The University of Minnesota Hospital and Clinic

Board of Governors

July 23, 1986

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Other Attachments

"Task force urges organ transplant network", Minneapolis Star and Tribune, Wednesday, July 16, 1986

"U Hospital considering girl, 3, for triple-organ transplant", Minneapolis Star and Tribune, Wednesday, July 16, 1986

Report of the Task force on Organ Transplantation, Executive Summary

The University of Minnesota Hospital and Clinic
Board of Governors

July 23, 1986
1:30 P.M.
8-106 University Hospital

AGENDA

I.	Approval of June 25, 1986 Minutes	Approval
II.	Chairman's Report Ms. Barbara O'Grady	Information
III.	Special Introductions: Dr. William Thompson Dr. Bruce Work	Information
IV.	Hospital Director's Report Mr. C. Edward Schwartz	Information
V.	Committee Reports	
	A. Planning and Development Committee Report Mr. Robert Latz Planning and Development Committee did not meet in July.	
	B. Joint Conference Committee Report Ms. Nancy Raymond	
	1. "Patients First" Update	Information
	C. Finance Committee Report Mr. Jerry Meilahn	
	1. 1985-86 Fourth Quarter Bad Debts	Approval
	2. PCN Equity Contribution	Endorsement

3. Parking Ramp Tunnel — Information

4. Medicare Capital Cost Reimbursement Update — Information

VI. Other

VII. Adjournment

MINUTES

Board of Governors

The University of Minnesota Hospital and Clinic

June 25, 1986

CALL TO ORDER:

Chairman Barbara O'Grady called the June 25, 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. Phyllis Ellis Al Hanser George Heenan Kris Johnson Jerry Meilahn James Moller, M.D. Robert Nickoloff Barbara O'Grady Nancy Raymond C. Edward Schwartz Neal Vanselow, M.D.
Absent:	Robert Latz David Lilly

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the May 28, 1986 meeting as written.

CHAIRMAN'S REPORT:

Chairman Barbara O'Grady introduced three visitors to the meeting: Lauren Brockway, Outpatient Clinic Assistant, Jan Brockway, Director of Quality Assurance, and Dee Lutz from the Minnesota Daily.

On June 13, 1986, Chairman O'Grady reported, the Board of Regents had reviewed the Hospital's 1986-1987 budgets for informational purposes. The

budgets are scheduled to be reviewed for approval in July. The Board of Regents also reviewed the Quarterly Report of the Board of Governors on that day.

Chairman O'Grady also reviewed a topical outline for the August 25, 26 and 27, 1986 retreat. The focus of that retreat will be the examination of common priorities of medical staff and the hospital. Dr. Vanselow suggested that Walter McClure might be an appropriate keynote speaker. Dr. Brown suggested that more emphasis be placed on the topics of research and education during the the August 26th discussion of medical staff and hospital priorities. Mr. Heenan suggested that the myths discussed at the 1985 retreat be reviewed again this year.

HOSPITAL DIRECTOR'S REPORT:

Dr. Neal A. Vanselow and Mr. Jan Halverson outlined the findings of the Task Force on House Officer Professional Liability. The Task Force had been charged with developing ideas for minimizing the risk of liability to residents and for exploring options for funding premiums. Five recommendations were reviewed. The Board of Governors expressed general concurrence with the recommendations. The Board of Regents will also be asked to review the findings of the Task Force.

On the topic of recruitment, Mr. Schwartz reported that the search for Chairman in the Department of Neurology continues to progress well. A final candidate is expected to revisit the Hospital in late July. Mr. Schwartz announced that Mr. Fred Bertschinger had been hired as the new Director of Hospital Development. Mr. Bertschinger will begin working here August 1, 1986.

Lastly, Mr. Schwartz made note of the fact June is Employee Recognition Month. A number of activities have been planned to honor outstanding employees.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

In the absence of Committee Chairman Robert Latz, Ms. Kris Johnson presented the report of the Planning and Development Committee. The report included a closing summary of the building project and a status report on the construction of the parking ramp tunnel.

Mr. Mark Koenig reported that the last two departments to move into Unit J, Endoscopy and the Cardiopulmonary Labs, had done so. Vendors are currently in the process of working out difficulties with the pneumatic tube and materials distribution systems. All contractors are scheduled to be off-site by September 1, 1986, three months ahead of the certified completed date. The final costs of the project are expected to total an amount that is 6.2 to 7.2 million dollars under budget.

The parking ramp tunnel project, Mr. Koenig reported, is currently out on bid. It is hoped that construction will begin in August and be completed by the end

of the calendar year. The most recent cost estimate for this project is $2,000,000, about $500,000 more than originally anticipated. As the bids come in, options for cost savings will be discussed.

JOINT CONFERENCE COMMITTEE REPORT:

Committee Chairman Phyllis Ellis presented four items for approval by the Board. They included the Credentials Committee report, the recommendations for Medical Staff-Hospital Council chairmen, the annual appointment or reappointment of clinical chiefs of service, and the approval of the appointment of Dr. Robert Maxwell as Vice Chief of Staff.

Mr. Greg Hart provided background information on each of the agenda items. The Credentials Committee report included several types of actions including new appointments to the staff, biennual reappointments, termination of medical staff appointments, additions and deletions of clinical privileges, changes in staff category and resignations from the medical staff. The Medical Staff-Hospital Council chairmen appointments included a recommendation to approve 16 committee chairmen. There are actually 17 Medical Staff-Hospital Council committees. The Utilization Management Committee chair will be presented for approval at a later date as will a recommendation for a co-chair to work with Dr. Ted Thompson on the Bio-Ethics Committee. The Hospital Director, in consultation with the Chief of Staff, had also recommended the appointment or reappointment of 19 clinical chiefs. Five of those chiefs are being recommended as heads of their department for the first time. Lastly, Mr. Hart reviewed the process by which the Vice Chief of Staff is elected. The term of office for Dr. Robert Howe will expire on June 30, 1986. Dr. Robert Maxwell had been elected by the Medical Staff as the Vice Chief in May. This appointment does require approval by the Board.

With that information, the Board of Governors seconded and passed four separate motions approving the Credentials Committee Report, the recommendations for Medical Staff-Hospital Council committee chairmen, the annual appointment of Clinical Chiefs of Service, and the appointment of Dr. Robert Maxwell as Vice Chief of Staff.

Ms. Jan Brockway presented a update on the Quality Assurance Program. She described the goals for 1986, which included involvement of all clinical services as well as hospital based departments in the development of programs to monitor quality of care. The Quality Assurance staff works with each service or department in tailoring a monitoring tool that is based on criteria appropriate for that area. Ms. Brockway gave examples of the type of data base monitoring tools already in use. She also described the approach used for follow-up on problems that are deemed to be in need of attention.

FINANCE COMMITTEE REPORT:

Committee Chairman Jerry Meilahn and Mr. Cliff Fearing reviewed the report of operations for the period of July 1, 1985 through May 31, 1986. Admission levels had increased during the month of May in most services with the largest

favorable variances occurring in Pediatrics, Surgery and Urology. Admissions year-to-date are 2.1% below budget. The average length of stay year-to-date is 8.3 days, 2.5% above budgeted levels. The total number of patient days for the year are nearly on budget with 132,707 days. Clinic visits in May totalled 19,715, 5.3% above projected visits. The May year-to-date clinic census totalled 203,941 visits, 6.6% above budget.

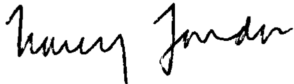
The Hospital Statement of Operations shows total variance of revenue over expenses of $11,674,738, a favorable variance of $3,817,889. This variance is due to both a favorable variance in operating revenues ($1.5 million) and a favorable variance in non-operating revenues ($2.3 million).

Mr. Fearing also briefly updated the Board on the status of the debate on Medicare reimbursement for capital expenditures. The current proposal would result in a slightly less severe decline in reimbursement to our hospital.

ADJOURNMENT:

There being no further business, the June 25, 1986 meeting of the Board of Governors was adjourned at 3:20 P.M.

Respectfully submitted,



Nancy C. Janda
Assistant Director and
Secretary to the Board of Governors

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

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 18, 1986

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director and Director of Operations

REGARDING: Patients First Program Update

On July 23, 1986 Ms. Nancy Green, Director of Patient Relations, will provide you with an update on the Patients First Program. Attached you will find a six month summary of feedback received from discharged patients, results of a hospital employee survey and plans describing think tank sessions that are designed to solicit input and support for the Patients First Program from attending physicians, residents and hospital staff.

We will look forward to hearing any ideas that you have about the program on Wednesday.

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.

Month	Count	Rate
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	188.0	643.0	418.0		
		1.7	14.8	50.6	32.9	3.148	1270
2.	The UMHC employees are courteous and kind to patients.	5.0	81.0	491.0	644.0		
		0.4	6.6	40.2	52.7	3.453	1221
3.	I see physicians being courteous and kind to patients.	10.0	166.0	620.0	351.0		
		0.9	14.5	54.1	30.6	3.144	1147
4.	In my experience, employee concerns are responded to in a prompt and helpful manner.	152.0	507.0	398.0	139.0		
		12.7	42.4	33.3	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	223.0	512.0	341.0		
		3.8	19.9	45.8	30.5	3.030	1118
6.	The people I work with find UMHC to be open to ideas in general.	138.0	448.0	440.0	199.0		
		11.3	36.6	35.9	16.2	2.571	1225
7.	Patients and visitors are encouraged to voice their concerns.	45.0	201.0	415.0	451.0		
		4.0	18.1	37.3	40.6	3.144	1112
8.	UMHC is a place where courtesy and kindness to patients and visitors are top priorities.	115.0	343.0	463.0	285.0		
		9.5	28.4	38.4	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	148.0	449.0	561.0		
		4.0	12.3	37.2	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	363.0	442.0	246.0		
		8.0	31.8	38.7	21.5	2.738	1142
11.	Hospital employees are neat and professional in their dress.	65.0	412.0	590.0	204.0		
		5.1	32.4	46.4	16.1	2.734	1271
12.	Physicians are neat and professional in their dress.	44.0	327.0	608.0	266.0		
		3.5	26.3	48.8	21.4	2.880	1245
13.	It has been my experience that courtesy and kindness are rewarded at UMHC.	365.0	446.0	247.0	101.0		
		31.5	38.5	21.3	8.7	2.072	1159
14.	I have seen that staff who are discourteous are reminded and confronted in constructive ways.	364.0	370.0	237.0	56.0		
		35.4	36.0	23.1	5.5	1.985	1027
15.	I am proud to be a part of UMHC.	29.0	169.0	442.0	617.0		
		2.3	13.4	35.2	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

HEALTH SCIENCES

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

Minutes
Meeting of the
Board of Governors Finance Committee
University of Minnesota Hospitals & Clinics
June 25, 1986

MEMBERS PRESENT:
Robert Nickoloff, Chair
Carol Campbell
Edward Ciriacy, M.D.
Clifford Fearing
William Krivit, M.D., Ph.D.
Jerry Meilahn
C. Edward Schwartz
Vic Vikmanis

MEMBER ABSENT:
Al Hanser

STAFF:
Greg Hart
Nels Larson
Jane Morris
Barbara Tebbitt

CALL TO ORDER:
The meeting of the Finance Committee was chaired by Mr. Robert Nickoloff and was called to order at 10:40 a.m. in The Dale Shepherd Room of the Campus Club.

MINUTES APPROVED:
The minutes of the Finance Committee meeting held on 5/28/86 were approved.

MAY YTD FINANCIAL STATEMENTS (INFORMATION):
Mr. Fearing reviewed the Report of Operations for the period July 1, 1985 through May 31, 1986. He reported that admissions through May of 16,042 were 2.1% below projections and patient days for the period totaling 132,707 were 176 below budget. Overall length of stay of 8.3 days was slightly above the projected level of 8.1 days.

The surge in census levels seen in April has continued during the month of May. Mr. Fearing stated that the increase seems to be occurring in areas where the higher level of activity will continue and does not appear to be a short term phenomenon. Three areas where it is particularly evident are Urology (increase due to lithotripsy patients), Surgery (increase in organ transplants) and Pediatrics (more bone marrow transplants).

Clinic visits for the month of May totaled 19,715 or 5.3% above projected visits of 18,731. Outpatient clinic visits year-to-date were 203,941 or 11,628 (6.0%) above projected visits.

Total revenues over expense through May 31, 1986 are $11,674,738, a favorable variance of $3,817,889 reflecting both a favorable

variance in net operating and non-operating revenues. Patient care charges through May totaled $180,711,046 (6.6% above budget). Ancillary revenue is approximately $9,466,000 (8.1%) above budget. Operating expenditures for the period were $166,910,754, or approximately $9,423,000 above budgeted levels.

The balance in patient accounts receivable as of May 31, 1986 totaled $54,473,579 representing 92.1 days of revenue outstanding.

Mr. Fearing gave an itemized review of the May year-to-date Cash Flow statement. He stated that total operating cash of -$554,872 plus transfers to plant of $7,189,363 plus transfer to sinking fund of $9,433,685 equals cash generated from operations of $16,068,176. He concluded that the Hospital continues to be in a very good position financially.

RESERVE FUND PROPOSAL (INFORMATION): Mr. Fearing summarized his memo to the Committee indicating available depreciation reserves and considerations to be evaluated regarding use of these funds. Some of the reserves will be required to provide for capital, malpractice contingency, third party liability reserve liability, short term note reserve and for a general operating contingency. The remaining funds are available for designation by the Board of Governors.

Following Mr. Fearing's presentation, members of the Committee discussed possible options for investment and use of these funds. Dr. Ciriacy felt that consideration should be given to support for graduate medical education, and Mr. Nickoloff suggested that the problem of resident support be addressed at a future Executive Committee meeting. It was agreed that additional investigation needs to be done before any proposal can be made for use of the funds. This topic will continue to be discussed at next month's meeting of the Finance Committee.

GILLETTE HOSPITAL AFFILIATION (INFORMATION): Mr. Schwartz informed the Committee that discussions have been continuing regarding a possible affiliation with Gillette Hospital. Mr. Hart outlined the pros and cons of such an affiliation.

ADJOURNMENT: There being no further business, the meeting of the Finance Committee was adjourned at 12:10 pm.

Respectfully submitted,

Jane E. Morris
Recording Secretary

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 23, 1986

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Bad Debts -- July 1, 1985 through June 30, 1986.

The total amount recommended for bad debt of Hospital accounts receivable during the fourth quarter of 1985-86 is $705,676.77, represented by 1,579 accounts. Bad debt recoveries during the period amounted to $6,334.69, leaving a net charge off of $699,342.08.

Total bad debts for fiscal year 1985-86 amount to $2,301,364.21 which is 1.16% of gross charges. This compares to a budgeted level of bad debts of 1.33%.

Also recommended for your approval are $5,326.03 of Home Health Services accounts.

CPF/jem

enc.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 23, 1986

TO: Members, Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Parking Ramp Tunnel.

The construction bids for the tunnel connecting the parking ramp and Masonic Hospital and Unit J have been received. The construction cost bids were awarded to the Sheehy Construction. Costs plus associated fees, contingencies and landscaping will bring the total cost of the tunnel to approximately $1,800,000.

The original estimate of total project cost was $1,500,000. The increase in cost is due primarily to the site work required around existing utilities under Harvard and Delaware Streets.

Because of the cost variance, a preliminary estimate of constructing a skyway to the Phillips Wagensteen building (PWB) and Unit J were evaluated and rejected at this time due to the significant cost differentials. The distance of a skyway to Unit J would be a minimum of 595 feet with the link to PWB an additional 155 feet. Total costs of the Unit J link is estimated at $2,677,500 and the PWB link an additional $697,500.

The bids were awarded on July 18, 1986 and the project has an expected completion date of January 1987.

CPF/jem

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

July 23, 1986

TO: Members, Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Medicare Capital Cost Reimbursement Update.

Since last fall we have been providing the Finance Committee and the full Board of Governors with periodic updates on the status of impending changes in the way Medicare pays hospitals for capital costs. In the last six weeks the activity in Washington regarding this issue has accelerated.

Before describing the current status of the proposed changes, a brief review of the history of this issue seems appropriate.

Two years ago Congress set in place a new payment system for Medicare hospital services. This system, based on a payment for episodes of illness for 468 diagnosis related groups, was designed to change the incentives for hospitals -- to encourage them to manage resources more efficiently. However, not all of Medicare's expenses for hospital services were included in the new methodology.

One item excluded from the DRG fixed-price was capital costs. Capital costs have continued to be paid on a "reasonable cost" basis, as has been the case since the inception of the Medicare program. Capital-related costs include items such as depreciation, leases and rentals for the use of depreciable assets, insurance expense on depreciable assets, interest expense incurred in acquiring land and depreciable assets, and taxes on land or depreciable assets.

From August of 1985 through May of 1986, two bills were introduced in Congress addressing this issue including one by Senator Durenberger of Minnesota. The Department of Health and Human Services introduced their proposal before the Health Subcommittee of the Senate Finance Committee in December of 1985. Although each had a different approach in developing the add-on, they all attempted to achieve an approximate 7% capital payment outcome. The 7% is the national average for hospitals' capital costs compared to total costs for fiscal year 1983.

UMHC financial analysis has demonstrated that the magnitude of difference between one bill and another is primarily a function of how each bill makes the transition from the current system of cost reimbursement to a DRG add-on for capital for UMHC reimbursement. Once the transition is complete, all bills basically revert to a national average form of payment. Total pass through payments for UMHC from 1987 through 1997 would be

approximately $68 million. Under the December HCFA proposal, UMHC's payments would be reduced by $41 million and Senator Durenberger's second proposal would reduce the $68 million by $13 million.

Many of the differences between the HCFA proposal and Senator Durenberger's second proposal (S2121) were due to the extensive efforts of many people, including the Board of Governors, to inform Senator Durenberger and others of the problems inherent in the HCFA proposal. These differences included, but were not limited to, a longer transition period of ten years with S2121 versus 4 years with the HCFA proposal, adjustments for case mix, indirect medical education and an outlier provision with Senator Durenberger's proposal, whereas the HCFA proposal had no adjustment for these factors.

On June 3, 1986, HCFA published its proposed capital reimbursement regulations. Although there were some changes from their December 1985 proposals, the implementation of these regulations was scheduled for 10/1/86 and would have meant $41 million in lost payments to UMHC from 1987 to 1997.

In late June 1986, both the House and the Senate agreed to enact legislation prohibiting HCFA from implementing these regulations. This was done through an amendment to the fiscal year 1986 Urgent Supplemental Appropriations Bill and although the administration strongly objected to its inclusion in the bill, President Reagan signed the bill on July 2, 1986.

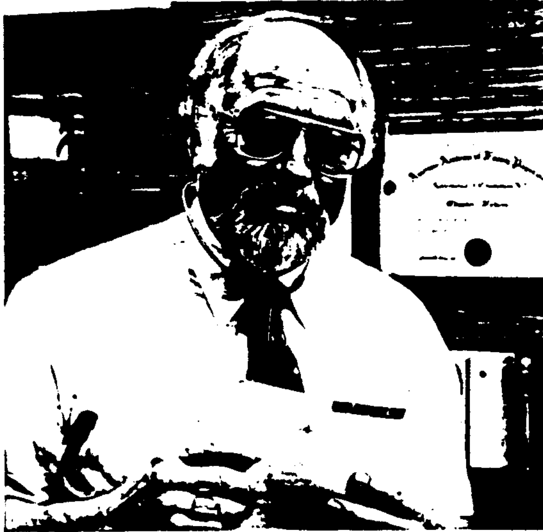
On July 15, 1986, we were contacted by Senator Durenberger's staff to review proposed changes they wanted to add to Senator Durenberger's bill. These changes are technical in nature but would essentially improve UMHC's Medicare capital payments over those in his earlier proposal. UMHC losses in Medicare reimbursement would decline from $13 million to $7 million under the revised proposals.

With the financial deficits presently facing Congress, we believe that the approach to capital payments being proposed by Senator Durenberger is a vast improvement over what we could expect from HCFA.

If Senator Durenberger's proposal is implemented, the challenge we still face is to structure our financial strategies to assure that the $5 - $6 million per year payment reductions that will exist in 1998 and beyond can be met through other sources of funds. A first step in this process is the designation of Board assets that is currently being discussed in the Finance Committee.

We will continue to provide you with information as these issues proceed. In the interim, if you have any questions, please feel free to contact me at your convenience.

CPF/jem



Dr. Raymond Lindeman is a family physician in Paynesville, Minnesota.

Dr. John S. Najarian is Regents' Professor and Chairman, Department of Surgery, University of Minnesota Medical School.

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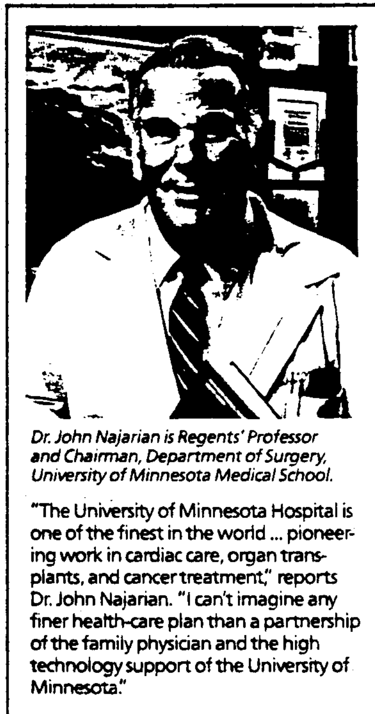

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Dr. John Myers is a family physician in Canby, Minnesota.

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RESOLUTION

WHEREAS, in August, 1985, the Board of Regents approved the purchase by the University of 34% of the stock in Primary Care Network Management Company, and

WHEREAS, the closing with respect to the acquisition of Primary Care Management Company occurred on September 5, 1985, and,

WHEREAS, as the total cost to the University included a $50,000 deposit, an equity contribution of $744,000 and a credit line loan guarantee of $190,000,

WHEREAS, it has become necessary for Primary Care Network Management Company to increase its credit line,

WHEREAS, Whitehead and Associates has committed to granting its proportionate share of the credit line increment and the University of Minnesota Clinical Associates has expressed its intent to accept assignment of one third of the University portion of the guarantee,

NOW THEREFORE BE IT RESOLVED, that the Hospital Board of Governors endorse an increase of the University's guarantee of Primary Care Network Management Company debt from the University's current obligation of $190,000 to an amount not to exceed $600,000 and ask the Vice President for Health Sciences to forward the same recommendation to the Board of Regents for approval.

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Task force urges organ transplant network

Associated Press

Washington, D.C.
A federal task force urged Congress Tuesday to create a national system of organ sharing, saying the current approach is plagued by commercialization that includes the illegal selling of organs for transplants.

The 25-member Task Force on Organ Transplantation reported a number of other abuses, including charges that transplant centers ignore waiting lists and solicit foreigners to receive transplants in the United States.

"Although transfer of an organ for valuable consideration is a felony under federal law ... the task force became aware of reports of serious abuses in the procurement, distribution and use of human organs for transplantation," the panel said.

The task force recommended a national procurement network to match organs with patients. The network would collect transplant data, linking about 110 organ procurement centers nationwide. The report also recommends that states adopt "required request" laws, which would require doctors to ask a family's permission to use suitable organs when a member of that family dies.

Dr. Nancy Ascher, a University of Minnesota transplant surgeon who served on the task force, said she's convinced that "We can get many more donors," and save more lives with transplants, if the recommendations are adopted. About 350 kidney, heart, liver and pancreas transplants were done in Minnesota last year, and she said that number easily could be increased to more than 500 a year.

Ascher said the abuses cited in the report occurred in states other than Minnesota. She said the University of Minnesota Hospitals, one of the nation's largest transplant centers, would not have any problem meeting task force recommendations, although the Minnesota Legislature would have to adopt the proposed "required request" law.

The commission also recommended that public funds be made available for liver and heart transplants for those who cannot afford them. Last month, the Reagan administration changed its policy to allow Medicare, which already pays for kidney transplants, to begin paying for some heart transplants.

For 17 million Americans who are uninsured, the task force proposed a last resort: a government-funded program to pay for transplants.

In a recommendation debated extensively by panel members, it was suggested that foreigners comprise no more than 10 percent of all cadaveric (when the kidney comes from someone who dies) kidney recipients in any transplant center. Prospective organ recipients have complained that some doctors profit by pushing foreigners ahead of Americans on waiting lists for organs.

Ascher noted that the American Red Cross already operates an organ-procurement network for Minnesota hospitals that do transplants, and she said this is just the type of regional networks that the task force suggests.

The report also recommends that any medical centers performing transplants meet minimum requirements designed to assure excellence. In response to a question at a press conference, Ascher said, "as I understand it" the heart transplant program at Abbott Northwestern Hospital in Minneapolis would not meet the requirement of having a surgeon with a year's specialized training in transplantation.

But Mark Dixon, an Abbott Northwestern spokesman, said the hospital's program has demonstrated its excellence. Of eight heart transplant recipients, only one has died since the hospital began performing the operation last October.

"Our surgeons had performed transplants at University Hospital" before coming to Abbott Northwestern, he added.

Dixon said his hospital's program would meet the minimum requirement of 12 heart transplants a year, another task force recommendation.

The task force was established in January 1985 by former Health and Human Services Secretary Margaret Heckler. It was asked to assess public and private efforts to procure human organs and identify problems that reduce the number of organs available for transplants.

The task force report was made available by Sen. Albert Gore, D-Tenn., a critic of the Reagan administration's handling of the transplant issue.

Both houses of Congress voted overwhelmingly in 1984 to set up the Organ Procurement and Transplantation Network. But Gore said the administration failed to establish a national program, then counseled against release of the task force report.

The administration has said it backs a program of public awareness to stress the need for organ donors. But it opposed creation of the task force, saying the private sector should handle the issue. Heckler made appointments to the group after Congress required it.

Linda Sheaffer of the Office of Organ Transplantation at Health and Human Services denied that the administration had ignored congressional directives or had sought to block the task force report.

Staff Writer Lewis Cope contributed to this report.

'U' Hospital considering girl, 3, for triple-organ transplant

A 3½-year-old girl from out of state was being considered for a triple-organ transplant at the University of Minnesota Hospital, but the hospital's chief of surgery said Tuesday that it hadn't been determined whether the combined heart, lung and liver transplant that she needs to survive will be possible.

Dr. John Najarian said the youngster had been turned down at two other transplant centers.

"No one has ever done a heart-lung transplant in someone that small," he said of the 18-pound girl. Doing a liver transplant at the same time would make the surgery even more difficult, he added.

University Hospital has a heart-lung transplant program for adults and is a leader in liver transplants for youngsters. Najarian said doctors are examining the girl to see whether the triple transplant stands a reasonable chance of saving her life.

He said the girl has a rare condition that started with problems in her liver, the body's main "chemical factory." That condition led to problems with blood vessels in her lungs, where blood goes to pick up oxygen. The girl's heart then tried to compensate for these problems by pumping the blood harder, causing the heart to give out, he said.

REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION

EXECUTIVE SUMMARY

In response to widespread public interest and involvement in the field of organ transplantation, the Congress enacted the National Organ Transplant Act of 1984 (PL 98-507). In addition to prohibiting the purchase of organs, the act provided for the establishment of grants to organ procurement agencies (OPAs) and a national organ-sharing system. This act also established a twenty-five member Task Force on Organ Transplantation representing medicine, law, theology, ethics, allied health, the health insurance industry, and the general public. The Office of the Surgeon General of the Public Health Service, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and the Health Care Financing Administration (HCFA) were also represented.

The mandate given to the Task Force was to conduct comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation and to report on these issues within one year. In addition, we were asked to assess immunosuppressive medications used to prevent rejection and to report on our findings within seven months; this report also was to include a series of recommendations, including recommending a means of assuring that individuals who need such medications can obtain

them.

During the twelve months following its organizational meeting on February 11, 1985, the Task Force met in public session on nine occasions and held two public hearings. We were supported by staff from the Office of Organ Transplantation and by consultants from HFCA and other agencies and organizations. Data were obtained through surveys, literature reviews, commissioned studies, consultations, and public testimony. Five workgroups were established within the Task Force to address each of the mandated issues identified by Congress and to prepare presentations and recommendations for consideration by the full membership.

As required by the act, the Task Force completed an assessment of immunosuppressive medications and the costs of these therapies, and submitted its report and recommendations to the Secretary and the Congress on October 21, 1985. Briefly, we found that the new immunosuppressive regimens, although expensive, proved to be cost-saving due to improvement in outcome; therefore, the Task Force recommended that the federal government establish a mechanism to provide immunosuppressive drugs to recipients otherwise unable to pay for these drugs, when Medicare paid for the transplantation procedure.

In this final report, the Task Force summarizes its

arguments on the issues identified as major concerns by the Congress, and presents a series of recommendations for consideration of federal and state legislators, public health officials, the organ and tissue transplantation community, organized medicine, nursing, and the NIH.

ORGAN AND TISSUE DONATION AND PROCUREMENT

The serious gap between the need for organs and tissues and the supply of donors is common to all programs in organ transplantation, as well as to tissue banking and transplantation. The Task Force believes that substantial improvements in organ donation would ensue through new, innovative, and expanded programs in public and professional education and the coordination of efforts of the many organizations and agencies that engage in these activities. In particular, we support both the enactment of legislation in states that have not clarified determination of death based on irreversible cessation of brain function (the Uniform Determination of Death Act), and the enactment of legislation requiring implementation of routine hospital policies and procedures to provide the next-of-kin with the opportunity of donating organs and tissues. In addition, we found both a serious lack of uniform standards of accountability and quality assurance in organ and tissue procurement and a spectrum of effectiveness of procurement activities. Therefore, the Task

Force supports the development both of minimum performance and certification standards, and of monitoring mechanisms.

Recommendations

1. The Task Force recommends that the Uniform Determination of Death Act be enacted by the legislatures of states that have not adopted this or a similar act.

2. The Task Force recommends that each state medical association develop and adopt model hospital policies and protocols for the determination of death based upon irreversible cessation of brain function that will be available to guide hospitals in developing and implementing institutional policies and protocols concerning brain death.

3. The Task Force recommends that states enact legislation requiring coroners and medical examiners to give permission for organ and tissue procurement when families consent unless the surgical procedure would compromise medicolegal evidence. The Task Force further recommends that states enact legislation that (1) requires coroners and medical examiners to develop policies that facilitate the evaluation of all nonheart-beating cadavers under their jurisdiction for organ and tissue donation, and (2) provides the next-of-kin with the opportunity to consider postmortem tissue donation. The Task Force further recommends

that coroners develop agreements with local tissue banks to help implement these policies.

4. The Task Force recommends that all health professionals involved in caring for potential organ and tissue donors voluntarily accept the responsibility for identifying these donors and for referring such donors to appropriate organ procurement organizations.

5. The Task Force recommends that hospitals adopt routine inquiry/required request policies and procedures for identifying potential organ and tissue donors and for providing next of kin with appropriate opportunities for donation.

6. The Task Force recommends that the Joint Commission on the Accreditation of Hospitals develop a standard that requires all acute care hospitals to both have an affiliation with an organ procurement agency and have formal policies and procedures for identifying potential organ and tissue donors and for providing next of kin with appropriate opportunities for donation. The Task Force further recommends that the Department of Defense and the Veterans Administration require their hospitals to have routine inquiry policies.

7. The Task Force recommends that the Health Care Financing Administration incorporate into the Medicare conditions of

participation for hospitals certified under subpart U of the Code of Federal Regulations, a condition that requires hospitals to have routine inquiry policies.

8. The Task Force recommends that all state legislatures formulate, introduce, and enact routine inquiry legislation.

9. The Task Force recommends that the Commission for Uniform State Laws develop model legislation that requires acute care hospitals to develop an affiliation with an organ procurement agency and to adopt routine inquiry policies and procedures.

10. The Task Force recommends that a study of the potential donor pool be conducted using data available through the National Hospital Discharge Survey, supplemented by regional retrospective hospital record reviews.

11. The Task Force recommends that living donors be fully informed about the risks of kidney donation. Health care professionals must guarantee that the decision to donate is entirely voluntary. In the case of all living donors, special emphasis should be placed on histocompatibility.

12. The Task Force recommends that educational efforts aimed at increasing organ donation among minority populations be developed and implemented, so that the donor population will come to more

closely resemble the ethnic profile of the pool of potential recipients.

13. The Task Force recommends that at the regional level, single consortia, composed of public, private, and voluntary groups that have an interest in education on organ and tissue donation develop, coordinate, and implement public and professional education to supplement, but not replace, activities undertaken by local programs.

14. The Task Force recommends that a single organization, such as the American Council on Transplantation, composed of public, private, and voluntary groups that are national in scope and have an interest in education for organ and tissue donation, develop and coordinate broad scale public and professional educational programs and materials on the national level. This umbrella organization would both develop and distribute model educational materials for use by national and local organizations and plan, coordinate, and develop national efforts using nationwide electronic and print media.

15. The Task Force recommends establishment of a national educational program, similar to the High Blood Pressure Education Program of NIH's National Heart, Lung, and Blood Institute, aimed at increasing organ donation. This program should include development both of curricula and instructional materials for use

in primary and secondary schools throughout the nation, and of programs directed to special target populations, e.g., minority groups, family units, and churches.

16. The Task Force recommends that medical and nursing schools incorporate curricula focusing on organ and tissue procurement and transplantation.

17. The Task Force recommends that the Accreditation Council of Graduate Medical Education, the body responsible for accrediting residency programs, include requirements for exposure to organ and tissue donation and transplantation in relevant graduate medical education programs, such as emergency and critical care medicine and the neurological sciences.

18. The Task Force recommends that each appropriate medical and nursing specialty board require demonstration of knowledge of organ and tissue donation and transplantation for board certification.

19. The Task Force recommends that all professional associations of physicians and nurses involved in caring for potential organ and tissue donors (especially neurosurgeons; trauma surgeons; emergency physicians; and critical care, emergency room, and trauma team nurses), establish programs to educate and encourage their members both to participate in the referral of donors and

to cooperate in the organ donation process.

20. The Task Force recommends that organizations of physician specialists who frequently come in contact with organ and tissue donors should establish mechanisms, such as a committee on transplantation, to facilitate communication and cooperation with physicians in the transplantation specialties.

21. The Task Force recommends that a national registry of human organ donors not be established.

22. The Task Force recommends that professional peer group organizations, e.g., the North American Transplant Coordinators Organization (NATCO), establish mechanisms for certification of nonphysician organ and tissue procurement specialists and standards for evaluation of performance at regular intervals.

23. The Task Force recommends that HFCA certify no more than one OPA in any standard metropolitan statistical area or existing organ donor referral area, whichever is larger.

24. The Task Force recommends that the Health Care Financing Administration use the criteria developed by the Association of Independent Organ Procurement Agencies as a guideline to develop consistent certification standards for Independent Organ Procurement Agencies and Hospital-Based Organ Procurement

Agencies.

25. The Task Force recommends that the Health Care Financing Administration establish minimal performance productivity standards as part of a recertification process that could be conducted at regular intervals. Such standards should address procurement activity, organizational structure and programs, staff training and competence, and fiscal accountability.

26. The Task Force recommends that the Health Care Financing Administration collect uniform data on organ procurement activities of all Organ Procurement Agencies, including, at a minimum, the number of kidneys procured, kidneys transplanted, kidneys procured but not transplanted, kidneys exported abroad, and relevant cost data. (The data could be collected through the Organ Procurement Transplantation Network or from each Organ Procurement Agency.)

27. The Task Force recommends that HFCA require all Organ Procurement Agencies to have, as a minimum, a form of governance that would be similar to that described for the national Organ Procurement and Transplantation Network, i.e., it should include adequate representation from each of the following categories: transplant surgeons from participating transplant centers, transplant physicians from participating transplant centers, histocompatibility experts from the affiliated histocompatibility

laboratories, representatives of the Organ Procurement Agencies, and members of the general public. Representatives of the general public should have no direct or indirect professional affiliation with the transplant centers or the Organ Procurement Agency. Not more than 50 percent of the Board of Directors may be surgeons or physicians directly involved in transplantation, and at least 20 percent should be members of the general public. Where the governing boards of existing Organ Procurement Agencies differ from this composition, it is desirable that those boards be modified over a maximum to two years to achieve this distribution. The Task Force believes that all Organ Procurement Agency boards should consider immediate steps to include public representatives.

28. The Task Force recommends that appropriate peer organizations develop standards for certification of tissue banks and conducting performance evaluations at regular intervals. Such standards should include assessment of quality and quantity of performance, organizational structure and programs, staff training and competency, and fiscal responsibility.

29. The Task Force recommends that formal cooperative agreements be established among eye, skin, and bone banks.

30. The Task Force recommends that all Organ Procurement Agencies evaluate all potential donors for multiple organ and

tissue donation.

31. The Task Force recommends that organ procurement agencies and tissue banks enter into formal agreements for collaborative programs to educate the public and health professionals and to coordinate donor identifications, discussions with next-of-kin, and the procurement process.

ORGAN SHARING

The Task Force believes that establishment of a unified national system of organ sharing that encompasses a patient registry and coordinates organ allocation and distribution will go far in assuring equity and fairness in the allocation of organs. In addition, a national network organization, through adoption of agreed upon standards and policies, may serve as the vehicle both for improving matching of donors and recipients and for improving access of groups at special disadvantage (the sensitized and small pediatric recipients); thus, the outcome of organ transplantation in this country will surely improve. The development of a national network will permit the gathering and analysis of comprehensive data and, through the establishment of a scientific registry, will facilitate the exchange of new information vital to progress in the field. We assisted the Office of Organ Transplantation in developing specifications for a model network, and urge that the National Organ Procurement and

Transplantation Network be established promptly; in addition, we urge Congress to appropriate the funds necessary to initiate the development of the scientific registry.

Recommendations

1. The Task Force recommends that a single national system for organ sharing be established; that its participants agree on and adopt uniform policies and standards by which all will abide; and that its governance include a broad range of viewpoints, interests, and expertise, including the public.

2. The Task Force recommends regional centralization of histocompatibility testing where it is geographically feasible, and standardization of key typing reagents and crossmatching techniques.

3. The Task Force recommends that organ sharing be mandated for perfectly matched (HLA A, B, and DR) donor-recipient pairs and for donors and recipients with zero antigen mismatches (assuming that at least one antigen has been identified at each locus for both donor and recipient).

4. To increase the rate of transplantation in the highly sensitized patient group by increasing the effective size of the donor pool, the Task Force recommends that a system of serum

sharing and/or allocation of organs based on computer-determined prediction of a negative crossmatch, be developed.

5. Because of the limited local and regional donor pools available to small pediatric patients, the Task Force recommends implementation of a national organ-sharing system that provides pediatric extrarenal transplant patients access to a national pool of pediatric donors.

6. The Task Force recommends that blood group "O" organs be transplanted only into blood group "O" recipients.

7. The Task Force recommends that the national organ-sharing network, when established, conduct ongoing reviews of organ procurement activities, particularly organ discard rates, and develop mechanisms to assist those agencies and programs with high discard rates. In the meantime, the Task Force recommends that the Health Care Financing Administration conduct a study to identify why procured kidneys are not transplanted and why the discard rates vary widely from one organ procurement program to another.

8. The Task Force recommends that the national network establish a method to systematically collect and analyze data related to both kidney and extrarenal organ procurement and transplantation. Further, to provide an ongoing evaluation of

the scientific and clinical status of organ transplantation, the Task Force recommends that a scientific registry of the recipients of kidney and extrarenal organ transplants be developed and administered through the national network, and urges the Congress to appropriate funds to initiate this activity.

9. The Task Force recommends that the Congress appropriate funds to establish a national ESRD registry that would combine a renal transplant registry with a dialysis registry. The Task Force further recommends that the national organ-sharing network be represented on any committee responsible for management and data analysis of a national ESRD registry.

EQUITABLE ACCESS TO ORGAN TRANSPLANTATION

The process of selecting patients for transplantation, both in the formation of the waiting list and in the final selection for allocation of the organ, is generally fair and for the most part has succeeded in achieving equitable distribution of organs. However, the Task Force believes that these processes must be defined by each center and by the system as a whole, and that the standards for patient selection and organ allocation must be based solely on objective medical criteria that are applied fairly and are open to public examination. Moreover, as vital participants in the process, the public must be included in

developing these standards and in implementing the policies. We recognized the complex conflict between need for an organ (medical urgency) and the probability of success of the transplant, and did not presume to make recommendations in this sphere; rather we believe that a thoughtful process of development of policies for organ allocation, which takes into account both medical utility and good stewardship, must take place within a broadly representative group.

The Task Force condemns commercialization of organ transplantation and the exploitation of living unrelated donors. The Task Force also addressed the difficult problem of offering organ transplantation to non-immigrant aliens. When transplantable organs are scarce, we have recommended that no more than 10 percent of all cadaveric kidney transplants in any center be performed in non-immigrant aliens and that extrarenal transplants be offered only when no suitable recipient who is a resident of this country can be found. The Task Force also concluded that equitable access of patients to extrarenal organ transplantation is impeded unfairly by financial barriers, and recommends that all transplant procedures that are efficacious and cost effective be made available to patients, regardless of their ability to pay, through existing public and private health insurance or, as a last resort, through a publicly funded program for patients who are without insurance, Medicare, or Medicaid who could not otherwise afford to obtain the organ transplant.

Recommendations

1. The Task Force recommends that donated organs be considered a resource to be used for the community good; the public must participate in the decisions of how this resource can be used to best serve the public interest.

2. The Task Force recommends that health professionals provide unbiased, timely, and accurate information to all patients who could possibly benefit from organ transplantation so that they can make informed choices about whether they want to be evaluated and placed on a waiting list.

3. The Task Force recommends that information be published annually for patients and physicians on the graft and patient survival data by transplant center. A clear explanation of what the data represent should preface the presentation of data. A strong recommendation should be made in the publication that each patient discuss with his or her attending physician the circumstances of medical suitability for transplantation and where that patient may best be served.

4. The Task Force recommends that selection of patients both for waiting lists and for allocation of organs be based on medical criteria that are publicly stated and fairly applied.

The Task Force also recommends that the criteria be developed by a broadly representative group that will take into account both need and probability of success. Selection of patients otherwise equally medically qualified should be based on length of time on the waiting list.

5. The Task Force recommends that selection of patients for transplants not be subject to favoritism, discrimination on the basis of race or sex, or ability to pay.

6. The Task Force recommends that organ-sharing programs that are designed to improve the probability of success be implemented in the interests of justice and the effective and efficient use of organs, and that the effect of mandated organ sharing be constantly assessed to identify and rectify imbalances that might reduce access of any group.

7. The Task Force recommends that non-immigrant aliens not comprise more than 10 percent of the total number of kidney transplant recipients at each transplant center, until the Organ Procurement and Transplantation Network has had an opportunity to review the issue. In addition, extrarenal organs should not be offered for transplantation to a non-immigrant alien unless it has been determined that no other suitable recipient can be found.

8. The Task Force recommends that as a condition of membership in the Organ Procurement Transplantation Network, each transplant center be required to report every transplant or organ procurement procedure to the OPTN. Moreover, transplantation procedures should not be reimbursed under Medicare, Medicaid, CHAMPUS, and other public payers, unless the transplant center meets payment, organ sharing, reporting, and other guidelines to be established by the OPTN or another agency administratively responsible for the development of such guidelines. Failure to comply with these guidelines will require that the center show cause why it should not be excluded from further organ sharing through the OPTN.

9. The Task Force recommends that exportation and importation of donor organs be prohibited except when distribution is arranged or coordinated by the Organ Procurement and Transplantation Network and the organs are to be sent to recognized national networks. Even then, when an organ is to be exported from the United States, documentation must be available to demonstrate that all appropriate efforts have been made to locate a recipient in the United States and/or Canada. The Task Force has every expectation that these international organ sharing programs will be reciprocal.

10. The Task Force recommends that the practice of soliciting or advertising for non-immigrant aliens and performing a transplant

for such patients, without regard to the waiting list, cease.

11. The Task Force recommends that transplanting kidneys from living unrelated donors should be prohibited when financial gain rather than altruism is the motivating factor.

12. To the extent that federal law does not prohibit the intrastate sale of organs, the Task Force recommends that states prohibit the sale of organs from cadavers or living donors within their boundaries.

13. The Task Force recommends that private and public health benefit programs, including Medicare and Medicaid, should cover heart and liver transplants, including outpatient immunosuppressive therapy that is an essential part of post-transplant care.

14. The Task Force recommends that a public program should be set up to cover the costs of people who are medically eligible for organ transplants but who are not covered by private insurance, Medicare, or Medicaid and who are unable to obtain an organ transplant due to lack of funds.

DIFFUSION OF ORGAN TRANSPLANTATION TECHNOLOGY

The number of organ transplant centers in this country is

rapidly increasing. As the technical aspects of the procedures have been mastered and patient management has become better understood and standardized, it is not surprising that diffusion of this technology has taken place. The issue of designating centers for reimbursement purposes requires careful consideration of many factors, including cost, criteria for facilities, resources, staffing, and the training and experience of personnel. After lengthy debate, the Task Force agreed with the widely accepted principle within surgery that the volume of surgical procedures performed is positively associated with outcomes and inversely related to cost and believe that this principle applies to organ transplantation procedures as well. Therefore, we recommend that a minimum volume criterion be enforced, together with other criteria defining the minimal requirements for both institutional and professional support and outcome of transplantation procedures. In the context of scarcity of donor organs, we strongly support regulating diffusion of transplantation technology.

Recommendations

1. **The Task Force recommends that transplant centers be designated by an explicit, formal process using well-defined, published criteria.**

2. **The Task Force recommends that the Health Care Financing**

Administration designate centers to perform kidney, heart, and liver transplants, and that the centers be evaluated against explicit criteria to ensure that only those institutions with requisite capabilities are allowed to perform the procedures.

3. The Task Force recommends that the Health Care Financing Administration adopt minimum criteria for kidney, heart, and liver transplant centers that address facility requirements, staff experience, training requirements, volume of transplants to be performed each year, and minimum patient and graft survival rates.

RESEARCH IN ORGAN TRANSPLANTATION

Organ transplantation continues to evolve and improve at a fast pace. Strong research programs in basic and applied clinical sciences have been vital to this fortunate development. As is clearly evident in the concerns of the public that resulted in the enactment of the National Organ Transplant Act, research also is needed in the social, ethical, economic, and legal aspects of organ donation and transplantation. The Task Force acknowledges the important role played by the NIH in transplantation research, and encourages the NIH to coordinate the free flow of information regarding transplant-related research through an interinstitutional council on transplantation. Moreover, we strongly urge that research on all

aspects of transplantation be fostered, encouraged, and funded. Therein lies the future of transplantation.

Recommendations

1. The Task Force recommends that basic research continue to receive high priority.

2. The Task Force recommends that both laboratory and clinical research be fostered, encouraged, and funded. For the immediate benefit of patients, the Task Force further recommends that research be aggressively pursued in organ preservation and optimal immunosuppression techniques. The Task Force also wishes to emphasize the importance of sponsoring prospective clinical trials, involving multiple institutions, to solve certain problems in patient management.

3. The Task Force recommends that continuing attention be devoted to collecting complete information on the status and efficacy of transplantation treatments.

4. The Task Force recommends that the National Institutes of Health and other agencies encourage the continuing free flow of information in the transplant field. We believe that better coordination of National Institutes of Health activities might be achieved by reactivating an interinstitute council on

Dr. Raymond Lindeman is a family physician in Paynesville, Minnesota.

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