Category
Karl D. Self	Clinical
Dermatology	
Peter J. Lynch	Attending
Family Practice and Community Health	
Patricia M. Cole	Clinical
John Foxen	Clinical
Gregory J. Gepner	Clinical
Medicine	
Neal P. Christiansen	Attending
Robert L. Colbert	Attending
Spencer H. Kubo	Attending
Frak Linn	Attending - ER
Randall S. Moore	Attending - ER/Medicine Clinic
Michael J. Shaw	Attending
Carl W. White	Attending
Obstetrics and Gynecology	
Mark L. Jutras	Attending
William R. Phipps	Attending
Klaus J. Staisch	Clinical
Bruce Work	Attending

Provisional status and clinical privileges recommendations continued:

Otolaryngology	Category
Samuel C. Levine	Attending

Psychiatry	
Frederick G. Hicks	Attending
Barry R. Rittberg	Attending

Radiology	
Andrew H. Cragg	Attending
David G. Drake	Attending
Rene P. du Cret	Attending
William J. Ford	Attending
Timothy L. Larson	Attending
William M. Thompson	Attending

Surgery	
John G. Buls	Clinical
David J. Dunn	Attending
Stuart W. Jamieson	Attending
David A. Rothenberger	Clinical
John G. Shearen	Clinical

Urology	
George A. Haikel	Clinical
Harold J. Hoppmann	Clinical
Keith W. Kaye	Clinical

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

Family Practice and Community Health	Category
John Halvorsen	Attending
Nancy Richardson	Clinical

Regular Appointment recommendations continued:

Medicine	
Kenneth W. Baran	Attending - ER
Peter B. Bitterman	Attending
Brian T. Lew	Attending - ER
Peter B. Meier	Clinical
Andrew G. McGinn	Attending - ER
John R. Raines	Clinical
Gregroy L. Silvis	Attending
Coleman I. Smith	Attending
Randall P. Stark	Attending - ER
Christopher Sullivan	Attending - ER

Otolaryngology	
James I. Cohen	Clinical

Physical Medicine and Rehabilitation	
Rita Bistevins	Clinical

The Committee reviewed a leave of absence from the following physician

Obstetrics and Gynecology	Category
Julius Butler	Attending

The following Specified Professional Personnel (Psychologists) have applied for appointment to the psychology staff and have requested clinical privileges. The Committee hereby recommends approval of these applicants and requests for privileges.

Family Practice and Community Health	Category
Margretta Dwyer	Attending
Michael Metz	Attending

Psychiatry	
William Grove	Attending

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

Family Practice and Community Health	Category
John E. Sutherland	Attending
Laboratory Medicine and Pathology	
Richard K. Sibley	Attending
Medicine	
Adrian Almquist	Attending
T. Barry Levine	Attending
Peter Reissmann	Attending
Joel Taurog	Attending
Neurology	
Allan P. Ingenito	Attending
Radiology	
Bradford Allan	Attending
Dean A. Elias	Attending
Surgery	
Santhat Nivatvongs	Attending

HB/cf

handout at Sept 10 JCC

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

September 8, 1986

TO: Joint Conference Committee Members

FROM: Geoff Kaufmann
Nancy Raymond

SUBJECT: Student/Resident Attitudes of UMHC

Many physicians who have either completed medical school at the University of Minnesota or completed residencies at UMHC do not refer patients to UMHC upon leaving this setting and establishing practices in Minnesota. If they do refer, any pattern of referral takes years rather than months to develop.

There is a growing concern by a number of individuals that negative experiences during the training years here, from any number of source contribute to this lack of referral behavior.

Our goal should be to change the experience so that students and residents feel committed to UMHC after graduation and so that referrals flow earlier as a result.

The major questions we believe need to be answered include:

- Do students and residents have negative experiences at UMHC that affect post-graduation referral patterns?
- What are these negative experiences?
- What can be done to resolve any major problems?
- How can we monitor and support necessary changes?

We conducted a small pilot study of third-year medical students who had completed rotations at UMHC, the results of which are attached for your review. It should be noted that while the Hospital and Medical School share the implications of medical students' experiences, it is the Medical School which has the leadership responsibility for structuring the students' education and experience. The Hospital needs to play a supportive role, largely in terms of organization of patient care, hospital staff interactions, and facility/logistical matters. The Joint Conference Committee discussion should keep those responsibilities in mind; Dr. McCollister and Dean Brown will attend the meeting to discuss the Medical School's perspectives.

/kj

attachment

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
Third-Year Medical School Student Questionnaire

As noted in the cover letter, your individual responses will be kept confidential. Your responses to this questionnaire will help us to create a broader survey tool that will measure our progress in insuring the quality of rotations and residencies at The University of Minnesota Hospital and Clinic. Thank you for your candid responses.

We are requesting information in 3 major areas: the physical environment of the facilities, the quality of interaction with personnel, and the overall educational quality of the program. Based on your experiences in the rotation you are just completing, please give 3 major strengths and weaknesses regarding each area listed below and then rate each area on the following rating scale:

1 = excellent 2 = very good 3 = fairly good 4 = fair 5 = poor

1. Educational quality (e.g., lectures, rounds, and tutoring from attending staff, etc.)

Strengths	Weaknesses
1.	1.
2.	2.
3.	3.

Overall Rating (1-5) 2.7

2. Physical environment in the new University Hospital (e.g., student work space, on call rooms, food in the cafeteria, patient areas, etc.)

Strengths	Weaknesses
1.	1.
2.	2.
3.	3.

Rating 2.75

3. Physical environment in the Mayo building (e.g., lecture halls, purposed on call rooms, etc.)

Strengths	Weaknesses
1.	1.
2.	2.
3.	3.

Rating 3.76

OVER

4. Working relationships with attending staff physicians. (List ways in which your interactions had a positive or negative effect on your experience?)

Positive	Negative
1.	1.
2.	2.
3.	3.

Rating 3.1

5. Working relationships with residents and fellows.

Positive	Negative
1.	1.
2.	2.
3.	3.

Rating 2.5

6. Working relationship with other UMHC staff (nurses, technicians, etc.).

Positive	Negative
1.	1.
2.	2.
3.	3.

Rating 2.42

7. Regarding the weaknesses you mentioned above what do you think are the most important improvements needed in the rotation you are just completing.

8. Will you recommend this rotation at UMHC to other students?

Yes 13 No 8 Undecided ____

9. How did your rotations at UMHC compare overall with rotations at other area hospitals? (Please elaborate)

10. University Hospital, like others, is responding to the current economic environment by shortening length of patient stays. Do you feel this is affecting the quality of education on your clinical rotations, and do you have any recommendations in this regard?

Yes - 1
No - 17

11. If you wish to give me your comments on any other rotations you have done at the UMHC please feel free to do so.

Thanks again for taking the time to complete this form.

Question 1 (Educational quality (e.g., lectures, rounds, and tutoring from attending staff, etc.)
The major strengths of the educational quality were the interested residents, the wide variety of cases, a knowledgeable staff and the availability of experts to consult with and question. Lectures and department conferences were listed as very good, but should be held more frequently. Finally, the responsibility given to students was appreciated by many.

The two major weaknesses listed by almost everyone were that there was too much emphasis on rare and unusual diseases, rather than common ones; there was not enough contact with the attending staff, either because they were too busy or were not interested in teaching the medical students. Other weaknesses were that students felt they were being used for many menial tasks and as errand boys, rounds were too long; lack of time to read and study.

Question 2 (Physical environment in the new University Hospital (e.g., student work space, on call rooms, food in the cafeteria, patient areas, etc.)
The new University Hospital is often described as clean, bright, organized, and having a great view. The patient rooms and resident work rooms were well praised (specifically the resident work rooms with computers at each station).

The most common weakness was lack of space: storage space (lockers), more call rooms, more resident work rooms, private space to study and read. Everyone complained that the food was of poor quality and much too expensive. It was felt that students should at least get meals at a discount price, if not for free. Other weaknesses were lack of parking space, inefficient elevators, and its distance from the library.

Question 3 (Physical environment in the Mayo bulding (e.g. lecture halls, purposed on call rooms, etc.)
The strengths of the Mayo building were the Todd and Eustis lecture halls, available lockers (although in poor condition), multiple skyway connections, and quiet call rooms in Masonic. Other things that were appreciated were clinical lab results on the computer and the accessibility to the medicine room.

The Mayo building was described by most students as run-down, dark, unorganized, dirty, too big, depressing, cramped, etc. It was generally felt that it is hard to get your bearings in the Mayo building and that it was too far for lectures. They also thought that there was a lack of privacy (only curtain dividers) in the patient's rooms and that the call rooms are too far from the wards.

Question 4 (Working relationships with attending staff physicians. (list ways in which your interactions had a positive or negative effect on your experience.)
The most frequent compliment given attending staff physicians was that they were good role models for doctor/patient relationships. Some were described as open and responsive to talking with students, receptive to questions, friendly, and good lecturers. Others were seen as distant, arrogant, and providing little or no feedback.

Question 5 (Working relationships with residents and fellows).
Residents and fellows were considered good teachers and role models (very industrious and methodical). They were receptive to the students' needs and allowed students to formulate patient care plans. They were willing to challenge students and provide them with positive criticism.

It was generally felt that the residents were overworked, which took away from their time to teach and provide feedback.

Question 6 (Working relationship with other UMHC staff - nurses, technicians, etc.)
The nurses were very helpful and friendly. They were very receptive to questions and willing to bring you in and make you a part of the team. They could be serious and fun. Only a few had pre-conceived notions about medical students, making them defensive and unwilling to take initiative.

Question 8 (Will you recommend this rotation at UMHC to other students?)
Yes 13
No 8

Question 9 (How did your rotations at UMHC compare overall with rotations at other hospitals?)
It is generally felt that the quality of the staff and residents is the best. The UMHC is seen as a more formal and academic institution that provided good lectures and interested patients.

Many of the students felt that the residents at UMHC are over worked and treated poorly, resulting in a lower morale than at other hospitals. The attending staff physicians were scattered through the hospital and harder to locate. It also seems that there is less space here than at other hospitals for the students to work. Finally, it has been said that food and parking are provided free of charge or at a discount rate for students at other hospitals.

Some students went as far as saying, "It is the worst rotation I have ever had," because the hours were excessively long (100 hours/week), lack of general information (mostly obscure cases), an excess of "scut" work and poor communication between attending staff physicians and students.

Question 10 (University Hospital, like others, is responding to the current economic environment by shortening length of patient stays. Do you feel this is affecting the quality of education on your clinical rotations, and do you have any recommendations in this regard?
Yes 1
(Medicine - don't get much of a chance to do a work up on patients)

No 17
"It's better for patient recovery to get home as soon as possible"

Creates a higher patient turnover and students get to see more patients per round, as well as a wider variety.

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

October 10, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The October meeting of the Joint Conference Committee will be held on:

Wednesday, October 15, 1986
4:30 P.M.
The Board Room (8-106) University Hospital

The agenda and background materials for the meeting are enclosed. I will look forward to seeing you on Wednesday.

cc: Marjorie Carey
Greg Hart
Jan Halverson
David Hurd, M.D.
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt
Ron Werft

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, October 15, 1986
4:30 P.M.
The Board Room (8-106) University Hospital

AGENDA

I.	Approval of Minutes	Approval
II.	AIDS Task Force Report - David Hurd, M.D. - Ronald Werft	Information
III.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee/Medical Staff-Hospital Council Report and Recommendations	Endorsement
IV.	Clinical Chiefs Report - Jack Duvall, M.D. - Seymour Levitt, M.D.	Information
V.	Adjournment	

PLEASE NOTE: The AIDS Task Force Report will be distributed and discussed at the meeting.

MINUTES
Joint Conference Committee
Board of Governors
September 10, 1986

ATTENDANCE: Present: Phyllis Ellis, Committee Chair
George Heenan
Dr. Michael Popkin
Nancy Raymond

Absent: Dr. Jack Duvall
Dr. Seymour Levitt
Dr. James Moller
C. Edward Schwartz

Staff: Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann

Guests: Marjorie Carey
Dr. Robert McCollister

APPROVAL OF MINUTES

The minutes of the July 9, 1986 meeting of the Joint Conference Committee were approved as submitted.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

Mr. Hart reported on behalf of Dr. Moller on the most recent meeting of the Medical Staff-Hospital Council. The Credentials Committee report was first presented for Joint Conference Committee endorsement. As part of the Credentials Committee discussion, a question was raised regarding whether or not the Medical Staff Bylaws ought to include a requirement for board certification or board eligibility for University Hospital's medical staff. Mr. Hart agreed to carry this question back to the Credentials Committee and the Bylaws Committee for their consideration. The Credentials Committee report was then endorsed as submitted.

Mr. Hart and Mr. Halverson then reported on the Medical Staff-Hospital Council discussion of a policy on patients' rights and

the withdrawal of treatment, developed by the Biomedical Ethics Committee. This policy is meant to serve as a guideline for the medical staff and other clinical staff relative to this sensitive subject. The policy in particular emphasizes the role of and need for patient and family involvement in such decisions.

MEDICAL SCHOOL STUDENT SURVEY

Ms. Raymond presented a survey which she and Geoff Kaufmann had developed on medical student response to their rotations at UMHC. The results of the survey indicate generally that the clinical rotations at University Hospital are of high quality, and also offered some suggestions for improvement. Mr. Kaufmann noted that one of the motivations for this survey relates to the need to view medical students as potential referring physicians in the future.

Another question asked in the study related to the medical students' perceptions of the impact of prospective payment systems on their educational experience. Specifically, is the decreasing length of stay viewed as an impediment to the student's ability to learn about the patients and their cases. The overwhelming response from the medical students was that this is not a concern.

Mr. Kaufmann and Ms. Raymond indicated that they would continue to pursue data collection and follow up on a number of items identified in the survey, and it was agreed that collection of similar data from residents would be of value.

There being no further business the meeting adjourned at approximately 5:30 p.m.

Respectfully submitted,

Greg Hart

GH/kj

UNIVERSITY OF MINNESOTA
TWIN CITIES

Office of the Chief of Staff

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

October 9, 1986

TO: Joint Conference Committee

FROM: James H. Moller, 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 will act on the attached Credentials Committee Report and Recommendations on October 14, 1986, a day prior to the next Joint Conference Committee meeting.

I am forwarding these recommendations to you for your review and consideration on October 15, 1986. I will report the outcome of the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on October 22, 1986.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

October 9, 1986

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

Obstetrics and Gynecology	Category
Linda F. Carson	Attending

Otolaryngology	
Lawrence J. Marentette	Attending

HHB/cf

JCC handout
Oct 15, 1986

STATE OF MINNESOTA

COUNTY OF REDWOOD

IN COUNTY COURT

FAMILY DIVISION

In the Matter of the Welfare of

Lance Tyler Steinhaus,

a Minor

AMENDED
FINDINGS OF FACT AND
ORDER

The above matter came before this court upon the motions of Amy Steinhaus and Dr. David Steinhorn in the Courtroom of the Redwood County Courthouse in the City of Redwood Falls, Minnesota on the 6th day of October, 1986. Mr. David Peterson, Marshall, Minnesota 56258 appeared on behalf of the Redwood County Welfare Department, Ms. Natalie Hauschild, 315 South Washington, Box 377, Redwood Falls, Minnesota 56283 appeared on behalf of the petitioner Amy Steinhaus; Jan D. Halverson, University of Minnesota Hospital and Clinic, Box 708, Harvard St. at East River Road, Minneapolis, Minnesota 55755 appeared on behalf of Dr. David Steinhorn; Cecil Naatz, Attorney at Law, Marshall, Minnesota appeared on behalf of Timothy Steinhaus; Michael Boyle, Attorney at Law, Springfield, Minnesota appeared on behalf of the guardian ad litem and the child..

The motion brought by Petitioner Amy Steinhaus is for an order amending the Findings of Fact, Conclusions of Law and Order of this Court dated September 11, 1986 so as to find that the minor child, Lance Tyler Steinhaus is "chronically and irreversibly comatose" so as not to require resuscitation or other heroic measures as set forth in that except in 42 U.S.C.A. 5102 (3) (B) (Supp.1986); Minnesota Statutes 260.015 Subd. 10 (e) (1) (Supp. 1986).

The motion by Dr. David Steinhorn is for an order to amend the Findings of Fact, Conclusions of Law and Order of September 11, 1986 finding that a decision by the legal custodian to withold treatment other than appropriate nutrition, hydration or medication would not constitute medical neglect or the witholding of medically indicated treatment as defined in Minn. Stat. ss260.015 Subd. (10) e.

The undersigned, upon all the evidence introduced at this hearing and upon all the records and files herein, find as follows:

FINDINGS OF FACT

1. That on August 14, 1986, Dr. David Steinhorn, one of the treating doctors of Lance Steinhaus, testified that the child was in a "persistant vegetative state" and that he also testified that the child was chronically and irreversibly comatose.

2. That on October 6, 1986, the court received the testimony of Doctor Stephen Smith, a pediatric neurologist. That Dr. Smith testified that he had received the medical record of Lance Steinhaus and that he had examined the child on October 1, 2, 4 and 5, 1986. That the Doctor testified that he had received a CAT scan of Lance Steinhaus taken May 20, 1986 and a MR (Magnetic Resonance) Scan taken September 26, 1986.

3. The Court was presented the CAT Scan of Lance Steinhaus' brain which was contrasted with a CAT Scan of a normal brain. That likewise an MR Scan of Lance Steinhaus' brain was contracted to a MR Scan of a normal brain. That Doctor Smith testified that based upon his examination and an examination of the CAT Scan and MR Scan that both of the hemispheres of the child's brain have been "virtually destroyed". He testified that the normal architecture of the brain is missing and that the major areas of the brain have been replaced by fluid.

4. The doctor testified that only area of the brain not completely destroyed is the brainstem. That the brain stem which controls very basic life control systems such as respiration and temperature shows considerable damage.

5. That the doctor testified that based upon his examination and tests that it is his opinion that while the child has some of the criteria of a "persistent vegetative state" that the child does not have the normal "sleep-wake patterns of that state. The doctor testified that the child in his opinion was chronically and irreversibly comatose. The Doctor further testified that in his opinion there are no foreseeable advances in medical science which could hope to improve the child's condition.

6. That it was the opinion of Dr. Smith at appropriate medical practice would dictate that the child be given nutrition, warmth, cleanliness and medication such antibiotics to treat infection. The doctor testified that approprite medical practice would not require resuscitation or intubation or any heroic efforts for the child.

From the above findings the Court makes the following:

CONCLUSIONS OF LAW

1. That the minor child, Lance Tyler Steinhaus is chronically and irreversibly comatose.

2. That State and Federal law require that the child received "comfort care" consisting of appropriate nutrition, hydration, warmth and medication.

3. That Federal Law, 42 U.S.C.A. 5102 (3) (Supp. 1986) and Minnesota State Law, Minn. State ss 260.015, Subd. 10 (e) under the circumstances of this case do not require treatment other than appropriate nutrition, hydration, warmth and medication.

4. That a decision by the legal custodian of the child to withold treatment other than appropriate nutrition, hydration or medication would not constitute medical neglect or the witholdings of medically indicated treatment as defined Minn. Stat. ^{ss}260.015 Subd. 10 (e).

NOW THEREFORE, IT IS HEREBY ORDERED:

1. That the motion of petitioner, Amy Steinhaus is hereby granted.

2. That the motion of petitioner Dr. David Steinhorn is hereby granted.

Dated: October 13, 1986

George I. Harrelson
Judge of County Court

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

September 25, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Chair

REGARDING: Change in October Meeting Date

The October 8, 1986 meeting of the Joint Conference Committee has been changed to Wednesday, October 15, 1986 at 4:30 P.M. in the Board Room.

Kay Fuecker will call to confirm your ability to attend that meeting.

cc: Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt

PE/kf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 6, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The November meeting of the Joint Conference Committee will be held on:

Wednesday, November 12, 1986
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. I will look forward to seeing you on Wednesday.

cc: Marjorie Carey
Nancy Green
Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt

JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, November 12, 1986
4:30 p.m.
The Board Room (8-106) University Hospital

AGENDA

I.	Approval of Minutes	Approval
II.	AIDS Task Force Update - Dr. Moller	Information
III.	"Patients First" Update - Nancy Green - Greg Hart	Information
IV.	Medical Staff-Hospital Council Report - Dr. Moller	Information
V.	Clinical Chiefs Report - Dr. Duvall - Dr. Levitt	Information
VI.	Other	
VII.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
October 15, 1986

ATTENDANCE: Present: Phyllis Ellis, Chair
George Heenan
Dr. James Moller
Dr. Michael Popkin
C. Edward Schwartz

Absent: Dr. Jack Duvall
Dr. Seymour Levitt
Nancy Raymond

Staff: Jan Halverson
Greg Hart
Nancy Janda

Guests: Dr. David Hurd
Ron Werft

APPROVAL OF MINUTES

The minutes of the September 10, 1986 meeting of the Joint Conference Committee were approved as submitted.

AIDS TASK FORCE REPORT

Dr. David Hurd and Mr. Ronald Werft presented the report and recommendations of the AIDS Task Force. Dr. Hurd indicated that Dr. Moller and Mr. Schwartz had appointed this group several months ago to develop recommendations regarding our management of AIDS-related issues. Dr. Hurd then reviewed the Task Force recommendations.

It was noted that the Medical Staff-Hospital Council has received and approved the Task Force recommendations, and that the Council of Clinical Chiefs will be discussing the recommendations in several weeks. Dr. Moller will then report back to the Joint Conference Committee on the status of implementation of the report.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

The Joint Conference Committee received and endorsed the recommendations of the Credentials Committee.

Mr. Hart also reported that the Medical Staff-Hospital Council heard a summary from Jan Brockway on the local PRO contract recently awarded by the Federal Government to the Foundation for Health Care Evaluation. Mr. Hart reviewed the five objectives which the Foundation will be working on with the local hospitals this year. Those objectives include efforts on generic quality screens, adverse outcomes by certain physicians and hospitals, adverse outcomes by certain diagnostic related groups, unnecessary admissions or procedures by certain hospitals or physicians, and unnecessary admissions or procedures by certain diagnostic related groups. It was noted that for two of these objectives the Foundation will be looking in particular at a subset of the total State hospital population, and that it does not appear that UMHC will be part of that subset.

Mr. Hart also indicated that the Semiannual Medical Staff Meeting had been held on October 14, 1986, in conjunction with the University of Minnesota Clinical Associates. Reaction to the meeting content and format, which was primarily directed at the joint efforts of the Hospital and UMCA relative to HMO contracts, was received favorably.

CLINICAL CHIEFS REPORT

Mr. Hart indicated that the most recent Clinical Chiefs' meeting had been devoted to a discussion of the Hospital's new activity level and financial forecast, which will be shared with the Board of Governors' Finance Committee and full Board at the October meetings.

There being no further business, the meeting adjourned at approximately 6 p.m.

Respectfully submitted,

Greg Hart

GH/kjs

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 6, 1986

TO: Members, Joint Conference Committee

FROM: Greg Hart
Senior Associate Director

SUBJECT: "Patients First"

Nancy Green will be joining us at next week's meeting of the Joint Conference Committee to provide an update on the "Patients First" program. The program has moved into a high visibility phase with our employees, as we are now several weeks into training sessions, which will continue for approximately two months. All employees in the Hospital are expected to attend these sessions. Ms. Green will distribute some examples of the materials used for employee training at the Joint Conference Committee meeting.

Also, attached for your information is the most recent three month summary of the returns received from the patient survey.

We look forward to next week's discussion.

GH/kj

attachments

PATIENT RELATIONS

"Your Opinion Counts"

TEN MONTH UPDATE

"Your Opinion Counts" surveys are mailed to all patients discharged from UMHC with the exception of those previously hospitalized within the past seven months and those who have died. Return rate is based on those returned from that months mailing.

NOVEMBER -	1,100 mailed 249 returned	- 23%
DECEMBER	931 mailed 308 returned	- 33%
JANUARY	1,005 mailed 366 returned	- 36%
FEBRUARY	872 mailed 308 returned	- 35%
MARCH	1,009 mailed 367 returned	- 36%
APRIL	844 mailed 342 returned	- 41%
MAY	985 mailed 313 returned	- 32%
JUNE	959 mailed 358 returned	- 37%
JULY	878 mailed 362 returned	- 41%
AUGUST	977 mailed 464 returned	- 47%

Approximately 1/3 of those returned request follow-up which involves various degrees of problem solving. Thank you letters are sent to those who provide us with complimentary feedback. Overall, patients and visitors are pleased with an opportunity to provide feedback and impressed with the follow-up.

"YOUR OPINION COUNTS"
SIX MONTH COMPARISON

	OLD			NEW		
	MAR. %	APR. %	MAY %	JUNE %	JULY %	AUG. %
I. General Information						
A. Reasons of choosing UMHC						
Physician's referral	49	48	49	47	48	56
Physician is here	24	26	12	28	24	21
University reputation	14	21	19	18	23	26
B. Gender						
Female	45	52	52	49	53	51
Male	55	48	40	50	43	48
II. Directions/Registration						
A. Parking difficulty	26	24	22	21	21	31
B. Directions difficulty	17	14	13	10	7	15
C. Reasonable admission time	89	92	88	92	91	92
D. Staff friendliness	97	99	98	98	97	98
III. Accomodations						
A. Room ready and clean	93	93	96	95	98	96
B. Room clean during stay	86	89	90	90	89	89
C. Disturbed by noise	39	36	32	28	32	32
IV. Food Service						
A. Proper temperature	72	75	78	84	81	77
B. Quality of food	76	74	82	83	84	78
C. Food choice satisfactory	80	79	85	83	88	80
D. Received food ordered	79	77	82	80	75	84
V. Physicians						
A. Medical staff introduction	93	96	94	97	94	89
B. Aware of teaching role	91	90	92	91	89	87
C. Positive effect of role	81	80	78	83	85	74
D. Care coordinated	90	90	91	92	88	92
E. Physicians courteous	95	99	97	98	96	99
VI. Diagnostic Procedures						
A. Diagnostic & lab explained	92	94	94	96	98	96
B. Results received	77	78	79	78	86	71
C. Delays in therapy	11	6	11	3	12	10
D. Delays in tests/xrays	18	17	23	12	19	18
E. Delays in surgery	21	21	21	24	20	20
VII. Nursing Staff						
A. Respond promptly	91	92	95	95	92	95
B. Courteous and caring	96	98	99	95	97	99
C. Questions answered	96	97	97	97	98	99
VIII. Hospital Staff						
A. General staff courteous	99	99	99	99	98	98

	OLD			NEW		
	Mar. %	Apr. %	May %	June %	July %	Aug. %
IX. Discharge						
A. Received assistance	94	95	93	98	93	96
B. Received meds timely	89	90	85	81	87	89
C. D/c questions answered	95	96	94	94	93	95
X. Overall Impressions						
A. Treated in caring manner	95	98	97	98	97	98
B. Privacy respected	96	95	97	98	99	98
C. Would you choose UMHC again	93	95	96	98	95	98

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 5, 1986

TO: Joint Conference Committee Members

Jack Duvall, M.D.
George Heenan
Seymour Levitt, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Nancy Raymond
C. Edward Schwartz

FROM: Phyllis Ellis, Committee Chair

The December meeting of the Joint Conference Committee will be held on:

Wednesday, December 10, 1986
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. I will look forward to seeing you on Wednesday.

cc: Marjorie Carey
Al Dees
Greg Hart
Jan Halverson
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, December 10, 1986
4:30 P.M.
The Board Room (8-106) University Hospital

AGENDA

I.	Approval of Minutes	Approval
II.	Severity Indexing Systems - Al Dees	Information
III.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee Report	Endorsement
	• PRO Contract Amendments	Information
IV.	Clinical Chiefs Report - Arndt Duvall, M.D. - Seymour Levitt, M.D.	Information
V.	Other	
VI.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
November 12, 1986

ATTENDANCE: Present: Phyllis Ellis, Chair
George Heenan
Dr. James Moller
Dr. Michael Popkin
Nancy Raymond

Absent: Dr. Jack Duvall
Dr. Seymour Levitt
C. Edward Schwartz

Staff: Greg Hart
Geoff Kaufmann
Nancy Janda
Barbara Tebbitt

Guests: Nancy Green

APPROVAL OF MINUTES

The minutes of the October 15, 1986 meeting of the Joint Conference Committee were approved as submitted.

AIDS TASK FORCE UPDATE

Dr. Moller indicated that the Clinical Chiefs reviewed and endorsed the recommendations and report of the AIDS Task Force. The Medical Staff-Hospital Council had previously approved this report at its October meeting. Dr. Moller indicated that he will now be initiating the necessary actions to implement the recommendations contained in the report, including the appointment of an ongoing committee and the reallocation of beds relative to the AIDS patient population. Ms. Tebbitt indicated that the Bed Allocation Committee will be starting a review of bed allocation in Unit J on November 17.

PATIENTS FIRST UPDATE

Nancy Green reviewed progress on the Patients First program with the Committee. She indicated that employee training sessions are well underway, and that over 3,000 employees will have participated in those sessions by early December. The employees are generally responding well to the training sessions; also coming out of the sessions are employee observations and recommendations on priority systems problems which need the attention of Hospital management. Ms. Green then reviewed some of the materials used in the employee sessions.

It was also noted that the Patients First program will become more visible with the medical staff in December and January, and that Dr. Frank Cerra is leading a group of medical staff who are designing a Patients First program to be used with the physicians.

The most recent data from the patient surveys was also reviewed and discussed. A continuing positive response from patients is evident in the survey. Ms. Green also discussed future information gathering plans which her department will be initiating, including a visit with each patient shortly after admission by a member of the Patient Relations Department.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

There were no action items requiring the Committee's endorsement from the most recent Medical Staff-Hospital Council meeting. Dr. Moller indicated that the meeting was largely used as a planning session for future agenda topics of interest. Assessment of quality, patient severity, and cost were items which the Council expressed particular interest in pursuing further in future months.

CLINICAL CHIEFS REPORT

Mr. Hart indicated that most recent Clinical Chiefs meetings have included presentation of the AIDS Task Force report, and presentation of a plan for operation of the new patient and visitor parking ramp. Clinical Chiefs meetings in the next several weeks will include discussion of graduate medical education, a visit from Senator Durenburger's new health aide, and a visit from Dr. Arthur Kaplan, new director of the Center for Biomedical Ethics.

OTHER

Mr. Hart reported that the Council of Community Hospitals price disclosure project will likely be reported on by the media in the next few days. The COCH price data indicates that University Hospital is at a level approximately 20% higher than the community norm for the case mix groups studied.

The COCH price data led into a discussion about the importance of attempting to quantify differences in types of patients seen at University Hospital compared to those seen at other hospitals. The concept of severity measurement was also a major topic at a recent Metro Trustees Conference; Mr. Hart and Mr. Heenan discussed the MEDISGRPS system which was presented at that conference. Mr. Hart indicated that Mr. Al Dees will be making a presentation to the Joint Conference Committee at its December meeting on severity measurement systems. The Committee agreed that this will be an important agenda topic in the future, and that the Committee's work plan should incorporate this subject as a priority item.

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

Respectfully submitted,

Greg Hart

GH/kj

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 5, 1986

TO: Members of the Joint Conference Committee

FROM: Greg Hart
Senior Associate Director

SUBJECT: Severity Indexing Systems

At last month's meetings of the Joint Conference Committee and the Board of Governors the importance of future use of severity indexing systems was discussed. We indicated that a more formal presentation on this subject would be made on this subject in December.

Mr. Al Dees, Associate Director, will join us on December 10th to lead a discussion on this important subject. Attached is some introductory material on severity indexing which you may wish to review prior to the meeting. Mr. Dees will present additional background information next week, and, presuming Committee interest, we would intend to make follow-up presentations on our future plans and actions.

We look forward to the Committee discussion.

Text of Testimony Given To The

SENATE SPECIAL COMMITTEE ON AGING

November 12, 1985

by SUSAN D. HORN, Ph.D.

The introduction of prospective payment of hospitals, based on DRG classification, has been a positive initial step toward cost containment in the health care industry. However, experience over the last two years suggests that there are important ways in which the system can be improved. In a prospective payment system based on fixed payments per case within a group, it is critical that patients classified together require similar quantities of resources. Large differences in resource consumption within groups lead to unintended financial risk for hospitals, undesirable incentives for poor quality of care through mechanisms such as premature discharge, and improper profit through opportunistic patient selection.

Research shows that most DRGs classify together patients who require widely different resources[1,2,3]. This is reflected by the fact that the DRGs explain only about 30% of the differences in hospital resource use per case[1,4,5,6,7].

Further research confirms the clinical intuition that differences in the severity of illness of patients explain a large part of the remaining differences[4,5,6]. Several examples will illustrate this point. Figure 1 demonstrates how the average cost per case for patients in DRG 403 (Lymphoma or Leukemia, Age $\geq$ 70, and/or Complication or Comorbidity) varies both by severity of illness and by whether or not the patient had an operating room

procedure. Neither factor is recognized within this DRG.*[1] Hospitals that treat proportionately greater numbers of the more severely ill patients can be substantially under-paid. A hospital receives about $4000 for each patient in DRG 403, although this hospital's average cost per patient in DRG 403 was $6288.

A common disease among the elderly, Chronic Obstructive Pulmonary Disease, (DRG 88) is represented in Figure 2. The data are from two hospitals; Hospital A is a university teaching hospital with an average cost per case of $2703, and Hospital B is a community hospital with an average cost per case of $5078. The community hospital's average cost is almost twice that of the university teaching hospital because the patients in the community hospital are more severely ill. There are nine patients in severity levels 3 and 4 in the sample from Hospital B, while there is only one such patient in the sample from Hospital A. Thus, adverse impact of severity of illness differences in DRGs is not restricted to university teaching hospitals. Type of <u>hospital</u> is not the issue, but rather the type of <u>patient</u>. The current DRG-based prospective payment system, even with multiple adjustments for teaching status, urban and rural status, proportion of indigent patients, and tertiary referral center designation (all attempted surrogates for severity), does not adequately recognize this[4,5,6,8].

These are not atypical examples. In a recent study funded by HCFA, 94% of the DRGs were found to contain a wide variation of severity[4,5]. The

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[1]Patient severity is quantified by a four-level scale of increasing severity from level one to level four. Procedures are classified into three groups: non-operating room, moderate operating room, or major operating room, according to a fixed table for all procedures.

result is that when hospital payments are based on DRGs alone, some hospitals will be greatly over-paid and others will be greatly under-paid[4,6]. This is demonstrated in Figure 3, where we have simulated paying each of 14 studied hospitals on the basis of an unadjusted DRG payment system, shown in red, and on the basis of a severity-adjusted DRG payment system, shown in blue. Both payment mechanisms are budget neutral; the total amount of money paid out to the 14 hospitals is the same under both systems. However, unadjusted DRGs result in much greater over-payments and under-payments than severity-adjusted DRGs[4,6]. The severity-adjusted system is fairer, relies less on internal cross-subsidization, and sends rational market signals to the hospitals.

If the DRGs were adjusted for severity of illness, many disincentives in the current prospective payment system could be diminished or eliminated altogether. In particular:

1. Hospitals treating a less severely ill case load would not be UNDULY REWARDED; over-payment of less severely ill cases using the present DRG system provides no incentive for the efficient production of services.

2. Hospitals treating a more severely ill case load would not be UNDULY PENALIZED; patients who are more severely ill have justifiably higher costs which must be paid for somehow if these hospitals are not to be bankrupted and our national treatment system destroyed.

3. There would be no incentive to over-admit less severely ill patients, since the level of payment for such patients would be reduced.

4. The incentive for premature discharge of sicker patients, or

"dumping" of the more severely ill, would be reduced if the justifiable extra costs of caring for such patients were appropriately paid for.

5. Improved control of resource use would result from a more accurate matching of resource requirements to each patient's burden of illness. One hospital now using severity of illness classification for internal management purposes has estimated that as much as 30% of variable costs could be saved by evaluating resource use by severity level.

6. Atypically high patterns of resource use at the hospital level or at the physician level can be more easily identified, and then corrected, when severity grouping is used.

Prospective payment has, in principle, many excellent incentives to control health care costs. However, steps to control or reduce costs should be equitable and should provide incentives to maintain high quality care. A patient classification system used for prospective payment should be fair and should accurately describe a patient's resource needs. It is clear that DRGs alone are too coarse for this purpose, and research has shown that the surrogates now being used for severity of illness do not adequately address the differences. If DRGs were modified by a direct severity of illness adjustment, a large part of the present inequity in payment could be avoided, all hospitals would have improved incentives to deliver efficient and high quality care, no matter what the age or wealth of the patient, and government expenditures for hospitalization could be more effectively restrained.

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HCFA Administrator Dr. Carolyne Davis and two other correspondents (together with our comments) were published as Letters to the Editor in the October 31, 1985 issue of the New England Journal of Medicine, pages 1163-1165.

Figure 1

DRG 403 – LYMPHOMA OR LEUKEMIA AGE > 70 AND/OR C.C.

WAGE-ADJUSTED COST

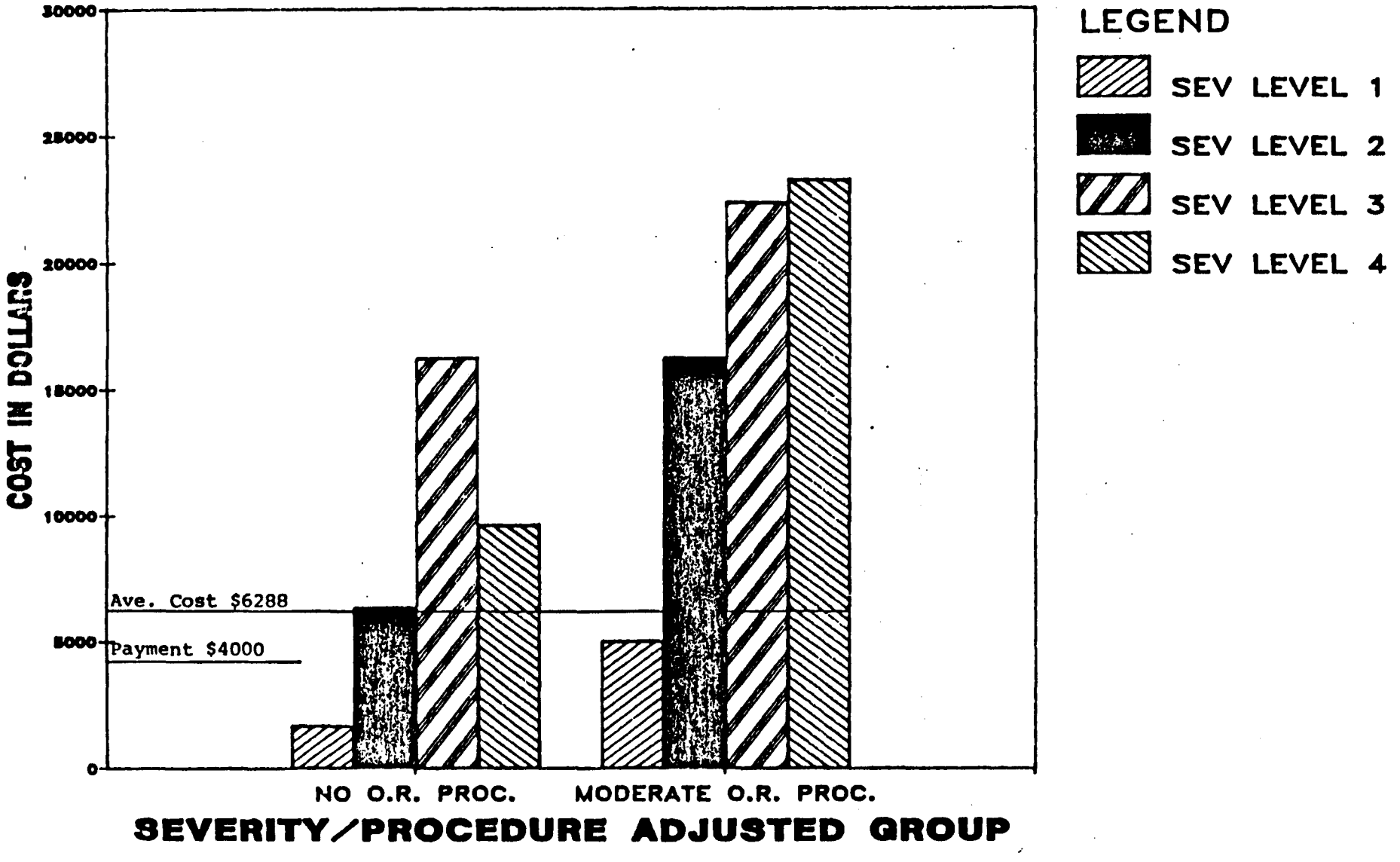


Figure 2

DRG 88
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
WAGE-ADJUSTED COST

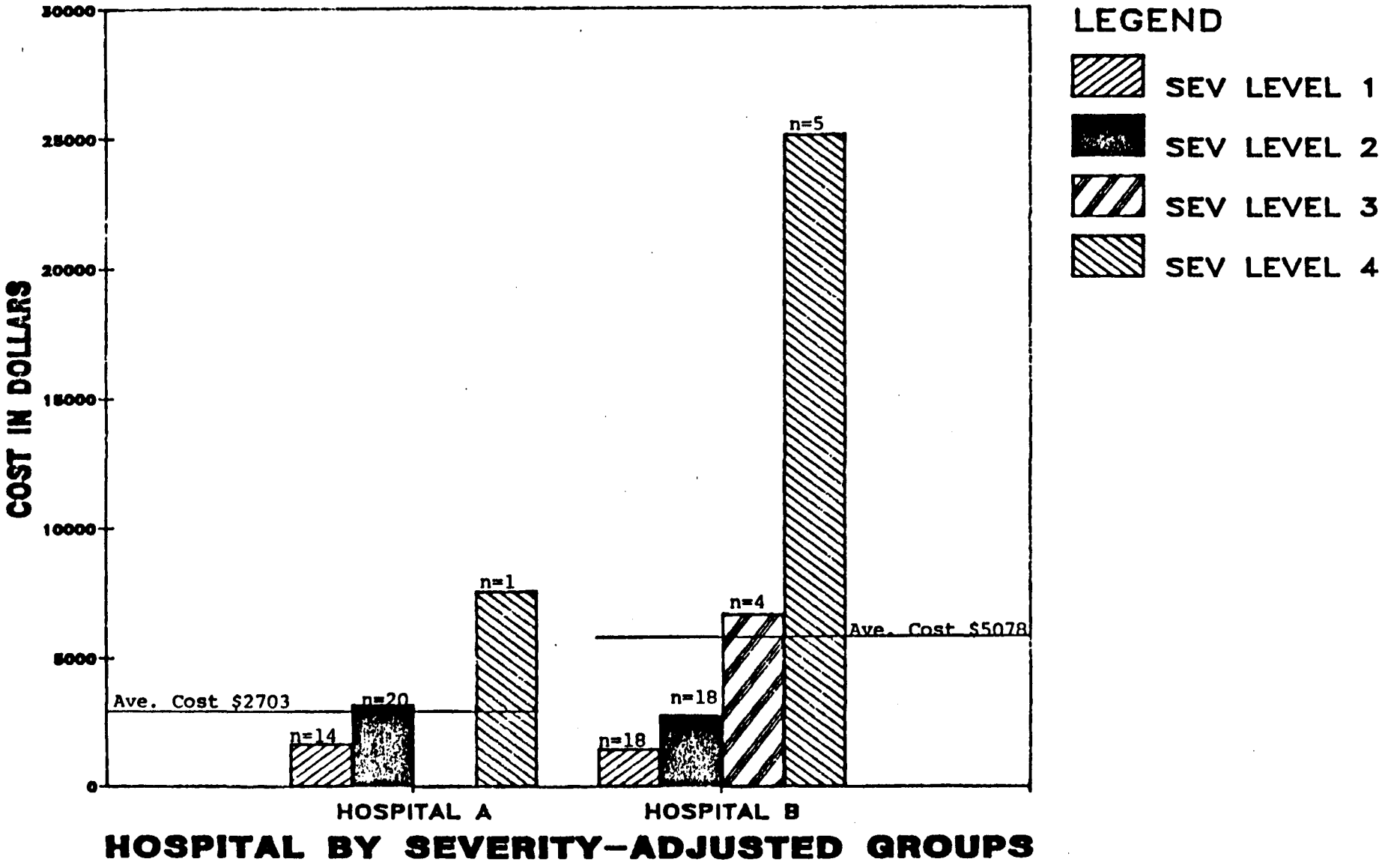
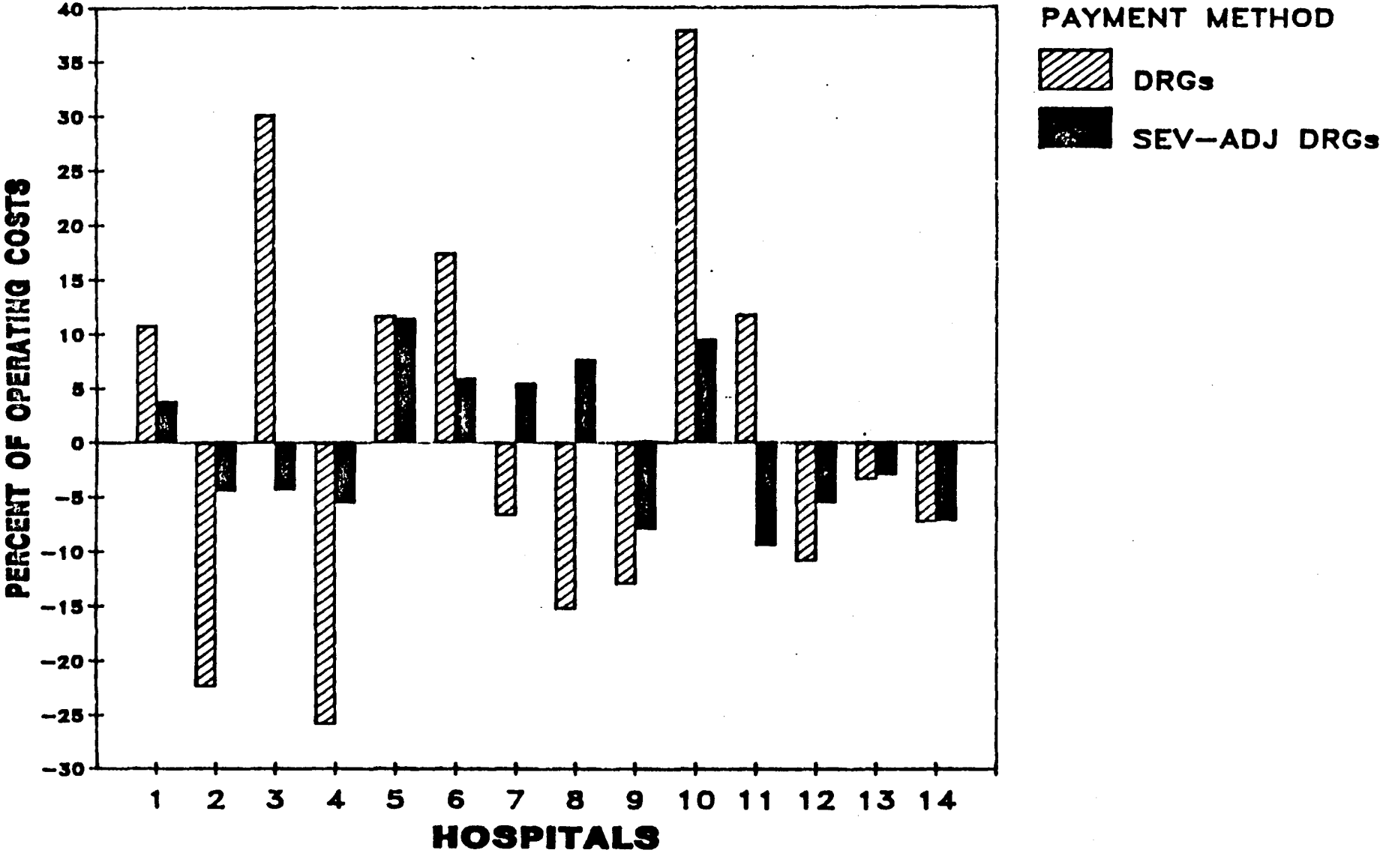
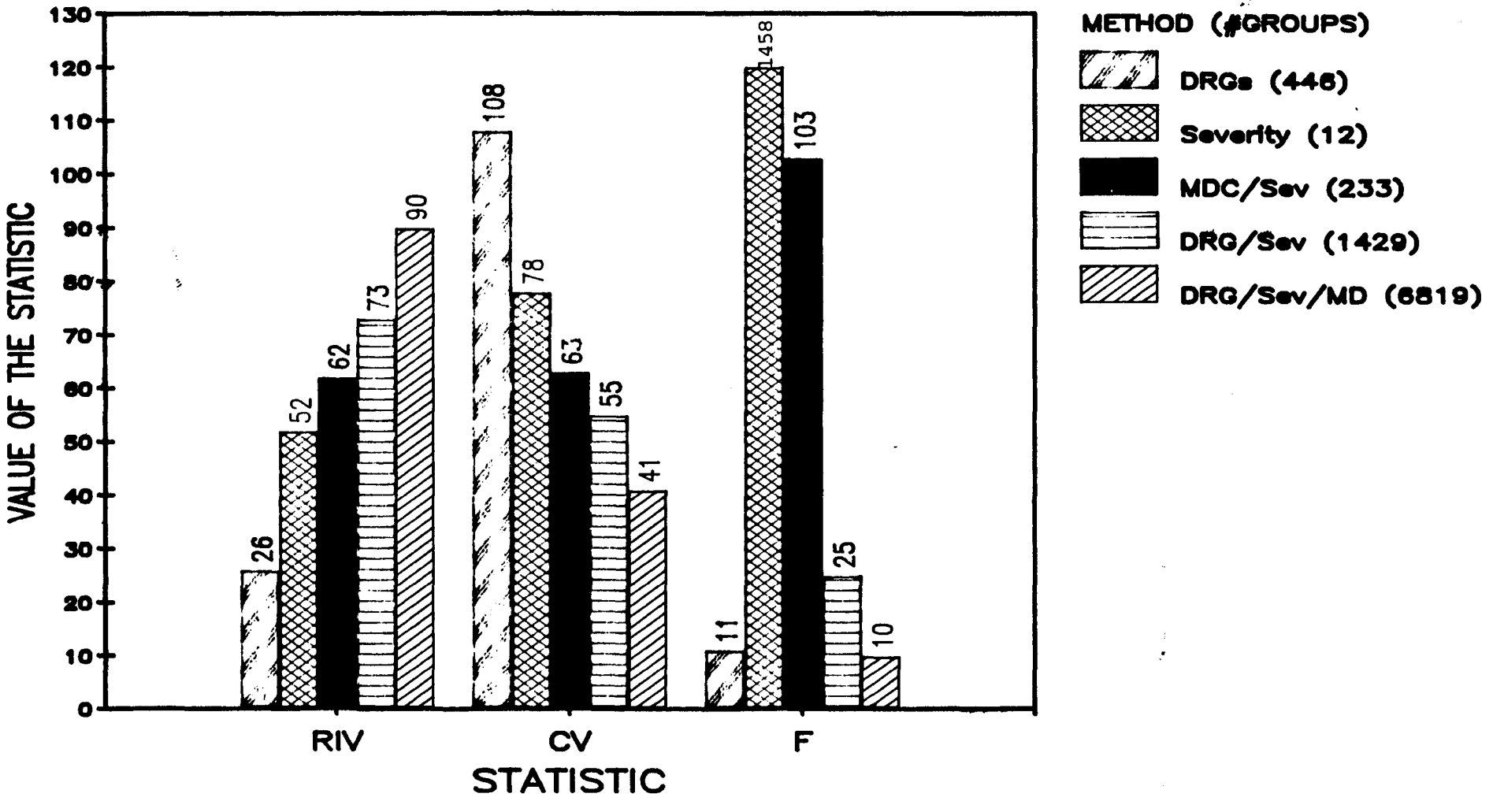


Figure 3

IMPACT ON PROSPECTIVE PAYMENT
OVERPAYMENTS AND UNDERPAYMENTS AS A PERCENT OF TOTAL OPERATING COSTS



COMPARISON OF CASE-MIX METHODS
CHARGE DATA - ALL MDCs COMBINED
HOMOGENEITY STATISTICS N = 15,043
UNIVERSITY OF MINNESOTA HOSPITAL



FY83 QC Inc 4/20/84

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 3, 1986

TO: Joint Conference Committee

FROM: James H. Moller, 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 will act on the attached Credentials Committee Report and Recommendations on December 9, a day prior to the next Joint Conference Committee meeting.

I am forwarding these recommendations to you for your review and consideration on December 10. I will report the outcome of the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on December 17.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 2, 1986

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

ANESTHESIOLOGY	CATEGORY
Ellen L. Finch	Attending
DERMATOLOGY	
Mitchell E. Bender	Clinical
MEDICINE	
Kathryn E. Dusenbery	Attending - ER
Connie L. Manske	Attending
Roderick P. Robertson	Attending
David B. Staub	Attending - ER
Robert F. Wilson	Attending
RADIOLOGY	
Christopher C. Kuni	Attending
Robert E. McGeachie	Attending
Richard J. Patterson	Attending
William A. Wilcox	Clinical

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

SURGERY	CATEGORY	PRIVILEGES
Bruce L. Cunningham	Clinical	**Add**-Extremity transplants, extremity harvesting
Victor Gilbertsen	Attending	**Delete**-All surgical privileges
UROLOGY		
Pratap K. Reddy	Attending	**Add**-Extracorporel shockwave lithotripsy

PEDIATRICS	FROM	TO
Thomas B. Ferrara	Attending	Clinical

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

HOSPITAL DENTISTRY	CATEGORY	DATE ELIGIBLE
William P. Hoffmann	Clinical	August 26, 1986
Robert E. Derr	Clinical	August 26, 1986
MEDICINE		
N. L. Gault	Attending	August 26, 1986
Gary Baker	Clinical	August 26, 1986
PEDIATRICS		
Bruce R. Blazar	Attending	August 26, 1986
Helena B. Kosina	Clinical	August 26, 1986
Gary J. Remafedi	Attending	August 26, 1986
John C. Ring	Clinical	August 26, 1986
Chester B. Whitley	Attending	August 26, 1986

Regular appointments continued:

UROLOGY		
Cesar Ercole	Clinical	August 26, 1986
Erol Uke	Clinical	August 26, 1986

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

ANESTHESIOLOGY	CATEGORY
Edward Hanisch	Attenting
HOSPITAL DENTISTRY	
Thomas J. Dixon	Clinical
FAMILY PRACTICE AND COMMUNITY HEALTH	
John Foxen	Clinical
John H. Kiernan	Attending
LABORATORY MEDICINE AND PATHOLOGY	
Bonnie S. Bean	Attending
Edward P. Scott	Attending
MEDICINE	
C. Vicky Thomas	Attending
I. Dodd Wilson	Attending
PEDIATRICS	
Ann C. Dunnigan	Attending
RADIOLOGY	
John D. Roll	Attending

HB/cf

Joint Conference Committee
Handout
December 10, 1986

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 5, 1986

Ms. Julie Sanderson
Director of Medical Services
Foundation for Health Care Evaluation
Suite 700
One Appletree Square
Minneapolis, Minnesota 55420

Dear Ms. Sanderson,

Thank you for forwarding the new appendices to the PRO/Hospital agreement, and for providing us with the opportunity for comment. The University of Minnesota Hospital has reviewed the new appendices, and while we continue to support the Foundation's federally mandated responsibilities of a Utilization and Quality Control Peer Review Organization (PRO) we believe there are a number of areas that require further change.

(1) Twelve of the appendices (PRO Random Sample Review, PRO Focused DRG Review, PRO Readmission Review, PRO Medicare Code Editor Review, PRO Transfer Review, PRO Cost Outlier Review, PRO Day Outlier Review, PRO Notice of Noncoverage Review, PRO Review for Cases Referred by Fiscal Intermediary, PRO Non-Covered Admission Review, PRO Specialty Hospital Review, and PRO Percutaneous Lithotripsy Review) contain a review process relative to quality of care. Specifically, as stated in these appendices, the review, in every case, will include (a) discharge review to detect premature discharge and (b) generic quality review to detect quality issues.

With this new emphasis on quality of care, we find that a major shortcoming of the contract is the absence of a description of the steps that will be taken when the PRO review of an individual case results in a determination of substandard quality of care. Given the potential consequences of a determination of substandard quality of care we believe it is essential that the responsible staff physician and the hospital be provided with the specifics of each determination with an opportunity to submit additional information and to request a reconsideration. As has been done for denial and DRG change determinations, this notification should be carried out within a specified period of time following each PRO determination of substandard quality of care, e.g. 30 days.

This provision for notification and response should be delineated in the Review Process section found in each of the twelve appendices as has been done for denial and DRG change determinations.

(2) Similar to our concern identified above but specific to the PRO Readmission Review Process, the contract does not provide a description of the steps that will be taken when there is a determination that a premature discharge occurred. If a premature discharge determination is made and classified and handled as a substandard quality of care issue, we believe this determination must be clearly communicated to the attending physician and the hospital and they must be given the same opportunity for early input as is described in 1. above. To date, we have found that premature discharge determinations have not always been communicated clearly.

(3) We have a number of recommendations with regard to the PRO Sanction Process. As you are well aware, our experience in this regard has been of great concern to us. We believe the following recommendations will strengthen the review process, ensure necessary due process, and result in an improved situation for both the PRO and the local hospitals.

(a) While section IV. C. states that the PRO will "apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within its geographical area, or national norms, where appropriate, to ensure that all practitioners under its monitoring authority continue to meet their obligations.", we have never been provided with any norms (i.e. casemix adjusted rates for mortality, morbidity, or other indicators used to judge clinical performance) despite our repeated requests for such data. Further, based on our experience with the sanctions process, determinations of substantial or gross and flagrant violations are being made without any comparison with norms, many of which are readily available in the literature. We would recommend that the contract require communication of such norms as well as reference to the validating source for such norms, preferably literature-based.

(b) Regarding selection of members of Subcommittees that will review the performance of practitioners or providers, we believe each individual should be required to sign a statement that clearly declares that he/she has no conflict of interest concerning the practitioner or provider under investigation.

(c) Regarding the Subcommittee review process, we believe that when the subcommittee reviews "all available information" the information must include all information received from the practitioner or hospital in response to the individual determinations of substandard care, inappropriate admissions, or unnecessary hospital days or medical services, and that this should be an obligation of the PRO stated in the contract.

(d) Again regarding the Subcommittee review process, it would seem appropriate that the involved physician and hospital contractually have the opportunity to provide information to and meet with the Subcommittee prior to its potentially reaching a conclusion of "problem verified." This will result in a greater amount of information being available in the fact-finding stages of the review, rather than in the appeal process, and may avoid unnecessary adversial proceedings.

(e) Page 4 of the sanction appendix refers to an overview of the PRO Intervention Process. Either the Intervention sections contained in the contract need to provide the specific steps of the intervention process or a separate appendix outlining the steps should be added.

(f) We note that copies of sanction notices of alleged practitioner violations are not sent to the hospital. We strongly disagree with this practice since it is the hospital that assumes responsibility for monitoring the quality and appropriateness of care and it is the hospital and not the individual practitioners that sign the contract with the PRO. The contract should thus require hospital notification concurrent with notification of the practitioner. The Foundation's past practice has been highly inconsistent in this regard.

(g) The contract states that legal counsel is excluded from the initial hearing of a substantial violation charge. Under what statuatory regulation is this based?

(h) Based on our experience with the sanction process we believe Sections A.3. and A.6. under Due Process need to be rewritten to reflect the need for the FHCE to obtain approval from the FHCE Board before acting on any sanction process determination made by the Medical Standards and Practice Committee. Also, as stated earlier, these sections should reflect the need for the PRO to notify the hospital as well as the practitioner of any recommended sanctions.

(i) The contract should also clearly state that the PRO cannot submit any information to OIG or to any other professional or governmental agency until (1) it has completed the entire review process, fully involving the practitioner and the hospital, and (2) it has obtained full review and approval of all determinations by the FHCE Board.

4. The appendices outlining review of noncovered services and preadmission review do not include timeframes during which the PRO is to complete its review. We would ask that these be added.

5. The Intensified Review Process states that the DRG Error Rate is determined by dividing "Cases with a DRG assignment change" by "All Cases in the 3% random sample." It is our understanding the numerator should be "Cases in the 3% random sample with a DRG assignment change."

6. The original appendix titled PRO Acquisition; Protection, and Disclosure of Peer Review Information is not included in the replacement appendices. We believe it is essential that this Appendix be re-instated as a part of the agreement.

7. The August 1, 1984, PRO/Hospital Agreement to which these appendices will be attached states "The parties further agree that the PRO may amend the Appendix to this Agreement, provided that it notifies the Hospital of any proposed amendment, allows the Hospital thirty (30) days to comment on the amendment, and notifies the Hospital of the final amendment at least ten (10) days prior to its effective date." Numerous programmatic changes were made during the 1984-86 contract period not always with corresponding updates to the Appendix. Further, the comment period was rarely, if ever, observed. We would request that during this second two-year period this important aspect of the agreement be closely followed.

We hope our comments will result in the changes which we believe are needed for a positive peer review process. We thank you for giving us an opportunity to provide our input.

Sincerely,

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

C. Edward Schwartz
Hospital Director

cc. Steve Rogness, Minnesota Hospital Association
John Herman, Methodist Hospital
Shari Levy, United Hospital
Jim Roseveer
Calvin Brandt, M.D., Chairman of the Board

TABLE OF CONTENTS

****OTHER ATTACHMENTS****

The University of Minnesota Hospital and Clinic
Board of Governors

November 19, 1986
1:30 P.M.
The Board Room, The University Hospital

AGENDA

I.	Approval of October 22, 1986 Minutes	Approval
II.	Chairman's Report - Ms. Barbara O'Grady	Information
III.	Legislative Update - Mr. John Kingrey Vice President of Government Relations Minnesota Hospital Association	Discussion
IV.	Hospital Director's Report - Mr. C. Edward Schwartz	Information
V.	Committee Reports	
	A. Planning and Development Committee Report - Mr. Robert Latz	
	1. Policy on Gifts and Gratuities	Approval
	2. Quarterly Purchasing Report	Approval
	B. Joint Conference Committee Report - Ms. Phyllis Ellis	
	1. "Patients First" Update	Information
	C. Finance Committee Report - Mr. Robert Nickoloff	Information
VI.	Other Business	
VII.	Adjournment	

MINUTES

Board of Governors

The University of Minnesota Hospital and Clinic

October 22, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the October 22, 1986 meeting of the Board of Governors to order at 1:40 P.M. in the Board Room of the University Hospital.

ATTENDANCE:

Present:	Leonard Bienias David Brown, M.D. Shelley Chou, M.D. Al Hanser George Heenan Robert Latz Jerry Meilahn James Moller, M.D. Barbara O'Grady C. Edward Schwartz Neal Vanselow, M.D.
Absent:	Phyllis Ellis Kris Johnson David Lilly Robert Nickoloff Nancy Raymond

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the September 24, 1986 meeting as written.

CHAIRMAN'S REPORT:

Chairman Barbara O'Grady introduced Ms. Marjorie Carey, Administrative Fellow, and Ms. Dee Lutz from the Minnesota Daily.

Chairman O'Grady reported that the Board of Governors Executive Committee met on October 9, 1986 to discuss the outcomes of the Board of Governors Retreat

and a work plan for the Board of Governors for the coming year. The Committee recognized the importance of continuing to explore the relationship of the hospital and the medical staff.

The Committee discussed the current work method of the Board and made the following suggestions:

- The Board should continue to receive Committee minutes each month but devote less attention to the routine business items of the Board.

- More time should be allotted to review of major strategy items.

Chairman O'Grady suggested that John Kingrey, the MHA lobbyist, be invited to the November meeting, to discuss the upcoming legislative issues that will be of concern to The University of Minnesota Hospital and Clinic. Chairman O'Grady also suggested that Helen Darling, a legislative assistant for Senator Durenberger, meet with the Board to discuss some of the new federal programs and policy implications.

Chairman O'Grady introduced a video tape on board self-evaluation. The Board discussed the process of self-evaluation and Chairman O'Grady indicated that a questionnaire will be distributed to Board members in December to solicit impressions of Board performance.

Chairman O'Grady brought to the Board's attention a news summary that will be issued monthly by the Metro Trustee Council. The newsletter was developed in an effort to improve communication among hospital trustees in the Twin Cities.

Chairman O'Grady also reminded the Board of the October 31, 1986 Metro Trustee XIII Conference entitled "The Quest for Quality: The Next Competitive Wave" and suggested that members interested in attending contact Kay in the Board Office.

Chairman O'Grady congratulated Ms. Barbara Tebbitt for receiving the Moline Recognition Award given by the Minnesota Organization of Nurse Executives. The award recognizes leadership and innovation in nursing administration.

HOSPITAL DIRECTOR'S REPORT:

Mr. Schwartz discussed two pieces of correspondence sent to members of the Board from a representative of the Burroughs Corporation regarding the Hospital's computer needs in financial accounting. In sum, Mr. Schwartz noted that software and hardware options for the general ledger system are still being evaluated. The Board will be asked to approve the expenditure of funds for this acquisition in November.

Secondly, Mr. Schwartz noted that the Hospital was very well represented at the National Leadership Homecoming and at the September 21, 1986 Minnesota Medical Foundation dinner. He spoke briefly about the purpose of each event.

The Tonka Toy Company, Mr. Schwartz reported, contributed the funds and the actual time and effort of its staff to build a play area for pediatric patients and their siblings. The playground is located in the courtyard between Diehl Hall, Mayo and the University Hospital.

Lastly, Mr. Schwartz noted that the Hospital Consolidated Fund Drive, headed this year by Mr. Al Dees, is underway. The Hospital will be included in the community's hospital data base this year so we have the opportunity to compare our results with the other hospitals in the metropolitan area.

FINANCE COMMITTEE REPORT:

Mr. Meilahn and Mr. Cliff Fearing highlighted the Report of Operations for the period July 1, 1986 through September 30, 1986. Mr. Fearing reported that admissions are running 5.7% over budget. Patient days are 4.7% over budget. The average length of stay is 8.1 days vs. the 8.2 days originally budgeted. Outpatient clinic visits are 5,600 ahead of budget now, with 62,000 clinic visits for the first quarter; a 10.1% variance. Revenue over expense for the first quarter totalled $1,883,298; a favorable variance of $3,094,036.

The Board discussed the current trend in payment practices of third party payers. Two contracts, Blue Cross/Blue Shield and the Indian Health Service contract, are currently up for renewal. Both groups have proposed some very significant changes to current contracts. The Board of Governors Executive Committee will meet to discuss the contract proposals and to discuss general negotiating strategies for these and other contractual arrangements.

Mr. Meilahn and Mr. Fearing reviewed the bad debts for the period July 1, 1986 through September 30, 1986. Bad debts less those recovered for the period totalled $359,132.62. The Board of Governors seconded and passed a motion to write off the bad debts as submitted by the Finance Committee.

Mr. Greg Hart reviewed the merit pay plan for approval by the Board of Governors. This new compensation plan is intended as a management tool that will allow supervisors to recognize and reward superior performance. The plan will cover approximately 40% of all hospital employees. It will not be extended to our unionized employees, our general staff nurses or to our pharmacy staff. The members of the Board suggested that good communication with the employees and quality performance evaluations would be essential to the successful implementation of a merit based compensation system. The Board seconded and passed a motion authorizing the administrative staff to proceed with the design of a merit pay plan for 1987-88 and to announce to hospital employees that performance will become a consideration in next year's pay plan.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Mr. Latz noted that the Policy on Gifts and Gratuities was inadvertently included in the Board materials. The policy has not yet been endorsed by the Planning and Development Committee.

Mr. Greg Hart introduced three computer related projects that will be brought to the Board of Governors in the near future. The laboratory computer project is proceeding ahead of the other two. The computer system for Financial Accounting will be reviewed in more detail by the Planning and Development Committee in November prior to review by the Board. The third project, an upgrade of the central mainframe hardware, will be presented after the first of the year. Each of the three projects was anticipated in the Hospital 1986-87 budget.

Mr. Al Dees traced the development of the laboratory data system, the status of the current system, the cost of the proposed replacement and the financing options for the acquisition. The total cost of replacing the lab computer system is $1,500,000. The Board of Governors seconded and passed a motion to approve the acquisition of the laboratory computer system as presented.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan reported that the AIDS Task Force report was presented by Dr. David Hurd and Mr. Ron Werft at the Joint Conference Committee meeting. That report will be reviewed again by the Joint Conference Committee and will be discussed with the Board in the future.

The Committee spent considerable time discussing the PRO contract recently forwarded by the Federal Government to the Foundation for Health Care Evaluation. The Foundation will apparently be working in five areas with local hospitals this year. Those efforts include generic quality screens, adverse outcomes by certain physicians and hospitals, adverse outcomes by certain diagnostic related groups, unnecessary admissions or procedures by certain hospitals or physicians and unnecessary admissions or procedures by certain diagnostic groups.

OTHER BUSINESS:

The Board of Governors discussed their monthly meeting time and concluded that the 1:30 P.M. start time remains a convenient one. Increased efforts will be made to start the meetings promptly.

ADJOURNMENT:

There being no further business, the October 22, 1986 meeting of the Board of Governors was adjourned at 3:52 p.m.

Respectfully submitted,

Kay Fuecker

Kay Fuecker
Secretary, Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 14, 1986

TO: Members of the Board of Governors

FROM: C. Edward Schwartz C. E. Schwartz
Hospital Director

REGARDING: Legislative Update

On November 19, 1986 Mr. John Kingrey will be coming to our Board meeting to discuss several health care related issues that will be examined by the state legislature in the coming months. A summary of those issues is attached for your review.

Mr. Kingrey is the Vice President of the Government Relations Division of the Minnesota Hospital Association. From 1976-1978 Mr. Kingrey served as an Administrative Assistant to Governor Perpich. From 1978 to 1980 he served as an Assistant to the House Health and Human Services Committee and has been with the Minnesota Hospital Association since 1981.

Please join me in welcoming Mr. Kingrey for what we expect to be a very informative discussion.

Thank you.

CES/kff

Attachments

MA/GAMC

Background:

As in past years, the 1985 Legislature provided an increase in government assistance programs but below the level of inflation. For fiscal years 1985 -1987, the hospital inpatient rate was capped at 5%. The cap is set to expire on June 30, 1987. The Legislature also continued to phase-out the GAMC ratable reductions. For FY 1987, the ratable reductions are 15% for inpatient hospital CD and MI services, 10% for all other inpatient hospital care, and 5% for outpatient care, prescription drugs, etc. Like the inpatient hospital cap, the GAMC ratable reductions are due to sunset on June 30, 1987. In addition, the 1985 Legislature increased the fees to medical care providers (impacts hospital outpatient reimbursement) for the first time in six years. Payments to medical care providers rose to the 50th percentile of 1982 usual and customary rates for both MA and GAMC.

At this time, state agencies are assembling their biennial budgets. It appears that the Governor is directing the agency heads to hold down their increases and requests for new programs in order to have money available for tax relief.

To a large extent, what happens to increases under MA/GAMC will depend on the fate of any prepaid/capitation legislation under consideration and the amount of dollars left in the state coffers after the Governor provides for tax relief.

Recommended Member Action:

Area legislators should be informed of the increased disparity between the cost of providing service under government programs and what MA/GAMC will pay. In many cases, hospitals are being reimbursed 55¢ - 65¢ for every $1.00 of care provided. Other third-party payers (especially HMOs) are no longer willing to let hospitals shift these shortfalls. This results in a further erosion of hospitals' financial solvency and may lead to closures or reduced quality of care. Members should identify specific examples of inadequate payment under MA/GAMC, payment delays, and generally discuss the financial status of their facilities and what it will mean to the community if the hospital is forced to close its doors.

EDUCATIONAL PREPARATION FOR NURSING PRACTICE (BASIC ENTRY LEVEL)

Background:

Currently, there are four levels of nursing education. The Minnesota Nurses Association (MNA) believes that after 1990, there should be two levels of nursing practice--the professional nurse with a baccalaureate degree in

nursing and the assistant to the professional nurse with an associate degree in nursing. The professional nurse would be licensed by the Minnesota Board of Nursing and be legally titled Registered Nurse (RN) and the assistant would also be licensed by the Board and legally titled Licensed Practical Nurse (LPN). This proposed change would only apply to those persons entering nursing after 1990. Currently licensed RNs and LPNs, prior to 1990, would retain their licenses. MNA has indicated that they will seek legislation during the 1987 Session to implement their proposal for nursing education.

MHA's longstanding position on this issue has been to oppose any legislative proposal that would mandate the baccalaureate degree in nursing as the educational preparation for entry into professional nursing. MHA supports all levels of nursing education as well as educational mobility programs which allow licensed nurses to continue their formal education.

Recommended Member Action:

Members should alert their legislators to the possible introduction of the BEL proposal. Indicate to your legislators that the proposal is very controversial and MHA has concerns about the impact of the proposal on future manpower needs and health care costs. Currently, MHA supports all levels of nursing education.

CON/HOSPITAL MORATORIUM

Background:

The hospital moratorium was adopted in 1984. It prohibits, until June 30, 1987, the establishment of any new hospitals, as well as any construction or building modifications that increases the bed capacity of a hospital; relocates beds from one physical facility, complex, or site to another; or otherwise results in an increase or redistribution of hospital beds within the state (1984 laws of Minnesota, Chapter 654). The primary force behind adoption of the hospital moratorium was the scheduled expiration of Minnesota's CON law in 1984. The state CON law was allowed to sunset because it failed to adequately control growth in the health care industry. Although the state program expired in 1984, the state Health Planning and Development Agency has continued to conduct "modified" Section 1122 reviews.

In 1984, the MHA Board supported the repeal of CON and a moratorium on the construction of new hospitals or the addition of new inpatient beds. Earlier bills introduced that Session would have extended the CON dollar thresholds, above which there would have been an absolute moratorium on services, construction, and renovation.

The scheduled sunset of the hospital moratorium in 1987 will force the Legislature (1) to re-examine the appropriateness of the moratorium as a method of regulating health facility growth, (2) to determine the need, if the moratorium is appropriate, for exceptions to allow construction of new facilities under special circumstances or to permit some changes in existing facilities (e.g., relocation), and (3) if the moratorium is an inappropriate regulatory mechanism, what form of planning/review mechanism should be put in place.

Recommended Member Action:

Legislators should be informed that the existing hospital moratorium has worked to limit hospital inpatient bed expansion. A lifting of the moratorium or establishing a new CON program would only serve to add costs to the health care system.

CHEMICAL DEPENDENCY CONSOLIDATED FUND

Background:

During the 1986 Legislative Session, legislation was enacted to create a consolidated fund for payment of chemical dependency treatment under MA and GAMC. The CD Fund is intended to introduce more competition into the CD treatment system. State policy-makers hope that the fund will create incentives to place clients in the most economical and appropriate treatment settings. The new system will allow hospitals to be on more equal footing with regional treatment centers. Counties will be able to negotiate rates with eligible providers. However, to participate, hospital programs will have to meet additional regulatory requirements, including licensure, constraints on expansion, and additional placement criteria.

Although enabling legislation was passed during the last Session, the fund will not be in effect until July 1, 1987 and is contingent on a one-time start-up appropriation for the state hospitals by the Legislature next Session. In anticipation of the Legislature appropriating the necessary money, the Department of Human Services is drafting a number of rules to implement the legislation. These include the following: Rule 35-inpatient licensure, Rule 43-outpatient licensure, Rule 25-uniform placement criteria, and CD Fund implementation rule. DHS has targeted July 1, 1987 as the effective date for these rules. Most of the rules are in the drafting stage now and will be scheduled for public hearing, sometime in February.

Recommended Member Action:

Administrators should express concern over the additional licensure requirements for hospital-based CD programs and the assessment of need process for expansion of CD services. Point out to your legislators that hospital-based CD programs are already JCAH accredited and DHS should recognize these standards before requiring programs to meet additional and duplicative state regulation. If DHS is unwilling to accommodate these concerns, legislative relief will be needed.

JUVENILE JUSTICE

Background:

During the 1986 Legislative Session, major revisions to the Juvenile Code were proposed which would have significantly altered inpatient chemical dependency and mental illness treatment for minors. These revisions were based on recommendations from the Minnesota Juvenile Code Revision Task Force, which was concerned that there had been an increase in the use of restrictive inpatient MI and CD facilities without corresponding procedural protections or external oversight. Some of their recommendations included state licensure through DHS for all CD and MI facilities, a civil commitment process for all

minor admissions to CD and MI treatment facilities, establishment of the Office of Childrens' Advocate, an absolute right to legal counsel and a Minor Patient Bill of Rights with penalties for denial of rights.

Though the most controversial reforms were defeated, several non-controversial MHA-supported provisions were adopted--collection of program data by the MDH, inclusion in the Patient Bill of Rights of provisions concerning isolation and restraint and informing minors 16 years and older of their right to contact an advocate and to seek or leave treatment. Although certain issues concerning CD and MI treatment of minors were dealt with during the last Session, a number of advocates did not feel that these changes went far enough. A group called the Coalition for Juvenile Code Reform has been meeting during the interim and is pursuing such issues as uniform licensing for CD and MI treatment programs, child advocacy for institutionalized children, criteria for locked units, and independent examination of admissions. As a result, there will probably be another legislative initiative this Session.

Recommended Member Action:

No action required at this time. Members may consider using this time before January to get local legislators through their CD and MI juvenile programs. It is important to stress the negative impact that additional state requirements would have on the placement of juveniles and interfere with decisions that belong with family members and health care professionals.

SMALL/RURAL HOSPITALS

Background:

Small, rural hospitals face a challenging health care environment. Recent changes such as the Medicare prospective pricing system and the general shift from inpatient to outpatient care have resulted in declining occupancy rates and shortened length of stay (LOS). Congress has attempted to respond to some of the inequities facing small, rural hospitals under the Medicare prospective pricing system by providing special adjustments or exclusions for sole community providers and small, rural hospitals.

The fundamental concern, however, of small, rural hospitals operating under Medicare's PPS, which Congress has not addressed, is the urban/rural rate differential. Many rural hospitals can easily point to the glaring rate differential between what Medicare pays the urban hospital 25 miles down the road for a certain DRG versus what the rural hospital receives for the same diagnosis.

Recommended Member Action:

Until specific recommendations are developed, members should continue to inform area legislators of problems affecting their individual facilities.

WORKERS' COMPENSATION

Background:

The establishment of the two-tier system in the 1983 Workers' Compensation Act created significant new incentives for both employers and most employees to

return to work. However, the act left intact the minimum weekly compensation benefits for temporary total disability which creates a financial disincentive for certain types of employees to return to work. Minnesota presently has one of the highest minimum benefit provisions in the country. The present law guarantees that claimants will receive not less than 50 percent of the statewide average weekly wage or the injured employee's actual weekly wage, whichever is less. Thus, a claimant making $171.00 per week or less is entitled to 100 percent of his/her actual weekly wage. Higher paid claimants, on the other hand, receive only 66 2/3 percent of the daily wage (i.e., an employee earning $500.00 per week would recover only $300.00). During the 1986 Session, MHA worked with the Minnesota Retail Merchants Association to amend the minimum benefit provision. Both the House and Senate authors were committed to the revision, however, the issue became entangled in the larger unemployment compensation battle.

Unemployment compensation reform rather than workers' compensation continues to be a high legislative priority for most legislators. However, many of the legislators have told MHA staff that they do not view amending the minimum benefit provision as a major overhaul of the system. Most agree that the issue should have been taken care of during the 1983 Session and are sympathetic to the disincentive Minnesota's minimum benefit creates to return to work.

Recommended Member Action:

Members should provide legislators with any anecdotal information on how the minimum benefit serves as a financial disincentive to get employees back to work. Stress that a reform in this area would not overhaul the system. In fact, such a change is consistent with the goals of the 1983 Workers' Comp. Reform--to create incentives to return to work.

HMO ISSUES - PREPAID/CAPITATION LEGISLATION

Background:

The Medical Assistance Prepaid Demonstration Project is finally up and operating in all three demonstration counties (Itasca, Hennepin, and Dakota). Authorized by the Legislature in 1983, the demonstration project's stated goal is to determine where (and how) prepayment of Medical Assistance can be applied statewide to replace the current payment system and increase state savings. Despite the fact that the experiment is far from complete, legislative attempts (so far unsuccessful) have already been made to expand prepayment statewide.

In 1985, legislation mandating enrollment of AFDC and Medicare/MA recipients in prepaid plans died in the House-Senate Conference Committee when legislators failed to agree on other health-related provisions. In 1986, the Governor proposed expanding the project statewide to help alleviate the projected budget deficit. (The Governor's proposal would have based prepayment rates on 85 percent instead of the current 90 percent of fee-for-service expenditures.) MHA opposed the proposals on the grounds that it was premature to implement prepayment statewide when so little was known about the project. To participate in the project, health plans responded to a state RFP (except in Itasca County, where the county board acts as the health plan).

Qualified plans are contracted with providers which, in most cases, were formed to accept the health plan's rate.

Recommended Member Action:

No action at this time.

HMO ISSUES - REGULATION

Background:

Hospitals have expressed concern relating to HMO regulation, especially in regards to perceived preferential treatment HMOs receive under state and federal laws. As a result, they argue that hospitals are placed at a disadvantage at the bargaining table when negotiating HMO contracts. Hospitals are also concerned that MDH oversight authority has not kept pace with the growth of the HMO industry, resulting in a lack of sufficient screening of HMO activities. Legislation overhauling the state's regulation of HMOs was passed in 1984. The legislation was intended to eliminate some of the differences between HMOs and insurers by establishing the same mandated benefits and minimum eligibility requirements for both. The legislation also established HMO deposit requirements for the first time (in addition to working capital), minimum standards for consumer right statements, fines, and provides for review of management contracts. The legislation did not specifically direct MDH to promulgate rules to enforce these changes.

To provide an opportunity for hospitals to air their HMO-related concerns and formulate, if necessary, a legislative or regulatory response, a MHA Task Force on HMO/Prepaid Capitation has been established. The task force which will meet during the fall of 1986 is expected to focus on a statewide prepaid plan (MA/GAMC), health insurance regulatory requirements, PPO regulations, and assignment of benefits issues.

Recommended Member Action:

No action at this time.

MEDICAL MALPRACTICE/TORT REFORM

Background:

After lengthy, heated debate, the 1986 Legislature adopted the most substantive changes in liability insurance and tort reform in the last ten years. While legislators did not address the issues of limits on attorney's fees and caps on all non-economic losses, the changes should provide some relief from skyrocketing insurance premiums and the availability of insurance coverage.

The Civil Justice Coalition (CJC), representing business, municipalities, the insurance industry and the medical professions, was organized by the Minnesota Association of Commerce and Industry (MACI) prior to the 1986 session.

The CJC's goal is to develop and implement a comprehensive plan to advocate for tort reform. Draft legislation currently under consideration by the Steering Committee includes: prohibiting punitive damages; limiting "non-economic loss" to $100,000; abolishing joint and several liability;

offsetting collateral sources, except life insurance benefits; informing juries of the existence of the amount of all collateral sources and future benefits available to the plaintiff; and structuring awards when future damages exceed $100,000.

Recommended Member Action:

Members should express support and appreciation for the tort reform passed by the 1986 Legislature. However, the increasing malpractice premiums continue to be a major financial burden on hospitals. Members should share their recent premium history with area legislators.

CHARITY CARE

Background

Hospitals have a tradition of caring for patients regardless of the patient's ability to pay. In the past, the costs of providing charity care were shifted to private patients through higher hospital charges. The provision of hospital charity care, however, may be in jeopardy today due to the current economic forces facing the health care industry. Hospitals can no longer afford to shift charity care costs to other payers, i.e., government, private insurance, HMOs, since these payers are demanding and receiving discount hospital rates for their beneficiaries. Without the ability, then, to shift the costs of charity care, hospitals may become less willing to serve patients who cannot pay. From a public policy perspective, the question becomes how to ensure financial access to health care in a competitive health care environment.

Two initiatives have been undertaken within the past year to improve the consistency and accuracy of reporting charity care by hospitals. When hospitals fill out their HIRM Revenue and Expense reporting forms this year (1985), a new category has been included for "charity care and bad debt" which allows hospitals the opportunity to provide specific financial information on funding sources for indigent care. Hospitals are also encouraged to indicate definitions of charity care and procedures followed to distinguish charity care from bad debt. The other initiative involves a joint effort by MDH, CoCH, and MHA to conduct a survey of Minnesota hospitals regarding the provision of charity care. The purpose of the survey is to assess the nature and extent of hospital charity care in 1984 and learn about hospitals' policies, perceptions, and concerns regarding the issue. Survey results and key findings will be presented to the 1987 Legislature.

Recommended Member Action:

No action requested at this time.

ORGAN DONATION

Background:

Over the past two years, 27 states have enacted legislation aimed at increasing the availability of scarce organs for transplantation. The so-called organ donor required request laws are of two types--those requiring

the hospital administrator or designee to request the anatomical gift and those requiring the hospital to establish protocols for requesting the gift. The protocol laws which have been passed in 12 out of the 27 states tend to allow more flexibility for hospitals in designating who will make the request based on their own capabilities and staffing.

The statutes on organ donation requests have some basic similarities. They are cumulative with other anatomical gift statutes. The statutes and protocols include provisions for the documentation of the request and its disposition. Exceptions to requesting donations for unsuitability of organs or tissues, religious beliefs and opposition from family members are included in the statutes. In order to build upon the existing organ procurement system, the statutes require the notification of an organ procurement agency once consent to the donation is given. Most statutes require special training for persons requesting the anatomical gift. Finally, a number of states provide for immunity from civil damages and criminal prosecution for good-faith efforts.

Recommended Member Action:

No action at this time.

PATIENTS BILL OF RIGHTS

Background:

Extensive changes were made to the Patient Bill of Rights in 1983. The changes added a number of new "rights" (primarily for residents) which, coupled with the changes since 1983, have made for a rather lengthy document. In addition, the 1986 Legislature extended the Bill of Rights to cover people receiving outpatient mental health treatment and minors receiving residential CD and MI treatment. As a result, the current Bill of Rights contains provisions which do not always apply to the hospitals which must post them. For example, why should hospitals post information on the rights of minors in CD programs when they offer no such program. Finally, the wording in some provisions may need to be clarified.

MDH has expressed an interest in clarifying which provisions of the Bill of Rights apply to which type of facility. Also, other provider organizations are as interested in setting up separate Bills of Rights. There would probably be a separate Bill of Rights for inpatient and outpatient hospital services, nursing homes, free-standing CD and MI facilities and physicians' clinics. The result would be a more scaled-down and, hopefully, readable Bill of Rights. In "cleaning up" the Bill of Rights, we run the risk that other legislators and groups may use the bill to hang on their favorite causes. With or without such a bill, there will undoubtedly still be Bill of Rights legislation under consideration this Session.

Recommended Member Action:

No action at this time.

MINUTES
Planning and Development Committee
November 12, 1986

CALL TO ORDER
Committee Chairman, Mr. Robert Latz, called the November 12, 1986 meeting of the Planning and Development Committee to order at 10:06 a.m. in Room 8-106 in the University Hospital.

Attendance:	Present	Robert Latz, Chair Frank Cerra, M.D. Clint Hewitt Geoff Kaufmann John LaBree, M.D. C. Edward Schwartz I. Dodd Wilson, M.D.
	Absent	Leonard Bienias B. Kristine Johnson
	Staff	Fred Bertschinger Marge Carey Al Dees Cliff Fearing Greg Hart Nancy Janda Mark Koenig Nels Larson Lisa McDonald
	Guests	Lou Vietti

APPROVAL OF MINUTES
The minutes of the October 8, 1986 meeting were approved as distributed.

UMCA UPDATE
Dr. Wilson reported that there is movement toward a general contract with MedCenters. Totally, more than 1,000 patients have been processed through Mr. Coombes' office to date. There will be outreach visits to Hibbing and Marshfield in November.

The Planning and Marketing Committee of UMCA is moving ahead with a communications directory system.

MEDCENTER DISCUSSIONS
Mr. Kaufmann said that the agreement with MedCenter could be in place by Thanksgiving and certainly during this calendar year. We currently have an existing contract on the lithotripter and we will use that as a base for the broad referral base contract.

STRATEGIC PLANNING STEERING COMMITTEE UPDATE

Mr. Schwartz said that at the BOG Retreat they focused on strategic planning and agreed that it should be more action-oriented. Following a meeting with Dr. Shelley Chou, it was decided that Dr. Ferris and Dr. Roby Thompson will continue to serve as representatives of the Council of Clinical Chiefs on the Strategic Planning Steering Committee.

At the last Strategic Planning meeting the status of the Gillette negotiations was discussed. At this point those negotiations are not going forward. Gillette has hired a consultant to assist in their decision-making process.

UMHC has had three meetings with St. Paul Children's at their initiative. The meetings went well and it was decided to hire a consultant to gather data to aid in any decision making involving joint programming. Discussions with St. Paul Children's center around creating a network of children's providers rather than the current fractionalized children's care.

There have been some initial discussions with Health East. There is a movement in St. Paul away from single and small group offices to larger physician groups.

HIBBING PROPOSAL

Mr. Kaufmann told the committee that we have been working with Hibbing for some time in supporting their hospital and clinics. There are looking to associate with a tertiary care facility and sent out four proposals. That field has been narrowed to two hospitals, including UMHC. A trip to Hibbing this month has been planned to let them know what we can do for them. Discussion of issues pertaining to a possible affiliation agreement with Hibbing followed. Dr. LaBree said that there is no problem in the planning phase with outstate physicians but we could encounter problems in implementation in the future if we are successful in a number of negotiations.

REVISED PURCHASING POLICY - GIFTS AND GRATUITIES

Mr. Koenig reviewed the revised policy for gifts and gratuities. The following changes were incorporated. At the beginning of the first paragraph add "Consistent with Minnesota Statutes (Minn. Stat. 15.43 [1984])". The second paragraph of the Policy will read, "No University of Minnesota Hospital and Clinic employee who may directly or indirectly influence a purchasing decision may accept a rebate, gift, money or anything of value, other than an item of nominal value, from any individual or organization involved in or potentially involved in selling or leasing products or services to the University Hospital and Clinic."

The amended policy was unanimously endorsed.

COMPUTER SYSTEM PROPOSAL

Mr. Fearing, at the Committee's request at the October meeting, distributed a memo that discussed in detail the need for modernizing the financial system computer system. He explained that our present budget system cannot handle

all of the functions we need to have available. He said we are presently keeping two sets of records--one for the University and one for the Hospital--and that we need to work to combine these records.

Mr. Fearing said that they would not ask for endorsement of the proposal at this meeting because they are further evaluating the Burroughs system to see if we can stay with Burroughs and grow. Because discussions with Burroughs are still underway it is too early to ask this Committee for endorsement. The proposal will be on the agenda again in December.

QUARTERLY PURCHASING REPORT

Mr. Koenig highlighted several items in the quarterly purchasing report. He explained that the large dollar amounts on the sole source list were bought to fit in with current systems. He reported $112,000 spent through the Consortium with a savings of just under $9,000. Mr. Vietti said that the Consortium had just signed a contract with Travenol that could mean a savings of $200,000. He also said that they are looking at sending out bids on several items and are anticipating further savings. Ms. Janda said that the Pharmacy is beginning to use the Consortium and are getting substantial savings.

The Quarterly Purchasing Report was unanimously endorsed.

OTHER

Mr. Latz presented a gift to Dr. Wilson, who is leaving the University for Arkansas, in appreciation for his service and contributions to the University.

ADJOURNMENT

The Planning and Development Committee adjourned at 12:00 noon.

Respectfully submitted,

Ann S. Frohrip

Ann S. Frohrip
Secretary
Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 14, 1986

TO: Members of the Board of Governors

FROM: C. Edward Schwartz C. E. Schwartz

Attached is the revised Purchasing Policy on Acceptance of Gifts and Gratuities. This policy has been revised three times to address three separate issues.

As a result of discussions at the September Board meeting, the policy was amended to allow for acceptance of gifts "of nominal value". This exclusion was added to prevent the policy from becoming unrealistically restrictive.

At the October Planning and Development Committee meeting many questions were raised regarding the intent and scope of the policy. An introductory paragraph was added to clarify these issues.

At the November Planning and Development meeting various revisions were made to the policy for clarification. These revisions have been underlined.

Also included for informational purposes is a copy of the statute which relates to the Gifts and Gratuities policy.

The revised policy is submitted for your review and approval.

CES/kff

Attachments

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

POLICY AND PROCEDURES MANUAL

REVISION

SECTION	Page 1 of 1
VOL.	**POLICY NUMBER**
SUBJECT	GIFTS AND GRATUITIES
EFFECTIVE	1/3/84
REVISION	10/7/86
SOURCE	MATERIALS SERVICES
REVIEWED	12/31/85

Policy

Consistent with Minnesota Statutes (Minn. Stat. 15.43 [1984]), the intent of this policy is to insure that Purchasing decisions at The University of Minnesota Hospital and Clinic are not influenced by the provision of gifts or gratuities by vendors to employees.

No University of Minnesota Hospital and Clinic employee who may directly or indirectly influence a purchasing decision may accept a rebate, gift, money or anything of value, other than an item of nominal value, from any individual or organization involved in or potentially involved in selling or leasing products or services to the University Hospital and Clinic.

Procedure

Any employee not complying with this policy is subject to appropriate disciplinary action.

APPROVED	**DATE**
TITLE	

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

November 14, 1986

TO: Members of the Board of Governors

FROM: C. Edward Schwartz C. E. Schwartz

SUBJECT: Quarterly Purchasing Report

Attached is a copy of the Hospital's Quarterly Purchasing Report for the period August through October, 1986.

This report is submitted for your approval at the November Board meeting.

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

CES/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD August - October 1986

I. PURCHASE ORDER ANALYSIS

Range	Number of P.O.'s	Total Dollar value
$0 - $499	5,436	$ 859,047.24
$500 - $1,999	1,942	2,031,782.57
$2,000 - $4,999	539	1,665,617.02
$5,000 - $9,999	204	1,407,997.80
$10,000 - OVER	229	5,068,502.87
TOTAL PURCHASE ORDERS	8,350	11,032,947.50

II. CONFIRMING ORDERS

Range	Number of P.O.'s	Total Dollar Value
$0 - $99	152	$ 8,577.31
$100 - $499	241	62,190.83
$500 - $999	123	79,956.20
$1,000 - $1,999	89	127,418.37
$2,000 - OVER	22	165,088.38
TOTAL CONFIRMING ORDERS	627	443,231.09
TOTAL	8,977	$11,476,178.59

III. SET ASIDE AWARDS

(Attachment C)

IV. PURCHASE AWARDS TO OTHER THAN APPARENT LOW BIDDER

(Attachment A)

V. SOLE SOURCE

(Attachment B)

VI. VENDOR APPEALS

(Attachment D)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

(Attachment E)

ATTACHMENT C

III. SET ASIDE AWARDS

A. Awarded Bids

CATEGORY	VENDOR	TOTAL DOLLAR VALUE
1. Audio-Visual	Audio-Visual Wholesalers	$ 1,980.43
2. Personal Health Care Products	Halcon Distributors	1,382.40
3. Computer Supplies	Computer Supply Store	2,108.00
4. Computer Supplies	H. A. Roberts	520.00
5. Computer Supplies	Kelly Computer Supplies	400.00
6. Draperies	Window TRT	930.00
7. Computer Ribbons	Allanson Business Products	8,000.00 (Est.)
8. Diskettes	Sexton Data Products	1,000.00 (Est.)
9. Window Washing	Your Way Cleaning Service	8,590.00 (Est.)
10. Restraints	Quality Medical	1,356.00
	TOTAL AWARDED BIDS:	$ 26,266.83

B. Departmental Purchases

1. August 1986

P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1. H 061385	Quality Medical	$ 177.90
2. H 062561	Design Concepts	1,348.40
3. H 317373	Sexton Data Products	144.50
4. H 061393	Quality Medical	125.84
5. H 062433	Quality Medical	330.00
6. H 317556	Medical Legal Visuals	171.00
	AUGUST TOTAL:	$ 2,297.64

III. SET ASIDE AWARDS

B. Departmental Purchases

2. September 1986

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H 061399	Quality Medical	$ 243.84
2.	H 044025	Quality Medical	478.28
3.	H 061400	Quality Medical	125.40
4.	H 318338	Budget Paper	44.30
5.	H 318529	Sexton Data Products	153.00
6.	H 318478	Budget Paper	88.60
7.	H 318773	Audio Visual Wholesalers	928.00
8.	H 318887	MO Sales	200.00
9.	H 062183	Quality Medical	43.55
10.	H 318976	Sexton Data Products	146.00
11.	H 319403	General Teepee	125.04
12.	H 319636	Art Materials	22.74
13.	H 319630	Audio Visual Wholesalers	845.00
14.	H 063304	Quality Medical	262.32
15.	H 318064	Halcon	113.88
16.	H 318251	Halcon	129.40
17.	H 318435	Halcon	150.12
18.	H 318895	Halcon	155.28
19.	H 319142	Halcon	129.40
20.	H 319918	Halcon	312.00
21.	H 319719	Halcon	207.04
22.	H 317914	Quality Medical	165.60
		SEPTEMBER TOTAL:	$ 5,068.79

III. SET ASIDE AWARDS

B. Departmental Purchases

3. October 1986

	P.O. NUMBER	VENDOR	TOTAL DOLLAR VALUE
1.	H 063362	Hartmann Office	$ 1,011.20
2.	H 063310	Quality Medical	87.20
3.	H 321083	Audio Visual Wholesalers	277.50
4.	H 064465	Quality Medical	43.55
		OCTOBER TOTAL:	$ 1,419.45

C. Quarterly Grand Total

AWARDED BIDS	$ 26,266.83
AUGUST 1986 PURCHASES	$ 2,297.64
SEPTEMBER 1986 PURCHASES	5,068.79
OCTOBER 1986 PURCHASES	1,419.45
GRAND TOTAL PURCHASES	$ 35,052.71

ATTACHMENT A
Page One

IV. Purchase Award to Other Than Lower Bidder, $5,000.00 or More

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
1. H 061896	Burroughs/Page Printer	$ 66,940.00	$ 42,300.00	I.S.D.
	REASON: Printer offered was not a Page Printer as specified.			
H 061896	D.S.I./Page Printer	66,940.00	63,940.00	I.S.D.
	REASON: Evaluation provided proof that the Awarded Equipment provides UMHC a 25% Increase in Production, over Rejected Equipment, for less than 5% Increase in Cost.			
H 061896	Tony Pitman Corp/ Page Printer	66,940.00	65,000.00	I.S.D.
	REASON: Equipemnt does not have Forms overlay, as specified.			
2. 86-625	Kendall/ Disp. Drape Sheet	17,280.00	10,816.00	Materials
	REASON: Inadequate size.			
86-625	Medix/ Disp. Drape Sheet	17,280.00	10,816.00	Materials
	REASON: Product is too slippery when used in Multiple Layers.			
86-625	McKesson/Disp. Drape Sheet	17,280.00	14,723.84	Materials
	REASON: Evaluation samples were not provided.			
3. 86-625	McKesson/CV Split Sheet	10,044.00	8,424.29	Materials

IV. Purchase Award to Other Than Lower Bidder, $5,000.00 or More

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
3. (Cont'd)				
	REASON: Split is too narrow and edges are not reinforced to provide for adequate attachement of Tubes and Cords.			
4. 86-636	McKesson/ Laparotomy Drape	$ 19,810.00	$ 18,431.00	Materials
	REASON: Product was not Bilaterally Winged as specified, tears easily and had an unpleasant odor.			
5. H 061894	Keomed/Fetal Monitor	12,252.15	7,800.00	Nursing
	REASON: The product bid, failed to meet specifications for Ten Basic Elements: 1) Cannot monitor twins; 2) No Autocorellation feature; 3) No ECG Patient Cable; 4) No Self Check of each Mode; 5) No Display and Patient Cable Check; 6) No Digital Serial Interface; 7) No Interface with the PDM System; 8) No Signal Quality Indicator; 9) No Artifact Rejection Switch; and 10) Unable to offer External Cardio or TOCO Channel Recording.			
H 0618894	Sonicaid/Fetal Monitor	12,252.15	Unknown	Nursing
	REASON: The Price Quotation was not included with the Bid.			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
6. 86-594	Medix/Chest Suction Equipment	$ 97,762.00	$ 75,096.00	Materials
	REASON: The Vendor did not provide samples for Testing and Evaluation.			
7. H 063596	Toll Co./Liquid Nitrogen System (Cryopreservation)	8,276.85	$ 7,991.07	Labs
	REASON: Inadequate Patient Specimen Storage Capability.			
8. H 062789	Fisher Centrifuge	5,780.00	3,540.00	Labs
	REASON: Maximum Speed and Time Set is insufficient. Speed Display increments were not 10 RPM as specified. Did not have Two-Step Deceleration.			
H 062789	DuPont	5,780.00	4,470.00	Labs
	REASON: Insufficient Maximum Speed. Did not have Two-Step Deceleration. Rotor Tube Capacity too small.			
9. 86-730	American Edwards/ Transducer Domes	22,500.00	11,500.00	Materials
	REASON: Samples for Testing and Evaluation were not provided.			
86-730	Graphic Control/ Transducer Domes	22,500.00	15,500.00	Materials
	REASON: Poor Frequency Response. Connection fittings were cumbersome. Primimg requires excessive fluid. Packaging is large and awkward.			
86-730	Intermed/ Transducer Domes	22,500.00	14,500.00	Materials
	REASON: The Vendor was unable to fill an order for product to be tested and Evaluated.			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
86-730	Key Medical/ Transducer Domes	$ 22,500.00	$ 19,900.00	Materials
	REASON: Inappropriate fittings for UMHC Equipment.			
10) H 062146	Simmons/ Hospital Beds	$ 86,875.95	$ 47,600.00	Nursing
	REASON: Equipment does not meet the following specifications: 1) Mattress support is Pan-Type rather than Spring-Type; 2) Head and Foot-Boards are Particle Board rather than molded; 3) One I.V. Socket rather than six; 4) Not Adaptable to Orthopedic Equipment; 5) No Drainage Bag Hook; and 6) Bumpers are Roller Type.			
H 062146	Amedco/ Hospital Bed	$ 86,875.95	$ 71,351.00	Nursing
	REASON: Equipemnt does not meet the following specifications: 1) Head and Foot-Boards are not Molded; 2) Mattress support is Pan-Type rather than Spring Type; 3) Casters are Rhombus; 4) Does not include six I.V. Sockets; 5) Not adaptable to Orthopedic Equipment; and 6) No Drainage Bag Hook.			
H 062146	Joern's/Hospital Beds	$ 86,875.95	$ 73,476.55	Nursing
	REASON: Equipment does not meet the following specifications: 1) Head and Foot-Boards are not Molded; 2) Mattress support is Pan-Type rather than Spring-Type; 3) Casters are not recessed;			

	P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
	H062146	Reason: (cont'd)			
		4) Not adaptable to Orthopedic Equipment; and 5) Operates on one motor rather than three.			
11.	H 060358 Line #1	Fujinon/Fiberoptic Light Source	$ 17,700.00	$ 14,850.00	Endoscopy
		REASON: Excessive heat, difficult adaptation and noise generation.			
	H 060358 Line #1	Pentax/Fiberoptic Light Source	$ 17,700.00	$ 14,580.00	Endoscopy
		REASON: Excessive heat, difficult adaptation and noise generation.			
12.	H 060358 Line #2	Fujinon/ Duodenoscope	$ 21,300.00	$ 17,240.00	Endoscopy
		REASON: Inadequate Field of Vision, inadequate Optical Resolution for examination of Upper GI Tract and Cannulation of the Biliary-Pancreatic Ducts.			
	H 060358 Line #2	Pentax/ Duodenscope	$ 21,300.00	$ 17,370	Endoscopy
		REASON: Inadequate Field of Vision, inadequate Optical Resolution for examination of Upper GI Tract and Cannulation of the Biliary-Pancreatic Ducts.			
13.	H 063400	Road Rescue/ Resuscitator	$ 10,230.00	$ 8,604.75	Cardio-Respiratory
		REASON: Product does not provide for the addition of a Peep Valve or Peep Valve Adapter.			
14.	86-598	Proctor and Gamble/ Disp. Diapers	$ 37,640.00	$ 23,094.00	Materials

(Continued)

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
14. 86-598 (cont'd)	REASON: Vendor's prices are not firm.			
15. 86-696	Proctor and Gamble/ Incontinent Briefs	$ 7,340.61	$ 6,176.00	Materials
	REASON: Poor absorption. Padding separated. Uncomfortable fit for the patient.			
16. H 047101	Network Systems/ Software and Hardware	$ 198,435.00	$ 53,430.00	Labs
	REASON: Equipment Bid did not include Printers, CRT's and Microcomputers as specified.			
H 047101	Emulating Equipment/ Software and Hardware	$ 198,435.00	$ 19,380.00	Labs
	REASON: Equipment Bid is not compatable with Tandem Hardware and Systemed Software which utilizes Osync, Block Mode Transfer.			
17. 87-2	AHS/Nasal Tubes	$ 8,900.00	$ 5,568.00	Materials
	REASON: The Low Bidder is unable to provide a complete product line of the specified sizes.			
18. H 063048	Roger Meill/Microscope	6,775.00	$ 5,758.00	Labs
	REASON: Inadequate Sensitivity and Definition, cumbersome Filter Operation, Diaphram not centerable and alignment of Light Source is cumbersome.			
19. H 063858	Fisher Sci./ Spectrophotometer	$ 10,035.00	$ 9,405.00	Labs
	REASON: Equipment Bid did not meet the following specifications:			
	1) Inadequate Heating and Cooling;			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
19. H 063858	REASON: (cont'd)			
	2) Inadequate Printer/Plotter Columns; 3) No Analog Plot; 4) No Storage for Kinetic Data; 5) Will not Replicate Averaging of Unknowns and no Step Programming capability.			
20. 86-685	Sexton Data/ Computer Ribbon	$ 6,960.00	$ 4,740.00	Materials
	REASON: Bidder did not submit a sample for testing and evaluation.			
21. 86-672	Abbott/Epidural Anesthesia Tray	$ 9,240.00	$ 8,033.20	Materials
	REASON: Tray contains Open Ended Catheter, inadequate connector and contained only one Drape, thus not meeting specifications.			
86-672	Kendall/Epidural Anesthesia Tray	$ 9,240.00	$ 9,205.84	Materials
	REASON: Inadequate Connector, no Test Dose, Glass Syringe is rough and Catheter did not withstand stress well.			
22. 86-676 Line #2	Kendall/Foley Catheter with Syringe	$ 8,866.00	$ 8,077.16	Materials
	REASON: The Balloon is not Ribbed and failed to inflate during testing. Staff was unable to pass the Stylet with Balloon inflated.			
23. 86-676 Line #3	Kendall/Foley Catheters	$ 8,754.72	$ 6,886.67	Materials
	REASON: The eye of the Catheter is too close to the tip. The Balloon and Catheter is Asymmetrical. The Tip of the Catheter migrates to the weak side of the Balloon, thus posing a risk of Ulcers.			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
24. 86-676 Line #6	Kendall/Foley Catheter Trays	$ 22,716.00	$ 18,698.40	Materials
	REASON: The Glove is small, tight and tears easily. The tweezer breaks easily. The Specimen Container does not have Ml/CC markings. The Aperture Drape is too crisp and does not conform well to the patient contour.			
25. 86-676 Line #9	Kendall/Straight Catheter Tray	$ 29,083.20	$ 27,135.02	Materials
	REASON: Outer package is difficult to open. The gloves are very small. The tray configuration is awkward (ie. gloves are backward). The Aperture Drape is too crisp. The O.R. cup is unmarked. Forceps break easily and are difficult to handle.			
26. 86-676 Line #10	Kendall/Urine Straight Drainage Bag	$ 11,400.00	$ 11,035.20	Materials
	REASON: Bag does not hang straight. Single plastic hanger breaks easily. Plastic Clamp does not fit tight. Tubing too narrow.			
27. 86-676 Line #12	Kendall/Urine Meter with Bag	$ 22,386.00	$ 20,580.00	Materials
	REASON: The Meter and Bag come apart and are difficult to reassemble. Single Hanger is fragile. The Bag has a protruding Port that can be tampered with easily. Plastic Bag is brittle composition.			
28. 86-676 Lines #1 & 3	James Phillips/ Foley Catheters	$ 14,154.72	$ 10,449.31	Materials
	REASON: The Balloon is Asymmetrical and obstructs the eye when traction is applied.			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
29. 86-676 Line #6	AHS/Foley Catheter Trays	$ 22,716.00	$ 21,888.00	Materials
	REASON: Glove Cuffs are too short. The Drape material is too thin. Tray Configuration is difficult to utilize. The Betadine and Tweezers are difficult to use.			
30. 86-676 Line #10	AHS/Urine Straight Drainage Bag	$ 11,400.00	$ 10,852.80	Materials
	REASON: The Sampling Port Protrudes and is movable. Tubing is too narrow. The Hanger Clamp is too fragile.			
31. 86-676 Line #9	AHS/Straight Catheter Tray	$ 29,083.20	$ 26,493.60	Materials
	REASON: The CS Wrap does not lay properly. Short Glove Cuff. Tray configuration is difficult to extract gloves from.			
32. 86-676 Line #3	Medline/Foley Catheters	$ 8,754.72	$ 5,124.00	Materials
	REASON: The Catheter is Asymmetrical with a Non-Ribbed Balloon. The Balloon obstructs the eye when traction is applied. The Tip is not reinforced.			
33. 86-676 Line #10	Medline/Urine Straight Drainage Bag	$ 11,400.00	$ 11,035.00	Materials
	REASON: The Plastic Clamp and Single Hanger are prone to break easily. The Tubing is too narrow and disengages from the Bag when full.			
34. 86-676 Line #3	C.R. Bard/Foley Catheters	$ 8,754.72	$ 5,797.44	Materials
	REASON: The Balloon is Asymmetrical and the Catheter migrates to the unfilled side.			

P.O. NUMBER	VENDOR/ITEM	TOTAL DOLLAR VALUE	DOLLAR VALUE LOW BIDDER	DEPARTMENT
35. 86-676 Line #6	C.R. Bard/Foley Catheter Tray	$ 22,716.00	$ 21,420.00 21,600.00	Materials
	REASON: The Single Plastic Hanger is easily broken. The gloves are difficult to retrieve without contamination. The Forceps are not as specified. The Drain Collector protrudes and an Outpouching Drainage Chamber was not as specified.			
36. 86-676 Line #10	C.R. Bard/Urine Straight Drainage Bag	$ 11,400.00	$ 10,351.20	Materials
	REASON: The Single Hanger is easily broken. The Tubing kinks at the Drainage Tube. The plastic piece on the bag scrapes the Patient's leg when Ambulating.			
37. 86-676	C.R. Bard/Urine Meter with Bag	$ 22,386.00	$ 21,336.00	Materials
	REASON: The plastic has no memory and is brittle. The Outlet and Tip are broken easily. The Connector is not as specified.			
38. 86-677 Lines #2 - 6	AHS/China	$ 81,443.20	$ 41,284.80	Materials
	REASON: Samples for testing and evaluation were not made available as specified in the bid.			
39. 86-677 Line #3	MN Food Service/ China	$ 19,958.40	$ 16,769.28	Materials
	REASON: Due to the contractual administrative costs, the award was made to the vendor with the lowest overall cost.			

COMPUTER SYSTEM PROPOSAL

Mr. Fearing and Mr. Larson reviewed their software vendor evaluation results which has been narrowed down from 13 to 2 vendors. An extensive software evaluation search is being conducted because the current system is at maximum capacity and outdated. The two vendors were chosen after evaluating application dependent requirements, cross application tools, support and product lines. Next steps are to meet with the two finalists and negotiate price and support.

The new software will require the purchase of IBM hardware because it is not compatible with the Burroughs mainframes which will continue to be used. Burroughs was not chosen because their software is in the developmental phase. Initially, the upgrading of UMHC's financial applications will increase annual overhead by $145,000. However, it is believed that the increase in overhead will be offset by reduced internal development cost in the future as well as a more responsive, integrated, and expanded system.

Mr. Bienias moved, and Mr. Hewitt seconded the motion which was approved by the Committee to acquire the necessary computer hardware and software to support the recommended software.

HIBBING RELATIONSHIP

Mr. Kaufmann and Dr. LaBree told the committee that the Hibbing affiliation with UMHC has been approved by their medical staff. The affiliation will involve consultations in Hibbing by UMHC staff, referrals to UMHC and joint marketing programs.

CHILDREN'S NETWORK PROPOSAL

Mr. Kaufmann reported that proposals have been requested from consultants to determine the feasibility of UMHC entering into a children's network in the metro area. The study will be available March 31, 1987.

GERIATRIC STUDY

Results of a joint geriatric study were communicated to the committee by Mr. Kaufmann. The task force's findings and recommendations regarding the establishment of a geriatric discipline and assessment center are being reviewed by the Vice President of Health Sciences.

OTHER BUSINESS

Mr. Fearing informed the committee that UMHC signed a contract with Blue Cross/Blue Shield on December 8, 1986 that takes into consideration reimbursement of transferred patients from A and B Class hospitals as well as unique patients.

Ms. Janda informed the committee that Dr. Wilson will be replaced the beginning of next year when committee assignments are made.

The next Planning and Development Committee meeting will be on January 14, 1987 at 10:00 a.m.

ADJOURNMENT
The Planning and Development Committee adjourned at 11:35 a.m.

Respectfully submitted,

Lisa G. McDonald

Lisa Gaines McDonald
Assistant Director
Planning and Marketing

MINUTES
Joint Conference Committee
Board of Governors
December 10, 1986

ATTENDANCE:

Present: Phyllis Ellis, Chair
Dr. Jack Duvall
George Heenan
Dr. James Moller
Nancy Raymond

Absent: Dr. Seymour Levitt
Dr. Michael Popkin
C. Edward Schwartz

Staff: Jan Halverson
Greg Hart
Nancy Janda

Guests: Marjorie Carey
Al Dees

APPROVAL OF MINUTES

The minutes of the November 12, 1986 meeting of the Joint Conference Committee were approved as submitted.

SEVERITY INDEXING SYSTEMS

Mr. Al Dees presented an overview of severity indexing systems and their potential applications. Mr. Dees reviewed the historical development of these systems, compared and contrasted the various systems, and provided several examples of their potential application, particularly in the areas of reimbursement and utilization evaluation. Mr. Dees also stressed the limitations of the systems in their current stage of development.

The Committee had extensive discussion following Mr. Dees' presentation. The Committee approved a motion requesting staff to develop a "white paper" on severity indexing, focusing especially on the

policy position which the Board should take as it relates to application of these systems. There was one dissenting vote to the motion.

MEDICAL STAFF-HOSPITAL COUNCIL REPORT

Dr. Moller presented the recommendations of the Credentials Committee as approved by the Medical Staff-Hospital Council. The Joint Conference Committee endorsed the Credentials Committee report and recommendations.

Dr. Moller and Mr. Hart distributed and discussed a letter from University Hospital to the Foundation for Health Care Evaluation regarding the Foundation's proposed amendments to the Hospital PRO contract. The modifications proposed by University Hospital in the sanctions process portion of the proposed amendments were discussed in detail by Dr. Moller.

Dr. Moller also indicated that the Medical Staff-Hospital Council heard a report from Dr. Frank Cerra on the subject of Home TPN. Dr. Moller indicated that the Hospital, the involved clinical departments, and UMCA have developed an acceptable organizational model for proceeding with the Home TPN program; that model is essentially a joint venture within the context of a Hospital-based program. Dr. Moller also indicated that he will be appointing a task force to make recommendations on coordination of home care programs as they may evolve in the future.

CLINICAL CHIEFS REPORT

Dr. Duvall indicated that recent Clinical Chiefs' meetings have included discussion of severity indexing, as heard by the Joint Conference Committee, as well as a presentation from Senator Durenberger's new health aide, Helen Darling.

ADJOURNMENT

There being no further business the meeting was adjourned at 6:45 p.m.

Respectfully submitted,

Greg Hart

GH/kj

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 12, 1986

TO: Members of the Board of Governors

FROM: James H. Moller, 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 acted on the attached Credentials Committee Report and Recommendations on November 18, 1986 and the Joint Conference Comittee endorsed these recommendations on November 19, 1986.

I am forwarding these recommendations to you for your approval on December 17, 1986.

Thank you.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 2, 1986

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

ANESTHESIOLOGY	CATEGORY
Ellen L. Finch	Attending
DERMATOLOGY	
Mitchell E. Bender	Clinical
MEDICINE	
Kathryn E. Dusenbery	Attending - ER
Connie L. Manske	Attending
Roderick P. Robertson	Attending
David B. Staub	Attending - ER
Robert F. Wilson	Attending
RADIOLOGY	
Christopher C. Kuni	Attending
Robert E. McGeachie	Attending
Richard J. Patterson	Attending
William A. Wilcox	Clinical

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

SURGERY	CATEGORY	PRIVILEGES
Bruce L. Cunningham	Clinical	**Add**-Extremity transplants, extremity harvesting
Victor Gilbertsen	Attending	**Delete**-All surgical privileges
UROLOGY		
Pratap K. Reddy	Attending	**Add**-Extracorporel shockwave lithotripsy
PEDIATRICS	FROM	TO
Thomas B. Ferrara	Attending	Clinical

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

HOSPITAL DENTISTRY	CATEGORY	DATE ELIGIBLE
William P. Hoffmann	Clinical	August 26, 1986
Robert E. Derr	Clinical	August 26, 1986
MEDICINE		
N. L. Gault	Attending	August 26, 1986
Gary Baker	Clinical	August 26, 1986
PEDIATRICS		
Bruce R. Blazar	Attending	August 26, 1986
Helena B. Kosina	Clinical	August 26, 1986
Gary J. Remafedi	Attending	August 26, 1986
John C. Ring	Clinical	August 26, 1986
Chester B. Whitley	Attending	August 26, 1986

Regular appointments continued:

UROLOGY		
Cesar Ercole	Clinical	August 26, 1986
Erol Uke	Clinical	August 26, 1986

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

ANESTHESIOLOGY	CATEGORY
Edward Hanisch	Attenting
HOSPITAL DENTISTRY	
Thomas J. Dixon	Clinical
FAMILY PRACTICE AND COMMUNITY HEALTH	
John Foxen	Clinical
John H. Kiernan	Attending
LABORATORY MEDICINE AND PATHOLOGY	
Bonnie S. Bean	Attending
Edward P. Scott	Attending
MEDICINE	
C. Vicky Thomas	Attending
I. Dodd Wilson	Attending
PEDIATRICS	
Ann C. Dunnigan	Attending
RADIOLOGY	
John D. Roll	Attending

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 12, 1986

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Severity Indexing Systems

At last month's meeting of the Joint Conference Committee and the Board of Governors the importance of future use of severity indexing systems was discussed. We indicated that a more formal presentation on this subject would be made on this subject in December.

Mr. Al Dees, Associate Director, led a discussion on this important subject at the December 10, 1986 Joint Conference Committee meeting. Attached is the introductory material on severity indexing presented at that time. Mr. Dees will be available to present additional background information and answer questions at next week's Board meeting.

We look forward to discussion this with you.

GH/kff

Attachments

Text of Testimony Given To The

SENATE SPECIAL COMMITTEE ON AGING

November 12, 1985

by SUSAN D. HORN, Ph.D.

The introduction of prospective payment of hospitals, based on DRG classification, has been a positive initial step toward cost containment in the health care industry. However, experience over the last two years suggests that there are important ways in which the system can be improved. In a prospective payment system based on fixed payments per case within a group, it is critical that patients classified together require similar quantities of resources. Large differences in resource consumption within groups lead to unintended financial risk for hospitals, undesirable incentives for poor quality of care through mechanisms such as premature discharge, and improper profit through opportunistic patient selection.

Research shows that most DRGs classify together patients who require widely different resources[1,2,3]. This is reflected by the fact that the DRGs explain only about 30% of the differences in hospital resource use per case[1,4,5,6,7].

Further research confirms the clinical intuition that differences in the severity of illness of patients explain a large part of the remaining differences[4,5,6]. Several examples will illustrate this point. Figure 1 demonstrates how the average cost per case for patients in DRG 403 (Lymphoma or Leukemia, Age $\geq$ 70, and/or Complication or Comorbidity) varies both by severity of illness and by whether or not the patient had an operating room

procedure. Neither factor is recognized within this DRG.*[1] Hospitals that treat proportionately greater numbers of the more severely ill patients can be substantially under-paid. A hospital receives about $4000 for each patient in DRG 403, although this hospital's average cost per patient in DRG 403 was $6288.

A common disease among the elderly, Chronic Obstructive Pulmonary Disease, (DRG 88) is represented in Figure 2. The data are from two hospitals; Hospital A is a university teaching hospital with an average cost per case of $2703, and Hospital B is a community hospital with an average cost per case of $5078. The community hospital's average cost is almost twice that of the university teaching hospital because the patients in the community hospital are more severely ill. There are nine patients in severity levels 3 and 4 in the sample from Hospital B, while there is only one such patient in the sample from Hospital A. Thus, adverse impact of severity of illness differences in DRGs is not restricted to university teaching hospitals. Type of <u>hospital</u> is not the issue, but rather the type of <u>patient</u>. The current DRG-based prospective payment system, even with multiple adjustments for teaching status, urban and rural status, proportion of indigent patients, and tertiary referral center designation (all attempted surrogates for severity), does not adequately recognize this[4,5,6,8].

These are not atypical examples. In a recent study funded by HCFA, 94% of the DRGs were found to contain a wide variation of severity[4,5]. The

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[1]Patient severity is quantified by a four-level scale of increasing severity from level one to level four. Procedures are classified into three groups: non-operating room, moderate operating room, or major operating room, according to a fixed table for all procedures.

result is that when hospital payments are based on DRGs alone, some hospitals will be greatly over-paid and others will be greatly under-paid[4,6]. This is demonstrated in Figure 3, where we have simulated paying each of 14 studied hospitals on the basis of an unadjusted DRG payment system, shown in red, and on the basis of a severity-adjusted DRG payment system, shown in blue. Both payment mechanisms are budget neutral; the total amount of money paid out to the 14 hospitals is the same under both systems. However, unadjusted DRGs result in much greater over-payments and under-payments than severity-adjusted DRGs[4,6]. The severity-adjusted system is fairer, relies less on internal cross-subsidization, and sends rational market signals to the hospitals.

If the DRGs were adjusted for severity of illness, many disincentives in the current prospective payment system could be diminished or eliminated altogether. In particular:

1. Hospitals treating a less severely ill case load would not be UNDULY REWARDED; over-payment of less severely ill cases using the present DRG system provides no incentive for the efficient production of services.

2. Hospitals treating a more severely ill case load would not be UNDULY PENALIZED; patients who are more severely ill have justifiably higher costs which must be paid for somehow if these hospitals are not to be bankrupted and our national treatment system destroyed.

3. There would be no incentive to over-admit less severely ill patients, since the level of payment for such patients would be reduced.

4. The incentive for premature discharge of sicker patients, or

"dumping" of the more severely ill, would be reduced if the justifiable extra costs of caring for such patients were appropriately paid for.

5. Improved control of resource use would result from a more accurate matching of resource requirements to each patient's burden of illness. One hospital now using severity of illness classification for internal management purposes has estimated that as much as 30% of variable costs could be saved by evaluating resource use by severity level.

6. Atypically high patterns of resource use at the hospital level or at the physician level can be more easily identified, and then corrected, when severity grouping is used.

Prospective payment has, in principle, many excellent incentives to control health care costs. However, steps to control or reduce costs should be equitable and should provide incentives to maintain high quality care. A patient classification system used for prospective payment should be fair and should accurately describe a patient's resource needs. It is clear that DRGs alone are too coarse for this purpose, and research has shown that the surrogates now being used for severity of illness do not adequately address the differences. If DRGs were modified by a direct severity of illness adjustment, a large part of the present inequity in payment could be avoided, all hospitals would have improved incentives to deliver efficient and high quality care, no matter what the age or wealth of the patient, and government expenditures for hospitalization could be more effectively restrained.

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3. Horn SD, Horn RA, Sharkey PD. The Severity of Illness Index as a severity adjustment to DRGs. Health Care Financing Review (November 1984 Annual Supplement) 33-45.

4. Horn SD, Sharkey PD, Chambers AF, and Horn RA. Severity of Illness Within DRGs. Final report on HCFA Grant 18-P-98378/3-01. Baltimore MD: Johns Hopkins University, 1984.

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7. Coffey R and Goldfarb M. DRGs and Disease Staging for Reimbursing Medicare Patients, Hospital Studies Program Working Paper No.1. National Center for Health Services Research, Rockville, Maryland. October, 1984

8. Horn SD, Bulkley G, Sharkey PD, Chambers AF, Horn RA, and Schramm CJ. Inter-hospital differences in patient severity: problems for prospective payment based on diagnosis related groups. New England Journal of Medicine (July 4, 1985) 313: 20-24. Responses to this paper from former

HCFA Administrator Dr. Carolyne Davis and two other correspondents (together with our comments) were published as Letters to the Editor in the October 31, 1985 issue of the New England Journal of Medicine, pages 1163-1165.

Figure 1

DRG 403 – LYMPHOMA OR LEUKEMIA AGE > 70 AND/OR C.C.

WAGE-ADJUSTED COST

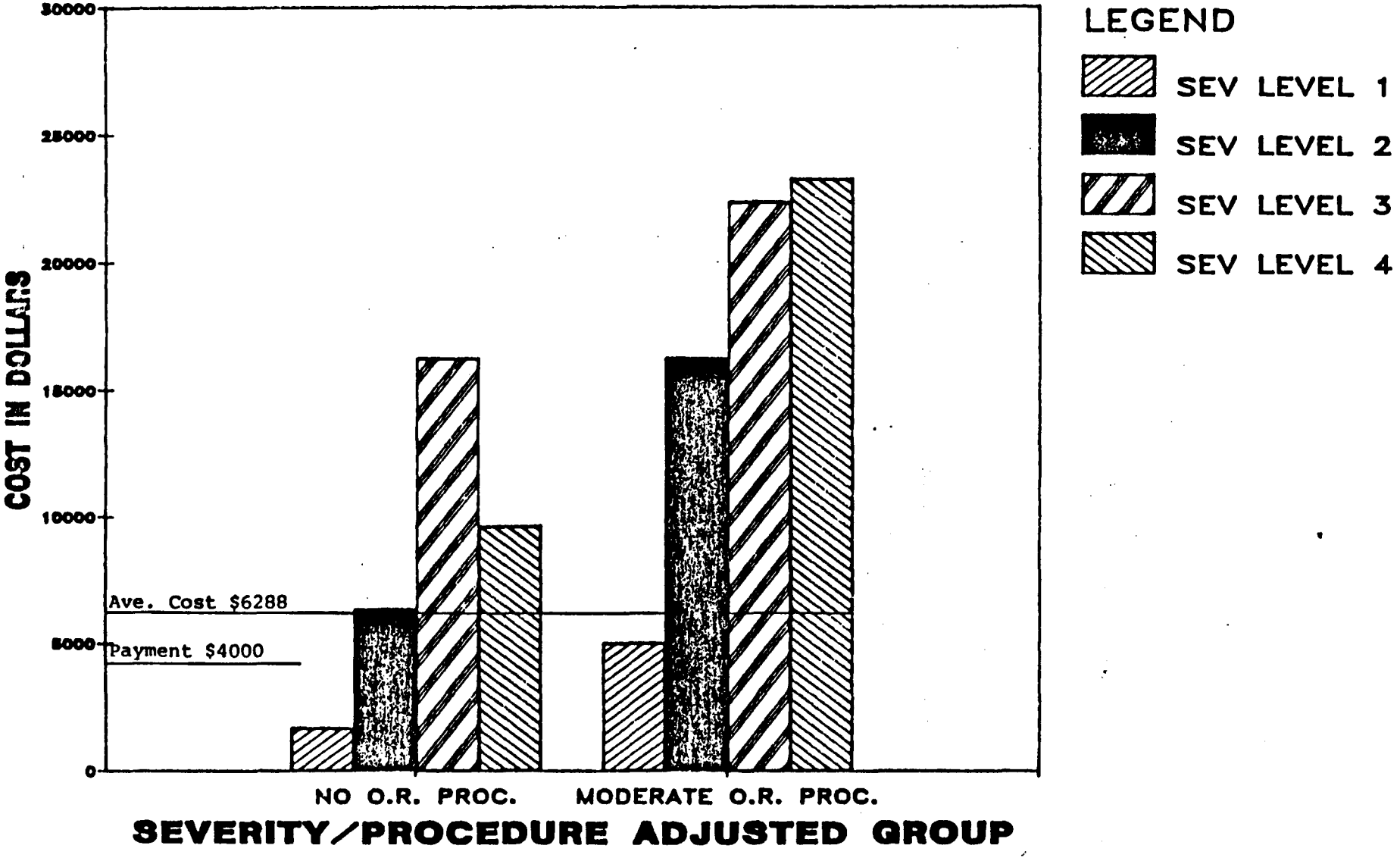


Figure 2

DRG 88
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
WAGE-ADJUSTED COST

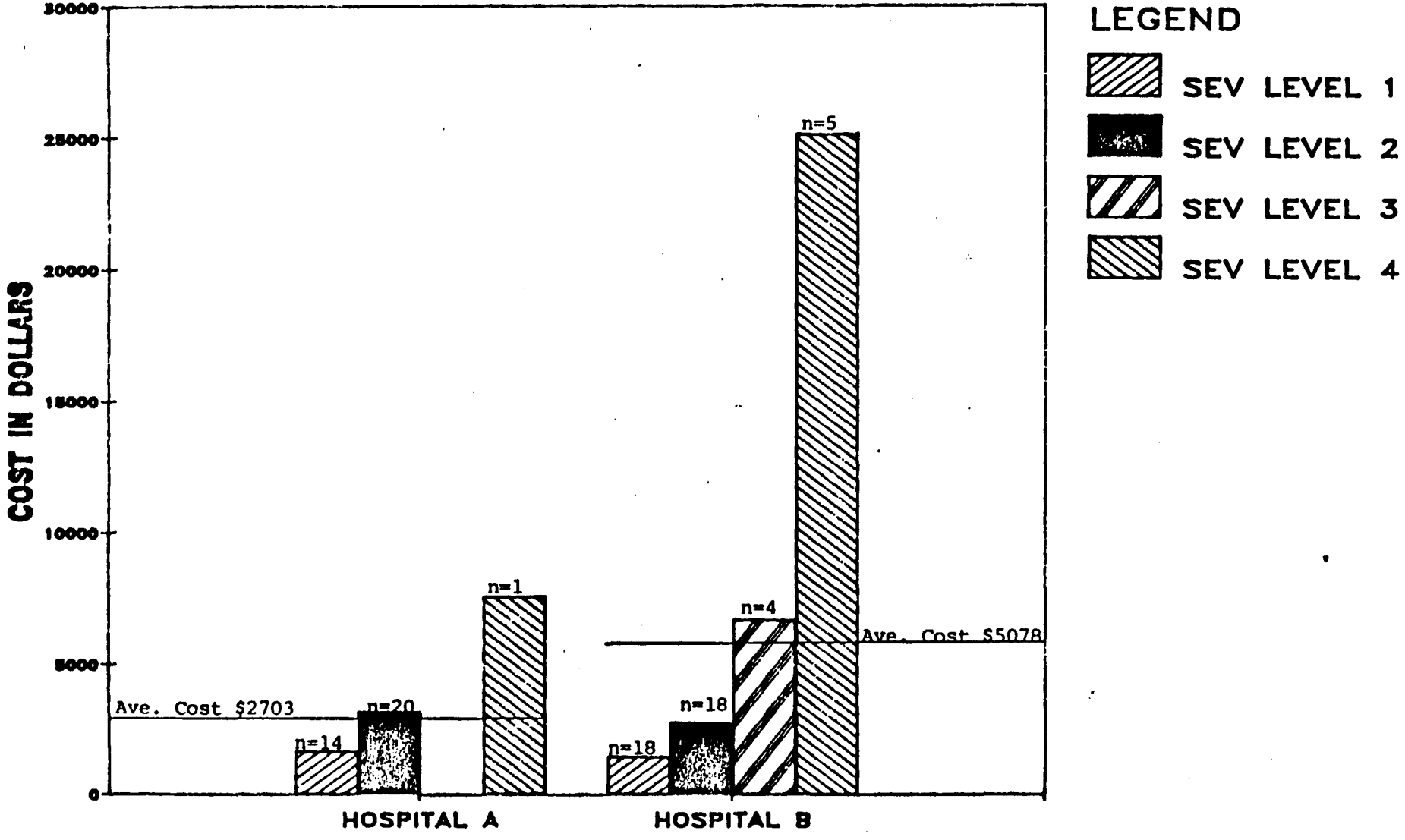
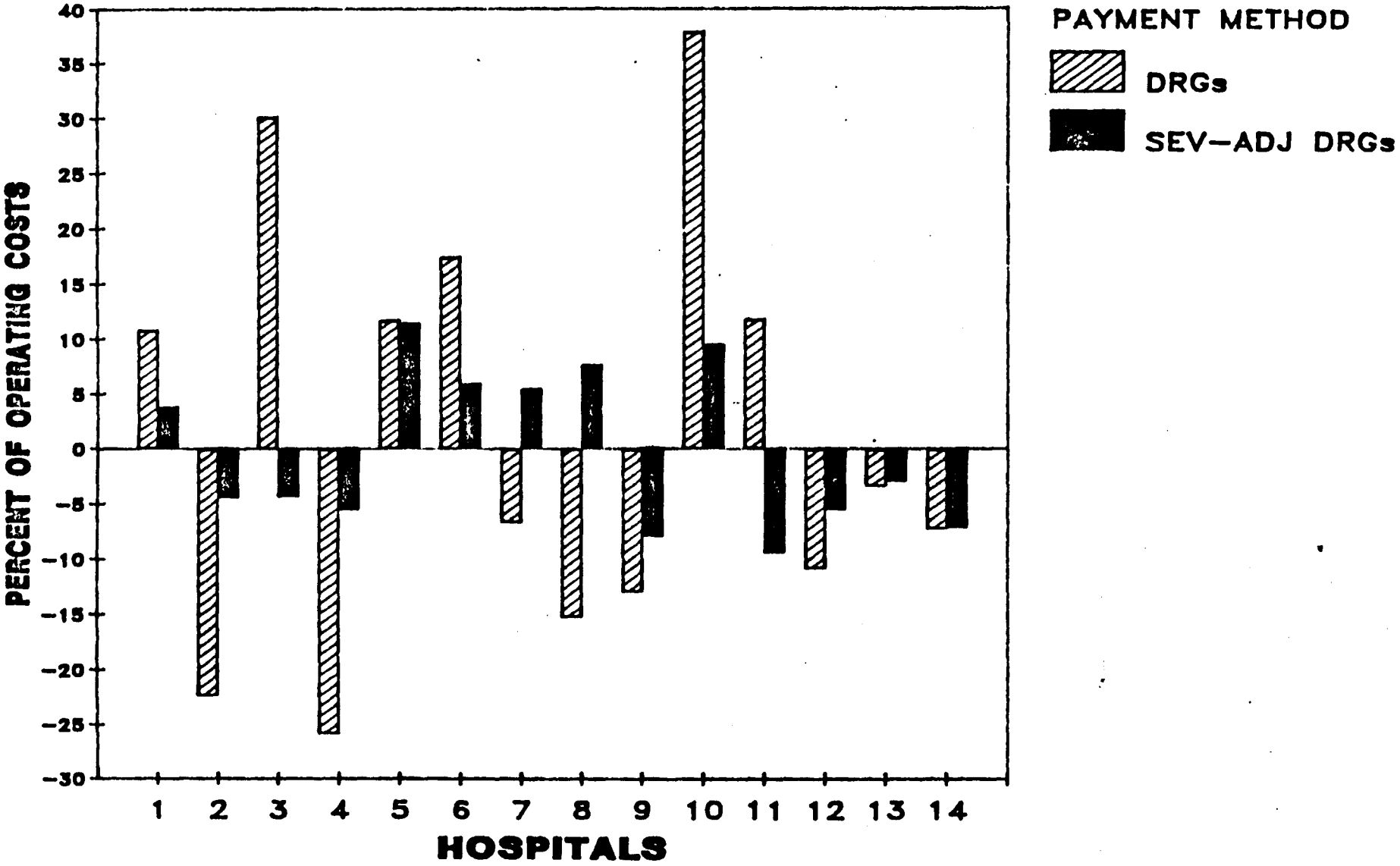
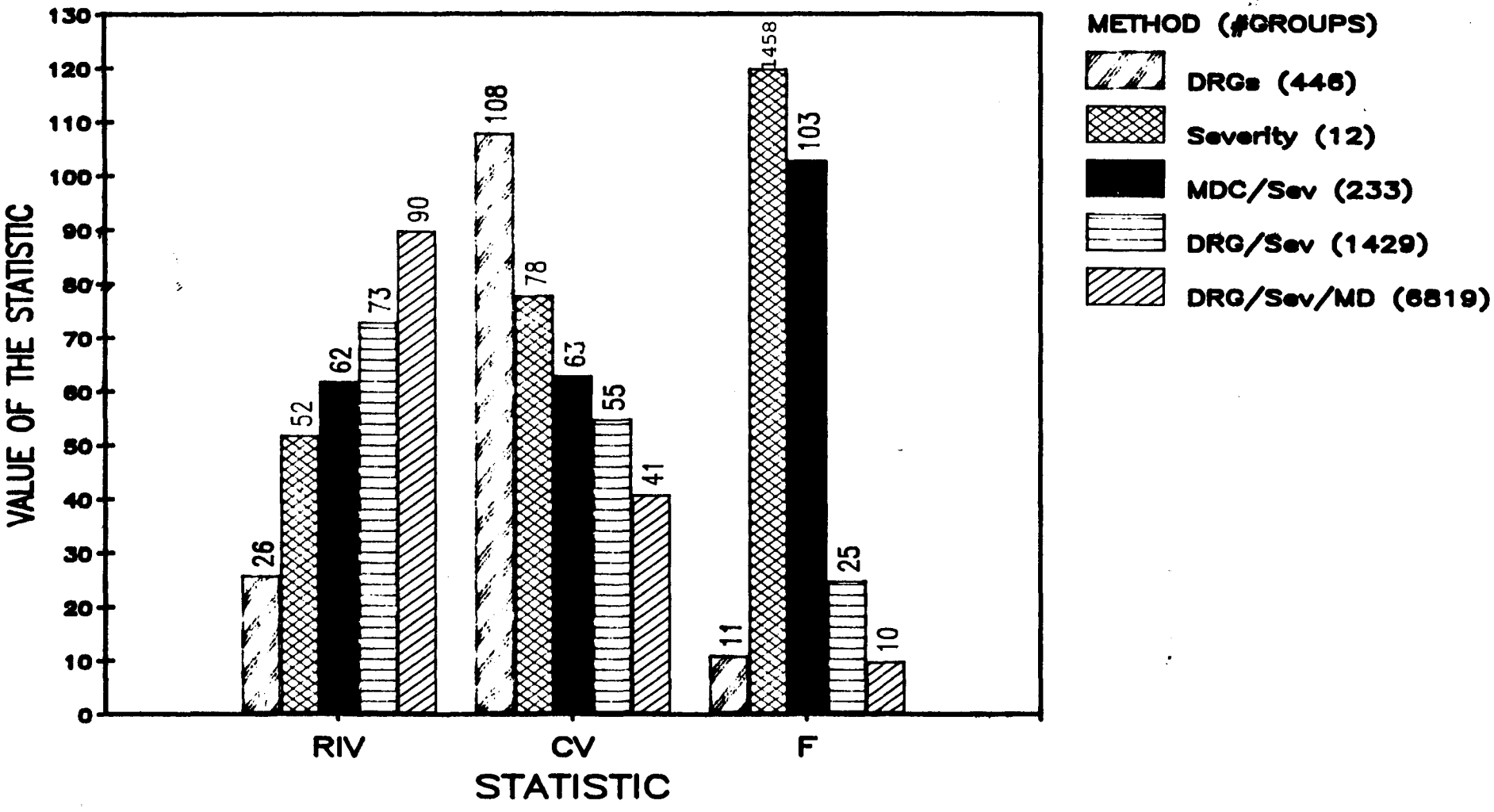


Figure 3

IMPACT ON PROSPECTIVE PAYMENT OVERPAYMENTS AND UNDERPAYMENTS AS A PERCENT OF TOTAL OPERATING COSTS



COMPARISON OF CASE-MIX METHODS
CHARGE DATA - ALL MDCs COMBINED
HOMOGENEITY STATISTICS N = 15,043
UNIVERSITY OF MINNESOTA HOSPITAL



FY83 QC Inc 4/20/84

Minutes
Meeting of the
Board of Governors Finance Committee
The University of Minnesota Hospital and Clinic
November 19, 1986

MEMBERS PRESENT:	Clifford Fearing William Krivit, M.D., Ph.D. Robert Nickoloff C. Edward Schwartz Vic Vikmanis
MEMBERS ABSENT:	Carol Campbell Edward Ciriacy, M.D. Al Hanser Jerry Meilahn
STAFF:	Kay Fuecker Greg Hart Nancy Janda Nels Larson Barbara Tebbitt

CALL TO ORDER: The meeting of the Finance Committee was called to order by Chairman Robert Nickoloff at 10:15 A.M. in the Dale Shepherd Room of the Campus Club. A quorum was not present.

MINUTES APPROVED: Dr. Krivit questioned whether the Board Designated Utilization Funding had been finalized. Mr. Fearing reported the Education Committee will be meeting in about 1-2 weeks, then meeting with the Clinical Chiefs, and finally brought to the Finance Committee. With no further discussion, the minutes of the Finance Committee meeting held on 11/19/86 were approved.

10/31/86 FINANCIAL STATEMENTS: Mr. Fearing reviewed the Report of Operations for the period July 1, 1986 through October 31, 1986. Census continues at a high level of 153 admissions above the budgeted levels and 1,330 patient days over the target budget for the month of October. Average daily census year-to-date is 425, while the average October daily census is 427. Outpatient Clinic visits are 2,800 over budget during October, and 8,500 visits over budget year-to-date. This census increase reflects in the operating statements as total revenue over expenses of $2,160,000 for a favorable variance of $3,579,591. Patient care charges through October totaled $78,410,683 and is 12.4% above budget. Routine revenue is 5.4% above budget and reflects our favorable patient day variance. Ancillary revenue is approximately $7,515,000 (15.5%) above budget

and reflects (1) the favorable variance in both admissions and clinic visits; and (2) the utilization of ancillary services per patient are higher than anticipated. Inpatient ancillary revenue has averaged $6,593 per admission compared to the budgeted average of $6,199. Outpatient revenue per clinic visit is averaging $167 compared to the budgeted average of $153.

Operating expenditures through October totaled $72,420,039 and are approximately $2,117,000 (3.0%) above budgeted levels. The overall unfavorable variance continues to relate to the increase in demand for patient services and is seen primarily as increased personnel costs (salaries and fringe benefits) and patient care supplies (drugs, blood, medical supplies).

The Accounts Receivables show a 4.6 day increase in October, now totaling 100.5 days. In the near future we expect to resolve the Blue Cross/Blue Shield payments due with a check for $1,200,000 to reduce the accounts receivables. This will be the second check in excess of $1,000,000 since September 1st because they adjust payments to us on a quarterly basis. We are also working with the State Department of Human Services to receive an advance on their older receivables.

Mr. Fearing reported the Hospital has received a bill from the State of Wisconsin indicating we owe them $1,463,000 because they paid us incorrectly in 1983-1984. We are meeting with our legal council to challenge this issue. We will report back to you our progress as we pursue this matter. In the meantime our auditors have adjusted our June 30, 1986 financial statements to reflect this possible payable.

Interest Expense is $1,277,000 under budget due to the refinancing and more money remaining in the Unit J Construction Account than anticipated because of a slower flow of payments for construction and therefore more interest earned on those funds. The interest income on this will offset the interest expense on the bonds.

The Cash Flow shows an operating deficit of $2,081,000 that is due to the $8,500,000 increase in accounts receiveable.

1986-87 FISCAL YEAR PROJECTIONS:

Mr. Nels Larson reported that for year-end financial statement projections we are projecting 18,200 admissions, up 1,250 from budget (6.9% variance). Length of Length of Stay is projected at 8.2 days, down .10 due to changes in the Epilepsy Program. Outpatient visits are projected to be 10% over budget by year-end.

Revenue from Operations will be $20,074,000 over budget and expenditure levels will be $15,665,000 over budget. Net revenues over expense are projected to be $3,473,000 better than those projected in the original budget. These changes will result in a net operations loss for 1986-87 of $7,796,000 as compared to the original budget of $11,269,500. The net cash projection for June 30, 1987 is only an increase of $1,120,000, because of the increase in accounts receivables and increase of $1,000,000 in capital expense purchases.

FINANCIAL SYSTEMS MODERNIZATION: Mr. Fearing presented the information distributed to the Planning and Development Committee On November 12, 1986 that discussed in detail the need for modernizing the financial system computer system. He explained that our present budget system cannot handle all of the functions we need to have available. He said we are presently keeping two sets of records -- one for the University and one for the Hospital -- and that we need to work to combine these records.

Mr. Fearing said they would not ask for endorsement of the proposal at this meeting because they are further evaluating the Burroughs system to see if we can stay with Burroughs. Because discussions with Burroughs are still underway it is too early to ask this Committee for endorsement. The proposal will be on the agenda again in December.

ADJOURNMENT: There being no further business, the meeting was adjourned at 11:20 A.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

December 17, 1986

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Report of Operations for the Period
July 1, 1986 through November 30, 1986

The Hospital's operations through the month of November continue to reflect both inpatient admissions and outpatient visit activity that are above budgeted levels. In addition, we continue to experience ancillary service utilization that is higher than anticipated. To highlight our position:

Inpatient Census: For the month of November, inpatient admissions totaled 1,480 or 128 above budgeted admissions of 1,352. Our overall average length of stay for the month was 8.4 days. Patient days for November totaled 12,726 and were 1,352 days above budget. The increase in admission levels is primarily in the areas of Medicine, Pediatrics, Surgery, and Urology.

To recap our year-to-date inpatient census:

	1985-86 Actual	1986-87 Budget	1986-87 Actual	Variance	% Variance
Admissions	7,320	7,289	7,828	539	7.4
Avg.Lnth.of Stay	8.3	8.3	8.4	0.1	1.2
Patient Days	61,066	60,564	65,010	4,446	7.3
Percent Occupancy	67.2	66.0	71.3	5.3	8.0
Avg.Daily Census	399.1	395.8	424.9	29.1	7.4

Outpatient Census: Clinic visits for the month of November totaled 18,464 or 1,114 (6.4%) above budgeted visits of 17,350. The November year-to-date clinic census totals 103,036 visits and is 10.2% (9,553 visits) above budget and 10.3% (9,607 visits) above our November total of a year ago. The increase in activity has been experienced in nearly all clinic areas with the largest increases occurring in Medicine, Psychiatry, and Urology.

Financial Operations: The Hospital's Statement of Operations shows total revenues over expense of $4,374,721, a favorable variance of $7,109,803.

Patient care charges through November totaled $96,875,648 and is 13.0% above budget. Routine revenue is 6.6% above budget and reflects our favorable patient day variance. Ancillary revenue is approximately $9,419,900 (15.8%) above budget and reflects (1) the favorable variance in both admissions and clinic visits; and (2) the utilization of ancillary services per patient being higher than anticipated. Inpatient ancillary revenue has averaged $6,602 per admission compared to the budgeted average of $6,199 per admission. Outpatient revenue per clinic visit is averaging $167 compared to the budgeted average of $153.

Operating expenditures through November totaled $91,059,149 and are approximately $3,529,300 (4.0%) above budgeted levels. The overall unfavorable variance continues to relate to the increase in demand for patient services and is seen primarily in increased personnel costs (salaries and fringe benefits) and patient care supplies (drugs, blood, medical supplies).

Accounts Receivable: The balance in patient accounts receivable as of November 30, 1986 totaled $69,853,705 and represents 106 days of revenue outstanding. The overall increase in our patient receivables in November of 5.5 days occurred primarily in the Medicare, Medical Assistance, Blue Cross, and HMO categories.

Conclusion: The Hospital's overall operating position continues to be positive and above budgeted levels. Both inpatient and outpatient census levels remain above budget. We continue to monitor our demand for service closely and make those operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1986 TO NOVEMBER 30, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$85,718,446	$96,875,648	$11,157,202	13.0%
Deductions from Charges	-13,282,999	-13,632,908	-349,909	-2.6%
Other Operating Revenue	2,199,643	2,195,114	-4,529	-0.2%
Total Operating Revenue	74,635,090	85,437,854	10,802,764	14.5%
Total Expenditures	-87,529,849	-91,059,149	-3,529,300	-4.0%
Net Operating Revenue	-12,894,759	-5,621,295	7,273,464	0.0%
Non-Operating Revenue and Expenses	10,159,677	9,996,016	-163,661	-1.6%
Revenue Over Expense	-2,735,082	$4,374,721	$7,109,803	(1)

(1) Variance equals 8.4 % of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	7,289	7,828	539	7.4%
Patient Days	60,564	65,010	4,446	7.3%
Average Daily Census	395.8	424.9	29.1	7.4%
Average Length of Stay	8.3	8.4	0.1	1.1%
Percentage Occupancy	66.0%	71.3%	5.3%	8.0%
Outpatient Clinic Visits	93,483	103,036	9,553	10.2%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1986 TO NOVEMBER 30, 1986

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$85,718,446	$96,875,648	$11,157,202	13.0%
Deductions from Charges	13,282,999	13,632,908	349,909	2.6%
Other Operating Revenue	2,199,643	2,195,114	-4,529	-0.2%
Total Revenue from Operations	$74,635,090	$85,437,854	$10,802,764	14.5%
Expenditures				
Salaries	$37,029,107	$39,737,524	$2,708,417	7.3%
Fringe Benefits	7,181,247	7,549,932	368,685	5.1
Contract Compensation	3,653,915	3,672,703	18,788	0.5
Medical Supplies, Drugs, Blood	12,835,023	13,924,758	1,089,735	8.5
Campus Administration Expense	2,608,335	2,608,335	0	
Depreciation and Amortization	5,911,837	6,751,552	839,715	14.2
General Supplies & Expense	18,310,385	16,814,345	-1,496,040	-8.2
Total Expenditures	$87,529,849	$91,059,149	$3,529,300	4.0%
Net Revenue from Operations	$-12,894,759	$-5,621,295	$7,273,464	
Non-Operating Revenues and Expenses				
Appropriations	$6,056,070	$6,191,362	$135,292	2.2%
Interest Income on Reserves	3,081,401	2,888,286	-193,115	-6.3
Shared Services	152,707	158,924	6,217	4.1
Investment Income on Trustee Held Assets	869,499	757,444	-112,055	-12.9
Total Non-Operating Revenues and Expenses	$10,159,677	$9,996,016	$-163,661	-1.6%
Revenue Over / -Under Expenses	$-2,735,082	$4,374,721	$7,109,803	(1)

(1) Variance equals 8.4% of total budgeted revenue.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

December 12, 1986

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director and Director of Finance

SUBJECT: Financial Systems Modernization Recommendations

At the November and December meetings of the Planning and Development and Finance Committees we covered in detail the need to modernize our financial application software in order to correct systems deficiencies and provide UMHC with financial information that meets our information needs. In addition we provided the Committees with an update of our general ledger software evaluation process and indicated that we had also reviewed a proposal within our existing computer environment to determine if it would meet our requirements for our financial systems plan.

In the process of planning for the replacement of our financial application software, the general ledger was selected as the initial system to be upgraded. The current general ledger is deficient in many respects and the new general ledger will serve as a foundation around which we will upgrade our other financial applications.

In establishing the long range plan and developing detailed requirements for the general ledger system, several key criteria were established to assure the correction of the existing major financial system deficiencies and reduce development and operational costs. They were:

- Systems must be flexible and have large enough capacity to accommodate UMHC data elements.

- State of the art, compatible financial subsystems, i.e. payroll/personnel, cost accounting, case mix management, etc., must be available in the market place to avoid internal development costs and subsystems must be able to interface with one another.

- Systems must all be interactive to financial data base.

- Systems must have the flexibility to allow the user to generate analysis and reporting consistent with senior management needs. Examples here would include:

    - Disease category utilization analysis by payor
    - Ancillary utilization by disease category
    - Charges per ICU day by payor
    - Salary information by employee class and department
    - Salary cost per unit of service
    - Allows management to extract information from multiple systems and design reports to fit their needs.

- Systems must be installed and operational at other user sites.

Thirteen general ledger systems were evaluated against these and more detailed criteria. Three vendors were determined to meet the critical criteria. These vendors were Data Design Associates (DDA), Management Science America (MSA), and McCormick & Dodge (M&D). All three systems under consideration require a change in computer hardware. Requests for proposals were solicited from these three vendors in early October and were received back on November 11, 1986. These proposals were then thoroughly evaluated by a project team comprised of members from both our finance and data processing departments.

In addition to completing our evaluation of the three general ledger application vendors, we also reviewed an alterative proposal within our existing hardware environment. We concluded from our evaluation that the application software technology we are seeking is not currently available within our current hardware environment.

On the basis of our evaluations we are confident that the long term solutions to our financial application system needs are best met within an IBM environment. We have reviewed the types and sizes of computers and believe that an IBM 4381-12 would meet our needs today as well as allow capacity for growth as we continue to replace our other financial systems (Fixed Assets, Accounts Payable, Inventory/Purchasing, Payroll/Time Reporting, Case-mix Reporting, Cost Accounting, and Patient Accounting). This size computer would also allow us to utilize a state-of-the-art operating system.

Our review of acquiring IBM hardware considered three options: purchase, lease/purchase or straight lease. The following is a summary of costs in implementing these options:

	Purchase	Lease/ Purchase	Lease
One-Time Costs:			
Hardware	$842,000	$ -0-	$ -0-
System Software	33,000	33,000	33,000
Facility Preparation (est.)	50,000	50,000	50,000
	$925,000	$ 83,000	$ 83,000
On-Going costs:			
Hardware Lease	$ -0-	$220,000	$208,000
Hardware Maintenance	40,000	40,000	40,000
System Software Maintenance	72,000	72,000	72,000
Staffing	145,000	145,000	145,000
	$257,000	$477,000	$465,000

For our 1986-87 budget we made an assumption that we would utilize the lease/purchase option and had included a projection of $720,000. This amount included a projected cost of the general ledger application software of $200,000.

We are requesting your approval to acquire, through the lease/purchase option, the necessary computer hardware and computer operating system software to support the application software we have selected. The cost of the purchase option on a five year leave/purchase agreement, over the cost of a straight lease agreement, would be a maximum of approximately $60,000 at the end of five years. While the lease/purchase option is slightly more expensive than a straight lease, the lease/purchase allows UMHC significantly better buyout terms in the event we would wish to purchase the hardware or trade up to a larger processor.

We are cognizant that in a dual vendor hardware environment there is some increased overhead. Initially, with the upgrading of our financial applications, the increased annual overhead will approximate $145,000. Because of the availability of application software within the IBM environment however, we believe that the increase in overhead incurred now will be offset by reduced internal development costs in the future.

We have included supplementary material for your review regarding the selection of the general ledger application software and the IBM hardware, these include a software evaluation summary, a software availability comparison between IBM and Burroughs products and a simulated hardware cost comparison. We look forward to discussing our hardware recommendation with you at the December 17, 1986 meeting.

G/L Software Vendor Evaluation

The following evaluation addresses the deficiencies of the systems as evaluated by the General Ledger Project Team. Every effort was made to insure the evaluation was objective and subjectivity was held to an absolute minimum.

The final three vendors were selected from an initial group of thirteen candidates. This initial selection was based on the systems being state of the art, offering compatible financial subsystems such as Payroll/Personnel, Cost Accounting, Case Mix Management, etc. . All systems must be available to the public and demonstrable in a user site. All systems must also be interactive to a financial database.

All three of the finalists offer state of the art Cross Application Tools. This is basically a system which overlays the financial systems allowing the user to access data from multiple applications. This ties financial data together with data from other systems such as clinical data for budgeting and reporting functions. Other important features include "user friendly" Report Writer and implementation tools, such as those which assist the user in interfacing to foreign applications and data from other mainframes.

The three finalists selected are:
- Data Design Associates (DDA), Sunnyvale CA; Offering a fairly complete line of financial products with the exception of Payroll/Personnel.
- McCormack and Dodge (M&D), Natick MA; Offering a complete line of financial products.
- Management Science America (MSA), Atlanta GA; Offering a complete line of financial products and selected healthcare related products.

Selection Criteria

The vendors were provided with an RFP (Request for Proposal) to which each vendor responded. These responses were evaluated by the project team based on user interviews, vendor demonstrations and user site visits. The evaluation and the RFP followed identical formats, point by point, to allow easy reference back to the vendor responses.

The format followed included:
- Application Dependent Requirements: Eleven elements were identified and evaluated;
  - * Account Identification
  - * Data Entry
  - * Data Storage
  - * Budgeting
  - * Audit and Control
  - * Security
  - * Allocations
  - * Edits
  - * Statistics
  - * Project Accounting
  - * Reporting

- Cross Application Tools: Seven elements were identified and evaluated;
  * Inquiry
  * Report Generator
  * Screen Generator
  * Interface/Translator
  * Microcomputer Interface
  * Batch Processing
  * Recovery/Backup

- Support: Four elements relating to different aspects of support were identified and evaluated;
  * Training
  * Technical Support
  * Documentation
  * On-going Support

- Product Line: Each vendor's product line was broken down into two elements;
  * Financial Applications
  * Healthcare Applications

The elements listed above were further broken down into quantifiable features when possible, and a weighting of elements was developed based on the importance of the feature as identified by the users and the Information Services personnel. Each feature was then evaluated as to falling into one of four distinct categories:

  * Feature is not available
  * Feature has limited function
  * Feature has acceptable function
  * Feature is full function.

The result of the analysis based on the aforementioned criteria eliminated one vendor from consideration. Further discussions will be held with the remaining two vendors to determine what final terms will be offered, so that a choice can be made comprising the best mix of application features and price terms.

SOFTWARE PACKAGE AVAILABILITY

Because all the financial subsystems require upgrades, the availability of compatible subsystems is an important consideration in our decision. Given that the availability of financial application software within the IBM environment is significantly greater than within the Burroughs environment, there is greater opportunity for UMHC to achieve its financial information needs in an IBM environment. Examples of package availability include:

Application	Burroughs Environment	IBM Environment
Fixed Assets	3	14
Accounts Payable	4	15
Purchasing	2	13
Inventory Control	2	8
Payroll/Personnel	3	18
Patient Accounting	1	10
Case Mix Management	1	9

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
HARDWARE COSTS

ALTERNATIVE: BURROUGHS A10FX

APPLICATION	ESTIMATED IBM UTIL.(%)	IBM CPU U.O.P	IBM CPU $/U.O.P.	IBM DISK	IBM OTHER	IBM TOTAL	ESTIMATED BURROUGHS UTIL.(%)	BURROUGHS CPU U.O.P	BURROUGHS CPU $/U.O.P.	BURROUGHS DISK	BURROUGHS OTHER	BURROUGHS TOTAL
PHASE I												
1. GENERAL LEDGER	5.000	0.140	$16,500	$15,000	$12,250	$43,750	4.667	0.140	$27,067	$15,680	$4,275	$47,022
2. FIXED ASSETS	2.000	0.056	$6,600	$6,000	$4,900	$17,500	1.867	0.056	$10,827	$6,272	$1,710	$18,809
PHASE II												
3. ACCOUNTS PAYABLE	8.000	0.224	$26,400	$24,000	$19,600	$70,000	7.467	0.224	$43,307	$25,088	$6,839	$75,234
4. INVENTORY/PURCHASING	10.000	0.280	$33,000	$30,000	$24,500	$87,500	9.333	0.280	$54,133	$31,360	$8,549	$94,042
5. PAYROLL/TIMEREPORTING	10.000	0.280	$33,000	$30,000	$24,500	$87,500	9.333	0.280	$54,133	$31,360	$8,549	$94,042
6. VARIABLE BUDGETING	5.000	0.140	$16,500	$15,000	$12,250	$43,750	4.667	0.140	$27,067	$15,680	$4,275	$47,022
7. CASE MIX/COST ACCOUNTING	5.000	0.140	$16,500	$15,000	$12,250	$43,750	5.000	0.150	$29,000	$17,000	$4,580	$50,580
8. PATIENT ACCOUNTING	40.000	1.120	$132,000	$120,000	$98,000	$350,000	37.333	1.120	$216,533	$125,440	$34,199	$376,172
9. IBM EXCESS CAPACITY	15.000	0.420	$49,500	$45,000	$36,750	$131,250	13.667	0.410	$79,267	$45,720	$12,519	$137,506
T O T A L S	100.000	2.800	$330,000	$300,000	$245,000	$875,000	93.333	2.800	$541,334	$313,600	$85,494	$940,429
BURROUGHS EXCESS CAPACITY	0.000	0.000	$0	$0	$0	$0	6.667	0.200	$38,666	$22,400	$6,106	$67,172
	100.000	2.800	$330,000	$300,000	$245,000	$875,000	100.000	3.000	$580,000	$336,000	$91,600	$1,007,600

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUARTERLY REPORT TO THE REGENTS

DECEMBER 12, 1986

INTRODUCTION

When the Board of Governors last presented a quarterly report to the Regents there were several questions about the relationship between The University of Minnesota Hospital and Clinic staff physicians and the physicians who refer patients to our hospital. The Board of Governors, together with the Medical and Administrative staffs, consider these relationships to be of primary importance to our organization. As such, the majority of our report this quarter is devoted to a discussion of the methods currently in place to facilitate positive interactions with referring physicians. A brief update on census levels, purchasing activities and personnel policies is also included.

REFERRING PHYSICIAN RELATIONSHIPS

Approximately three quarters of the patients admitted to The University of Minnesota Hospital and Clinic are referred by a non-University physician. It has long been recognized that maintaining positive relationships with these referring physicians not only contributes to quality care for the individual patient, but is in the best interest of our organization. For those reasons, several processes have been implemented to monitor the attitudes of our referring physicians and to remind our staff of the need to relate closely

with their colleagues in the community and beyond. A hospital based Outreach Office serves as a point of coordination of these efforts. The office is headed by Dr. John LaBree, a Professor in the Department of Internal Medicine.

Each month, referring physicians from select clinical specialties are sent a written survey that solicits input on the outcomes of their experiences with The University of Minnesota Hospital and Clinic. Every clinical service is surveyed at least two times annually. The introductory paragraph to the written survey explains in a forthright manner that our hospital is making an effort to improve communication between our staff and the physicians who refer patients to us. The questions are quite detailed and inquire as to whether satisfactory care and communication about that care has been provided. Consistently, about ninety percent of the responses received are positive. Any difficulties noted are discussed directly with the attending physician or the chief of the clinical service involved.

Secondly, the physicians at the University Hospital are provided with a daily printout listing the names and phone numbers of the referring physician of all their patients hospitalized. This printout serves as one frequent reminder that correspondence and calls are important.

Thirdly, on a quarterly basis the Outreach Office provides each clinical service a summarization of the source of their patients. It includes the names and addresses of all referring physicians, allowing for detailed analysis of referral patterns. Upon request, a more detailed report is available to clinical departments that highlights over time information on geographic distribution of patients and diagnosis categories, for example.

Lastly, and perhaps most importantly, we have established a group of thirty physicians from around the state who meet semi-annually to rate the successes and failures of our program. The Outstate Physician Advisory Committee, as they are called, is extraordinarily helpful in providing a realistic assessment of our relationships with outstate physicians and often provides constructive and useful suggestions for change. For your information, the current membership of the Outstate Physicians Advisory Committee includes:

Lowell Becker, M.D.	Cambridge	Byron C. McGregor, M.D.	Mankato
Frank Bures, M.D.	Winona	John Mork, M.D.	Worthington
Michael Busian, M.D.	Morris	Mark Muesing, M.D.	Brainerd
Raymond Christensen, M.D.	Moose Lake	John Myers, M.D.	Canby
Owen Coe, M.D.	Virginia	Ben Owens, M.D.	Hibbing
James DeVinck, M.D.	St. Cloud	John H. Sargent, M.D.	St. Paul
W.G. Dicks, M.D.	Bemidji	Robert N. Schulenberg, M.D.	Red Wing
Richard Dinter, M.D.	Hibbing	John Smith, M.D.	Edina
Thomas R. Edwards, M.D.	Grand Rapids	Vernon Sommerdorf, M.D.	St. Paul
James Evans, M.D.	Northfield	Don Stewart, M.D.	Crookston
Norman Hagberg, M.D.	Montevideo	James J. Tiede, M.D.	Willmar
John Hagen, M.D.	Austin	Thomas Vanderpool, M.D.	Paynesville
Stephen G. Henry, M.D.	Alexandria	Frederick H. Walter, M.D.	International Falls
Jane Killgore, M.D.	Bemidji	Thomas Watts, M.D.	Blue Earth
John Kluge, M.D.	New Ulm	Elton G. Wing, M.D.	Slayton
George W. Knabe, Jr., M.D.	Virginia	Barbara Yawn, M.D.	Worthington
James Lehmann, M.D.	Waconia	Robert Zemke, M.D.	Fairmont
C. Paul Martin, M.D.	Marshall		

The Board of Governors recognizes that these measures do not constitute a fool proof communication system. The individual physician will always represent a link that can enhance or deter these partnerships. The Medical Staff has, however, been increasingly determined in its support for and utilization of this program. With the guidance of the Outstate Physicians Advisory Committee, Dr. LaBree's strong leadership and the appropriate allocation of resources to the Outreach Program, the Board of Governors will continue to encourage the positive growth of these relationships for the future.

CENSUS

We are pleased to report that the inpatient census at the hospital continues to hold at greater than expected levels. Through the end of October, both the number of admissions and the number of patient days are 6.3% above budgeted levels. The outpatient clinics also continue to be very busy. Through October, there were 11.6% more visits to the clinics than had been budgeted for.

The Board of Governors had hoped to present your Board with revised 1986-87 financial and activity forecasts this month. However, it has become apparent that two contracts with third party payors that are now under negotiation could significantly alter these projections. Substantial contract alterations have been proposed by both agencies. The Board of Governors feel, therefore, that more accurate projections can be presented next month.

As an aside, it is worth noting that contract negotiations with all third party payors are becoming increasingly more sophisticated. The insurers, representing their employer groups and individuals, seek discounts to the costs of care. The University of Minnesota Hospital and Clinic cares largely for a complex, very ill patient population, making general price comparisons with other Twin Cities hospitals difficult. Unfortunately, methodologies available to statistically document severity of illness currently lack refinement. The Board of Governors and the Hospital are committed to assisting in the development of these measurement tools. We would like to more objectively document the quality and where necessary, the intensity of services provided here.

MERIT PAY PLAN

In October the Board of Governors approved, in concept, the implementation of a merit based pay plan for about 40% of the hospital employees that will begin next summer with the start of the fiscal year. It will not be extended to our organized employees or to general staff nurses and pharmacy staff who are compensated under a step plan that reflects community comparability. Recognizing that good performance appraisals must serve as the basis for any merit based compensation system, the hospitals supervisory staff is now participating in day-long appraisal training sessions.

PURCHASING

During the months of August, September and October, 1986, 8,350 purchase orders were processed. The total dollar value of these purchases was $11,032,947.50 Both the number of purchase orders processed and the associated expenditures are consistent with the last several quarters.

Purchasing activity through the University Hospital Consortium totaled $112,428 this quarter. These same purchases would have cost $8,914 more, had they not been bought through the Consortium. Group purchasing activity with the University Hospital Consortium is expected to increase in coming months.

Hospital stays shorten, costs rise 5.3% for year

By Maura Lerner
Staff Writer

The cost of going to the hospital in the Twin Cities rose 5.3 percent last year, but the increase would have been higher if the average length of stay hadn't dropped to just under four days per patient, a new survey shows.

The survey, by the Council of Community Hospitals, showed that the average patient spent only 3.9 days in the hospital in 1985, compared with 4.3 days the year before, council chairman Scott Anderson said Friday. That follows a drop of a full day in the length of stay between 1983 and 1984.

The survey compared charges at 33 Minnesota hospitals, including 28 in the metropolitan area. And while the survey showed wide variations from hospital to hospital, Anderson said the overall rate increase was well below the 6.8 percent national average, which was calculated from the medical component of the Consumer Price Index in 1985.

However, the rate increase was greater than the overall rise in the Consumer Price Index of 3.8 percent last year.

Anderson said Twin Cities hospitals have been aggressively trying to reduce hospital stays as a way of controlling spiraling costs. But he said hospital rates continue to rise because of the cost of labor and medical technology. In addition, because patients who remain in the hospital now are generally sicker, they require more intensive care than in the past, he said.

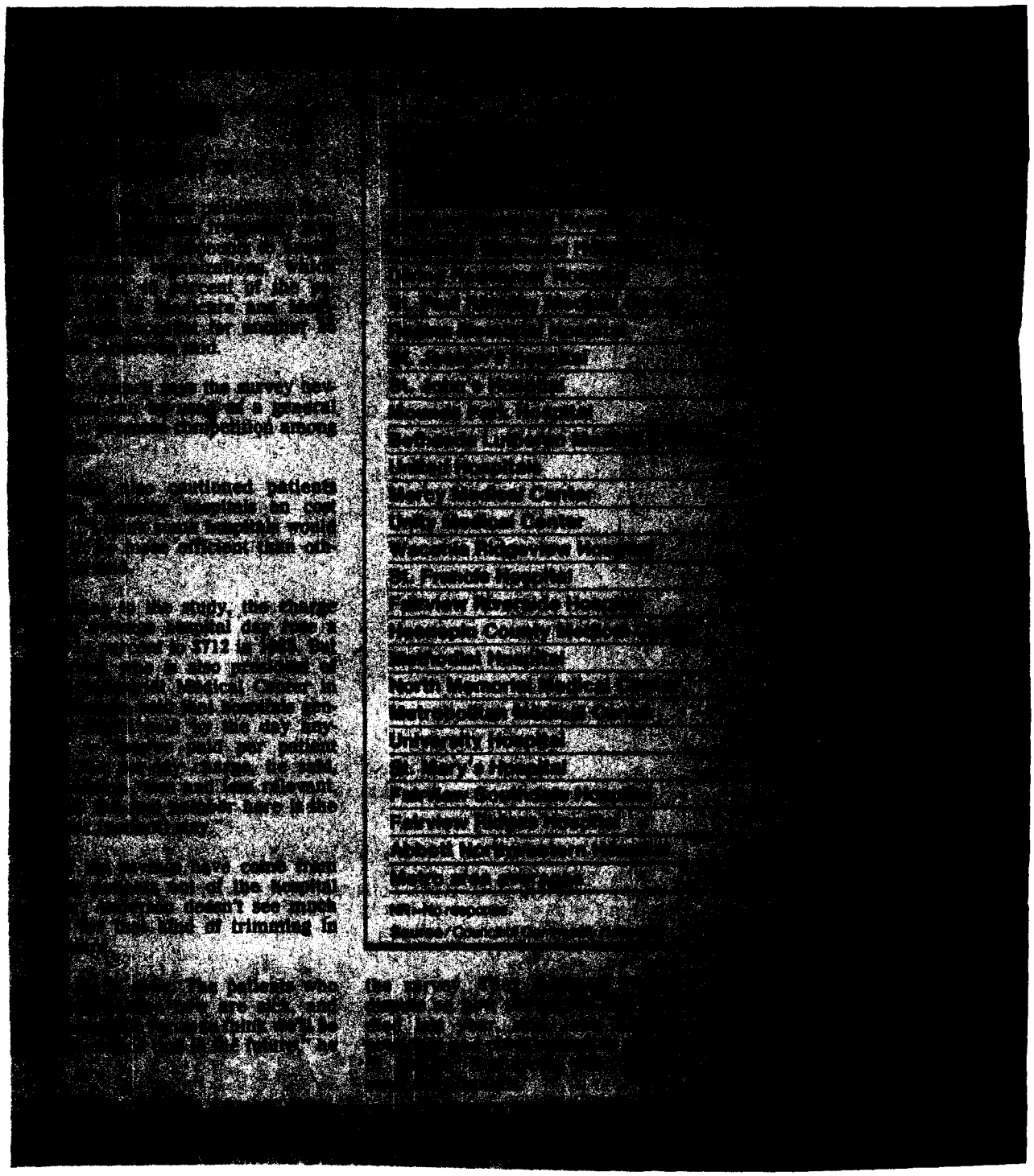
The survey itself, which has been published for four consecutive years by the council, compares area hospital charges for 25 medical diagnoses, from heart attacks to childbirth. A case of tonsillitis, for example, can cost a patient as little as $864 at St. Francis Hospital in Shakopee and as much as $1,462 at United Hospitals in St. Paul, according to the survey. Childbirth by normal delivery can cost from $709 at Lakeview Memorial Hospital in Stillwater to $1,472 at Metropolitan Medical Center in Minneapolis.

The survey, however, points out that the teaching hospitals, such as Hennepin County Medical Center, actually may have higher charges because of added costs associated with training doctors. To avoid penalizing those hospitals, the survey adjusted their charges downward to take those extra costs into account.

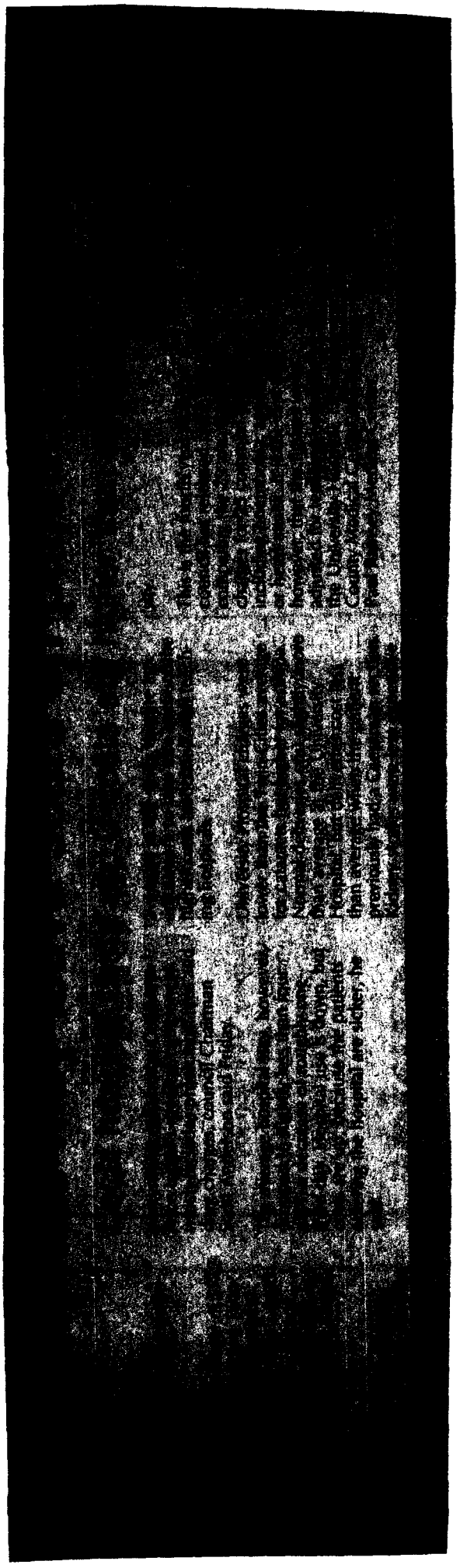
At the same time, the survey compared what hospitals charge, but not necessarily receive, for a given case. "This is like a sticker price on a car," said Edward Van Cleave, the council's vice president for information services.

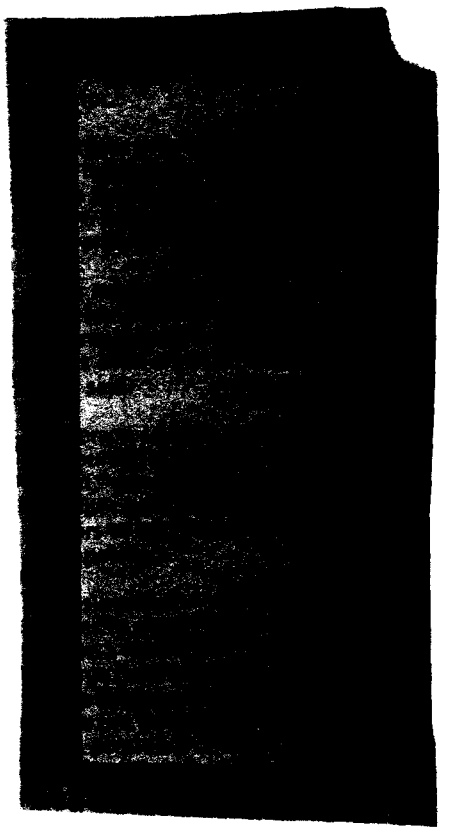
Hospitals continued on page 4B

November 15, 1986
Minneapolis Star & Tribune



November 17, 1986
Minnesota Daily





Wall Street Journal
November 24, 1986

Mayo Clinic to Bail Out Retirees' Home, Hoping to Avoid a Messy Legal Battle

By JEFF BAILEY and RICHARD GIBSON
Staff Reporters of THE WALL STREET JOURNAL

ROCHESTER, Minn.—The Mayo Clinic agreed to bail out an ill-conceived luxury retirement home here, hoping to avoid a messy legal battle that could have tarred the clinic and other powerful Minnesota institutions.

Directors of the general medical clinic's parent Mayo Foundation voted Friday to partly reimburse holders of $39 million in bonds that were sold to build the home. Named Charter House, the home has never filled more than about 60% of its 289 units and has been in default on interest payments since last February.

Under the agreement, to be announced today, bondholders will receive 60 cents for every dollar they invested. But that appears to be a far more generous settlement than a foreclosure would offer; consultants value Charter House today at only $4 million to $8 million. The retirement home will file for protection from creditors under Chapter 11 of federal bankruptcy law, though all creditors other than bondholders will be paid in full, says Richard F. Levy, a lawyer with Kirkland & Ellis in Chicago who represents Charter House.

"We wanted to make sure that no one could accuse Mayo of being unfair," says John H. Herrell, Mayo's chief financial officer, of the premium the clinic is paying over the asset value. Other trustees contacted yesterday declined to comment on the settlement.

Mayo isn't legally responsible for Charter House, a problem it inherited, but the bailout saves the clinic and others considerable time and trouble. A foreclosure of the property, a move that the trustee for the bondholders once threatened, would have been cheaper for Mayo. But it raised the specter of forcing [illegible] elderly people, all but a few of them former Mayo patients, from their homes. That didn't sit well with the foundation's high-profile board, which includes Federal Reserve Board Chairman Paul A. Volcker, former Tennessee Sen. Howard Baker and former Secretary of State Cyrus Vance. Robert L. Bartley, editor of The Wall Street Journal, is also a trustee.

"What a public relations [illegible]," says Ed Cladek, a consultant with [illegible] Hamilton Inc. who advised the clinic.

What's more, there were [illegible] inside the clinic that a nasty dispute could tarnish Mayo's sterling reputation amid an ambitious drive to expand nationally. It opened a satellite clinic in Jacksonville, Fla., last month and plans another in Arizona.

A dispute also could have included Minnesota's biggest bank, First Bank Minneapolis, trustee for the bondholders and one of Mayo's banks; the state's biggest law firm, Dorsey & Whitney, which represents both the bank and Mayo; Merrill Lynch & Co., underwriter of the bond offering; and Touche Ross & Co., the Mayo Foundation's auditor and author of a much-criticized feasibility study on the 22-story retirement home.

Mayo inherited the Charter House fiasco, and knew it faced problems, when it merged with two big Rochester hospitals earlier this year. One of them, Rochester Methodist, built the home and, when Charter House ran into problems, guaranteed millions of dollars in residents' deposits to keep them from fleeing. "There could have been a run on the bank," Mr. Cladek says. "It would have been a bad scene."

A Touche Ross study projected the home would be 90% full by the end of this year, but that turned out to be wildly optimistic. Charter House did well attracting Rochester residents, but neither farmers from surrounding areas nor residents from nearby states were inclined to retire there. "The best thing to do would be to put this thing on wheels and roll it down next to the Jacksonville clinic," Mr. Cladek says. Retirees generally move to warmer climates.

Indeed, Robert W. Fleming, vice chairman of the Mayo Foundation, doubts the home ever will be more than 60% occupied. And because of rapid turnover, even that won't be easy. "People die at a rate of about one a month," another Mayo official says.

Touche Ross officials say that prospects for Charter House looked good when the firm did its study, but they would [illegible] ment on what went wrong. [illegible] to the settlement said [illegible] still likely, though Mayo itself [illegible] to sue anyone.

George G. Collons, a retiree from Lincolnwood, Ill., invested $100,000, or almost a third of his nest egg, in the Charter House bonds and now is asking Merrill Lynch to cover his losses. "My broker indicated this was a good investment," he says.

Merrill Lynch stopped making [illegible] in the bonds, but it won't say [illegible] The securities firm says the [illegible] were fully disclosed in the [illegible] that it acted properly.

Meanwhile, some speculators have been buying up the bonds. Charles [illegible] Memphis, Tenn., bond trader, [illegible] tion at discount because "[illegible] bondholders will get 75 to 80 cents on the dollar.

The project also put First Bank [illegible] apolis, a unit of First Bank [illegible] a tough position. Mayo is [illegible] for the bank, but as [illegible] the bank legally must fight for every last penny. "The Chinese wall will be very high between the trust department and the bank," a source close to the settlement said. Terms call for Mayo to put up about $12 million cash and for the bank to apply that and another $12 million it holds in escrow from the project to pay holders. The bank agreed to the settlement.

Fight Grows Over Which Hospitals Should Perform Organ Transplants

By Alan L. Otten
Staff Reporter of The Wall Street Journal

Fairfax Hospital, a private medical center in the northern-Virginia suburbs of Washington, D.C., wanted to start a heart-transplant program. Citing its long experience with open-heart surgery, it argued that area citizens deserved a nearby transplant service as well.

The local health-planning agency bitterly disagreed. It argued that residents were already well-served by highly successful and comparatively low-cost programs at Johns Hopkins University Hospital in Baltimore and Medical College of Virginia in Richmond, both less than two hours away. Fairfax, it said, wasn't likely to be nearly so successful or cheap. Only after an appeal to the state health commissioner, and support from experts led by the South African transplant pioneer Christiaan Barnard, did Fairfax get a green light this year.

All across the U.S., similar battles are being waged. Federal and local officials and major private insurers are seeking to limit heart and liver transplants to a small number of "centers of excellence"—large hospitals with proven records of success and with the volume likely to keep costs down. But local hospitals—undoubtedly sincere in their desire to serve their communities better, but also anxious for the publicity and prestige likely to come with a transplant program—are fighting to enter the field.

"Hospitals feel that if they don't have a transplant program, they can't be considered first-class," says Marc Roberts, a Harvard University health-policy specialist. "It is the new local public-works project: Everyone wants one."

Political Sensitivity

In many states, hospitals can start transplant programs without permission from any government agency, and even in states where government sanction is required, politically sensitive officials find it hard to turn down a local hospital with powerful board members and community backing.

"It takes a very strong backbone to say no when one of these institutions comes in," says Roger Evans, a Battelle Memorial Institute expert who has directed several major transplant studies. "I fear efforts to limit centers will be undermined over time."

Last year, 71 centers claimed to have heart-transplant programs and 36 to have liver-transplant programs, but many have done only one or two operations each and some haven't yet done any. There were 719 heart transplants and 602 liver transplants performed last year, but a shortage of organs keeps the waiting lists long.

The basic argument for limiting centers concerns the chances of success. Most experts agree that the more extensive the hospital's experience—not only with the operation itself but also with the all-important post-operative care—the more likely the success of the operation and the recovery of the patient.

"All studies clearly indicate that it is a question of life and death for many people," says Sen. Albert Gore Jr., a Tennessee Democrat and a longtime activist in this field. "The same patient who will have an excellent chance of surviving at a center meeting reasonable criteria and having an established track record will have a reasonable chance of dying at a center without a track record and a critical mass of patients."

Last summer, a federal task force recommended that the government and private health insurers underwrite transplants only at a limited number of centers that meet minimum standards on annual volume, survival rates, staff experience and other criteria. For example, the task force suggested that a heart-transplant center be required to perform at least 12 transplants a year to win approval, and a liver-transplant center at least 15.

> 'HOSPITALS feel that if they don't have a transplant program, they can't be considered first-class,' says a health-policy specialist.

Testifying before a Senate committee shortly afterward, the task force's chairman, Olga Jonasson—a professor of surgery at the University of Illinois—said the group feared not only that less experienced centers would have poorer outcomes but also that "the costs of unnecessary duplication of expensive staff and resources will be very high. . . . Most serious of all, since the supply of organ donors is finite, every organ used in unqualified centers is an organ transplant denied to a recipient in a qualified center where the outcome is likely to be better and where new and improved treatments are developed and available."

Support for the "centers-of-excellence" approach appears to be growing among government and private insurers. Last month, the Department of Health and Human Services said it would pay for heart transplants for people on Medicare only at hospitals meeting strict tests. It estimated that only 10 centers currently meet its criteria, with perhaps another 10 joining them a year from now. In many states, Medicaid lays down similar tough limits on paying for heart or liver transplants for indigent patients. Private health-insurance groups such as the Health Insurance Association of America and the Blue Cross and Blue Shield Association are also pressing for limits.

But those who want new programs seem to make headway with their pitch for close-by care. "The key point is enhancing access for people in the area," says Frederick Green, the veteran George Washington University pediatrician who serves as spokesman for a consortium of six Washington-area hospitals seeking authority to do transplants for District of Columbia residents. "Heart-transplant operations require very intensive follow-up management for as much as six months, and there are major costs for an individual to have to relocate away from his home—not only economic costs but (also) social and psychological" costs.

The American Medical Association, the largest professional group for U.S. doctors, generally favors what it calls a "pluralistic approach" to medical facilities. "We don't want those complicated procedures done except where the hospital has the expertise to do it," says Roy Schwarz, an AMA official in Chicago. But, he adds, "if a hospital has trained staff, the equipment, the space, (then) we haven't chosen to take an exclusionary posture. We really aren't convinced it saves money."

Transplant Consortium

Clearly, holding the line on a limited number of centers is getting steadily more difficult. For example, Boston's Harvard-affiliated Brigham and Women's Hospital, an experienced heart-transplant center, yielded to local peer pressure and entered a transplant consortium with three other local hospitals. The promise was that the four would share doctors, staff training, post-operative care and other elements.

"But that was a political gimmick" to secure state approval, says George Annas, the Boston University bioethicist who headed a Massachusetts task force that urged restraint in approving new transplant programs. "Actually, except for using one procurement agency, each has its own separate program. The consortium has nothing to do with anything but raw political power."

In Ohio, the state health director is proposing to limit heart transplants to four hospitals able to handle the program without major capital expansion. Two of the hospitals are in Cleveland, one each in Columbus and Cincinnati. But now a Toledo hospital is seeking to join the group, claiming that patients in northwest Ohio would be at a disadvantage; if it wins, other applicants are bound to queue up.

It is far from clear how the struggle will finally come out, and results may continue to vary from area to area. Says Michael Batten, a White House aide involved in transplant issues, "Maybe the limited supply of organs and market economics will shake out the flash-in-the-panners."

The University of Minnesota Hospital and Clinic

Board of Governors

December 17, 1986

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****OTHER ATTACHMENTS****

Quarterly Report to the Regents, December 12, 1986
"Hospital Stays Shorten, Costs Rise 5.3% for Year, Minneapolis Star & Tribune, 11/15/86
"Area Hospitals May Leave Scars on Patients' Pocketbooks", Minnesota Daily, 11/17/86
"Mayo Clinic to Bail Out Retirees' Home, Hoping to Avoid a Messy Legal Battle" Wall Street Journal, 11/24/86
"Fight Grows Over Which Hospitals Should Perform Organ Transplants", Wall Street Journal, November 1986

*****PLEASE NOTE HOLIDAY GATHERING IN 5TH FLOOR LIBRARY OF THE CAMPUS CLUB IMMEDIATELY FOLLOWING THE MEETING*****

The University of Minnesota Hospital and Clinic
Board of Governors

December 17, 1986
1:30 P.M.
The Board Room, The University Hospital

AGENDA

I.	Approval of November 19, 1986 Minutes	Approval
II.	Chairman's Report - Ms. Barbara O'Grady	Information
III.	Hospital Director's Report - Mr. C. Edward Schwartz	Information
IV.	Committee Reports	
	A. Joint Conference Committee Report - Ms. Phyllis Ellis	
	1. Credential Committee/Medical Staff-Hospital Council Report and Recommendations	Approval
	2. Severity Indexing	Information
	B. Finance Committee Report - Mr. Robert Nickoloff	
	1. Financial Systems Modernization Plan	Approval
V.	Other Business	
VI.	Adjournment	

MINUTES

Board of Governors

The University of Minnesota Hospital and Clinic

November 19, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the November 19, 1986 meeting of the Board of Governors to order at 1:35 P.M. in the Board Room of the University Hospital.

ATTENDANCE:

Present:	Leonard Bienias David Brown, M.D. Shelley Chou, M.D. Phyllis Ellis Al Hanser George Heenan Kris Johnson Robert Latz David Lilly James Moller, M.D. Robert Nickoloff Barbara O'Grady Nancy Raymond Ed Schwartz Neal Vanselow, M.D.
Absent:	Jerry Meilahn

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the October 22, 1986 meeting as written.

CHAIRMAN'S REPORT:

Chairman Barbara O'Grady introduced Mr. John Kingrey, Vice President of Government Relations, Minnesota Hospital Association, and Ms. Dee Lutz of the Minnesota Daily.

Chairman O'Grady and Ms. Barbara Tebbitt described the National Commission on Nursing Implementation Project. The Commission is recommending direction on several aspects of professional nursing practice in this country.

Chairman O'Grady briefly outlined the October 31, 1986 Trustee Council Conference entitled "The Quest for Quality: The Next Competitive Wave". At that conference a panel of speakers discussed definitions of quality health care and reviewed patient information abstracting systems currently being developed or utilized. The Board of Governors expressed general support for the utilization of such information abstracting systems but questioned whether, in their current state, they accurately describe severity levels or quality of care. A comprehensive presentation on this topic will be presented at the December Board meeting.

Chairman O'Grady reported that the Nominating Committee will be appointed at the December Board meeting and reviewed the dates for membership, election of Chair/Vice Chair, and Committee Appointments:

Board of Governors membership finalized by Regents	December 12, 1986
Nominating Committee appointed at Board of Governors Meeting	December 17, 1986
Nominating Committee report made/officers elected	January 28, 1987
Board Secretary solicits committee preferences from Board members	January 23-30, 1987
Chairman of the Board makes committee appointments	January 30, 1987

Lastly, Chairman O'Grady reported that the Board Self-Evaluation questionnaire will be mailed out in December. Results will be presented at the January Board of Governors meeting.

JOHN KINGREY PRESENTATION:

Mr. Schwartz introduced Mr. John Kingrey, noting that he would overview several bills of interest to the Hospital that will be considered in the upcoming legislative session.

Mr. Kingrey explained that the Minnesota Hospital Association represents 167 hospitals in the state. His office formulates and communicates opinions on legislative initiatives on behalf of those hospitals. Mr. Kingrey reviewed the following issues:

1) **MA/GAMC:** The 1985 legislature provided an increase in government assistance programs but at a rate less than inflation. The legislature also continued to phase-out the GAMC ratable reductions. As biennial budgets will be considered in the upcoming session, the competition for funding increases will be intense. The Minnesota Hospital Association has recommended that legislators be informed of the increased disparity between the cost of providing services and what MA/GAMC will pay.

2) **Educational Preparation for Nursing Practice:** The Minnesota Hospital Association has long opposed any legislative proposal that would

mandate the baccalaureate degree in nursing as the educational preparation for entry into professional nursing. This opposition arises largely out of concern for nursing shortages and rising health care costs. It was noted that this issue is a controversial one where disagreement among member hospitals exists.

3) **Certificate of Need/Hospital Moratorium:** The scheduled sunset of the moratorium in 1987 will force the Legislature to re-examine its appropriateness or to consider alternate planning or review mechanisms. The Minnesota Hospital Association has taken the position that the moratorium has served to limit inpatient bed expansion and that it should be maintained. The Board of Governors questioned whether a new moratorium should allow for some flexibility to convert or relocate existing beds.

4) **Juvenile Justice Code:** During the 1986 session, revisions to the Juvenile Code were proposed which would have significantly altered inpatient chemical dependency and mental health illness treatment for minors. Recommendations included state licensure through D.H.S. for all chemical dependency and mental illness facilities and a civil commitment process for all minor admissions to chemical dependency and mental illness treatment programs, for example. The Minnesota Hospital Association anticipates that additional state requirements might interfere with treatment decisions that belong with family members and health care professionals.

5) **Workers Compensation:** The establishment of the two tier system in the 1983 Workers' Compensation Act did create new incentives for both employers and employees to return to work. However, the Minnesota Hospital Association feels that by leaving the minimum weekly compensationn benefit in tact, a financial disincentive still exists for certain employees to return to work. Some disagreement was expressed by Board members regarding the need for or merit of abolishing or lowering the minimum weekly compensation benefit.

6) **HMO Issues:** The Minnesota Hospital Association has opposed proposals to expand Medicaid demonstration projects statewide on the grounds that extension of the project is premature; the three demonstration counties experiment is far from complete.

   A Minnesota Hospital Association Task Force on HMO/Prepaid Capitation has been established and is currently examining health insurance regulatory requirements, PPO regulations and assignment of benefits issues. Minnesota Hospital Association is, therefore, not recommending action on issues related to HMO regulation at this time.

7) **Organ Donation:** In the passt two years, 27 states have enacted legislation aimed at increasing the availability of organs for transplantation. Minnesota Hospital Association has not recommended action at this time. Mr. Kingrey did describe the Minnesota Hospital Association Auxilliary project currently underway that is designed to increase public awareness about organ donation.

In conclusion, Mr. Kingrey briefly mentioned some upcoming and, at this point, less defined issues including living wills, property taxes for hospitals, home care licensure and a fetal disposal bill.

HOSPITAL DIRECTOR'S REPORT:

Mr. Schwartz noted that the Hospital's appropriation will be discussed in the next legislative session. Hospital representatives are currently working with the University Vice Presidents to review the current uses for and future necessity of this funding.

Mr. Schwartz noted that the Departments of Surgery, Medicine and Pediatrics, UMCA and the Hospital are finalizing an agreement for the provision of home alimentation services.

Ms. Helen Darling, Senator Durenberger's Health Aide, Mr. Schwartz noted, has been invited to the University the first week in December. She will be meeting with the Board of Governors 7:30 - 9:00 a.m. on Thursday, December 4, 1986. Vice President Vanselow is hosting an informal reception in Ms. Darling's honor on December 2, from 5:00 - 6:00 p.m. in the Campus Club.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

The Board of Governors seconded and passed a motion approving the purchasing policy on gifts and gratuities. It was noted that the policy covers hospital employees only and is not intended to be extended to the numbers of the Medical Staff or the Board of Governors.

A motion was seconded and passed to accept the Quarterly Purchasing Report as submitted. In reviewing the vendor appeals, the Board members inquired as to whether an increased level of specificity in writing bids might be in order.

JOINT CONFERENCE COMMITTEE REPORT:

Ms. Phyllis Ellis reported that the Patients First program is proceeding as planned. By early December, a vast majority of all hsopital employees will have participated in a training session. Dr. Frank Cerra from the Department of Surgery has assumed a leadership role in tailoring the Patients First program for the medical staff. The members of the Board of Governors emphasized the importance of including residents in this program and suggested that consideration also be given to communicating the principles of the program to medical students.

FINANCE COMMITTEE REPORT:

Mr. Robert Nickoloff briefly noted that the Finance Committee would continue to review financial statements every month but that detailed verbal presentations would be made to the full Board on a quarterly basis.

ADJOURNMENT:

There being no further business, the November 19, 1986 meeting of the Board of Governors was adjourned at 3:35 P.M.

Respectfully submitted,

Kay Fuecker

Kay Fuecker
Secretary, Board of Governors Office

MINUTES
Planning and Development Committee
December 10, 1986

CALL TO ORDER
Committee Chairman, Mr. Robert Latz, called the December 10, 1986 meeting of the Planning and Development Committee to order at 10:08 a.m. in Room 8-106 in the University Hospital.

Attendance:	Present	Robert Latz, Chair Leonard Bienias Clint Hewitt B. Kristine Johnson Geoff Kaufmann John LaBree, M.D.
	Absent	Frank Cerra, M.D. C. Edward Schwartz
	Staff	Fred Bertschinger Al Dees Cliff Fearing Greg Hart Nancy Janda Nels Larson Lisa McDonald

APPROVAL OF MINUTES
The minutes of the November 12, 1986 meeting were approved as distributed.

UNIVERSITY PLANNING PROCESS
Mr. Kaufmann informed the committee that UMHC will be participating in the University's five year planning process which consists of reviewing existing resources, determining future needs as well as contingency planning to assist the University in allocating resources. The Medical School's report, as well as Health Sciences, is due in January. In the interim, hospital administrators will serve on all the Health Sciences' task forces to provide ongoing information so that UMHC's plan will reflect Health Sciences assumptions.

UPDATE ON PATIENTS FUND SOLICITATION
Mr. Bertschinger reported on the annual Patients Fund Drive whose goal is to increase revenues, broaden the solicitation base from 200 to 5,500 potential donors, and cultivate employees. Three different letters were mailed on December 5, 1986 to employees, the medical staff, and the Board of Governors.