Board of Governors

University of Minnesota Hospitals & Clinics

October 17, 1979

1:30 P.M. - 555 Diehl Hall

Agenda

I. Announcements/Introductions

Al Hanser, Board Chairman

II. Minutes - September 19, 1979 Meeting

Al Hanser, Board Chairman

III. Introduction to Department of Pediatrics

William Krivit, Professor & Head, Department of Pediatrics

IV. Finance Committee Report

David Cost, Committee Chairman

V. Planning & Development Committee Report

Harry Atwood, Committee Chairman

VI. Joint Conference Committee Report

Sally Pillsbury, Committee Chairman

VII. General Director's Report

John Westerman, General Director

VIII. Board Concerns

Al Hanser, Board Chairman

Minutes
Board of Governors
University of Minnesota Hospitals and Clinics
October 17, 1979

Present: Mr. Al Hanser, Chairman
Mr. Harry Atwood
Ms. Jo-Anne Barr
Ms. Dionisa Coates
Mr. David Cost
Mr. Dave Domaas
Mr. Orville Evenson
Ms. Debbie Gruye
Mr. Ed La Fave
Ms. Mary Lebedoff
Mr. Virgil Moline
Dr. John Tiede
Ms. Timothy Vann
Dr. Paul Winchell

Absent: Ms. Sally Pillsbury, Vice Chairman
Mr. Al France
Ms. Jeanne Givens
Mr. John Mason
Dr. John Najarian
Dr. Paul Quie
Mr. Jack Quistgard
Ms. Margaret Sandberg
Dean Lawrence Weaver
Mr. John Westerman

The meeting of the Board of Governors of the University of Minnesota Hospitals and Clinics was called to order by Chairman Hanser at 1:35 p.m., in Room 555 of Diehl Hall.

I. Announcements/Introductions

Chairman Hanser introduced Ms. Estelle Sell who is a member of the Board of the University Hospitals Volunteer Association and that Board's liaision representative to the Board of Governors. Ms. Sell announced that the UHVA Board recently and enthusiastically endorsed the concept of UHVA's involvement in the communications program for the Renewal Project. She indicated that the UHVA Board is looking

forward to meeting with the Governors, Administration, and representatives of Padilla & Speer (the public relations firm for the project) to learn of the specifics of the program.

II. Minutes - September 19, 1979 Meeting

Chairman Hanser called for approval of the minutes of the last Board of Governors meeting. Ms. Barr moved that the minutes be approved. Her motion was seconded, voted upon, and passed.

III. Joint Conference Committee Report - Ms. Sally Pillsbury, Committee Chairman

Reporting in Ms. Pillsbury's absence was Ms. Mary Lebedoff, who chaired the Joint Conference Committee meeting of the previous night. Ms. Lebedoff first called upon Dr. Russell Lucas, Vice Chief of Staff, to report on various Medical Staff related items in place of Dr. Quie who was out of town.

Dr. Lucas began his comments by referring the Board members to their copies of the book entitled, "University of Minnesota Hospitals and Clinics End-Stage Disease Program and Policy Statement for the Renal Transplant Center and Dialysis Program." He explained that there exists a Federal regulation which requires that the policies and procedures for such a unit be approved by the governing body. This formality and others assure continued recognition of the program as a Federally designated center. Dr. Tiede moved for approval of the policies and procedures. His motion was seconded. It was pointed out that the book had also been approved by the Medical Staff/Hospital Council and the Joint Conference Committee. Mr. Moline commented on the great attention to detail in terms of safety precautions in the program. Dr. Tiede's motion was then voted upon and passed. Ms. Lebedoff added that she was hopeful that the new members would soon have an opportunity to tour the Kidney Dialysis area. Dr. Lucas also mentioned that similar compilations of policies and procedures have been gathered for the special care areas. He indicated that they too have been reviewed by the Medical Staff/Hospital Council but added that they did not require Board of Governor's approval.

Next, Dr. Lucas reviewed with the Board the appointments of the Chairmen of the various sub-committes of the Medical Staff/Hospital Council. He briefly described each committee, its chairmen and its functions. Dr. Lucas then moved for approval of the appointment of the positions through June 30, 1980. His motion was seconded by Ms. Coates, voted upon and passed.

The Credentials Committee report followed as Dr. Lucas' last item of business.

He reviewed the backgrounds of those individuals seeking provisional Medical Staff appointments, indicated those who were now ready for regular appointments, and commented on those resigning. He then moved that the Board approve the Credentials Committee report as recommended by the Medical Staff/Hospital Council and the Joint Conference Committee. His motion was seconded, voted upon, and passed.

Ms. Lebedoff mentioned that Dr. Seymour Levitt, Chief of Therapeutic Radiology, and Dr. Louis Dehner, Associate Professor, Lab/Med/& Pathology, were present at the Joint Conference Committee. Neither Dr. Levitt nor Dr. Dehner are members of the Committee but they were kind enough to attend representing the Council of Clinical Chiefs and the Medical Staff/Hospital Council so there would be a quorum for the meeting.

Ms. Lebedoff then reported on the audit on Respiratory Distress Syndrome in Newborns. She noted that the audit was presented to the Joint Conference Committee by Dr. Ted Thompson who is an Assistant Professor in Pediatrics and head of the Hospital Neo-Natology Program. She explained that the audit was a re-audit having first been conducted in 1975. She stated that the audit indicated that since that time, length of stay, complications, and deaths have been reduced. She briefly explained respiratory distress syndrome as a collapsed lung problem making breathing for tiny babies extremely difficult. She noted that while advances in equipment, such as a new ventillator, improved treatment the true credit goes to the dedication of the doctors and nurses who work in that unit. She also announced that of those babies who survive, 85% grow to lead normal lives and added that good parent education is stressed as the babies leave the hospital. Ms. Lebedoff then moved that the audit be approved. Her motion was seconded by Mr. Evenson and voted upon and passed. Ms. Sudduth was then asked to collect the audit summaries from the Board members as they are confidential.

Next, Ms. Lebedoff referred the Board of their copies of the Orange Alert Drill Critique. She reported that Dr. Daniel Hankins, the new Director of the Emergency Room and new Chairman of the External Disaster Committee, presented the critique to the Joint Conference Committee. She explained that the simulated disaster took place on September 9, 1979, at 8:35 p.m., and that it involved three seperate car accidents resulting in 17 casualties. She reported that the drill went well and pointed out that previously indentified problems were not repeated. She stressed that for the first time Surgery's response to the drill was very

good. Ms. Lebedoff indicated that discussion of the critique at the Joint Conference Committee meeting suggested the need to designate one triage officer rather than a triage team. She then moved for approval of the Orange Alert Disaster Drill Critique. Her motion was seconded by Mr. La Fave, voted upon and passed. Ms. Barr inquired as to how the casualties were obtained. Ms. Foley explained that Mr. Wally Caryl, Director of Emergency Preparedness for the University, secures volunteers, usually students who are made up as victims. She stated that the Hospital has little involvement in the process as it must not know of planning in advance of the drill for it to be an effective surprise. She indicated that she would be happy to accommodate any Board member's interest in participating in a drill.

In concluding her report of the Joint Conference Committee meeting, Ms. Lebedoff commented that Chairman Hanser had stated that he had forwarded to Dr. Quie a copy of an article from Fortune magazine about Johns Hopkins and a practice instituted there by which physicians review patient bills. She noted that Chairman Hanser's interest is that such a process be instituted here with a similar end result of reduced charges to patients. Also, she indicated that Mr. Evenson had raised a point regarding the further itemization of patient bills to demonstrate the cost of malpractice insurance. She stated that this matter was referred to the Executive Committee of the Board.

IV. Finance Committe Report - Mr. David Cost, Committee Chairman

Mr. Cost reported that there was no Finance Committee meeting due to a lack of quorum, but indicated that he was able to meet with Mr. Fearing and Mr. Larson. He indicated that they discussed projected year-end outcomes for the fiscal year and whether possible modifications may need to be made and brought before the Rate Review Board. He also stated that they considered the development of guidelines for budgeting for the coming fiscal year. Mr. Cost added that Ms. Barbara Tebbitt, Director of Nursing Services, had also planned to present to the Committee. He stated that all the above mentioned items will be covered at the November Finance Committee meeting.

Mr. Cost then called upon Mr. Nels Larson to highlight the current Statement of Operations. Mr. Larson reported that while Admissions were down, the Average Length of Stay has increased, and the end result is more patient days. He noted that the Occupancy Rate through September was 76%. Mr. Larson also stated however, that Out-Patient Visits are running 6% below projections. He mentioned that

Administration is examining this occurance but to this point, they have no significant findings. The resulting financial picture Mr. Larson viewed as positive in that there is an excess of revenue over expenses of $634,647. He stated that this position was due to a favorable balance in expenditures caused primarily by a decreased utilization of ancillary services. Specifically he indicated that activity in the Blood Bank and Operating Rooms had decreased without certainty as to whether the trend was temporary or long term. Mr. Larson suggested that there will be an in-depth analysis of the first quarter's trends at the November Finance Committee meeting.

V. Planning & Development Committee Report - Mr. Harry Atwood, Committee Chairman

Mr. Atwood reported that members of the Planning and Development Committee toured the Distribution Center prior to their meeting that morning. He added that Ms. Lebedoff, who had been a member of the Committee when the Distribution Center Project was planned, was also present for the tour. He noted that the Center was an impressive display of the state of the art techniques in materials handling. He added that he was sure that arrangements could be made through Ms. Foley or Mr. Dickler should anyone else wish to make the tour.

Mr. Atwood next raised with the Board members the subject of the proposed Clinical Laboratories Project and the pending Certificate of Need application. He reminded the Board that this subject had been introduced to them at their September meeting so that they would have time to review the project and application prior to taking action on it at this months meeting. He explained that the purpose of the project is to correct spatial deficiencies and improve quality considerations. He added that since it was presented, staff had further refined their original cost estimates of the project and had found an increase of $69,082 over preliminary figures. Mr. Atwood noted that the project was not unanticipated and reminded the Board that it was included in long range capital planning documents and in the Ernst and Ernst Debt Capacity Study. Mr. Atwood also stated that the Laboratory Project is completely seperate from the Hospitals' Renewal Project. He then called upon Mr. Dickler to comment further on the Project.

Mr. Dickler explained that activity in the Clinical Laboratories has more than doubled in the last ten years. He suggested that this project be considered a first phase approach to meeting that demand because this project will not

solve all laboratory problems but will certainly address the most immediate ones. He explained that the project involves remodeling some current lab space, moving into new space in the University Hospitals Clinics Building, (Floors 5, 7, and 15), and moving into new space in the Mayo Building. Mr. Atwood then moved that the Board of Governors approve the Planning and Development Committee's recommendation to proceed with the Certificate of Need application for the Clinical Laboratories Project with an estimated cost of $7,461,461. His motion was seconded. Mr. Domaas indicated that he had worked in the laboratories of University Hospitals in 1976. He stated that there existed spatial deficiencies then and added that he therefore, fully endorsed the project. Chairman Hanser then called for a vote on Mr. Atwood's motion to proceed with the Clinical Laboratories Project. The vote was taken and the motion was passed.

Mr. Atwood then asked to speak on the subject of the Minnesota Association of Public Teaching Hospitals although the issue had not been covered in the Planning and Development Committee meeting. He indicated that he was aware that MAPTH had been discussed at the September Board meeting and that no action had been taken of the incorporation business. He reviewed the background of University Hospitals' involvement in MAPTH, the study by the Health Services Research Center and the resulting recommendation that the organization be formalized by incorporating. He noted that at the September Board meeting draft Bylaws for the corporation were reviewed. He reminded the Board that the reasons for incorporation included better standing for the organization in the community and with community agencies, a tax exempt status and better likelihood of receiving grant funding, and also, better legal protection for its members in the event of wrong doing. Mr. Atwood stated that discussions in September indicated concern that University Hospitals did not have sufficient protection. He indicated that for that reason an arrangement was made in the Bylaws giving each institution veto power. He also added that the Board of Governors has very good representation on the MAPTH Board through three of its five members --- Dr. Quie, Mr. Westerman and himself. Another member happens to be a representative from the Office of the Vice President for the Health Sciences so, in essence, University Hospitals has six representatives on the MAPTH Board. Mr. Atwood went on to explain that budget projections for the corporation indicate that each institution will be required to commit from $25,000-$30,000 for a 3-5 year period. He added that he believed in the importance of MAPTH because of the current community environment for health care providers

and the need for the public teaching hospitals to join the unique forces for growth in the future. Mr. Atwood then moved for approval of the incorporation of MAPTH and University Hospitals and Clinics' membership in that organization and their annual commitment of $25-30,000 for a 3-5 year period. His motion was seconded. Mr. Domaas inquired as to whether Mr. Mason's concerns of the previous month regarding incorporation had been addressed. Mr. Diehl responded that he had discussed the matter with Mr. Mason and believed that Mr. Mason was cautioning the Hospitals against an unfortunate occurrence which the School Board had suffered. Mr. Mason was however, reassured that the veto clause in the MAPTH Bylaws would prevent such difficulties. Mr. Atwood's motion was voted upon and passed.

VI. Introduction to Department of Pediatrics - Dr. William Krivit, Professor and Head of Pediatrics

Dr. Krivit commented on his enthusiasm in taking on the leadership of the Department of Pediatrics. He noted that the challenges of the Department are exciting. Dr. Krivit then suggested that he respond to questions and comments.

Ms. Gruye commented on the newsletter she was familiar with from Pediatrics. Dr. Krivit noted that there have been three editions of Intercom. He stated that the first was on adolescent medicine, the second on echocardiography and the third, soon to be out, will be on the opening of the Ronald McDonald House. He stated that the publication is expected to be monthly and focused on unique medical topics. He added that the mailing covers parts of the five state area.

Mr. Cost asked Dr. Krivit how he found the Department of Pediatrics and where he wanted to lead it. Dr. Krivit commented that he found despair but hoped to inspire the Department to explore new areas of research and new methods of community involvement. He spoke to particular resident programs in community clinics and participation with Minneapolis Health Board activities.

Ms. Barr asked for clarification regarding the adolescent Health Care Program. Dr. Krivit explained that the Program is funded by a five year grant from H.E.W. He suggested that there will be considerable emphasis on teenage pregnancies.

Chairman Hanser asked about Dr. Krivit's involvement with other community hospitals. Dr. Krivit stated that he is making every effort to maintain good

relationships and open communication. Specifically he mentioned the county hospitals, and Group Health. He also added that with respect to Neo-Natology, the University, St. Paul Childrens, and Hennepin County Hospital have been meeting regularly to develop a co-ordinated plan of services.

Ms. Lebedoff inquired about the number of Neo-Natal Units in the Twin Cities and about the trend in teenage pregnancies and the decision to keep the baby. Dr. Krivit responded that he hopes the trend will reverse but added that it will be slow and will require much education in the high schools. With regard to Neo-Natal Units, Dr. Krivit explained that he counted those which are comparable to the University's, with similar research interests and with residents participating.

Dr. Tiede asked if there were difficulties in attracting good Pediatric residents and if the poor facilities for the Department impacted on that. Dr. Krivit commented that he uses a very good slide show for resident recruitment. He indicated no difficulties in attracting and no decrease in caliber. He added that there were 65 residents last year and that there will be 72 next year. In terms of the facilites he noted that there is always room for improvement but noted that more important was good nursing interaction.

Ms. Gruye asked if Dr. Krivit's Program reached rural parts of the State. Dr. Krivit indicated that the Department of Pediatrics is involved in continuing education program, the Rural Physicians Associate Program and the Rural Co-operative. There being no further questions Chairman Hanser thanked Dr. Krivit for his informative remarks.

VII. General Director's Report - Mr. John Westerman, General Director

In Mr. Westerman's absence, Mr. Dickler presented the General Director's report. He first commented that the Council of Community Hospitals has surveyed its group regarding the number of beds which have been taken out of operation to comply with the Metropolitan Health Board's requirements. He noted that the survey indicated that more than the 1000 beds requested have been shut down.

In terms of other forms of long range planning, Mr. Dickler stated that work has been initiated on up-dating the Hospitals' long range plan which must be annually submitted to the Metropolitan Health Board. He noted that there will be changes in the section dealing with services provided to accommodate planning in areas such as open-heart surgery and heart catheterization being addressed by MAPTH. With respect to University planning he indicated that

Draft II, is being prepared for the President's Office now that Draft I has been reviewed and in-put has been received.

With regard to upcoming events, Mr. Dickler spoke to the opening of the Ronald McDonald House which he characterized as a very positive venture for University Hospitals and Clinics, and the dedication of Abbott-Northwestern Hospitals new facility, soon to be followed by United Hospital's dedication.

Mr. Dickler also commented on a current issue which has surfaced regarding House Staff benefits such as health insurance. He indicated that this matter is being studied by the Clinical Chiefs.

VIII. Board Concerns - Mr. Al Hanser, Board Chairman

Chairman Hanser reported that the Nominating Committee process for this year has been initiated with a letter to Dr. French regarding those individuals whose terms expire December 31, 1979, and those who are not seeking re-election. He stated regretfully that Mr. Evenson and Mr. La Fave are not requesting another term and suggested that Board members with recommendations for their replacement make them known. Chairman Hanser reminded the Board that the Nominating Committee composition had been amended to include three Governors and three Regents. He listed the members as Ms. Lebedoff, Mr. Atwood, himself, Regents Moore, Latz, and Sherburne who chairs the Committee and will probably be calling a meeting soon. Chairman Hanser also added that the attendance records of all the Board members will be examined, as they are every year at re-appointment time, for the purpose of considering all continued membership.

Next, Chairman Hanser noted that the Regents did not take action on Mr. Dave Domaas' appointment as the Health Sciences student representative to the Board of Governors. Such final approval is anticipated to be granted in November. Chairman Hanser did however, welcome Mr. Domaas to the Board on behalf of the Governors.

Chairman Hanser reported that there will be an Executive Committee meeting on November 13, 1979, to discuss the proposed strategic options study being suggested by the Health Services Research Center for the purpose of examining those issues raised at the last Board Retreat.

Chairman Hanser also reported that Mr. Diehl is working to finalize the indemnification section of the Board Bylaws. Mr. Diehl stated that that section is also being re-vamped for the Regents and noted that the necessary changes have been transmitted to the University Attorney's Office.

Other items which Chairman Hanser covered included the changing of the dates of the next two Board meetings to November 14, and December 12, 1979, the presentation by Dr. Doughman at the November Board meeting as the new Chief of Opthamology, and the annual report to the Board of Regents being re-scheduled for December.

Chairman Hanser asked Mr. Atwood to comment on the activities of the East Metro Trustee Council. Mr. Atwood noted that discussions have centered around taking out a newspaper advertisement regarding the success of the bed reduction program in the East Metro area. With regard to the West Metro Trustee Council, Chairman Hanser reported that their Public Policy Task Force which he chairs, has been dealing with the issue of the proposed cost containment legislation. He commented that Board members are encouraged to contact Congressmen Sabo, Nolan, and Vento regarding the impracticalities of the proposed bill.

Chairman Hanser next announced that as a step in keeping communications open with the Board of Regents regarding the Renewal Project, a letter to the Regents providing a status report on that project has been drafted for Mr. Atwood's signature as Chairman of the Planning and Development Committee and the Board Chairman's signature.

Other matters covered under Board Concerns included Chairman Hanser's comment on facility renovations being limited in light of the Renewal Project plans, Ms. Vann's invitation to the upcoming conference of the Midwest Association of Community Health Centers on October 28-30, 1979, personnel changes in the Hospitals' Cardiovascular Program, and the timing of the media tour for the Renewal Project.

There being no further business, the meeting of the Board of Governors of the University of Minnesota Hospitals and Clinics was adjourned at 3:38 p.m.

Respectfully submitted,

Johnelle Foley/b

Johnelle Foley, Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

September 27, 1979

TO: Board of Governors - University Hospitals and Clinics

FROM: Paul Quie, Chief of Staff
John Westerman, General Director

SUBJECT: University Hospitals Quality Assurance System

This is written in response to the discussion at the September 19, 1979 Board of Governors meeting regarding quality of care issues which had come to the attention of individual Board members.

Recognizing that individual problems will not be completely eliminated in an organization as large and complex as the University Hospitals and Clinics, the policy level question which we discussed was:

> "Has University Hospitals and Clinics in place and operating a system of quality assurance which will routinely address and resolve issues such as those described at the meeting?"

This memo responds to that question.

As many of you know, University of Minnesota Hospitals and Clinics has a history of interest in and structured development of a broad range of quality assurance activities. These are recognized both within and outside the institution as activities which are operating at uniformly high performance levels.

University of Minnesota Hospitals and Clinics quality assurance activities are viewed as two synergistically related sub-systems. One system centers on the activities of the medical staff and of physician practice. The second focuses on activities of hospital departments, committees, and legal related activities other than those of medical practice. The listing of activities for each system includes:

Sub-System I - Physician Practice

IA. Medical Staff Organization

- Quality Assurance Committee (audit)
- Concurrent Review (utilization)
- Pharmacy and Therapeutics Committee
- Credentials Committee
- Operative Review Committee (tissue)
- Infection Control Committee

IB. Clinical Service Organization

- Activities of Clinical Departments (chart review, morbidity-mortality conferences, rounds)

Sub-System II - Other Professional Practice

IIA. Quality Management

- Incident Report Analysis
- Patient Relations Department Information Flow
- Fire Committee

Nursing Safety Committee
Safety Committee
Protection Services
Patient Questionaires

IIB. Hospital Department Audit Activities

Nursing
Pharmacy
Social Service
Respiratory Therapy
Medical Records
Etc...

Sub-System II is managed through the "line" organization of the hospital. Issues flow through the normal management chain and are addressed and resolved at appropriate levels.

Sub-System I has two groupings. The committees of medical staff report to the executive committee of the staff, the Medical-Staff Hospital Council, with the Chief of Staff and Chief Operating Officer sharing a "line" responsibility depending on the issue at hand. Clinical department quality assurance activities are reported through and addressed by normal departmental channels with the clinical chief of service as the "line" manager.

It is our opinion that this rather elaborate and structured quality assurance system functions well and to the benefit of most University Hospitals and Clinics patients.

Regarding the specific issues of patient complaints/grievances and communication with referring physicians, we have attached relevant sections from the Hospitals' Policy and Procedures Manual. Please note:

(1) From Policy 21.2

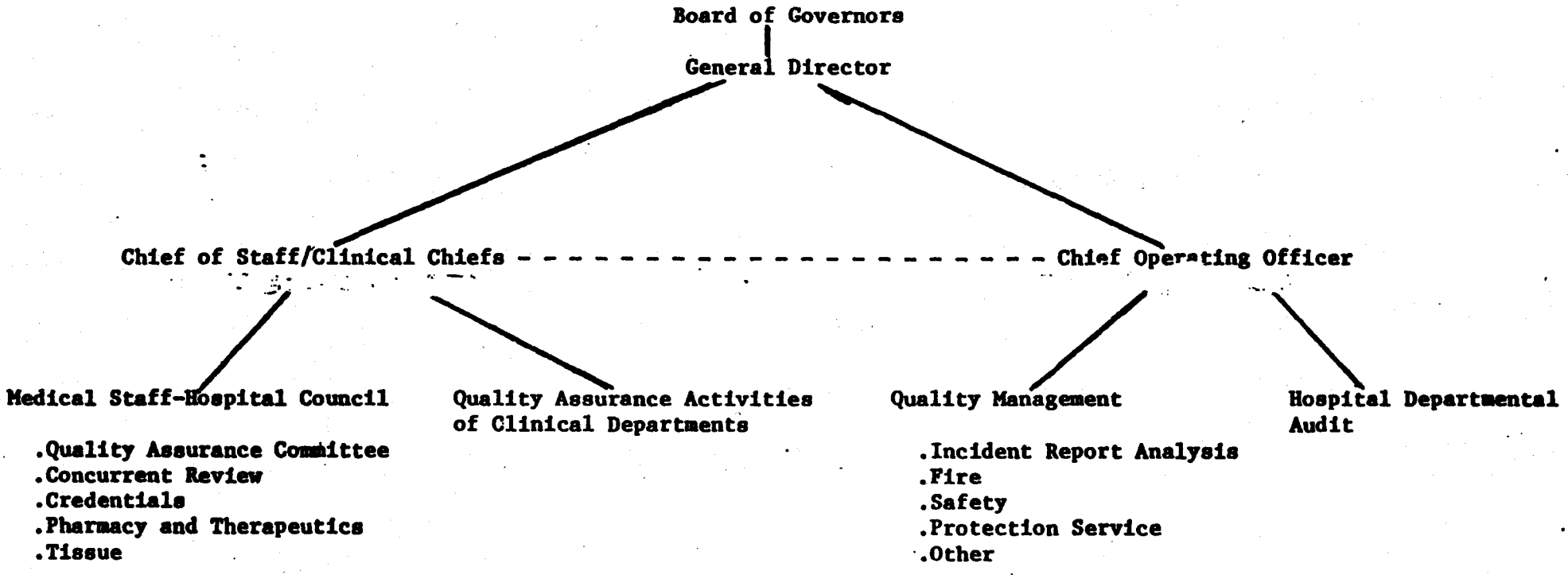
> "The Patient Relations Department (on behalf of the General Director) shall operate and maintain the Hospitals' grievance mechanism designated to process and resolve patient complaints and formal grievances while maintaining a comprehensive record of complaints presented to University Hospitals and Clinics."

(2) From Policy 14.1

> "A discharge summary (or discharge letter) should be dictated within 24 hours of discharge on all medical records of patients hospitalized. A discharge summary (or discharge letter) shall be completed and signed within 15 calendar days of discharge."

This review suggests to us that the system and its related policies and procedures are appropriate to address quality issues such as those discussed at the September 19 meeting. We also recognize that, on occasion, weaknesses may occur within the system. When these occur, please contact our Patient Relations Department (373-8982). The staff shall, in turn, direct the issue to the appropriate department or committee for evaluation and resolution.

Quality Assurance Organization Chart



POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

SECTION: PATIENT RELATIONS	
VOL.: II	POLICY NUMBER: 21.2
EFFECTIVE: June 1978	
REVISION:	
REVIEWED:	

SUBJECT: Patient Complaints/Grievances

SOURCE: Patient Relations Department

POLICY

The Patient Relations Department (on behalf of the General Director) shall operate and maintain the Hospital's grievance mechanism designated to process and resolve patient complaints and formal grievances while maintaining a comprehensive record of complaints presented to University Hospitals and Clinics.

PROCEDURE

I. Receipt of Complaints

A. Processing of Written Complaints

Upon receipt of a written complaint from a patient or his representative (relative, external agency or individual, etc.) the department receiving the complaint shall:

1. Note the date, name and phone number of the person who initially received the complaint using University of Minnesota Memo Form S92046 (yellow);
2. Determine if the complaint is singular regarding the source of the problem or is multiple, significant or political in nature and;
3. Immediately forward the complaint to:
   a. The Patient Relations Department (Box 49 Mayo) in those cases where the complaint addresses multiple concerns or is significant in content or tone;
   b. The Department Head in Patient Accounting (Box 602 Mayo) when the complaint solely addresses a Hospital's patient billing problem; or
   c. The Department Head of a department which is singularly identified in the complaint.

B. Processing of Oral Complaints

1. The person receiving the complaint should identify themself and their department;
2. Record the patient/caller's name, phone number, hospital number when possible and general nature of the complaint;

APPROVED: D. Lewis Kuglen	DATE: 8-14-78
TITLE: Senior Associate Director	

3. Promptly refer the patient to:
   a. The Patient Relations Department (373-8982) in those cases where the complaint addresses multiple concerns or is significant in its content or tone;
   b. The Hospital's Patient Accounting Department (373-8974) in those cases where the question/concern relates to Hospital patient billing; or
   c. The individual departmental office (by phone number) when one department is identified by the patient.

II. Handling of Patient Complaints

A. Patient Relations Department Responsibilities

1. For each complaint received by the Patient Relations Department, the Department shall:
   a. Log the complaint;
   b. Communicate with the patient (when appropriate) with a projected time of response and/or resolution;
   c. Investigate the complaint (involving all appropriate hospital/medical staff) to determine the facts surrounding the presenting circumstances.

2. Once the investigation is complete, communication of the outcome of the investigation and response/resolution of the concern will be shared with the patient (in written form when requested or advisable) as well as hospital and medical staff involved in the complaint. (This communication may require a collaborative effort on the part of all areas involved in a complaint.)

3. Appropriate documentation of all complaints (with the exception of Patient Accounting) will be maintained to provide a basis for identifying patterns of problems for preventative action while complying with Minnesota Statutes Section 144.691.

B. Patient Accounting Department Responsibilities

1. Patient Accounting shall assume responsibility for the handling of all complaints specific to hospital patient billing.

2. The Patient Accounting and Patient Relations Departments shall handle patient complaints which identify patient billing problems, but are not solely billing in their

content as well as a procedure for reporting coordination of complaint systems on an annual basis.

3. Appropriate documentation of all Patient Accounting complaints shall be maintained by Patient Accounting to provide a basis for identifying patterns of problems while facilitating the Hospital's compliance with Minnesota Statutes Section 144.691.

C. Individual Operating Department's Responsibilities

1. When received by an operating department, a complaint specific to that department shall be formally acknowledged immediately with a projected time of response and/or resolution.

2. All patient complaints shall be answered promptly (eg., within three weeks, except in those situations where data cannot be gathered in that period of time) with a closing statement reflecting the availability of the individual department, as well as the Patient Relations Department as a future problem solving resource.

   Example: If you have any further questions or concerns regarding this issue, please feel free to contact me at _____. In addition, the Hospital's Patient Relations Department can be reached by calling 373-8982 with any further questions you may have about University Hospitals.

3. A copy of each complaint and response shall be sent to the Patient Relations Department (Box 49 Mayo) using University of Minnesota Memo Form S92046 identifying the sender, phone number and action necessary (eg., note and file, please advise, please handle, etc.). Relevant departmental information/ correspondence shall be attached to the complaint in those situations where the complaint is being referred for handling.

III. When external advocacy services or agencies present complaints on behalf of the patient (eg., Office of Health Facilities Complaints, Governor's Office, Consumer Protection Agency, Action News, etc.), they shall be referred to the Patient Relations Department for coordination of response to the external source and the patient.

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

SECTION: Medical Records	
VOL.: I	POLICY NUMBER: 14.1
EFFECTIVE: Sept. 14, 1976	
REVISION: 6/12/79	
REVIEWED: 10/79	

SUBJECT: Medical Records Completion Policies
SOURCE: Quality Assurance Committee

POLICY

A complete medical record shall include a data base with patient profile, chief complaint, present illness, past history, family history, review of systems, physical examination, mental status, known laboratory results, provisional diagnosis(es) and/or impressions, and initial evaluation(s) by other health professionals; problem list; initial plans; special reports such as for consultations, clinical laboratory findings, radiology services, operative procedures, and pathological findings; progress notes numbered or titled according to the problem list; condition on discharge; final diagnosis; discharge summary; and autopsy report when performed.

1. The attending physician shall be responsible for the preparation of the history and physical examination, progress notes, final diagnosis, condition on discharge, and summary or discharge note.

2. All clinical entries in the patient's medical record shall be accurately dated and signed with the title of the person making the entry.

3. A medical record shall not be permanently filed until it is completed by the responsible physician.

Data Base/History And Physical

1. A complete data base shall be recorded within 24 hours of admission.

2. A history and physical must be repeated with each admission. If a complete history and physical has been performed by a UMH physician within one week prior to admission, a copy of this report may be used in the record, provided there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. It is the responsibility of the attending physician to see that this copy is on the record within 24 hours of admission.

3. If a patient is readmitted within 30 days for the same related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is less than one year old and it is readily available in the unit record.

APPROVED: D. Christopherson	DATE: 7-9-79
TITLE: Chief Operating Officer	

Action To Be Taken:

a. The Chairman of the Quality Assurance Committee shall send a letter of warning to any surgeon, and to the Chief of his Clinical Service, who has not dictated a report by the end of the day following surgery.

   If a report has not been dictated by the end of the second day following surgery, the Chairman of the Quality Assurance Committee shall recommend to the Medical Staff-Hospital Council that the surgeon's admitting privileges be suspended. Such suspension shall remain in effect until the report has been dictated.

b. The Chairman of the Quality Assurance Committee shall send a letter of warning to any surgeon, and to the Chief of his Clinical Service, who has not signed an operative report by the end of the third day following surgery.

c. A second letter of warning will be sent at the end of one week after surgery. If the report has not been signed at the end of two days after this warning, the Chairman of the Quality Assurance Committee shall recommend to the Medical Staff-Hospital Council that the surgeon's admitting privileges be suspended. Such suspension shall remain in effect until the report has been signed.

Discharge Summary

A discharge summary (or discharge letter) should be dictated within 24 hours of discharge on all medical records of patients hospitalized. A discharge summary (or discharge letter) shall be completed and signed within 15 calender days of discharge.

Action To Be Taken

a. Failure to do so shall result in a recommendation to the Chief of Staff that the attending physician's admitting privileges be suspended.

Monitoring Procedures:

(1) The Medical Word Processing Center shall be responsible for monitoring completion of summaries.

   a. To facilitate monitoring of all services, those departments not using Medical Word Processing transcription services shall be required to send to Word Processing a signed copy of each discharge summary.

   b. If a discharge summary is not completed and signed within seven days following a patient's discharge, a warning letter shall be sent to the attending physician and the chairman of his/her service.

d. If a discharge summary is not completed and signed within twelve days following a patient's discharge, a second warning letter shall be sent to the attending physician and the chairman of his/her service.

e. If the summary has not been signed at the end of 15 calender days following discharge, the chairman of the Quality Assurance Committee shall recommend to the Medical Staff-Hospital Council that the attending physician's admitting privileges be suspended. Such suspension shall remain in effect until the report has been signed.

Medical Record Completion

1. The patient's medical record shall be completed within 30 days after discharge unless the record is in active use for ongoing patient care. In order to avoid disruption of patient care, medical record completion standards for all services shall be:

   75% of all medical records shall be complete within 30 days after the discharge month

   95% of all medical records shall be complete within 60 days after the discharge month

   100% of all medical records shall be complete within 80 days after the discharge month

Action To Be Taken and Monitoring Procedures

a. The Medical Records Department shall prepare a monthly report of the total number of delinquent medical records 30, 60, and 80 days after the month of discharge.

   (1) The report shall be sent to the chairman of each clinical service, the Chief of Staff, and the Chairman of the Quality Assurance Committee.

   (2) If a service does not meet the compliance standards, the Chairman of the Quality Assurance Committee will speak with the chief of the service to determine what disciplinary action should be taken.

b. The Medical Records Department shall be responsible for conducting a daily monitor of delinquent medical records. If a medical record remains incomplete 30 days after discharge, the following monitoring procedures and action will be carried out:

   (1) If an incomplete record is signed out for a readmission, a clinic visit on that day, or a patient care conference on that day, the Medical Records Department will not follow up on the record until the following week.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

October 17, 1979

TO: Board of Governors Finance Committee

FROM: Nels E. Larson
Assistant Controller

SUBJECT: Report of Operations for the Period July 1, 1979 through September 30, 1979

The operations for the first quarter of the fiscal year reflects a slight decrease in the utilization of ancillary sources and an increase in patient days brought about by an increase in the average length of stay.. To highlight this position:

Inpatient Census - The inpatient census for the first quarter of the fiscal year was 51,995 days or 778 days over the budgeted 51,217 days. This represents a 1.5% favorable variance. Inpatient admissions were 5,552 through September or 49 under the budgeted 5,601 admissions. The overall length of stay through the quarter is 9.4 days or .4 days over the projected 9.0 days. The occupancy through September averaged 75.8%.

Outpatient Census - Total clinic visits for the first quarter of the fiscal year were 50,610. This represents a decrease of 3,281 visits from our projected visits of 53,891 or a 6% unfavorable variance.

Financial Operations - First quarter operations resulted in a year-to-date excess of revenue over expense of $923,378. This position is due primarily to the $634,647 favorable variance in total expenditures. This variance related primarily to the decrease in the utilization of ancillary services and a normal lag in recognizing remodeling costs within Maintenance and Repair and Depreciation expense on assets not yet purchased.

Accounts Receivable - The balance in patient accounts receivable increased through the first quarter by $1,685,732 to a balance of $21,727,043. The increase is consistent with the net increase in patient receivables due to the July 1, 1979 rate increase. The September balance represents 79.6 days of outstanding revenue down 1.1 days from June 30, 1979.

Given the overall operations of the Hospital at the end of the first quarter, our financial position appears good. Due to the changes we

have seen through the first quarter, an indepth analysis will be completed and projections of our position at the end of the fiscal year will be presented to the Finance Committee in November.

NEL/tr

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
INPATIENT CENSUS DATA BY MAJOR CATEGORY
SEPTEMBER 30, 1979 YEAR TO DATE

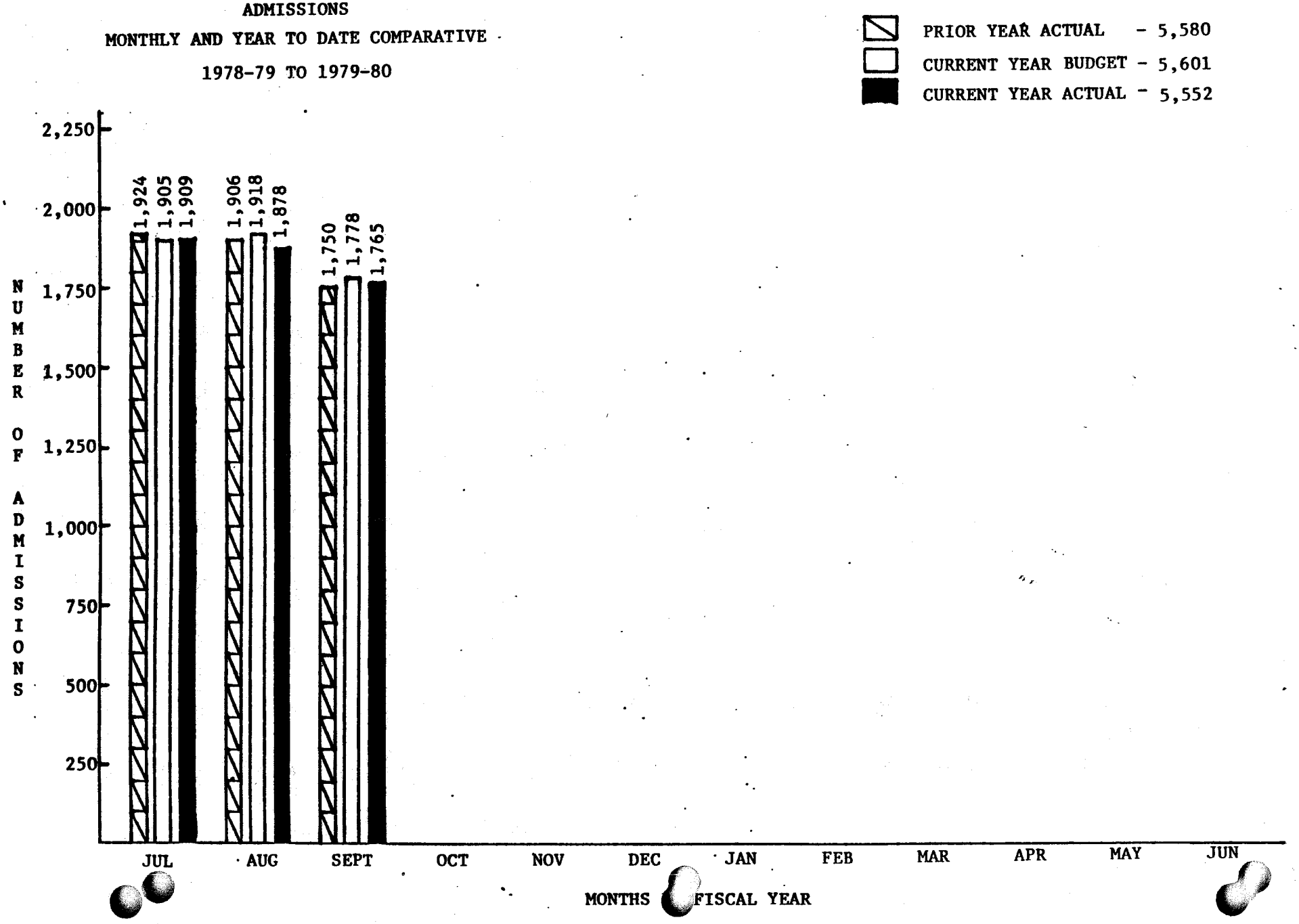
	Available Beds	Inpatient Days		Admissions		% Occupancy		Average L.O.S.	
		Current Bud	Actual	Current Bud	Actual	Current Bud	Actual	Prior Yr	Current Actual
Medical/Surgical	439	29,834	30,760	3,747	3,685	75.9	78.2	7.9	8.5
Pediatrics	99	6,387	6,406	720	730	73.7	73.9	9.1	8.9
Obstetrics	24	1,531	1,495	288	302	67.1	65.5	5.1	5.0
Newborn	20	1,132	1,128	248	248	61.5	61.3	4.4	4.6
Psychiatry	60	4,405	4,306	129	124	79.8	78.0	37.3	35.0
Rehabilitation	40	2,033	2,068	75	69	55.2	56.2	26.4	30.9
Intensive Care-Adult	29	3,882	3,768	280	298	76.9	74.6	13.4	12.3
Intensive Care-Peds	24	2,013	2,064	114	96	91.2	93.5	16.5	21.3
Total	735	51,217	51,995	5,601	5,552	74.7	75.8	9.1	9.4
Excluding Psychiatry and Rehabilitation - Total	635	44,779	45,621	5,397	5,359	75.4	76.8	8.3	8.6

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

ADMISSIONS

MONTHLY AND YEAR TO DATE COMPARATIVE

1978-79 TO 1979-80

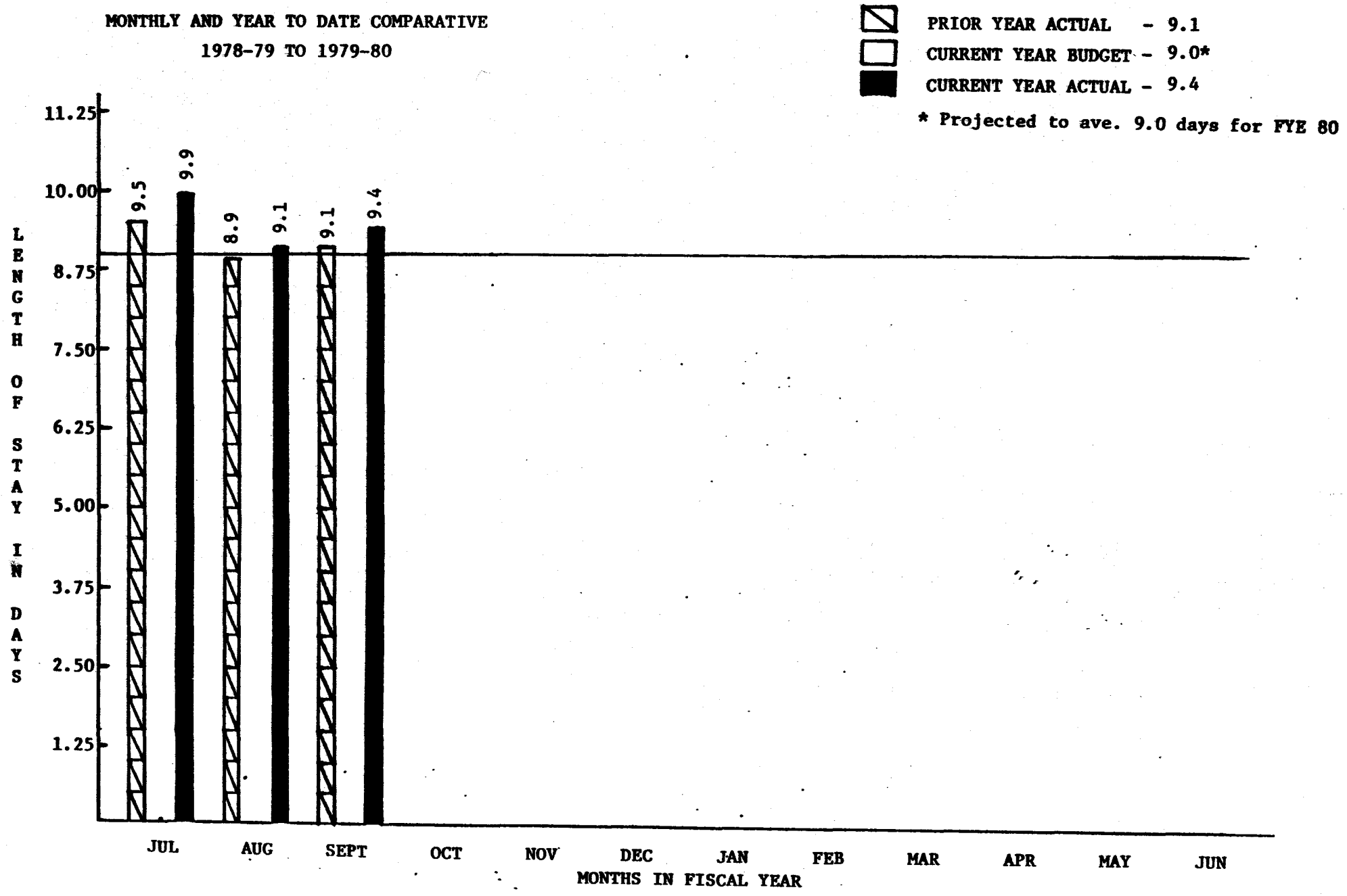


UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

LENGTH OF STAY

MONTHLY AND YEAR TO DATE COMPARATIVE

1978-79 TO 1979-80

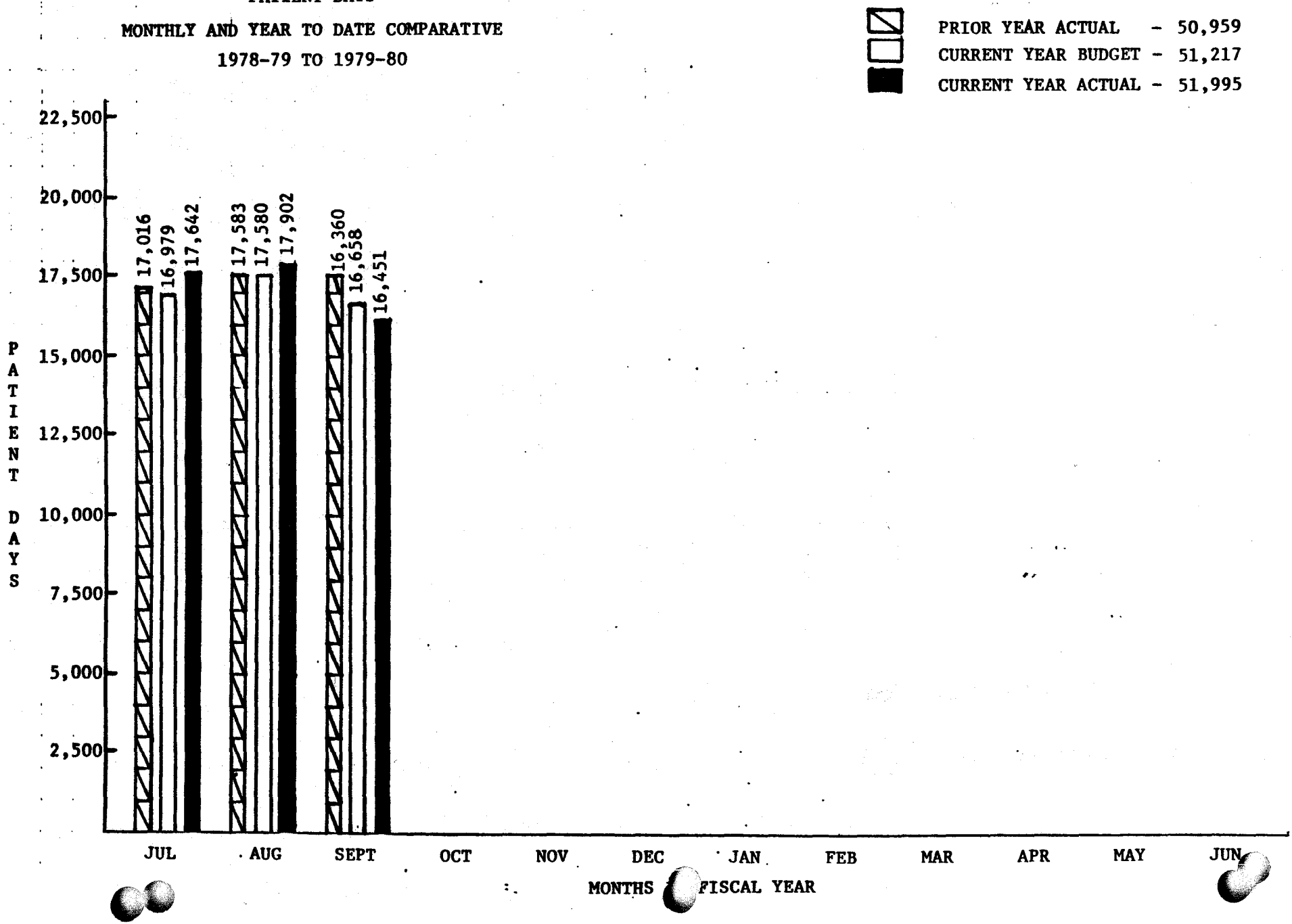


UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

PATIENT DAYS

MONTHLY AND YEAR TO DATE COMPARATIVE

1978-79 TO 1979-80

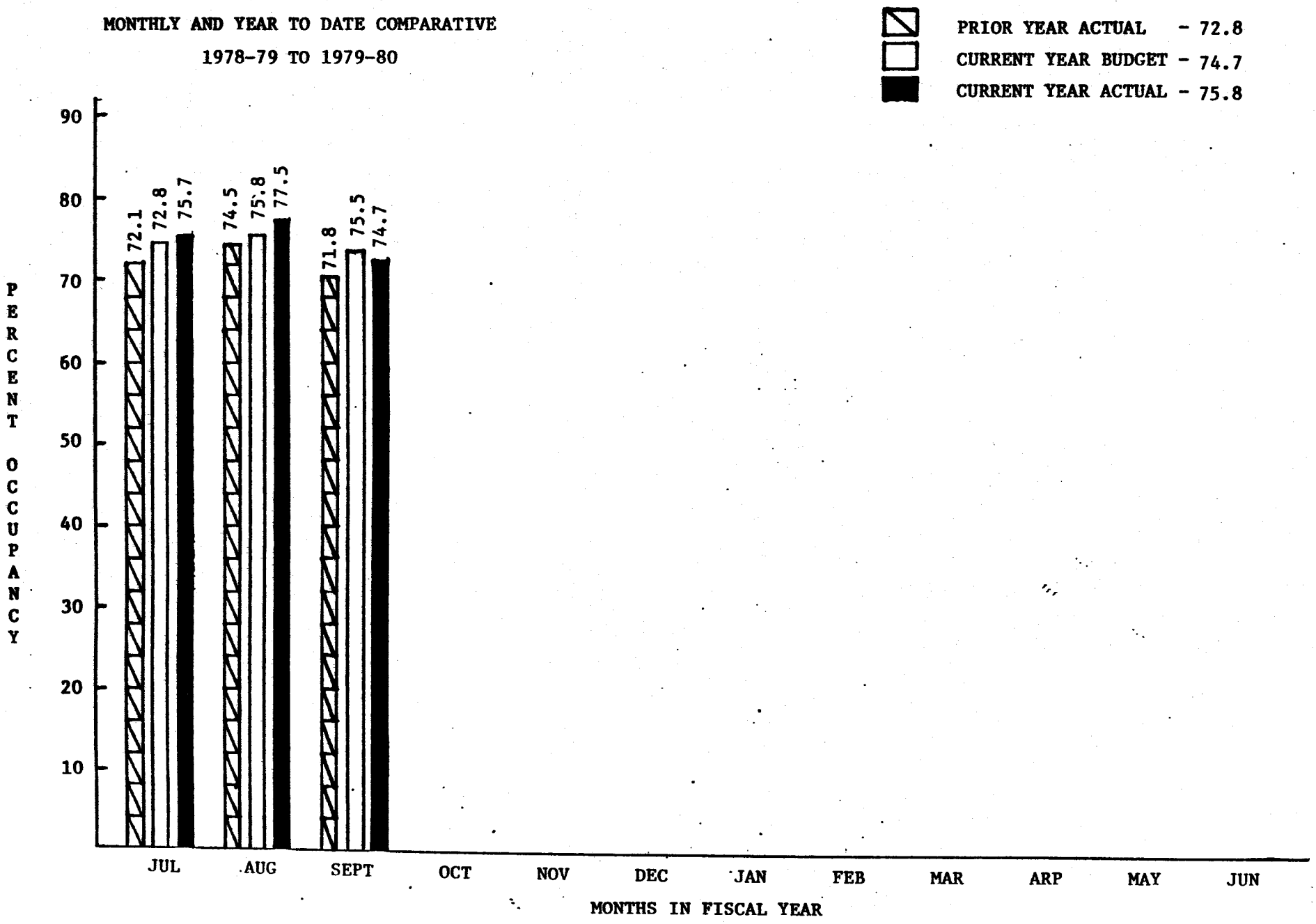


UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS

PERCENT OCCUPANCY

MONTHLY AND YEAR TO DATE COMPARATIVE

1978-79 TO 1979-80



UNIVERSITY OF MINNESOTA HOSPITALS
STATEMENT OF OPERATIONS
FOR PERIOD JULY 1, 1979 TO SEPTEMBER 30, 1979

	Budget	Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Charges	$25,589,337	$25,146,973	$(442,364)	(1.7)
Deductions from Charges	1,516,001	1,382,314	(133,687)	(8.8)
Other Operating Revenue	515,953	398,742	(117,211)	(22.7)
Total Revenue from Operations	$24,589,289	$24,163,401	$(425,888)	(1.7)
Expenditures				
Salaries	$12,220,363	$12,388,471	$ 168,108	1.4
Fringe Benefits	2,253,627	2,225,767	(27,860)	(1.2)
Contract Compensation	2,054,284	2,122,896	68,612	3.3
Med. Supplies, Drugs, Blood	3,928,671	3,769,040	(159,631)	(4.1)
Campus Admin. Expense	978,568	978,568	-	-
Depreciation	838,992	710,023	(128,969)	(15.4)
General Supplies & Expense	4,224,049	3,669,142	(554,907)	(13.1)
Total Expenditures	$26,498,554	$25,863,907	$(634,647)	(2.4)
Net Revenue from Operations	$(1,909,265)	$(1,700,506)	$ 208,759	
Non-Operating Revenue				
Appropriations/Univ. Support	$ 2,433,387	$ 2,433,387	-	-
Accrued Interest Income	190,497	190,497	-	-
Total Non-Oper. Rev.	$ 2,623,884	$ 2,623,884	-	-
Revenue Over/(Under) Expenses	$ 714,619	$ 923,378	$ 208,759 (1)	

(1) Variance equals 0.8% of Total Budgeted Revenue.

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
OPERATING CASH FLOW
FOR PERIOD JULY 1, 1979 TO SEPTEMBER 30, 1979

Source of Funds		
Beginning Cash Balance		$ 424,111
Loss from Operations	(1,700,506)	
Non-Operating Revenue	2,623,884	
Excess of Revenue over Expense		923,378
Items not Requiring the Outlay of Cash:		
Depreciation		710,023
University Support: G&A		978,568
K/E Utilities		17,321
Increase in Accrued Expenses		3,104,394
Total Funds Provided from Operations		$6,157,795
Funds Applied		
Transfers to Plant:		
Capital Expenditures	532,968	
Increase in Capital Encumbrances	611,158	
Total Transfers to Plant		1,144,126
Increase in Accounts Receivable		1,685,732
Increase in Accrued Revenue		128,984
Increase in Inventories		543,855
Total Funds Applied		$3,502,697
Total Net Operating Cash Available		$2,655,098 (1)

(1) Available for offsetting future cash need of $3,104,394 for increase in accrued expenses. The resulting net deficit of $449,296 is offset by the increase in accounts receivable of $1,685,732. The net working capital increase is $1,236,436.

UNIVERSITY OF MINNESOTA HOSPITALS AND CLINICS
STATEMENT OF CHANGES IN FUND BALANCES
JULY 1, 1979 THROUGH SEPTEMBER 30, 1979

	Operating Fund	Reserve Fund	Plant Fund	Total Unrestricted Funds
UNRESTRICTED FUNDS				
Beginning Balance	$13,418,792	$8,322,140	$60,599,349	$82,340,281
Net Income				
Excess of Revenue over Expense	1,442,904			
Accrued Reserve Interest Income		138,873		
Accrued Approp. Interest Income		51,624		
Depreciation Expense			(710,023)	
Loss on Sale/Disposal of Assets				
Total Unrestricted Income				923,378
Less Expenses				
Unrealized Appropriation Revenue	6,868,849			6,868,849
Campus Support: G&A	978,568			978,568
K/E Utilities	17,321			17,321
Transfers to Plant				
Major Building Projects (Hosp Only)		(300,221)	300,221	-0-
Capital Expenditures	(532,968)		532,968	-0-
Capital Encumbrance Change	(611,158)		611,158	-0-
Equip, Remodel & Other Adjust	56,792	(56,790)	108,854	108,856
Increase in Restrict Fund Commitment to Plant			33,759	33,759
Contribution from Masonic Hosp Fund			20,000	20,000
Ending Balance 9/30/79	$21,639,100	$8,155,626	$61,496,286	$91,291,012

	Gift	Endowment	Total
RESTRICTED FUNDS			
Beginning Balance	$815,898	$8,675,075	$9,490,973
Net Income			
Gifts	17,145		
Accrued Interest Income			
Misc. Expenses	(1,009)		
Charity Expenses			
Total Restricted Net Income	16,136		16,136
Increase in Commitment to Plant	(16,403)	(17,356)	(33,759)
Contribution to CUHCC		(24,366)	(24,366)
Ending Balance 9/30/79	$815,631	$8,633,353	$9,448,984

UNIVERSITY OF MINNESOTA HOSPITALS
STATEMENT OF FINANCIAL POSITION
SEPTEMBER 30, 1979

ASSETS

	9/30/79	6/30/79
UNRESTRICTED FUNDS		
CURRENT ASSETS		
Cash and Investments	$ 9,555,791	$ 455,955
Patient Receivables Less Allowance for Uncollectible Accounts	18,686,099	17,000,367
Contractual Adjustments Receivable from Third Party Payer Reimbursement Programs	460,605	582,837
Other Receivables	300,742	240,032
Inventories of Drugs and Supplies	3,592,776	3,048,921
TOTAL CURRENT ASSETS	$32,596,013	$21,328,112
BOARD DESIGNATED ASSETS		
Cash & Short Term Investments	$ 3,609,435	$ 3,966,452
Interest Receivable	478,881	288,375
Long Term Investments	4,067,310	4,067,313
TOTAL BOARD DESIGNATED ASSETS	$ 8,155,626	$ 8,322,140
PLANT AND EQUIPMENT		
Cash & Investments for Construction	$ 4,495,635	$ 3,968,213
Construction in Progress	4,909,286	4,057,574
Buildings and Improvements	58,579,757	58,579,744
Equipment	18,346,694	18,118,832
	86,331,372	84,724,363
Less Allowance for Depreciation	(24,835,086)	(24,125,014)
TOTAL PLANT AND EQUIPMENT	$61,496,286	$60,599,349
TOTAL UNRESTRICTED FUNDS	$102,247,925	$90,249,601
RESTRICTED FUNDS		
Cash and Investments-Current Acct	$ 815,631	$ 815,898
Cash and Investments-Prin. Acct	8,633,353	8,675,075
TOTAL RESTRICTED FUNDS	$ 9,448,984	$ 9,490,973
	$111,696,909	$99,740,574

LIABILITIES AND FUND BALANCES

	9/30/79	6/30/79
UNRESTRICTED FUNDS		
CURRENT LIABILITIES		
Trade Accounts Payable	$ 1,892,652	$ 1,322,450
Insurance Payable	956,291	664,763
Accrued Salaries and Wages Payable	3,354,924	1,769,373
Accrued Vacation Payable	2,626,287	2,543,333
Accrued Professional Fees and Physicians Compensation	770,721	706,609
Contracts Payable	402,178	
TOTAL CURRENT LIABILITIES	$10,003,053	$ 7,006,528
LONG TERM LIABILITIES	$ 953,860	$ 902,792
FUND BALANCES		
Operating Funds	$21,639,100	$13,418,792
Board Designated Funds	8,155,626	8,322,140
Plant Funds	61,496,286	60,599,349
	$91,291,012	$82,340,281
TOTAL UNRESTRICTED FUNDS	$102,247,925	$90,249,601
RESTRICTED FUNDS		
Gift Funds	$ 815,631	$ 815,898
Endowment Funds	8,633,353	8,675,075
TOTAL RESTRICTED FUNDS	$ 9,448,984	$ 9,490,973
	$111,696,909	$99,740,574