THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

MARCH 23, 1988

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The University of Minnesota Hospital and Clinic
Board of Governors
March 23, 1988
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of February 24, 1988 Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Special Presentation: Advances in the Care of the Critically ill Newborn Infant: Medical, Legal and Ethical Issues - Dr. Theodore R. Thompson	Information
V.	Committee Reports:	
	A. Planning and Development Committee - Ms. Kris Johnson	
	The Planning and Development Committee did not meet in March.	
	B. Joint Conference Committee - Mr. George Heenan	
	1. Medical Staff-Hospital Council Credentials Committee Recommendations	Approval
	2. Proposed Revisions to the Rules and Regulations of the Medical and Dental Staff	Approval
	3. New and Revised Policies for Kidney Dialysis Unit (KDU)	Approval
	C. Finance Committee - Mr. Jerry Meilahn	
	1. February Year-to-Date Financial Statements	Information
	2. 2nd Quarter Bad Debts	Approval
VI.	Other Business	
VII.	Adjournment	

Minutes

Board of Governors

The University of Minnesota Hospital and Clinic

February 24, 1988

CALL TO ORDER:

Chairman Robert Latz called the February 24, 1988 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias
	Sally Booth
	Shelley Chou, M.D.
	Robert Dickler
	Phyllis Ellis
	Al Hanser
	George Heenan
	Robert Latz
	David Lilly
	Jerry Meilahn
	James Moller, M.D.
Not Present:	David Brown, M.D.
	Kris Johnson
	Robert Nickoloff
	Barbara O'Grady
	Neal Vanselow, M.D.

SPECIAL PRESENTATION: BONE MARROW TRANSPLANT SERVICES:

Mr. Robert Dickler introduced Dr. John Kersey, Professor of Laboratory Medicine and Pathology, Professor of Pediatrics, Professor of Therapeutic Radiology and Director of the Bone Marrow Transplantation Program. Dr. Kersey, Mr. Dickler reported, is one of the world's foremost leaders in bone marrow transplantation.

Dr. Kersey reported that the first bone marrow transplant in the world was done at UMHC in 1968. Since 1974 our services have increased so that UMHC is now the 2nd largest transplant center in the world.

Three types of bone marrow transplants performed now include: allegenaic, where someone else is the donor, always a matched sibling; atologous, where one may donate ones own bone marrow through a special purging process; and allogenic, where unrelated donated donors are located through a national registry located in St. Paul. Dr. Kersey noted the numbers of bone marrow transplants by disease category from 1974 through 1987. The diseases that involve the bone marrow are leukemia, lymphoma and severe forms of anemia. Air quality is of concern to doctors in bone marrow cases. Patients are very susceptible to viral, fungal and bacterial infections. In response to this concern, UMHC has provided highly filtered air in bone marrow transplant patient rooms that are filtered at each room at the rate of 15 air exchanges per hour. Dr. Kersey emphasized that a patient needs approximately 6-8 weeks in the hospital after transplant to develop normal blood count and get the immune system working again.

The future of bone marrow transplantation, Dr. Kersey reported, is to make it more widely available and less costly to patients. Currently the Bone Marrow Transplant Services are able to "cure" approximately 50% of the patients they treat.

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the January 27, 1988 meeting as written.

CHAIRMAN'S REPORT:

Mr. Latz introduced Ms. Dee Lutz of the Minnesota Daily, and welcomed a number of individuals from the Phillips Neighborhood Association.

Dr. James Moller, Mr. Latz reported, was WCCO's Good Neighbor for February 24, 1988.

The Board Retreat, Mr. Latz reported, is being scheduled currently and the date will be announced shortly; two days in early October are likely choices.

The Committee appointments for 1988 are now being finalized, Mr. Latz noted. Ms. Sally Booth will be serving on the Joint Conference Committee. Otherwise, the Committee Chairs and appointments are unchanged.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler reported that the State of Minnesota Medicare Validation Survey held February 1-4, 1988 went well. Several specific areas for improvement were noted.

The census, Mr. Dickler reported, continues to be good, although somewhat softer than previous months. This may be due to the absence of several attending physicians in recent weeks.

Mr. Al Dees briefly reported on the legislative session, noting he will be forwarding information each week to Board members. Items of specific interest to the Hospital included: solvency requirements for HMO's; specific changes in the Open Meeting Law making it possible for public hospitals to hold closed sessions under certain circumstances; the Health Care Precision - Living Will Act; a change in peer review procedures requiring actions to be reported to the State Medical Board.

Mr. Dickler reported that the Hospital has begun the 1988-89 budget process. A larger rate increase than in previous years will be recommended. The increase would be within the range of a community-wide increases. Factors leading to a higher price increase include reductions in Medicare payments, increasing health insurance costs, pay equity (comparable worth) payments, loss of interest income on our legislative appropriation.

Mr. Dickler brought to the Board of Governors a CUHCC Replacement Facility proposal for approval. Mr. Greg Hart reported that Hospital Administration and CUHCC representatives had met with several groups concerned about the location of CUHCC in December, January, and February. A tentative agreement has been reached with the Minneapolis Community Development Agency that would allow CUHCC to remain in the Phillips Neighborhood. The city is considering assistance in financing construction and stabilizing current grant support to CUHCC.

The following resolution was proposed:

> "Whereas, the Board of Governors recently endorsed the continuation of the Community University Health Care Center (CUHCC) and funding for its replacement facility, and
>
> Whereas the Board of Governors requested further information regarding site selection, and
>
> Whereas community leaders have expressed interest in keeping CUHCC within the Phillips Neighborhood, and
>
> Whereas members of the Minneapolis City Council and the Minneapolis Community Development Agency have indicated a willingness to provide financial support for CUHCC through long term grant stability and $150,000 to offset construction costs,
>
> Now, therefore be it resolved, contingent upon City Council approval of the aforementioned support, that the Board of Governors endorses the acquisition of land at Franklin and Bloomington and construction of a new facility for CUHCC at that location, utilizing University Hospital funds in an amount not to exceed $1,350,000."

The Board of Governors seconded and passed this resolution as written.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Mr. Al Hanser reported that the Committee heard a report from Mr. Fred Bertschinger, Director of Development, on current fundraising at UMHC. Fundraising is progressing according to budgeted levels at this point in the fiscal year.

Mr. Hanser indicated that the Committee was given a general update on the activities of UMCA from Dr. Peter Lynch.

The CUHCC site selection proposal, as presented and passed by the Board, was discussed and endorsed at the Planning and Development Committee.

Mr. Hanser reported that Ms. Mary Ellen Wells and Dr. Peter Lynch presented a proposal for Dermatology Clinic expansion for information only this month. Ms. Wells briefly noted that the proposal is for the last shell space in the Phillips-Wangensteen Building. The Dermatology Clinic currently shares a module with Surgery on the 1st floor. The project has not been bid, but preliminary cost estimates would bring the hospital's contribution to the project to $631,000. Dr. Lynch briefly reviewed the proposed use of this new space: dermatology micrographic removal of cancer, laser procedures, and other dermatologic surgery and examination rooms. Dr. Lynch noted that the proposal would be brought back to the Planning and Development Committee and the Board for approval.

Lastly, Mr. Hanser reports that the Committee had reviewed the Quarterly Purchasing Report for the second quarter of 1987-88. The report reflected a purchasing activity of $13.5 million. The Committee reviewed the purchase awards other than low bidder, sole source and set asides. The Committee was informed that purchases from UHC continue to result in savings for UMHC. The report was endorsed by the Committee.

The Board of Governors seconded and passed a motion to accept the Quarterly Purchasing Report for the Second Quarter of 1987-88.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan noted that the Committee heard a presentation on the Clinical Pharmacy Relationships by Paul Abramowitz, Pharm. D., Clinical Chief of Pharmacy Services. He reviewed the changes of the past 20 years with a view of future practice. He described the drug distribution system at UMHC as centralized with several satellites in specific areas of the Hospital. Mr. Abramowitz also described the changing role of pharmacists as being for more clinically oriented. Pharmacists are increasingly on the patient care units consulting with physicians and nursing staff about selection and dosing of pharmaceuticals.

Mr. Heenan reported that Jan Halverson had apprised the Committee of a discussion by the State Board of Medical Examiners regarding the ascendancy of statutory obligation to report physician misconduct vs. the obligation for confidentiality in peer review. Mr. Halverson will be keeping the Committee informed as this issue develops over the course of the legislative session.

Ms. Phyllis Ellis reminded other Board members of the Metropolitan Hospital Trustee Council breakfast meeting at 7:30 - 9:30 a.m. on March 22, 1988 entitled "Aids in Your Hospital: The Big Issues are Board Issues" Those interested are asked to call Kay in the Board Office.

ADJOURNMENT:

There being no further business, the February 24, 1988 meeting of the Board of Governors adjourned at 4:25 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 16, 1988

TO: Members of the Board of Governors

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

REGARDING: Joint Commission Survey Findings

We recently received our written findings from the November, 1987 Joint Commission on Accreditation of Healthcare site visit. The Joint Commission did renew our accreditation for the maximum available accreditation term, three years.

The renewal of our accreditation is contingent upon the correction of twenty priority recommendations included in the report. Those priority recommendations are referred to as contingencies and are summarized for you on the attachment.

The Joint Commission will verify our correction of those contingencies in three ways: written progress reports, a focused site visit this fall and at their next regularly scheduled site visit. We have been asked to submit two written progress reports, one in May and one in December. The focused site visit will be scheduled for review of two specific findings in the Ambulatory Care area. We can expect that all findings not addressed through a progress report or the focused site visit will be carefully examined in three years at the Joint Commission's next regularly scheduled visit.

We are generally satisfied with the results of our survey. We understand from the Joint Commission that requests for written progress reports and follow up visits are common. There are, however, individual recommendations that we disagree with or are disappointed with. The Joint Conference Committee will be reviewing the findings in detail on April 13, 1988. At the conclusion of their review, we will schedule a more comprehensive review of findings for the full Board.

Thank you.

Attachment

November 13–16, 1987 Site Visit

THREE YEAR ACCREDITATION AWARDED
Summary of Contingencies

1. **GOVERNANCE:** The Board of Governors documentation of quality assurance reviews were limited.

2. **AMBULATORY CARE:** Medical records did not routinely include complete summary sheets.

3. **AMBULATORY CARE:** Examples of effective action taken as part of the Ambulatory Care Q.A. plan were limited.

4. **AMBULATORY CARE:** The effectiveness of actions taken to improve care should be evaluated more thoroughly.

5. **MEDICAL STAFF HOSPITAL COUNCIL:** The Medical Staff Hospital Council does not receive or act upon the findings of the all clinical departments' Q.A. plans.

6. **CLINICAL DEPARTMENT Q.A.:** Clinical departments do not uniformly hold monthly meetings to consider quality assurance findings.

7. **CLINICAL DEPARTMENT Q.A.:** Minutes of the clinical departmental meetings do not document conclusions, recommendations, actions and evaluations of actions taken as part of the quality assurance monitoring and evaluation plans.

8. **TISSUE AND PROCEDURE:** The Tissue and Procedure Committee meets every other month rather than every month. Documentation did not consistently indicate that all cases were reviewed at the meetings.

9. **MEDICAL STAFF MEDICAL RECORD REVIEW:** Medical Staff involvement in review of medical records for clinical pertinence was initiated only recently.

10. **MEDICAL STAFF MEDICAL RECORD REVIEW:** Only nine records have been reviewed by medical staff for clinical pertinence.

11. **BLOOD USAGE REVIEW:** Blood usage review does not include review of the ordering practices of all blood and blood products. Review activities addressed only the ordering of platelets.

12. **BLOOD USAGE REVIEW:** Blood usage review does not include criteria for the review of cases involving whole blood. Criteria for the review of cases involving the use of cryoprecipitates, fresh frozen plasma and red blood cells have been developted, but not implemented.

13. **NUCLEAR MEDICINE:** Actions taken to improve care are not sufficiently documented as part of Nuclear Medicine's Q.A. plan.

14. **NUCLEAR MEDICINE:** Evaluation of the effectiveness of actions taken as part of Nuclear Medicine's Q.A. plan is not documented.

15. **NUCLEAR MEDICINE:** The findings from and conclusions of the quality assurance activities should be reported; there was no evidence that findings are reported.

16. **OPERATING ROOMS:** Nonregistered nurses are assigned to the circulating nurse position in the O.R.

17. **PLANT, TECHNOLOGY:** Employee lockers on the first floor of Mayo are not protected by one hour fire resistant construction. The (C) in the margin of page 16 corresponding to recommendation 60 (a) is duplicative of this contingency.

18. **EMERGENCY PREPAREDNESS:** Emergency preparedness drills are not being conducted at six month intervals.

19. **EMERGENCY PREPAREDNESS:** Neither of the 1987 drills involved an influx of patients from outside of the hospital.

20. **PLANT, TECHNOLOGY:** Although weekly generator exercises have been conducted, the emergency generator has not been tested under full load.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 16, 1988

TO: Members of the Board of Governors

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

Dr. Theodore Thompson, Professor of Pediatrics and Director, Newborn Intensive Care Unit, has agreed to speak to the Board of Governors on March 23, 1988. Dr. Thompson will be speaking to the Board of Governors about the advances in the care of the critically ill newborn infant. As part of his presentation, Dr. Thompson also intends to discuss ethical issues associated with caring for this critically ill population. Dr. Thompson's curriculum vitae is attached for your review.

This presentation is another in a series of presentations that we have scheduled per the January, 1987 Board request that speakers who can broaden or enhance familiarity with current issues be engaged.

I will see you on Wednesday, March 23rd at 2:30 P.M.

NCJ/kff

Attachment

CURRICULUM VITAE

Name	Theodore Robert Thompson
Birthdate	July 18, 1943
Birthplace	Dayton, Ohio
Married	Lynette J. Shenk (12/21/68)
Children	Stephanie Beth Thompson
Board Qualifications	Board certified in Pediatrics - April 28, 1974 Board certified in Neonatal-Perinatal Medicine - November 15, 1975 Recertified in Pediatrics - 1981 Recertified in Neonatal-Perinatal Medicine - 1986
License	Minnesota - since July 16, 1971

EDUCATION

High School

Vandalia-Butler High School
Vandalia, Ohio
1957-1961
Co-Valedictorian

College

Wittenberg University
Springfield, Ohio
1961-1965 B.S. (Chemistry)
Magna cum laude
President of Senior Class
Phi Mu Delta Fraternity

Medical School

University of Pennsylvania
Philadelphia, Pennsylvania
1965-1969 M.D.
Alpha Omega Alpha
Phi Chi Medical Fraternity

Internship

University of Minnesota Hospitals
Pediatrics, 1969-1970

Residency

University of Minnesota Hospitals
Pediatrics, 1970-1971

Chief Residency

University of Minnesota Hospitals
Pediatrics, 1971-1972

Fellowship

University of Minnesota Hospitals
Neonatology
July 1, 1974 - October 1, 1975

POSITIONS HELD

Staff

1972-1974 — Michigan State University
College of Human Medicine
Department of Human Development
Instructor

1975-1977 — University of Minnesota Hospitals
Assistant Professor, Department of Pediatrics
and School of Public Health, Maternal and Child Health Program
Associate Director, Newborn Intensive Care Unit

1977-1979 — University of Minnesota Hospitals
Assistant Professor, Department of Pediatrics
and School of Public Health, Maternal and Child Health Progam
Director, Newborn Intensive Care Unit

1980-1985 — University of Minnesota Hospitals
Associate Professor, Department of Pediatrics
and School of Public Health, Maternal and Child Health Program
1982- and Department of Obstetrics and Gynecology
1984- Associate Professor and Consultant for Research Program,
Department of Family Practice & Community Health
Director, Newborn Intensive Care Unit

1985- — University of Minnesota Hospitals
Professor, Department of Pediatrics
and Department of Obstetrics and Gynecology
Professor and Consultant for Research Program,
Department of Family Practice & Community Health
and Associate Professor, School of Public Health,
Maternal and Child Health Program
Director, Newborn Intensive Care Unit
1987- Assistant Director, Medical Education, Department of Pediatrics
Co-Director, Medical Outreach

Consultant

1974- — Perinatal Health Care
Maternal and Child Health Division
Minnesota Department of Health

1974- — Clinical Consultant
Emergency Medical Services
Minnesota Department of Health

1974- — High Risk Infant Care
Emergency Medical Services Division
Minnesota Department of Health

1978- — Perinatal Health Care
Emergency Medical Services
Metropolitan Health Board

1978- — Medicaid Program
Neonatal Medicine
Department of Public Welfare

MILITARY

1972-1974 United States Public Health Service
Epidemiology Program at Center for Disease Control
Assigned as Epidemic Intelligence Service (EIS) Officer to the Michigan Department of Public Health, Lansing, Michigan

RESEARCH GRANTS

1) Surfactant Instillation to Premature Infants (Burroughs-Wellcome Co), 9/86-
2) Coinvestigator - Detection and Treatment of Retinopathy of Prematurity, 1/86-

MEMBERSHIPS AND COMMITTEES

Fellow, American Academy of Pediatrics (AAP)
Minnesota Perinatal Regionalization Committee - Past President
Metropolitan Health Board - Perinatal Consultant
Member of Section of Perinatal Pediatrics in AAP
Northwestern Pediatric Society
Midwest Society for Pediatric Research
Family Physician Educational Committee
of the Minnesota Academy of Family Physicians (completed)
Professional Education and Training Committee,
American Lung Association of Hennepin County-Previous Consultant
Great Plains Organization for Perinatal Health Care
Vice President, Minnesota Chapter (1975-1976)
President, Minnesota Chapter (1976-1977)
Past Chairman, Nominating Committee of the Regional GPO
Member, Board of Directors of the Regional GPO (ongoing)
Progam Planning Committee, Regional GPO (ongoing)
Secretary-Treasurer, Regional GPO (ongoing)
Co-Chairman, Education Committee, Minnesota Chapter
Co-Chairman, Education Committee, Regional GPO
Chairman, Finance Committee, Regional GPO
Member, Board of Directors, Minnesota Perinatal Organization
Editorial Board Member, **Perinatal Press**
Reviewer for **Pediatrics**
Reviewer for **Obstetrics and Gynecology**
Reviewer for **New York State Journal of Medicine**
Chairman, Fetal and Newborn Committee,
Minnesota Chapter of the American Academy of Pediatrics
Minnesota Network for Institutional Ethics Committees
(formerly Twin Cities Committee for Neonatal Life Support Policy)
Vice-Chair, Board of Directors, Critical Care Services, Inc.

UNIVERSITY COMMITTEES

Biomedical Ethics Committee, Chairman (1/1/81 - Present)
Transport Nurse Training Program
Emergency Cart and Drug Standards Subcommittee (Past)
Family Physicians Research Council
Cardio-Respiratory Advisory Committee
Perinatal Committee of the Department of Pediatrics
Medical Outreach Liaison Committee
Invasive Monitoring Subcommittee
Labor and Delivery Task Force - Building J

UNIVERSITY COMMITTEES (continued)

Transfusion Therapeutics Committee
Former Chief Residents Committee
3M Conference Committee of the Department of Pediatrics
Intensive Care Fees Committee, Pediatric Specialists
Infant Care Advisory Committee
Search Committee - OB-Gyn Department Chairman
Mission Statement Committee, Variety Club Children's Hospital
Helicopter Medical Staff Task Force
Emergency Room Task Force
Intensive Care Committee, Upper Midwest Center for Specialized Intensive Care
Pediatrics Residency Review Committee, Chairman
Pediatrics Educational Policy Committee
Medical Staff Hospital Council (7/01/85 - Present)
Quality Assurance, Department of Pediatrics
Planning and Development, Board of Governors
Board of Directors, Critical Care Services (Life Link III)

AWARDS

1970-1973
1973-1976 American Medical Association Physicians' Recognition Award
1976-1979 for Continuing Medical Education
1982-1985

MINUTES
Joint Conference Committee
Board of Governors
March 9, 1988

CALL TO ORDER:

Chairman Heenan being delayed, Phyllis Ellis called the March 9, 1988 meeting of the Joint Conference Committee to order at 4:38 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Sally Booth
Robert Dickler
Phyllis Ellis
George Heenan
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

Absent:
Patricia Ferrieri, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Sylvia Dickinson, R.N.

APPROVAL OF MINUTES:

The minutes of the January 10, 1988 meeting were approved as submitted.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work reported that at the February 16 meeting the group discussed the topic of house officers hours. He noted that this is not only a concern at UMHC, but is a national issue. At the meeting on the 23rd the topics of discussion included promotion and tenure of faculty as well as the implimentation of a uniform resident contract across the different medical departments. Dr. Work noted that LCGME is recommending this contracting strategy. Robert Dickler presented a discussion of current facility master planning at this meeting. On the 30th there was a discussion of the implications for UMHC of a new chief of surgery at Hennepin County Medical Center (HCMC). The group also noted that a new chief of medicine would soon be recruited there and that this recruitment may have some equally important

implications for UMHC. A the March 8th meeting the council discussed the committment to focus plan, revisions to the medical staff bylaws, malpractice insurance and documentation of progress notes. At that meeting Robert Dickler informed the group of the State sales tax issue, facility recommendation developed by the Strategic Planning Coordinating Committee and results of the Joint Commission, Medicare Validation and PPS review site surveys. Cliff Fearing also discussed future capital planning and expenditures with the group.

End Stage Renal Desease (ESRD) Policies

Barbara Tebbitt provided a brief overview of the proposed ESRD policies and then introduced Sylvia Dickenson, Head Nurse of the Kidney Dialysis Unit. Ms Dickenson provided more information about the policies and answered questions concerning the impact of Universal Blood and Body Fluid Precautions (UBBFP) on the renal dialysis units. She noted that most patients are very pleased that the staff is taking the extra precautions and that there are few complaints. Discussion also ensued concerning the relative merits of hemo and peritoneal dialysis and the procedures in place for dealing with patients who would like to discontinue dialysis.

It was noted that on page 16 of the proposal the ESRD organizational chart should be ammended to include Dr. David Dunn as the Medical Review Board Member instead of Dr. Richard Simmon.

A motion to endorse the ammended policies was heard, seconded and passed unanimously by the Committee.

Medical Staff - Hospital Council Report

Dr. James Moller described two revisions to the Rules and Regulations of the Medical and Dental Staff. He noted that both of the revisions had been endorsed by the Medical Staff-Hospital Council and the Chiefs of the Clinical Services. The first revision in Section I relates to the appearance of deductibles in insurance cetificates for Medical staff. The revision allows for reasonable deductibles to be included in insurance, but mandates a case-by-case evaluation of the coverage before the physician or dentist receives clinical privileges. The Second revisions, from Section V, were proposed to make the Rules and Regulations consistent with revisions made to medical record policies approved by the Medical Staff-Hospital Council on October 13, 1987. Most of the language was taken directly from the JCAHO Standards.

Discussion ensued concerning the rationale for a three day time period for Attending Staff to countersign progress notes to substantiate their active participation in patient care. Dr. Moller noted that this was the time specified in the Federal Regulations.

Dr. Moller noted that compliance with the current rules and regulation varied widely from department to department and physician to physician. He indicated that compliance to the new standard by the Medical Staff would be more closely monitored. Dr. Moller stressed that the Chairman of the Medical Records Committe, Dr. Marvin Goldberg, is the person that is responsible for medical record compliance and noted that he has done an outstanding job.

It was suggested that Dr. Goldberg be invited to a Committee meeting to discuss problems with medical record compliance.

Malpractice Insurance Update

Jan Halverson, Hospital Attorney, described the history and present status of of malpractice insurance at the UMHC. Mr. Halverson noted that until 1976 the Hospital was protected by the legal doctrine of Sovereign Immunity, which exempted public agencies from malpractice actions. As that legal doctrine eroded, the University developed its own captive insurance company, RUMINCO, to cover University Wide liability claims. However, there is currently a statutory limit to remedies against a public institution without liability coverage of $200,000 per individual claim or $600,000 total per incident. Though the University has a statutory limit to claims against it, it believes that the liability coverage is prudent since the statutory limitations could easily be tested in court.

Mr. Halverson wanted the Board to be aware that the maximum coverage for any claim has decreased from $100 million in 1983-84, to $5 million in 1986-87. This decrease has been instituted because the cost of liability coverage has increased dramatically and that in the University's experience there have been few sucessful cases that exceeded the statutory limits. Therefore, more trust has been put in the statutory limitations.

In fiscal 87, UMHC payed $634,000 of the $857,000 that the University paid to RUMINCO for liability coverage and that in fiscal 88 UMHC will be paying $1,004,000 of a total $1,500,000. It is difficult to determine the precise cause of the increase, since in general the number of cases is down, but the remedies for those cases are up. It was noted that though this is a large sum of money, it is very reasonable compared to similar coverage that UMHC could obtain on the market.

Mr. Halverson noted that Bob Dickler, as General Director of the Hospital, has been granted the authority to decide which Hospital liability cases should be settled and the size of those remedies. Mr. Dickler also noted that the RUMINCO policy covers the Board of Governors and beyond that the members are covered by the full faith and credit of the University.

Other Business

Robert Dickler apprised the Committee of a possible threat to the Hospital's sales tax exemption at the legislature and asked that members contact any legislators they know as well as their own Representative and Senator.

Greg Hart provided a brief summary of the findings from the November 1987 JCAHO site survey. It was noted that the Hospital recieved the maximum three year accreditation status and 21 contingencies. He explained that this was more of a reflection in changes in the survey process with the Joint Commission than a statement about the Hospital's operation. Additionally, there is some doubt that the Ambulatory Care section of the findings are those from UMHC.

Chairman Heenan suggested that the Committee should advise the Board as to the status of the findings and will bring a complete report to the Board when all questions have been answered.

Chairman Heenan and Phyllis Ellis shared with the Committtee that they had attended a CHC sponsored discussion of quality assurance in health care organizations that featured Don Wegmiller. He noted that Mr. Wegmiller's thoughts parallel our own thinking. He requested that a copy of our quality assurance plan be forwarded to Mr. Wegmiller.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:10 P.M.

Respectfully Submitted

Ted Yank

Theodore J. Yank

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 10, 1988

TO: Members of the Board of Governors

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

SUBJECT: Proposed Revisions to the Rules and Regulations of the Medical and Dental Staff

Enclosed are proposed revisions to the Rules and Regulations of the Medical and Dental Staff forwarded to you for your review and approval. The revisions have been endorsed by the Medical Staff-Hospital Council, Council of Chiefs of Clinical Services, and the Joint Conference Committee.

The following is an explanation of the revisions:

Section I. Staff Membership., D. Malpractice Insurance Requirements

Relates to the appearance of deductibles in insurance certificates for physician members associated with two large non-University group practices, three UMHC clinical services associate groups, and one individual policy of a full-time member of the Medical Staff

Section V. Conduct of patient Care., E. Medical Record Requirements

Revisions are proposed to make the Rules and Regulations consistent with revisions made to medical record policies approved by the Medical Staff-Hospital Council October 13, 1987. Most of the language is taken directly from the JCAH Standards.

JHM/cf

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

PROPOSED AMENDMENTS:

Section I. Staff Membership.

D. Malpractice Insurance Requirement.

1. General. In order for any physician or dentist to be qualified for membership on the Medical Staff or to exercise any particular clinical privileges, or for reappointment to the Medical Staff, the physician or dentist shall submit evidence that he or she is covered by a policy of liability insurance covering the legal defense of, and the possible liability for, cases of professional liability (malpractice) relative to the person's staff category. It shall be the duty of the physician or dentist to maintain the required coverage at all times during his or her membership on the Medical Staff, to provide the Hospital with current evidence of coverage at any time a policy is renewed or changed. If action is anticipated to change the limits of malpractice liability insurance coverage, or termination of coverage for any reason, immediate written notice must be submitted to the Medical Staff Office.

Reasonable deductibles shall be allowed by the Board of Governors at levels consistent with the community standards. Each situation will be evaluated on a case-by-case basis by the Chief of Staff and exceptional requests shall be brought to the attention of the Board of Governors.

E. Medical Record Completion Requirements

1. (No change)

2. Data Base/History and Physical

a. A history and physical report must be provided for each admission. It is the responsibility of the attending physician to see that the report is recorded in the record within 24 hours after admission. A complete history and physical shall include a patient profile, chief complaint, present illness, past history, family history, review of systems, physical examination, mental status, known laboratory results, and provisional diagnosis(es) and/or impressions.

b., c., d. (No change)

3. Progress Notes

a. Pertinent progress notes shall be recorded at the time of observation and be sufficient to permit continuity of care and transferability. Progress notes shall be written at least

daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem. Attending staff physicians shall countersign or write progress notes at least every three days and as often as is necessary to substantiate their active participation in and supervision of the patient's care.

4., 5. (No change)

6. Diagnostic Summary Sheet. A Diagnostic Summary Sheet must be completed prior to or at the time the discharge order is written. The Diagnostic Summary Sheet shall contain the principal diagnosis, additional diagnoses and/or complications, operations and/or procedures; names of the responsible attending physician, ~~Medical Fellow of Medical Fellow Specialist,~~ resident physican, and all consultants; the discharge service; admission and discharge dates; and discharge disposition. Abbreviations are not to be used on the Diagnostic Summary Sheet.

7. (No change)

8. Operative Reports

a. Operative reports shall include the preoperative diagnosis and a detailed account of the findings at surgery as well as the details of the surgical technique, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants.

b. A dictated operative report shall be required for all procedures performed in the Main Operating Rooms, Ambulatory Surgery, Cystoscopy Suite, the Heart Catheterizations Laboratories, or the Obstetrics Unit, except for normal deliveries and fiberoptic bronchoscopies, regardless of the type of anesthesia or whether performed on inpatients or outpatients. Fiberoptic bronchoscopies will be reported using the procedure report from which will be accepted as a substitute for a dictated operating report.

c. (No change)

9. Discharge Summary

a. Discharge summaries shall include the principal diagnosis and all other diagnoses, and complications, the reason for hospitalization, all significant findings, procedures

performed and treatment rendered, condition of the patient on discharge, and any specific instructions given to the patient and/or family including those relating to physical activity, medication, diet and follow-up care.

b. ~~a.~~ A discharge summary ~~should~~ shall be dictated within 24 hours of discharge.

c. ~~b.~~ A discharge summary shall be completed and signed within 21 calendar days of discharge. ~~unless a physician has been granted a permanent exception by the Utilization Medical Records Committee.~~

10. (No change)

11. (No change)

12., 13. (No change)

1mo-1

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 10, 1988

TO: Members of the Board of Governors

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

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

The Medical Staff-Hospital Council has endoresd the attached Credentials Committee Report and Recommendations on February 9 and the Joint Conference Committee endorsed this report on February 10.

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

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 2, 1988

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

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

Department of Medicine	Category
David Guidot	Attending-ER
Connie Standiford	Attending-ER

Department of Radiology	Category
Becky L. Murray	Attending

Department of Urology	
Jerome S. Mayersak	Clinical

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

Department of Neurology	Category	
Ilo Leppik	Attending	
Clinical Privileges:	Add:	Spinal Tap, Electroencephalography with pharmacologic agents, electroencephalography for evoked potentials, electroencephalography for special leads
	Delete:	Pneumonencephalography, myelography, cerebral angiography, brachial angiography

Addition and/or deletion of clinical privileges continued:

Department of Obstetrics and Gynecology	Category	Clinical Privileges
George E. Tagatz	Attending	Add: CO_2 Laser-Laparotomy and Laparoscopy YAG/KTP Laser-Endometrial Ablation
Department of Pediatrics		
Mark E. Nesbit	Attending	Add: Bone Marrow Harvest
Department of Surgery		
John G. Shearen	Clinical	Add: CO_2 and Nd:YAG Lasers-Endoscopic laser surgery

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

Hospital Dentistry	Category	Date Eligible
Judith L. Marshall	Clinical	December 24, 1987
Department of Family Pracitce and Community Health		
Joseph M. Keenan	Attending	December 24, 1987
Department of Radiology		
Bennett A. Alford	Attending	December 24, 1987
Kenneth P. Korte	Clinical	December 24, 1987

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Department of Anesthesiology	Category
Ellen L. Finch	Attending
Department of Ophthalmology	
Thomas Lindquist	Attending
Department of Surgery	
Nancy L. Ascher	Attending
W. Steves Ring	Attending
Department of Urology	
Dexter L. Jeffords	Clinical

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 16, 1988

TO: Members of the Board of Governors

FROM: Barbara Volk Tebbitt

RE: New and Revised Policies for Kidney Dialysis Unit (KDU)

Attached are the updated organizational structures and new and revised policies for KDU and corresponding justification.

Philosophy, Responsibilities and Objectives-Dialysis Unit II.2

The previous philosophy statement and a narrative description of resources and systems were combined and revised.

Consultation Process III.2

Policy title change was made to clarify purpose of policy. The consultation role was expanded to include physician, medical service and areas of responsibility.

Medical Records III.5

Policy was completely revised to comply with End Stage Renal Disease (ESRD) standards and specify accountability for confidential maintenance of patient medical records.

Patient Rights and Responsibilities III.7

Policy was expanded to include the patient and primary nurse accountability in information sharing regarding patient rights and responsibilities.

Patient Team Rounds and Care Conferences - Adult Area III.12

This is a new policy developed in response to End Stage Renal Disease standards which formalizes the responsibility of professional communication regarding patient care.

Kidney Dialysis: Medical Advisory Committee III.13

This is a new policy developed to assure accountability of professionals to comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for medical integration into unit activities.

Patient Selection Criteria III.14

Previously patient selection criteria were superficially contained within another Kidney Dialysis Policy. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards are explicit in the need to address specifics regarding patient selection. This policy now brings The University of Minnesota Hospital and Clinic (UMHC) into compliance with this JCAHO standard.

Termination of Treatment III.15

This is a new policy specifically to address the termination of treatment and complies with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

Charting by Kidney Dialysis Technicians IV.13

Change reflects the writing of a Data, Assessment and Plan (DAP) note by the technicians versus the Subjective, Objective, Assessment, Plan (SOAP) note to comply with changes in the nursing documentation system.

On Call Guidelines IV.15

Change indicates increase in time allowed for the on call staff to arrive at the hospital from 20 to 40 minutes which is considered a more realistic time frame and moves the on call pay from restricted to at home ($3.55 to $1.75).

Pregnant Personnel IV.20

Policy changes deleted requirements for employee health counseling, M.D. written permission, and signage of informed consent to conform with current hospital infection control policies.

Preparation and Connection of Equipment for Continuous Arterio-Venus Hemofiltration (CAVH) IV.24

This is a new policy/procedure developed to provide guidelines to establish clear lines of authority and accountability in preparing and connecting equipment for CAVH.

Chief Executive Officer Responsibilities V.2

Format changes were made and lines of accountability were clarified in response to revised ESRD standards.

Guidelines for Use of Universal Blood and Body Substance Technique for The Kidney Dialysis Unit VI.1

This is a new policy/procedure developed to provide guidelines for use of universal blood and body substance technique in the Kidney Dialysis Unit. These guidelines reflect the Center for Disease Control (CDC) recommendations for infection control.

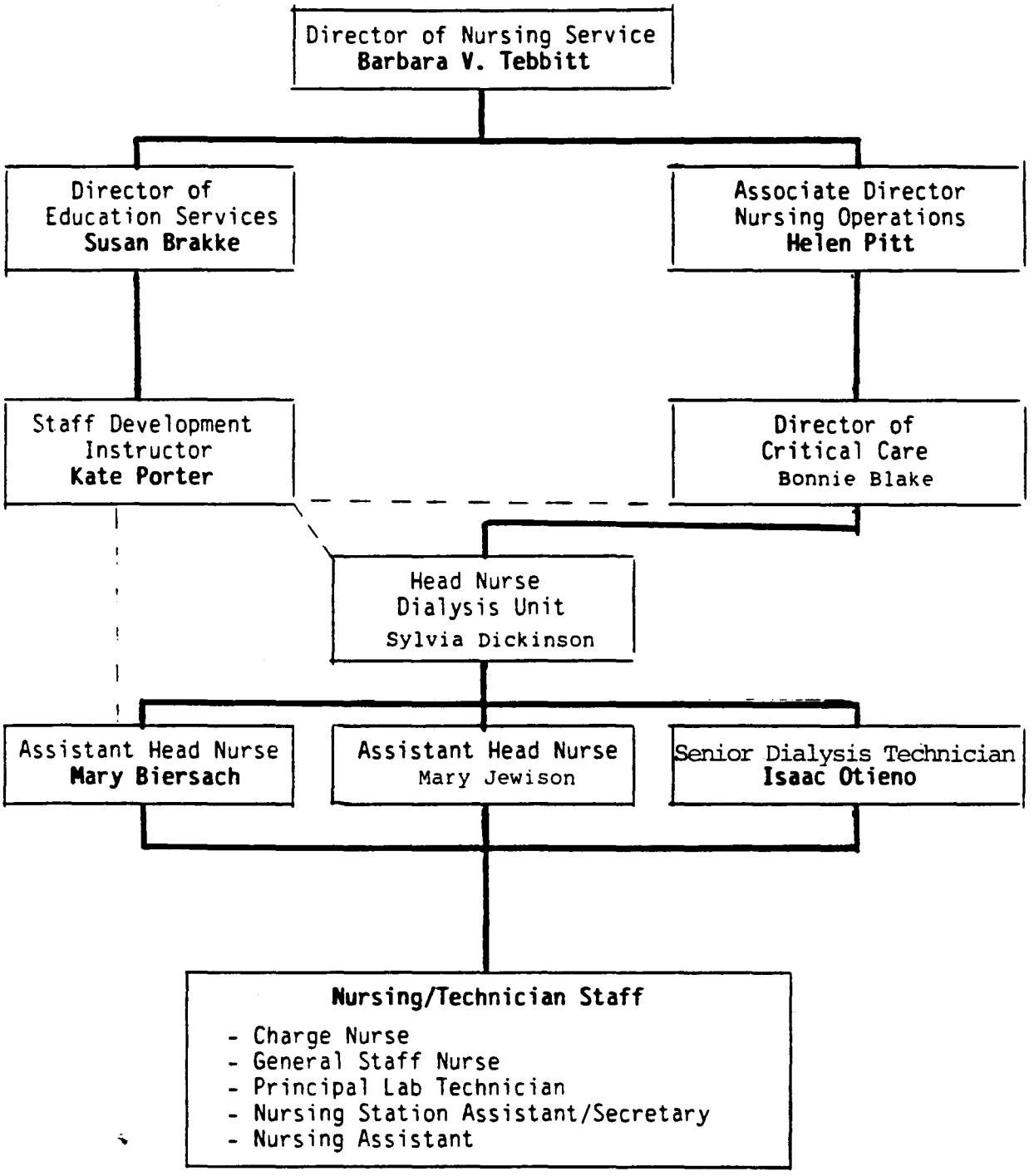
Electrical Safety IX.3

Policy deleted the statement indicating where hospital policies/procedures for prevention of electrical hazards are stored. Policies concerning electrical safety are located in the Hospital Policy and Procedure Book.

University of Minnesota Hospital and Clinic

NURSING SERVICE

ORGANIZATIONAL STRUCTURE
for the
DIALYSIS UNIT



LEGEND:

_____ indicates direct responsibility and authority

- - - -indicates consultation, education, reference/resource-sharing, etc.

Revised 1/88

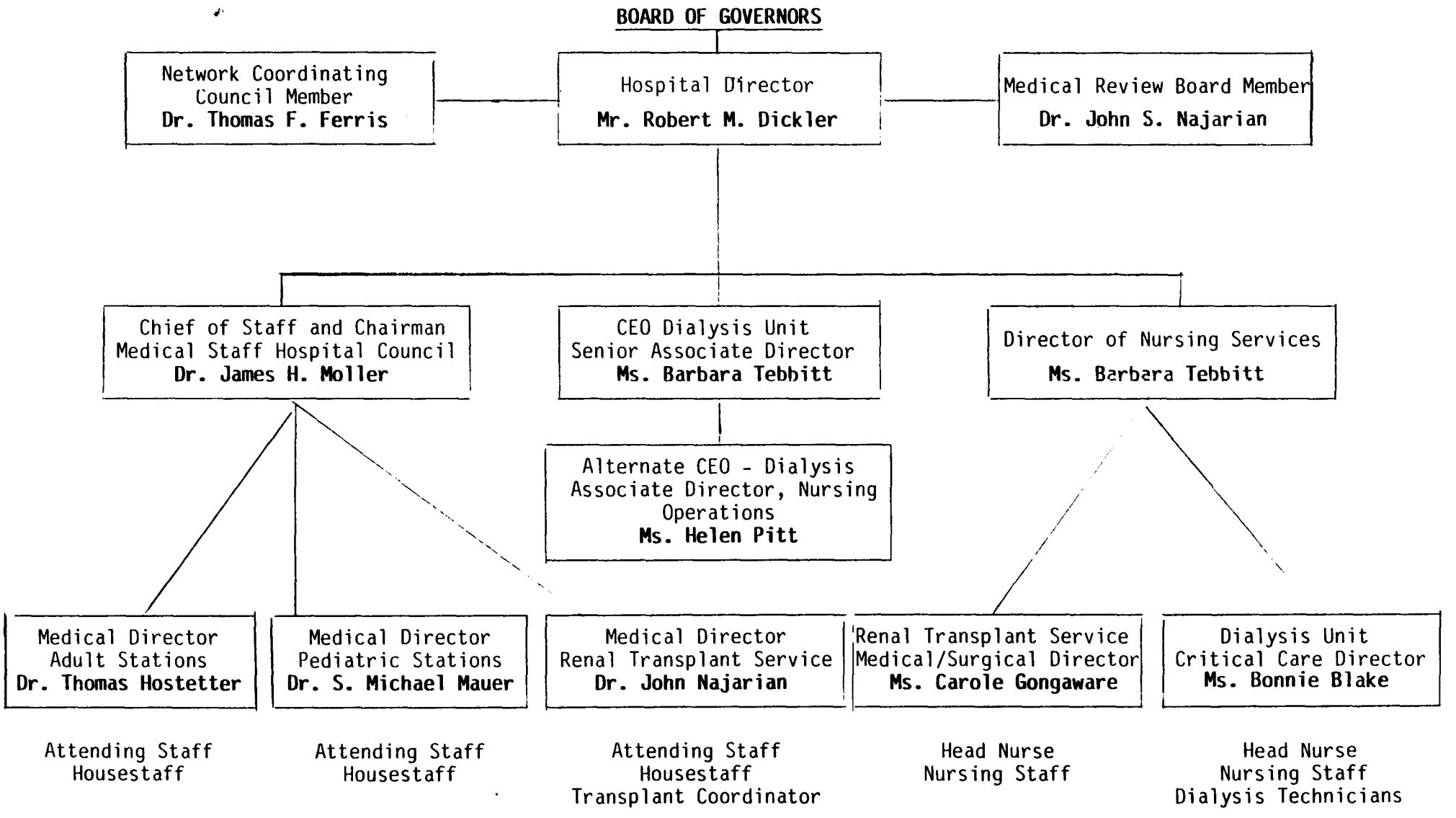
Revised 03/09/88

University of Minnesota Hospital and Clinic

Chart of Organization

End-Stage Renal Disease Program

Renal Transplant Service and Dialysis Unit



POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Goals and Objectives Page 1 of 7
VOL.:	POLICY NUMBER: 11.2
EFFECTIVE:	6/83
REVISION:	6/83, 1/86, 12/87
REVIEWED:	1/84, 1/85, 1/86, 12/87

SUBJECT: PHILOSOPHY, RESPONSIBILITIES AND OBJECTIVES - DIALYSIS UNIT

SOURCE: Medical Directors

PHILOSOPHY AND RESPONSIBILITIES

In order to reduce fear and anxiety and promote self-care and patient input, the patient will be provided:

1. An environment that provides physiological safety and psychological support.
2. Skilled assessment and monitoring of his/her symptoms and need with corresponding adjustment in care.
3. Care that provides ongoing individual adjustment in his/her care plan.
4. Ongoing dialogue regarding his/her condition, progress, plan of care, individual needs, and long term program.
5. Personnel that are trained to be proficient in hemodialysis, critical care nursing, pediatric dialysis, and peritoneal dialysis.

OBJECTIVES

1. The hemodialysis areas will provide procedures and policies that maintain safe and effective standards for patient care and operation of the Unit including:
   - A. Written Dialysis Orders
   - B. Standing Orders
   - C. Dialysis Procedures
   - D. Written Patient Orientation Program
   - E. Discharge and Interfacility Transfer Protocols
   - F. General Policies

kd1231877nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

2. Provide emergency equipment such as:
   A. Arrest Cart
   B. Tracheal and NG Suction
   C. Oxygen and accessory respiratory therapy equipment
   D. Tracheostomy Tray
   E. Defibrillator
   F. EKG Monitoring

3. Provide continuous infection control and monitoring including:
   A. Cleaning procedures and assignments
   B. Isolation procedures
   C. Sterile technique
   D. Hepatitis procedures
   E. Serum Hepatitis surveillance of patients and personnel

4. Provide safe maintenance and repair of equipment including:
   A. Procedures
   B. Assignments
   C. Maintenance schedule and program
   D. Periodic safety evaluations on all electronic patient care equipment

5. Provide continuous monitoring, assessment and treatment of the patient.
   A. Orientation Program for Personnel and Patients
   B. Dialysis Record
   C. Progress Notes
   D. Graphs and "Flow Sheets"
   E. Primary Nursing Care Plan
   F. Cumulative Records
   G. Categorization of each dialysis acuity level

6. Provide evaluation of continuity and quality of dialysis treatment.
   - A. Cumulative Records
   - B. Graphs
   - C. Dialysis Records
   - D. Categorization Records
   - E. Bedside assessment
   - F. Nursing Care Plans
   - G. Primary Nursing Care Audits
   - H. Patient Care Conferences
   - I. Long Term Program

7. Provide staff training and development.
   - A. Orientation program - (Central Orientation and Dialysis Orientation)
   - B. Clinical application
   - C. Assignments
   - D. Individual conferences with personnel
   - E. In-service classes
   - F. Hospital-wide courses
   - G. Personnel evaluations

8. Define roles of patient care personnel.
   - A. Unit Medical Directors
   - B. Renal Fellows
   - C. Job descriptions of Head Nurse, Assistant Head Nurse, Inservice Nurse, Senior Dialysis Technician, Principal Lab Technician, General Staff Nurse, Secretary, Nursing Assistant

9. Provide trained personnel for hemodialysis.
   - A. On-call system (Physician, Nurse and Technician)
   - B. Nursing/technician Hours scheduled four weeks in advance.

10. Promote staff participation.
    A. Open communication to critique the approach to care or organization of the areas in a constructive and organized manner.
    B. Regular meetings with the Medical Directors or their delegates
    C. Staff meetings at least six times per year
    D. Patient Care Conferences
    E. Staff Development Conferences

FACILITY AND STAFF RESOURCES

The Dialysis Areas at the University of Minnesota Hospital and Clinic are comprised of 4,000 square feet in Mayo Hospital and 1,171 square feet in the Main Hospital. The two areas combined have fourteen operating stations that are certified for chronic hemodialysis. Capabilities for acute hemodialysis elsewhere in the hospital exist with mobile hemodialysis units and peritoneal dialysis.

The patient care staff consists of a Head Nurse, one Chief Technician, two Assistant Head Nurses (one with an adult focus and one with a pediatric focus), registered nurses, technicians, nursing assistants, a nursing station secretary and a secretary.

The physician staff consists of Board Certified or Board Eligible Nephrologists who rotate to the Dialysis Areas approximately every two months. They are assisted by Medical Fellows who are Board Certified or Board Eligible in Internal Medicine or Pediatrics. Additionally, residents and medical students may be involved in the training and care of renal patients.

An on-call schedule is maintained with fellows on first call and staff members on second call. Both first and second on-call physicians can be reached either through the paging or by long range beeper system. Beeper numbers are kept at the Hospital Information Desk. One nurse and one technician are also on-call for treatment when the Dialysis Areas are closed.

All chronic dialysis patients are evaluated every dialysis by nurses and physicians, and weekly by the transplant service. The areas operate very closely with local dialysis facilities, and transfer and receive patients to and from dialysis units in all fifty states and throughout the world.

PATIENT INFORMATION

Before being accepted on dialysis, patients are informed about the procedure by nurses, social workers and/or physicians. During these discussions, patients are made aware of the relative merits of hemodialysis, CAPD and/or renal transplantation. Patients receive information about the dialysis procedure by nurses and technicians while the procedure is bieng performed and are given educational material to read. All patients who are not expected to regain renal function are worked-up and evaluated by the Transplant Team.

PRIORITY AND DIALYSIS

Under some circumstances, there may be more patients needing dialysis than the facility is able to accommodate. On these occasions, the Medical Director reviews all patients who need dialysis to determine the options available. Some patients may be able to undergo two rather than three dialysis per week or may be able to tolerate having their dialysis treatments shortened. When making such a decision, special attention will be paid to the potential consequences of decreasing dialysis time with regard to the patient's urea, potassium, creatinine and fluid status.

CARE EVALUATION SYSTEMS

Care is evaluated by the health care team in the following ways:

1. The patients are evaluated at each treatment by the nurses and technicians before and during the entire dialysis procedure. Their observations are charted and any changes are reflected in the Care Plan.

2. Staff physicians and fellows make daily rounds on the patients and review any chemistry studies.

3. At discharge, each patient's record is reviewed by the Medical Director for appropriateness of care and outcome.

ORIENTATION AND CONTINUING EDUCATION

New personnel (nurses and technicians) are oriented by designated registered nurses and technicians who have been trained and are proficient in the appropriate procedures. They prograss in a logical fashion from the dialysis of chronic dialysis patients to the dialysis of the extremely difficult acute newborn. The fellows and staff are oriented by the Medical Director or his substitutes.

Continuing education for nurses and technicians is arranged by the Staff Development Instructor and the Assistant Head Nurse. Inservice education is provided within the Units at least six times per year. Physician continued education is done through weekly conferences, journal clubs, lectures, and meetings where specialists from outside are invited to lecture.

SELECTION OF TREATMENT/MONITORING/VASCULAR ACCESS

On a short term basis, the most suitable treatment is decided by the Medical Director or his associates. The actual performance of these procedures is done following the Standing Orders available in the Dialysis Areas.

During Dialysis, all patients are closely monitored by nurses and technicians and daily rounds are performed by the dialysis physician or fellow covering dialysis. This is documented on the dialysis record.

Vascular access procedures are done under the supervision of a Board Certified surgeon. Except for the placement of temporary access, there are no vascular access operations done in the Dialysis Areas except on an emergency basis.

PLAN OF CARE

The care of patients with end-stage renal disease is a complicated matter involving all members of the health care team. All these members are skilled in obtaining and evaluating different forms of information. In order to facilitate the sharing of this expertise in planning care for a patient, all members of the health care team including: medical nephrologists, staff physicians, residents and fellows who are caring for dialysis patients, primary dialysis nurse, transplant surgeons, dieticians, social workers and the patient, are requested to participate in planned patient care conferences. The purpose of care conferences is to allow the widest dissemination and input of current information and changes in each of the patient's status. During these meetings, the patient's care plan is formed and/or updated and the long term care plan is from time to time updated and signed by the various members of the health care team.

END-STAGE RENAL DISEASE PROGRAM

MEDICAL SPECIALTIES AND SERVICES

Cardiology
Endocrinology
Hematology
Infectious Disease
Neurology
Orthopedics
Pathology
Pediatrics
Psychiatry
Urology
Vascular Surgery
Dietary
Inhalation Therapy
Inhospital Patient Care
Rehabilitation
Social Services
Angiography
EM and Immunomicroscopy
Urine Glucose
Urine Microscopic
CSF-Smear and Cultuer
CSF-Glucose
CSF-Protein

CSF-Cell Count
Prothrombin Time
CBC
Platelet Count
ABO Blood Grouping
ABO Blood Grouping, Rh typing, cross-matching
Blood Glucose (serum, plasma)
BUN
Creatinine
Serum Calcium
Serum Potassium
Serum Phosphorus
SGOT
LDH
Blood pH
Blood Gases
Fungal Smear and Culture
TB Smear and Culture
Cross-matching of recipient serum and donor lymphocytes
Phenotyping donor and recipients
Screening of recipient serum for preformed antibodies

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UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	
General Policies	
VOL.	POLICY NUMBER
	III.2
EFFECTIVE	
3/79	
REVISION	
6/83, 1/86, 12/87	
REVIEWED	
1/84, 1/85, 1/86, 12/87	

SUBJECT
CONSULTATION PROCESS ACUTE DIALYSIS - ADULT & PEDIATRIC
SOURCE
Dialysis Leadership Team

POLICY

Attending, Fellow and Pediatric Nephrologist consultation is provided for all patients requiring dialysis for acute renal failure in both adult and pediatric patients.

PROCEDURE

Responsible Individual	Action
Green Medicine Consultation Attending and Fellow or Pediatric Nephrologist	1. Evaluate patient. 2. Determine the need for acute hemodialysis. 3. Confer with the appropriate dialysis area physician. 4. Write appropriate orders. 5. Contact the Charge Nurse during regular hours or call the on-call nurse during on-call hours. 6. Are available for questions and problem solving.

kd1231874nm

APPROVED	DATE
T Hatt S M Marie Barbara Turlington	01/01/88
TITLE	
Medical Director Medical Director CEO	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 2
VOL.:	POLICY NUMBER: III.5
EFFECTIVE:	1/79
REVISION:	6/83, 1/86, 9/87, 1/88
REVIEWED:	1/84, 1/85, 1/86, 1/87, 1/88

SUBJECT: MEDICAL RECORDS

SOURCE: Dialysis Leadership Team

POLICY

The facility will maintain in a central location the complete medical record on all dialysis patients. The medical record will be readily available, and systematically organized to facilitate the compilation and retrieval of information. The facility will provide safeguards to protect the patient's medical record against loss, destruction, or unauthorized use. (See Hospital Policies #14.2 and #14.4.) With proper authorization, interchange of medical and other information necessary or useful in the care and treatment of patients will be provided.

PROCEDURE

Responsible Individual	Action
Medical Record Supervisor	1. Ensures that medical records are retained for a period of time that complies with state statutes.
	2. Provides for adequate facilities, equipment, and space for efficient processing of medical records.
Senior Dialysis Secretary	1. Ensures that current medical records and those of discharged patients are completed promptly.
	2. Centralizes all clinical information pertaining to the patient and includes it in the patient's medical record.
	3. Transfers the patient's medical record to the central medical records department in the facility.

kd0105881nm

APPROVED:			DATE: 01/01/88
TITLE: Medical Director	Medical Director	CEO	

SECTION	
Page 2 of 2	
VOL.	POLICY NUMBER III.5
SUBJECT Medical Records	

Responsible Individual	Action
Renal Fellow, Attending Physician	1. Document accurately in patient's medical record sufficient information to identify patient clearly, justify the diagnosis and treatment. 2. Document the results of treatment accurately.
Station Secretary, Nursing Staff	1. Ensure the following items are included in each outpatient medical record: a). face sheet b). physician's orders c). progress notes d). flow sheets e). all diagnostic results f). initial dialysis order form g). problem list h). kidney dialysis data base i). entry form j). nursing care plan k). long term program l). consultation reports m). correspondence n). discharge summaries o). care conference record p). parenteral fluid sheet 2. Provide new blank forms for each chart as needed.

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POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 1
VOL.:	POLICY NUMBER: III.7
EFFECTIVE:	1/79
REVISION:	6/83, 1/86, 4/87, 12/87
REVIEWED:	1/84, 1/85, 1/86, 1/87, 4/87, 12/87

SUBJECT: PATIENT RIGHTS AND RESPONSIBILITIES

SOURCE: Dialysis Leadership Team

POLICY

It is the policy of the University of Minnesota Hospital and Clinic to promote the interest and well-being of patients receiving care at the University Hospital. It is also our policy that these rights shall be respected and that no patient may be required to waive his or her rights as a condition of admission to the University of Minnesota Hospital Dialysis Unit.

PROCEDURE

Responsible Individual	Action
Primary Nurse	1. Gives the University of Minnesota Hospital and Clinic Patient Rights and Responsibilities Booklet to each patient or their guardian.
	2. Reads Rights and Responsibilities to patient if patient is visually impaired, or provides translator if language barrier exists.
	3. Answers questions patients and family may have regarding Rights and Responsibilities.
Patient (guardian, if patient unable)	1. Signs his or her name on Dialysis Patient Data Base, indicating that he or she has received and understands the Rights and Responsibilities information.

kd1231876nm

APPROVED:	[signature]	[signature]	DATE: 01/01/88
TITLE:	Medical Director	Medical Director	CEO

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 3
VOL.: III	POLICY NUMBER: 12
EFFECTIVE:	4/6/87
REVISION:	12/87
REVIEWED:	12/87

SUBJECT: PATIENT TEAM ROUNDS AND CARE CONFERENCES - ADULT AREA

SOURCE: Medical Director

POLICY

I. Purpose

Multidisciplinary Patient Team Rounds are held to provide patient care review and patient care conferences are monthly.

II. Participants

The following team members participate: Renal Fellow, Dialysis Attending R.N., dietician, social worker, Head Nurse, Assistant Head Nurse, Primary Staff Nurses, and the appropriate patient and/or his/her guardian or family. Additional informational resources are included as necessary (representatives from nursing homes, rehabilitation therapy, consult services, etc.).

III. Frequency

The care plans and lab work of all acute hemodialysis patients* and non-stable, chronic hemodialysis patients** will be reviewed at each meeting. Patients and/or families are welcome to participate in that portion of the review that is related to them.

Stable, chronic hemodialysis patients*** will have their care plans and Long Term Program reviewed in detail every six months during Patient Team Rounds. Patients and/or their families are invited to attend the care conference. If the patient is unable to attend, his/her Primary Nurse will share the outcome of the review process.

* Acute hemodialysis patients - patients in whom renal failure is expected to resolve: e.g., post-transplant patients with acute tubular necrosis, post trauma patients, drug overdose patients, ICU patients with any form of acute renal failure, etc.

kd1229874nm

APPROVED:	[signature]	[signature]	[signature]	DATE: 01/01/88
TITLE:	Medical Director	Medical Director	CEO	

** Non-stable, chronic hemodialysis patients - patients who require chronic hemodialysis but have complications that require very close follow-up: e.g., first 2-3 weeks after initiating hemodialysis, hospitalized for longer than 48 hours, major surgery, frequent chest pain and/or severe hypotensive episodes during dialysis, etc.

*** Stable, chronic hemodialysis patients - patients who, as outpatients, require very little to moderate follow-up of their disease and its complications: e.g., more than 3 weeks after the initiation of dialysis, stable weight gains, no chest pain during or off dialysis, etc.

PROCEDURE

IV. Schedule

Patient Team Rounds and Care Conferences will be held on alternating Tuesdays of each month.

Responsible Individual	Action
Assistant Head Nurse - Adult Area	1. Informs the Head Nurse in advance of a patient's need for a care conference.
	2. Follows up on the completion of the care plan review event.
Head Nurse	1. Prepares the agenda for each Tuesday meeting, citing the patients requiring review in each category.
	2. Forwards a copy to the patient team and to the Primary Nurse(s) whose patient(s) require(s) total care plan review.
	3. Assures that a Nurse is in attendance for Patient Team Rounds.
	4. Maintains documentation of meeting content for two years.

kd1229874nm

Responsible Individual	Action
Primary Nurse	1. Informs the patient and/or family of the date and time of his/her care plan review.
	2. Extends an invitation for them to attend.
	3. Has the patient/family member complete the End Stage Renal Disease (ESRD) Patient Care Plan Review Document.
	4. Represents the patient if he and/or his family are not able to attend and informs those people of the outcome of the care plan review.
	5. Leads the care conference for his/her primary patient.
Patient/Family Member	1. Completes and signs the End Stage Renal Disease (ESRD) Patient/Family Member Care Plan Review Document.
Renal Fellow	1. Presents current information.
	2. Assists in patient care problem solving.
All Team Members	1. Completes and signs the End Stage Renal Disease (ESRD) Patient Care Plan Review Document.

kd1229874nm, bp

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	General Policies Page 1 of 1
VOL.:	POLICY NUMBER: 111.13
EFFECTIVE:	11/87
REVISION:	
REVIEWED:	

SUBJECT:
KIDNEY DIALYSIS
MEDICAL ADVISORY COMMITTEE

SOURCE: Kidney Dialysis Medical Advisory Committee

POLICY

The Kidney Dialysis Medical Advisory committee is a multidisciplinary committee organized to guide the activities of the Renal Dialysis Unit (Adult and Pediatric areas). Informational resources from other disciplines will be invited to the committee as appropriate.

PROCEDURE

Responsible Individual	Action
Advisory Committee	1. Is accountable for developing renal dialysis program objectives, related policy/procedures reviewing Quality Assurance activities and problem solving.
	2. Meets bi-monthly or at least quarterly.
Medical Director or Designee	1. Chairs the committee.
	2. Is accountable for policy approval.
Kidney Dialysis Unit Head Nurse, Chief Technician, Assistant Head Nurses, and Director of Critical Care	1. Participate on the committee.
	2. Rotate documentation of minutes.
Head Nurse and Director of Critical Care	1. Maintain and review quality assurance activities.
	2. Submit changes annually to the University of Minnesota Hospital and Clinic, Board of Governors, for approval.

kd1229873nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: General Policies	
VOL.:	POLICY NUMBER: III.14
EFFECTIVE: 11/87	
REVISION:	
REVIEWED:	

SUBJECT:
PATIENT SELECTION CRITERIA

SOURCE: Dialysis Leadership Team, Critical Care Director, and Medical Directors

POLICY

CHRONIC DIALYSIS

Both stable and non-stable patients are considered for chronic dialysis when chronic renal failure can no longer be managed by more conservative measures. There is no specific disease or disease process that would automatically exclude a patient from receiving chronic dialysis. The interdisciplinary team (social worker, dietician, dialysis nurse, medical nephrologist, staff physicians, residents, and fellows) works with each individual patient and family to assess their rehabilitative, social, economic, psychological, and emotional factors concerned with adjusting to a dialysis regimen. The team considers these factors in the selection of treatment modalities. Patient selection for chronic dialysis is based on the patient's desire for treatment and approval of the medical nephrologists.

ACUTE DIALYSIS

Patients are considered for acute dialysis when they demonstrate acute renal failure that is not responsive to other treatment modalities. The option of dialysis is discussed and explained to the patient and/or family. Dialysis is begun only after informed approval. The patient's need for dialysis treatments will be evaluated daily. A patient judged by the nephrologist to be physically unable to tolerate the treatment will not receive dialysis. Improved or stabilized acute renal failure may result in terminating treatment. If the acute renal failure becomes chronic, the interdisciplinary team will follow the selection criteria for chronic renal failure.

kd1229871nm

APPROVED:			DATE:
TITLE:	Medical Director	Medical Director CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	General Policies
VOL.:	POLICY NUMBER: 111.15
EFFECTIVE:	12/87
REVISION:	-
REVIEWED:	

SUBJECT: TERMINATION OF TREATMENT

SOURCE: Dialysis Leadership Team, Critical Care Director and Medical Directors

POLICY

When circumstances arise which raise the issue of termination of treatment (e.g., advanced malignancy or dementia), interdisciplinary team conferences are held followed by discussions with the patient or family, as appropriate. No patient's treatment is terminated unless the patient or competent and responsible family members are in total agreement. In addition, Hospital Policy 4.7 will be utilized.

kd1229872nm

APPROVED:				DATE:
TITLE:	Medical Director	Medical Director	CEO	01/01/88

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	
Page 1 of 1	
VOL.	POLICY NUMBER IV.13
EFFECTIVE 9/76	
REVISION 6/83, 1/85, 1/86, 6/87, 12/87	
REVIEWED 1/84, 1/85, 1/86, 1/87	

SUBJECT

CHARTING BY KIDNEY DIALYSIS TECHNICIANS

SOURCE

Dialysis Leadership Team

POLICY

Kidney Dialysis Technicians will chart all pertinent data that they have collected on patients to whom they are assigned each shift. They will follow the charting policies using the Problem Oriented Medical Records (POMR) system after orientation to data collection and the policies. A Data Assessment Plan (DAP) note will be written on each patient pre-dialysis, describing the patient's condition and plan of care for the dialysis treatment. The charge nurse will read and review the DAP note, and sign his/her name to indicate awareness of the technician's charting.

PROCEDURE

Responsible Individual	Action
Dialysis Technician	1. Collects data on assigned patients.
	2. Writes Data Assessment Plan (DAP) note pre-dialysis, describing patient's condition, complaints, and plan of care for the dialysis treatment.
Charge Nurse	1. Reads and reviews charting completed by Dialysis Technician.
	2. Signs name to Data Assessment Plan (DAP) note.

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Personnel Policies Page 1 of 3
VOL.:	POLICY NUMBER: IV.15
EFFECTIVE:	6/83
REVISION:	1/84, 8/84, 1/86, 1/87, 12/87
REVIEWED:	1/84, 1/85, 1/86, 1/87, 12/87

SUBJECT: **ON-CALL GUIDELINES**

SOURCE: Dialysis Leadership Team

POLICY

New employees are assimilated into the Call Schedule 4 to 6 months after completing Dialysis Orientation. From time-to-time, this may vary depending on the new employee's background and experience in this Dialysis Unit.

Weekday Call starts at 12 Midnight Sunday and lasts until 7:30 a.m. Monday morning. From Monday - Friday, call begins at 11:30 p.m. and ends at 7:30 a.m. the following morning. Call starting at 11:30 p.m. Friday ends at 9:00 a.m. Saturday morning, resumes at 5:30 p.m. Saturday and ends at 12 Midnight Sunday.

On-call pay is $1.75 per hour. Call pay must be taken as pay rather than time back. When on-call staff are called in, the hours worked begin from the time they are called in and continue until they leave the hospital. When personnel are called in and dialysis is cancelled, staff should claim three hours on their paycards. If staff are called in, hours worked may be claimed as paid hours or time back.

Dialysis personnel are to be called in only by Dialysis Physicians. When on-call staff are contacted by others, such as a unit secretary or another physician, staff should feel comfortable in instructing that individual to contact the Dialysis Physician on call. The Dialysis Physician will then contact the on-call staff.

Staff should not hesitate to discuss the need for emergency dialysis with the Dialysis Physician. On-call personnel should be called only for emergency situations or when the dialysis schedule runs past the usual hours of Unit operation. On-call staff (nurse and technician) will not work more than 16 consecutive hours.

Pregnant staff members are deleted from the Call rotation because of the possibility of being called in to dialyze patients with contagious infections.

kd1231879nm

APPROVED:				DATE:
TITLE:	Medical Director	Medical Director	CEO	01/01/88

PROCEDURE

Responsible Individual	Action
Nurse and Technician On-Call	1. Carries a long range beeper when away from home.
	2. Reports to the Unit within 40 minutes when called in.
Nurse On-Call	1. Picks up the Unit and narcotic keys in the Resource Office on arrival.
	2. Locks the Unit and returns the Unit and narcotic keys to the Resource Office when leaving.
	3. Pages the Resource Nurse at the front desk of the Hospital if the Resource Office is locked.
	4. Requests help from the patient's Unit and/or the Resource Nurse if the patient's acuity is such that assistance is needed. One-to-one patients require that the Unit nurse provide care during dialysis.
	5. Contacts the Resource Nurse if: a. Staff anticipate exceeding 16 consecutive hours of work. b. The number of patients to be dialyzed exceeds: 1). One acute patient 2). One pediatric patient 3). Three stable chronic patients

kd1231879nm

Responsible Individual	Action
The Resource Nurse	1. Contacts other dialysis staff to come in to assist.
	2. Contacts the Head Nurse and then each Assistant Head Nurse if the Head Nurse is not available.
Dialysis Physician On-Call	1. Contacts both the nurse and technician on-call if emergency dialysis is needed.
	2. Sets priorities when more than one patient requires emergency dialysis.

kd1231879nm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	Page 1 of 1
VOL.	POLICY NUMBER IV.20
SUBJECT: PREGNANT PERSONNEL	EFFECTIVE: 3/79
	REVISION: 6/83, 11/85, 9/87, 12/87
SOURCE: Dialysis Leadership Team	REVIEWED: 1/84, 1/85, 1/86, 1/87 12/87

POLICY

The pregnant staff member will be given the option of transferring out of the Renal Unit. The pregnant nurse or technician will be removed from the on-call rotation.

PROCEDURE

Responsible Individual	Action
Nurse or Technician	1. Notifies the Head Nurse of her pregnancy as soon as it is known.
	2. Seeks information regarding the possible dangers of Cytomegalovirus and Hepatitis B to the fetus and to the mother.

kd1231872nm

APPROVED: [signatures]	DATE: 01/01/88
TITLE: Medical Director Medical Director CEO	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Personnel Policies
VOL.:	POLICY NUMBER: IV.24
EFFECTIVE:	9/9/87
REVISION:	12/24/87
REVIEWED:	12/87

SUBJECT: PREPARATION AND CONNECTION OF EQUIPMENT FOR CONTINUOUS ARTERIO-VENOUS HEMOFILTRATION (CAVH)

SOURCE: Dialysis Leadership Team

POLICY

When CAVH is required for patient care, a dialysis technician will prepare the required equipment and a dialysis technician or a dialysis nurse will complete the patient-blood pathway connection. All preparation and connection will be under the orders of an adult or pediatric nephrologist or renal fellow.

PROCEDURE - Pediatrics

Responsible Individual	Action
Pediatric Nephrologist or Pediatric Renal Fellow	1. Contacts the Charge Nurse in the pediatric dialysis area during regular working hours and requests a CAVH set-up; writes orders in the CAVH Record and Progress Note.
	2. Contacts the technician on call and requests a CAVH set-up and connection during on-call hours; writes orders on the CAVH Record and Progress Note.
	3. Remains with the technician and Pediatric ICU Nurse during the patient-blood pathway connection.
Charge Nurse - Dialysis (if during regular working hours)	1. Designates a technician to prepare and connect the CAVH set-up.
	2. Transcribes the doctor's orders.

kd1230871nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

Responsible Individual	Action
Charge Nurse - Peds ICU (if during Dialysis Unit on-call hours)	1. Transcribes the doctor's orders. 2. Reviews orders with the Dialysis Technician.
Dialysis Technician	1. Sets up and prepares the necessary equipment for CAVH. 2. Completes the middle section of the CAVH Record noting pre-treatment vital signs, lab results and all other information. 3. Makes any notes or comments in that section of the CAVH Record regarding special set-up, access problems, etc. 4. Completes the patient-blood pathway connection with the Pediatric Nephrologist present and with the assistance of the Pediatric ICU Nurse. 5. Notes the time the connection was complete. 6. Signs his/her name at the bottom of the CAVH Record.
The Individual Who Terminates the CAVH Treatment (technician or nurse or physician)	1. Notes the time the procedure was completed. 2. Signs his/her name at the bottom of the CAVH Record. 3. Notes the post-treatment vital signs and any other relevant lab work in the middle section of the CAVH Record.

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PROCEDURE - Adult

Responsible Individual	Action
Renal Fellow or Dialysis Nephrologist	1. Contacts the charge nurse in the adult dialysis area during regular working hours and requests a CAVH set-up; writes orders on the CAVH Record and Progress Note.
	2. Contacts the nurse and the technician on-call and requests a CAVH set-up during on-call hours; writes the orders on the CAVH Record and Progress Note.
	3. Remains available to the nurse on-call during the patient-blood pathway connection.
Charge Nurse - Dialysis (if during regular working hours)	1. Designates a technician to prepare the CAVH set-up.
	2. Transcribes the doctor's orders.
	3. Designates an R.N. to complete the CAVH patient-blood pathway connection.
Technician	1. Sets up and prepares the necessary equipment for CAVH.
	2. Accompanies nurse to the bedside.
Staff Nurse	1. Transcribes the doctor's orders, if on-call.
	2. Completes the middle section of the CAVH Record noting pre-treatment vital signs, lab results and all other information.

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Responsible Individual	Action
Staff Nurse (continued)	3. Makes any notes or comments in that section of the CAVH Record regarding special set-up, access problems, etc. 4. Completes the patient-blood pathway connection. 5. Notes the time the connection was complete. 6. Signs his/her name at the bottom of the CAVH Record.
The Individual Who Terminates the CAVH Treatment (technicians, dialysis nurse, Adult ICU nurse)	1. Notes the time the procedure was completed. 2. Signs his/her name at the bottom of the CAVH Record. 3. Notes the post-treatment vital signs and any other relevant lab work in the middle section of the CAVH Record.

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UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

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VOL. V	POLICY NUMBER 2
EFFECTIVE 1/85	
REVISION 8/86, 9/87	
REVIEWED 1/85, 1/86, 1/87	

SUBJECT	
CHIEF EXECUTIVE OFFICER RESPONSIBILITIES	
SOURCE KDU Management/Leadership	

POLICY

The Chief Executive Officer is responsible for overall administrative direction for the Renal Transplantation Center and is aware of communication regarding policies, rules, and regulations.

PROCEDURE

Responsible Individual	Action
Chief Executive Officer for End Stage Renal Disease (ESRD)	1. Implements the policies of the facility and coordinates the provision of services in accordance with delegations by the Board of Governors.
	2. Organizes and coordinates the administrative functions of the facility, redelegating duties as authorized, and establishes formal means of accountability.
	3. Assures administrative accountability for the competent financial management of the center.
	4. Assures staff orientation/education complies with all policies, rules and regulations, and applicable Federal, State and Local laws and regulations.

kd1231878nm

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

Responsible Individual	Action
Chief Executive Officer for ESRD (continued)	5. Submits such records and reports as may be required by the Medical Review Board for the ESRD program and other agencies including the Secretary of Health and Human Services.
	6. Participates in developing and implementing contract agreements into which the Hospital may enter subject to the approval of the University and Board of Governors as required.
Associate Director of Nursing Operations	1. Assumes responsibilities for Chief Executive Officer duties in his/her absence.

kd1231878nm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

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EFFECTIVE	
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SUBJECT

GENERAL GUIDELINES FOR UNIVERSAL BLOOD AND BODY SUBSTANCE TECHNIQUE FOR THE KIDNEY DIALYSIS UNIT

SOURCE

POLICY

In the dialysis population there exists the continual risk of exposure, contamination, cross contamination and infection of many different infectious agents. Standardization of practice in such a divergent, potentially infectious population is seen as the best approach to ensure that adequate infection control practices are used on all dialysis patients. All patients and patient specimens will be considered potentially infectious and will be cared for/handled using Universal Blood and Body Substance Technique. (See Hospital Policy 33.21)

PROCEDURE

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff	1. Wear gloves for: a) Touching blood and body fluids, mucous membranes or non-intact skin; b) Handling items or surfaces soiled with blood or body fluids; c) Initiation and termination of dialysis; d) All access procedures; e) Blood-drawing; f) IV medication administration via bloodlines; g) Initiation or termination of a blood transfusion;

APPROVED	DATE
TITLE: Medical Director; Medical Director; CEO	02/11/88

PROCEDURE (continued)

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff (continued)	h) Clean-up; i) Any emergency where leakage of blood is possible. 2. Change gloves (not washed or re-used) after each patient contact. 3. Perform handwashing/skin cleansing: a) Immediately after gloves are removed; b) After contamination with blood or body fluids; c) Upon entering and leaving the unit; d) Before and after attending to personal hygiene. 4. Wear a moisture resistant gown during all procedures that are likely to generate blood or other body fluids enough to soak through an ordinary fabric gown, such as: a) Initiation and termination of dialysis; b) All access procedures; c) During tearing-down of dialysis. 5. Remove gown when: a) It is soiled; b) Leaving patient care area.

PROCEDURE (continued)

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff (continued)	6. Wear masks and protective eyewear when involved in a procedure that is likely to generate droplets of blood or other body fluids such as: a) Initiation and termination of dialysis; b) All access procedure; c) Tearing-down of dialysis machine. 7. Dispose of sharps appropriately (see page 2 of Hospital Policy 33.32).
Respiratory Therapist, Kidney Dialysis Head Nurse, Assistant Head Nurses and Charge Nurses	1. Ensure that ventilation devices (mouthpiece, resuscitation bag) are available for emergencies. 2. Replace used ventilation devices with new ones, when contaminated.
Nursing Assistant	1. Ensures that each patient cubicle contains a puncture resistant container for all sharps. 2. Changes .5% bleach solution, used for mopping, every morning, and after each blood spill.
Kidney Dialysis Nurses and Technicians	1. Remove visible blood from machines with .5% bleach solution. 2. Clean entire surface of machine with .5% bleach solution. 3. Discard bloodlines and dialyzer into the bio-hazardous waste container.

PROCEDURE (continued)

Responsible Individual	Action
Kidney Dialysis Nurses and Technicians (continued)	4. Clean dialysate pathway with .5% bleach and heat cycle, if blood leak has occurred during run. 5. Put all machines through heat sterilization, daily.
All Kidney Dialysis Personnel	1. Document all actual and potential unprotected exposures. 2. Report all exposures immediately to Employee Health Service/Emergency Department. (see Hospital Policy 33.18).

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	IX. Miscellaneous
VOL.	POLICY NUMBER IX.3
SUBJECT	ELECTRICAL SAFETY
EFFECTIVE	3/79
REVISION	6/83, 1/87, 12/87
SOURCE	Dialysis Head Nurse
REVIEWED	1/84, 1/85, 1/86, 1/87 12/87

POLICY

The Dialysis Unit has an equipotential ground system. The Biomedical Engineer includes electrical safety checking within the routine preventive maintenance of equipment (Policy VIII.4).

PROCEDURE

Responsible Individual	Action
Biomedical Engineering	1. Performs electrical safety checks on dialysis related equipment: a. Dialysis delivery systems are checked every month. b. Defibrillator output and EKG operations checked every three months. 2. Places a sticker on the tested equipment indicating the date checked. 3. Records results of checks and keeps the records in the Biomedical Engineering Department.

kd1231871nm

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
Board of Governors Finance Committee
MARCH 11, 1988

MINUTES

CALL TO ORDER:

On March 11, 1988 the Finance Committee meeting was called to order by Mr. Robert Nickoloff at 10:38 a.m. in the Board Room.

ATTENDANCE:

Present:	Edward Ciriacy, M.D. Robert Dickler Cliff Fearing Elwin Fraley, M.D. Jerry Meilahn Robert Nickoloff
Absent:	Carol Campbell Barbara O'Grady Vic Vikmanis
Staff:	Greg Hart Nancy Janda Nels Larson Peter Lynch, M.D. Dan Rode Mary Ellen Wells

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the December 16, 1987 meeting as written.

BAD DEBTS:

Mr. Daniel Rode summarized a proposed bad debt write-off for the second quarter of the 1987-88 fiscal year. The bad debts for the period totaled $689,621.74. Net bad debts for the quarter are 1.09% of gross charges. A bad debt level of 1.33% of gross charges had been budgeted.

The Committee members agreed that an overview of our accounts receivable level and efforts underway aimed at reducing days in accounts receivable and bad debts would be helpful to the Committee. In conclusion, the bad debt write-off of $689,621.74 for the quarter was approved.

1988-89 Budget:

Mr. Robert Dickler overviewed several variables that influenced the establishment of the budget for the fiscal year 1988-89. Those variables are detailed in the attached letter from Robert Dickler and included:

Medicare Reimbursement: The Omnibus Reconciliation Act of 198[illegible] imposes several changes that will negatively influence our Medica[illegible] reimbursement level. Most notably, indirect medical education payments and capital expenditure reimbursement will together drop by some $850,000 for the fiscal year. Next year is also the final transition year for UMHC away from cost reimbursement to a full prospective payment reimbursement reducing UMHC Medicare payments by $2,200,000. These payments will likely not cover the costs of providing that care.

- Health Insurance Costs: Insurance costs for employees covered by Blue Cross are expected to rise by $2.1 million over budgeted 1987-88 levels. HMOs are also expected to raise premiums on January 1, 1989. The estimated annual cost to UMHC of HMO premium increases is $750,000.

- Malpractice Insurance: Premiums of malpractice insurance for employees and residents are expected to rise by $500,000 above current year rates to a $1,000,000 annually.

- Interest on Appropriations: State appropriations to the Hospital [illegible] been paid in a lump sum at the beginning of the year. Next ye[illegible], payments will be made in monthly increments, resulting in a loss of interest income of approximately $350,000 annually.

Capital Planning: The Strategic Planning Coordinating Committee is reviewing a ten year capital plan for equipment and non Unit J facilities. Preliminary estimates indicate that execution of this plan without new debt or additional state appropriations will require a $1 million to $1.5 million increase in net cash flows annually through 1998. A $1 million cash flow increase for the 1988-89 fiscal year is targeted for this purpose.

- Pay Equity: The Board of Governors approved a 4 year comparable worth plan in 1985 that will bring all employees within 5% of the marketline; 1988-89 is the fourth and final year of this implementation plan. Costs to complete the 1985 plan in 1988-89 are about $632,000. The Board of Regents is currently considering bringing all effected classes to the marketline by 1991. If the hospital were to pattern itself after the Regents, an additional $1 million would be needed for pay equity for next fiscal year.

The above factors, Mr. Dickler noted, indicate that recent annual price increases of 3% or less are clearly not achievable next fiscal year. Other Twin City hospitals have been employing double digit price increases. It is uncertain at this point as to whether we will achieve a price increase of less than 10%.

The Finance Committee will be asked to endorse the budget on April 28, 1988. The Committee will have another opportunity to review the budget in the interim.

DERMATOLOGY CLINIC EXPANSION:

Ms. Mary Ellen Wells and Dr. Peter Lynch outlined a plan for completing 4,497 net square feet on the fourth floor of the Phillips-Wangensteen building for Dermatology. The new space will allow for the Department to expand its dermatologic surgical services. Architects have recently completed initial design plans that include 4 exam rooms, 4 procedure rooms, a lab, 4 offices and a reception area. The total cost of the project is about $850,000. The hospital is being asked to assume responsibility for $631,629 of that cost to cover exam rooms, procedure rooms, the reception area and the corridors. The Department of Dermatology will assume responsibility for the remainder of the costs.

The Finance Committee passed a motion to approve the expenditure of $631,629 for Dermatology Clinic expansion.

AUDITED FINANCIAL STATEMENTS:

Mr. Nels Larson overviewed the audited financial statements for the fiscal years ending June 30, 1986 and June 30, 1987. The audit was done by Peat Marwick Main Company. The format for the statements used by Peat Marwick is different than the format usually presented to the Board of Governors. Mr. Larson has satisfactorily reconciled information presented in the audit to our internal statements. No significant changes in the results of operations were noted in the audit. The Peat Marwick management letter was recently received and will be reviewed with the Finance Committee at a future meeting.

OTHER:

Mr. Greg Hart overviewed the outcome of the March 11, 1988 Board of Regents meeting where President Keller presented his recommendations to strengthen the University's management accountability; the recommendations are intended to ensure that cost overruns similar to those experienced with the Eastcliff project will not recur.

ADJOURNMENT:

Their being no further business, the March 11, meeting of the Finance meeting was adjourned at 12:15 p.m.

Respectfully submitted,

Nancy C. Janda

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

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 2, 1988

TO: Board of Governors
Finance Committee

FROM: Robert Dickler

SUBJECT: 1988-1989 UMHC Budget Time Frames and Significant 1988-89 Issues

I would like to take this opportunity to bring forth for discussion the 1988-1989 budget time frames and to discuss several major issues we will need to address in the 1988-89 budget cycle. Since this is the first UMHC budget that will be brought to the Board of Governors since I became Director, I want to begin the process this month to allow ample time for discussion and review of our financial objectives for 1989.

As you know, the State of Minnesota maintains a hospital rate review program. The objective of the rate review program is to review and comment on the reasonableness of the rates hospitals charge for their services. The rate review program requires hospitals to file an application to raise rates 60 days in advance of implementing any rate increase. UMHC's fiscal year begins on July 1, 1988 at which time many of our costs also increase (salaries, fringe benefits, etc.). July 1 is also the anniversary date of many of our HMO contracts. For these reasons we have historically adjusted our rates on July 1. Since we would hope to adjust our rates on July 1, 1988, the final budget endorsement must be completed at the April 28, 1988 Board of Governors meeting.

Although there are various components of the budget process which I may wish to change over time the present process will serve us well as we plan for next year. In my opinion it is more important for the Board of Governors to consider the principals and objectives on which the budget is developed than to review detailed financial calculations. With appropriate review of budget principles and objectives, the Board will be able to provide Management with appropriate direction as to its desired objectives. Review of the final financial calculations can then be done as a reasonableness check on these goals and objectives. I would hope that we could develop this framework over the coming year.

For the next several meetings we will be presenting the Finance Committee and the full Board with various elements of 1988-89 Financial Plan.

Recent changes in reimbursement levels enacted by Congress, rising health care expenses for our employees, increasing malpractice insurance costs, pay equity costs, our need to modernize facilities and our need to acquire new technology will have a significant impact on the 1988-89 budget.

Due to the significance of these items we believe that it is important for the Board of Governors to understand their impact on the 1988-89 budget before the detailed plan is presented. Although each of these areas will be discussed with the Board of Governors in detail, we believe an overview of these items at this time is imperative.

The Omnibus Budget Reconciliation Act of 1987 (OBRA) contains several changes to UMHC's reimbursement levels for Medicare patients which will significantly reduce UMHC's revenues from this program. The most significant of this changes are in the areas of indirect medical education reimbursement and capital reimbursement. For 1988-89 these payment levels will drop from 1987-88 levels by approximately $850,000. 1988-89 is also the year UMHC will complete its transition from cost reimbursement under Medicare to full prospective payment reimbursement. Since UMHC's total budget is not yet known, the exact impact of this transition cannot be determined. However, based on a 5% average UMHC cost increase and a 1.5% DRG increase, the impact will require UMHC to cost shift approximately $2,200,000 to other payors.

Increases in costs over the 5% level are expected in several areas. Recent changes in health insurance costs negotiated between the State of Minnesota and BCBSM will increase UMHC's health insurance costs over current levels by $2,150,000. In addition, UMHC can expect HMO's to significantly increase their premium on 1/1/89. We expect these cost increases to increase at least $750,000 on an annual basis.

UMHC developed a pay equity plan in 1985 for implementation over a four year period. Under the final year of this plan 1988-89, UMHC would increase salaries to affected classes by $632,000. However, the Regents are presently considering a plan which would increase UMHC's cost under this program by $3,400,000 over three years. The 1988-89 impact of this change could increase UMHC's costs by $700,000. Fringe benefits related to this plan would increase UMHC's costs approximately $300,000 per year over the three year period. The policy position of the Board of Governors regarding pay equity will need to be explored in detail by the Board over the next several months.

1988-89 malpractice insurance premiums will probably be at least $500,000 higher than in 1987-88. Although initial premium increases proposed for the University and the Hospital were well in excess of final premiums, the excellent financial condition of the University's self insurance company (Ruminco) enabled the rates to be reduced by approximately 50%.

As of July 1, 1988, UMHC will no longer receive its State appropriation at the beginning of the year. Instead, the State will pay the Hospital throughout the year for this appropriation. This will eliminate UMHC's opportunity to invest the appropriation proceeds and will reduce our revenues by $350,000 per year.

The Strategic Planning Coordinating Committee is presently reviewing a ten year capital plan for equipment and for the modernization of facilities which were not replaced with Unit J. Preliminary estimates indicate that in order to complete this plan without new debt, increased appropriations or non-UMHC capital infusion will require a $1 million to $1.5 million increase in net cash flows annually through 1998 in uninflated dollars. For 1988-89 this cash flow increment is targeted at $1 million.

Unfortunately of the items described above the only areas of discretion are in the pay equity and capital cash flows. All other changes are either regulatory or are costs over which UMHC as an entity currently has no control.

Although many of these changes will not impact our competitors, the changes for Medicare and the operating positions of many Twin City hospitals will cause rate increases to be much higher in 1988-89. Recent rate increases by one of our major competitors are 11.5% or higher on an annual basis. We believe this will be the norm rather than the exception.

As usual in our budget process we will attempt to minimize expenses and maximize revenues. However we believe that recent annual rate increases of 3% or less are not achievable without significantly altering our programmatic base and/or deferring many of our capital plans for several years.

The health care providor and insurance market in the Metro area is under significant financial stress. UMHC's present position is strong and if we approach the next several years cautiously we will be in a position to secure our long term role as a major tertiary care teaching hospital

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 23, 1988

TO: Board of Governors Finance Committee

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period
July 1, 1987 through February 29, 1988

The Hospital's operations through the month of February continued to reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. In addition, we experienced ancillary service utilization that was higher than anticipated. To highlight our position:

Inpatient Census: For the month of February, inpatient admissions totaled 1,482 or 72 over budgeted admissions of 1,410. Our overall average length of stay for the month was 8.0 days. Patient days for February totaled 11,592 and were 326 days under budget. Admissions were primarily over budget in the areas of Medicine and Orthopedics. Patient days were under budget primarily in the areas of Pediatrics, Neurosurgery and Clinical Research.

To recap our year-to-date inpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Admissions	12,431	12,110	12,605	495	4.1
Avg. Lnth. of Stay	8.3	8.5	8.0	-0.5	-5.9
Patient Days	102,103	102,367	100,515	-1,852	-1.8
Avg. Daily Census	420.2	419.5	411.9	-7.6	-1.8
Percent Occupancy	71.3	72.1	71.0	-1.1	-1.5

Outpatient Census: Clinic visits for the month of February totaled 20,624 or 1,005 (5.1%) over budgeted visits of 19,619. Areas which experienced actual visits with large increases over budget were A.T.E.U., Radiation Therapy, Psychology, and the Diabetes Center. The largest decreases in activity were experienced in the Family Practice, Emergency Room and Adult Psychology. Community University

Health Care Center (CUHCC) visits for the month of February totaled 3,980 or 170 (4.5%) above budgeted visits of 3,810, while Home Health visits of 809 for the month were 98 (13.8%) above budgeted visits of 711.

To recap our year-to-date outpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Clinic Visits	161,973	166,641	169,704	3,063	1.8
CUHCC Visits	30,788	31,619	31,993	374	1.2
HHA Visits	6,534	6,171	5,925	-246	-4.0

Financial Operations: The Hospital's Statement of Operations shows total expenses over revenues of $724,956, a favorable variance of $4,905,669.

Patient care charges through February totaled $167,450,674 and were 1.5% over budget. Routine revenue was 2.8% under budget and reflected our unfavorable patient day variance. Ancillary revenue was approximately $3,773,258 (3.2%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,144 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $188 compared to the budgeted average of $184.

Operating expenditures through February totaled $163,434,706 and were approximately $3,877,398 (2.4%) over budgeted levels. The overall variance relates to increased salary and fringe benefit costs.

Accounts Receivable: The balance in patient accounts receivable as of February 29, 1988 totaled $78,175,009 and represented 113.06 days of revenue outstanding. The overall decrease in our patient receivables in February of 1.91 days occurred primarily in the Minnesota Medical Assistance, Commercial Insurance, VA and Indian Health.

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

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1987 TO FEBRUARY 29, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$164,987,329	$167,450,674	$2,463,345	1.5%
Deductions from Charges	-29,966,631	-26,092,278	3,874,353	12.9%
Other Operating Revenue	3,907,835	4,400,177	492,342	12.6%
Total Operating Revenue	138,928,533	145,758,573	6,830,040	4.9%
Total Expenditures	-159,557,308	-163,434,706	-3,877,398	-2.4%
Net Operating Revenue	-20,628,775	-17,676,133	2,952,642	0.0%
Non-Operating Revenue and Expenses	14,998,150	16,951,177	1,953,027	13.0%
Revenue over Expense	($5,630,625)	($724,956)	$4,905,669	(1)

(1) Variance equals 3.2% of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	12,110	12,605	495	4.1%
Patient Days	102,367	100,515	-1,852	-1.8%
Average Daily Census	419.5	411.9	-7.6	-1.8%
Average Length of Stay	8.5	8.0	-0.5	-5.9%
Percentage Occupancy	72.1%	71.0%	-1.1	-1.5%
Outpatient Clinic Visits	166,641	169,704	3,063	1.8%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1987 TO FEBRUARY 29, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$164,987,329	$167,450,674	$2,463,345	1.5%
Deductions from Charges	29,966,631	26,092,278	-3,874,353	-12.9%
Other Operating Revenue	3,907,835	4,400,177	492,342	12.6%
Total Revenue from Operations	$138,928,533	$145,758,573	$6,830,040	4.9%
Expenditures				
Salaries	$67,712,413	$70,179,079	$2,466,666	3.6%
Fringe Benefits	12,822,153	14,147,500	1,325,347	10.3
Contract Compensation	6,740,084	6,902,960	162,876	2.4
Medical Supplies, Drugs, Blood	26,331,246	25,839,791	-491,455	-1.9
Campus Administration Expense	4,314,267	4,314,267	0	
Depreciation and Amortization	11,120,506	11,679,728	559,222	5.0
General Supplies & Expense	30,516,639	30,371,381	-145,258	-0.5
Total Expenditures	$159,557,308	$163,434,706	$3,877,398	2.4%
Net Revenue from Operations	($20,628,775)	($17,676,133)	$2,952,642	
Non-Operating Revenues and Expenses				
Appropriations	$9,609,533	$9,606,036	($3,497)	-0.0%
Interest Income on Reserves	3,928,284	5,006,439	1,078,155	27.4
Shared Services	255,000	119,721	-135,279	-53.1
Investment Income on Trustee Held Assets	1,205,333	2,218,981	1,013,648	84.1
Total Non-Operating Revenues and Expenses	$14,998,150	$16,951,177	$1,953,027	13.0%
Revenue Over Expense	($5,630,625)	($724,956)	$4,905,669	(1)

(1) Variance equals 3.2% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1987 TO FEBRUARY 29, 1988

Annual Budget		Budgeted	Actual	Variance Over/-Under Budget	Variance %
	Patient Care Charges				
$70,025,500	Routine	$46,849,532	$45,539,619	($1,309,913)	-2.8%
179,592,300	Ancillary	118,137,797	121,911,055	3,773,258	3.2
249,617,800	Gross Charges	$164,987,329	$167,450,674	$2,463,345	1.5%
	Deductions from Charges				
$27,750,800	Third Party Contractual Adjustments	$18,342,163	$12,744,304	($5,597,859)	-30.5%
9,219,200	Billing Adjustments & Employee Benefits	6,117,748	7,524,245	1,406,497	23.0
663,800	Charitable Care	438,745	376,911	-61,834	-14.1
4,355,300	Other Contractual Adjustments	2,878,678	3,224,682	346,004	12.0
3,312,300	Provisions for Uncollectables	2,189,297	2,222,136	32,839	1.5
$45,301,400	Total Deductions	$29,966,631	$26,092,278	($3,874,353)	-12.9%
	Other Operating Revenue				
$1,348,500	Food Services	$899,000	$978,829	$79,829	8.9%
500,000	Parking Services	333,333	394,314	60,981	18.3%
78,700	Department Non-Patient	52,467	20,060	-32,407	-61.8
1,066,700	CUHCC Grants	699,888	745,439	45,551	6.5
1,543,700	Reference Lab Income	1,029,133	1,074,922	45,789	4.4
1,352,600	Pro Fees - Net Revenue	894,014	950,508	56,494	6.3
0	X-Ray Silver Salvage	0	216,753	216,753	
0	Donations from Restricted Funds	0	19,352	19,352	
$5,890,200	Total Other Revenue	$3,907,835	$4,400,177	$492,342	12.6%
210,206,600	Total Revenue from Operations	$138,928,533	$145,758,573	$6,830,040	4.9%
	Expenditures				
101,075,300	Salaries	$67,712,413	$70,179,079	$2,466,666	3.6%
19,139,500	Fringe Benefits	12,822,153	14,147,500	1,325,347	10.3
1,960,300	Academic Contracts	1,306,867	1,300,949	-5,918	-0.5
5,533,100	Resident Contracts	3,644,350	3,728,678	84,328	2.3
2,683,300	Physician Compensation	1,788,867	1,873,333	84,466	4.7
130,391,500	Total Salary, F.B. & Fees	$87,274,650	$91,229,539	$3,954,889	4.5
2,106,000	Laundry & Linen	1,401,151	1,475,144	73,993	5.3
1,688,200	Raw Food	1,127,603	1,092,703	-34,900	-3.1
20,236,500	Drugs	13,311,456	11,457,053	-1,854,403	-13.9
5,853,500	Blood & Blood Derivatives	3,850,400	4,673,891	823,491	21.4
13,939,600	Medical Supplies	9,169,390	9,708,847	539,457	5.9
4,254,600	Utilities	2,887,936	2,700,304	-187,632	-6.5
1,007,900	Insurance	618,057	730,400	112,343	18.2
2,902,200	Rental	1,934,800	2,137,758	202,958	10.5
4,252,100	Maintenance & Repair	2,834,733	2,828,172	-6,561	-0.2
1,475,700	Communications	983,800	1,106,047	122,247	12.4
0	Gain on Disposal of Assets	0	-38,500	-38,500	
6,471,400	Campus Administration Expense	4,314,267	4,314,267	0	
16,693,600	Depreciation and Amortization	11,120,506	11,679,728	559,222	5.0
10,428,000	Interest	6,997,759	6,774,659	-223,100	-3.2
17,596,200	General Supplies & Expense	11,730,800	11,564,694	-166,106	-1.4
239,297,000	Total Expenditures	$159,557,308	$163,434,706	$3,877,398	2.4
-29,090,400	Net Revenue from Operations	($20,628,775)	($17,676,133)	$2,952,642	
	Non-Operating Revenue and Expenses				
$14,414,300	Appropriations & Support	$9,609,533	$9,606,036	($3,497)	-0.0
0	Accrued Interest on Appropriation	0	226,251	226,251	
5,517,900	Interest Income on Reserves	3,928,284	4,780,188	851,904	21.7
382,500	Shared Services	255,000	119,721	-135,279	-53.1
1,808,000	Investment Income Held by Trustee	1,205,333	2,218,981	1,013,648	84.1
$22,122,700	Total Non-Operating Revenue and Expenses	$14,998,150	$16,951,177	$1,953,027	13.0
($6,967,700)	Revenue Over Expense	($5,630,625)	($724,956)	$4,905,669	(1

(1) Variance equals 3.2% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

BALANCE SHEETS

FEBRUARY 29, 1988 AND JUNE 30, 1987

ASSETS

	2/29/88	6/30/87
CURRENT ASSETS		
Operating Cash	-8,123,227	$34,475
Reserve Cash- Third Party Payable	13,414,598	14,305,005
Unrealized Appropriation Cash	4,803,116	0
Reserve Cash- Short Term Debt	2,500,000	2,500,000
Reserve Cash-Bond Int. & Prin. Pay.	1,422,909	4,214,376
Accounts Receivable		
Patient Receivables	78,175,009	72,366,775
Other Receivables	1,763,851	2,018,472
	79,938,860	74,385,247
Less Allowances for Losses in Collection	-5,869,416	-5,577,999
Less Allowances for Discounts to Third Party Payors	-11,341,598	-13,623,861
	62,727,846	55,183,387
Trustee Held Assets	0	1,020,755
Inventories of Drugs & Supplies	4,750,319	4,863,369
Prepaid Expenses	513,148	393,145
Silver Flake	216,753	0
TOTAL CURRENT ASSETS	$82,2[illegible]62	$82,514,512
BOARD DESIGNATED ASSETS:		
[illegible]rd Designated Assets		
[illegible]ilable for Assignment		
Cash & Investments	$63,823,331	$56,443,170
Accrued Interest	1,604,302	605,020
	65,427,633	57,048,190
Assigned Cash & Investments	11,545,575	8,510,966
TOTAL BOARD DESIGNATED ASSETS	$76,973,208	$65,559,156
DEFERRED THIRD PARTY REIMBURSEMENT	$9,651,251	$10,172,239
OTHER ASSETS	258,190	258,189
LAND, BUILDINGS & EQUIPMENT		
Land, Buildings & Improvements	$182,121,004	$180,359,060
Equipment	75,083,679	68,008,620
	257,204,683	248,367,680
Less Accumulated Depreciation	-78,759,043	-67,640,664
	178,445,640	180,727,016
Construction in Progress	5,433,634	8,136,413
TOTAL LAND, BUILDINGS & EQUIPMENT	$18[illegible]	$188,863,429
TRUSTEE HELD ASSETS	$4[illegible]	$51,195,164
DEFERRED DEBT EXPENSE	$1,[illegible]	$2,023,259
	$396,1[illegible]	$400,585,948

LIABILITIES AND FUND BALANCES

	2/29/88	6/30/87
CURRENT LIABILITIES		
Accounts Payable	$3,359,084	$6,101,515
Payable to Third Party Contr. Payors	13,414,598	14,305,005
Salaries, Wages and Payroll Taxes	5,608,596	7,080,113
Accrued Vacation	7,148,833	6,706,164
Accrued Professional Fees and Physician Compensation	2,136,594	1,625,515
Contracts Payable	1,371,312	2,368
Construction Retainages	0	918,370
Interest Payable	991,203	4,263,164
Current Portion of Long-Term Debt	3,971,163	3,796,447
Promissory Notes Payable	2,500,000	2,500,000
TOTAL CURRENT LIABILITIES	$40,501,383	$47,298,661
LONG-TERM DEBT, LESS CURRENT PORTION	$176,889,607	$182,896,903
UNRESTRICTED FUND BALANCE	$178,797,296	$170,390,384
	$396,188,286	$400,585,948

RESTRICTED ASSETS

Cash and Investments	$5,437,359	$4,856,396

RESTRICTED FUND BALANCES

Fund Balances		
Endowment Funds	$1,921,395	$1,846,730
Gift Funds	3,515,964	3,009,666
	$5,437,359	$4,85[illegible]

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
STATEMENT OF CHANGES IN FUND BALANCE
FOR THE PERIOD JULY 1, 1987 TO FEBRUARY 29, 1988

UNRESTRICTED FUNDS	OPERATING FUND	BOARD DESIGNATED FUND	TRUSTEE & PLANT FUND	TOTAL UNRESTRICTED FUNDS
Beginning Balance	$33,979,528	$57,048,190	$79,362,666	$170,390,384
Net Income				
Excess of Revenue over Expense	2,394,710			
Interest Income on Reserves		4,780,188		
Accrued Interest on Appropriations		226,251		
Depreciation Expense			-11,679,712	
Gain on Disposal of Assets			38,500	
Interest Expense			1,296,126	
Interest Income on Trustee Held Fund			2,218,981	
Extrordinary Item				
Total Income				-724,956
Less Expense				
Unrealized Appropriation Revenue	4,803,116			4,803,116
University Support: G & A	4,314,267			4,314,267
K/E Utilities	149,662			149,662
Transfers Between Funds				
Major Building Projects- Hospital Only	-23,500	-285,474	308,974	
Capital Expenditures	-6,141,146	0	6,141,146	
Capital Encumbrance Change	263,931		-263,931	
Major Equipment Requsition	-678,924	7,225,366	-6,546,442	
Bond Interest Payment	10,877,804	-10,668,397	-209,407	
Bond Principal Sinking Fund	-1,315,000	1,315,000		
Short Term Note Funding	2,500,000	-2,500,000		
Bond Interest Expense Funding	-5,170,983	5,170,983		
Prior Year End Bond Interest Transfer	-4,214,376	4,214,376		
Reimbursement from Trustee - Bond Interst		4,841,928	-4,841,928	
PCN liability payment	1,058,268	-1,058,268		
Increease in Restricted Gift Fund Committment to Plant			59,454	59,454
Unrestricted Donation			50,000	50,000
Adjustments to Hosptal Shared Buildings		270	-244,901	-244,631
Orthopaedic Surgery loan	56,900		-56,900	
Bond Principal Payment		-2,630,000	2,630,000	
Ending Balance	$42,854,257	$67,680,413	$68,262,626	$178,797,296

RESTRICTED FUNDS	Gift	Endowment	Total
Beginning Balance	$3,009,666	$1,846,730	$4,856,396
Income	1,085,104	74,665	1,159,769
Disbursment	-578,806		-578,806
Ending Balance	$3,515,964	$1,921,395	$5,437,359

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 10, 1988

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - Second Quarter, Fiscal Year 1988.

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the second quarter of 1987-88 is $689,621.74 represented by 1,336 accounts. Bad debt recoveries during the period amounted to $10,687.30, leaving a net charge-off of $678,934.44.

The net bad debts of $678,934.44 for the second quarter were 1.09% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($792,102).

A statistical summary is attached along with a detailed description of losses over $2,000.00 and recoveries over $200 for each month of the second quarter.

Year to date bad debts have amounted to $1,638,949.34 represented by 2938 accounts. Recoveries during these two quarters amounted to $17,863.58 leaving a net charge-off of $1,621,085.76.

The net bad debts of $1,621,085.76 for the two quarters were 1.28% of gross charges. This compares to a budgeted level of bad debts of 1.33% of ($1,651,570).

Along with a year-to-date statistical summary, we have also included reports with a breakdown of bad debts by residence and by the admitting clincal services.

attachments

ACCOUNTS RECEIVABLE HIGHLIGHTS
January 31, 1988

Category	Amount	+ or (-) Prev. Mo.	% Change	+ or (-) 6/30/87	% Change	1-31-88 Days
Total	$79,390,735[a]	$2,278,037	2.95%	7,141,102	9.88%	114.97
Inhouse	9,131,261[a]	(535,906)	(5.54)%	(59,544)	(0.65)%	13.22
DNFB[b]	10,737,692[a]	2,278,588	26.94%	775,881	7.79%	15.55
	- 2,253,336 - inpatient hold - 2,331,760 - outpatient hold - 4,522,116 - medical record hold - 1,630,480 - misc. billing hold					
Collections	5,225,242	(18,905)	(0.36)%	(188,583)	(3.48)%	7.57
Follow-up	5,053,176	(37,810)	(0.74)%	(11,172)	(0.22)%	7.32
Net DAR	49,243,363[a]	592,070	(1.22)%	6,624,520	15.54%	71.31

a. Figures shown are gross dollars or days and do not reflect contractual allowances or discounts (ie Net DAR after adjustment would be approximately $38,902,000 or 56.34 days)
b. Discharged not final billed.

Significant Changes:

- The DNFB category significantly increased this month reflecting a significant number of inpatients requiring medical recording and turned into the category towards the end of January along with a hold placed on outpatient Blue Cross billing to permit changes in the 1988 AWARE Contract.

- Increases in accounts receivable Net DAR were reflected in Commercial Insurance, $992T; Minnesota MA, $555T; HMO's, $413T; Agency Pending, $203T; Misc. Authorization, $162T; External Audits, $150T; Special Contracts, $135T; and Industrial Compensation, $128T. Special project: have begun with DH&S on Commercial Insurance and Medical Assistance. Increases in Authorization, Special Contracts and Industrial Compensation reflect new business.

- Decreases in accounts receivable Net DAR were reflected in Medicare, $520T, Blue Cross Out-of-State, $560T, Out-of-State Medical Assistance, $474T and Blue Cross, $84T.

NIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

OCTOBER 1987 THROUGH DECEMBER 1987

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	53,067.38	90	66,054.48	15	119,121.86	105
Bad Debt (702) Charity Care	19,965.05	28	131,036.39	19	151,001.44	47
Total	76,319.64	118	197,090.87	34	270,123.30	152
Recoveries	(2,090.45)	28	(000.00)	0	(2,090.45)	12
Net Total	$ 70,941.98	118	$ 197,090.87	34*	$ 268,032.85	152*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 11,894.26	31	$ 207,834.85	6	$ 215,264.68	25
Bad Debt (701) Write-Offs	273,585.75	2121	28,817.99	6	160,552.45	963
Bad Debt (702) Charity Care	70,825.62	360	4,775.60	2	37,306.50	183
Total	356,305.63	2512	241,428.44	16	413,123.63	1171
Recoveries	(10,283.58)	104	(2,231.35)	1	(8,596.85)	53
Net Total	$ 346,022.05	2512*	$ 239,197.09	16*	$ 404,526.78	1171*
INPATIENT AND OUTPATIENT TOTAL	$ 528,857.70	2810*	$ 436,287.96	50*	$ 672,559.63	1323*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 6,079.23	11	$ 000.00	0	$ 4,840.23	8
Outpatient (710)	1,534.58	5	.00	0	1,534.58	5
Total	7,613.81	16	000.00	0	6,374.81	13
Recoveries	(1,864.66)	2	(000.00)	0	(000.00)	0
Net Total	$ 5,749.15	16*	$ 000.00	0	$ 6,374.81	13*
TOTAL NET BAD DEBT	$ 534,606.85	2826*	$ 436,287.96	50*	$ 678,934.44	1336*

NOTE: More than $2,000 amount includes legal settlements totaling $12,967.41

DOLL BUDGETED **$ 792,102.00**

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

OCTOBER 1987 THROUGH DECEMBER 1987

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$1,027.55	22	23,766.54	50	28,273.29	18	66,054.48	15	0.00	0	119,121.86	105
Bad Debt (70E) Charity Care	$71.46	3	$6,000.05	16	$13,893.54	9	$59,780.16	16	$71,256.23	3	$151,001.44	47
Total	$1,099.01	25	$29,766.59	66	$42,166.83	27	$125,834.64	31	$71,256.23	3	$270,123.30	152
Recoveries	($287.90)	9	($200.00)	2	($1,602.55)	1	$0.00	0	0.00	0	($2,090.45)	12
Net Total	$811.11	25 *	$29,566.59	66 *	$40,564.28	27 *	$125,834.64	31 *	$71,256.23	3 *	$268,032.85	152 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$286.12	6	$2,466.05	8	$4,677.66	3	$29,502.56	6	$178,332.29	2	$215,264.68	25
BAD DEBT (701) WRITE-OFFS	$21,599.20	610	$89,516.36	332	$20,618.90	15	$28,817.99	6	$0.00	0	$160,552.45	963
Bad Debt (70E) Charity Care	$3,916.01	100	$22,804.50	77	$5,810.39	4	$4,775.60	2	$0.00	0	$37,306.50	183
Total	$25,801.33	716	$114,786.91	417	$31,106.95	22	$63,096.15	14	$178,332.29	2	$413,123.63	1171
Recoveries	($829.15)	30	($5,536.35)	22	$0.00	0	($2,231.35)	1	$0.00	0	($8,596.85)	53
Net Total	$24,972.18	716 *	$109,250.56	417 *	$31,106.95	22 *	$60,864.80	14 *	$178,332.29	2 *	$404,526.78	1171 *
INPATIENT AND OUTPATIENT TOTAL	$25,783.29	741 *	$138,817.15	483 *	$71,671.23	49 *	$186,699.44	45 *	$249,588.52	5 *	$672,559.63	1323 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$3,240.23	7	$1,600.00	1	$0.00	0	$0.00	0	$4,840.23	8
Outpatient (710)	$98.97	3	$1,435.61	2	$0.00	0	$0.00	0	$0.00	0	$1,534.58	5
Total	$98.97	3	$4,675.84	9	$1,600.00	1	$0.00	0	$0.00	0	$6,374.81	13
Recoveries	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Net Total	$98.97	3 *	$4,675.84	9 *	$1,600.00	1 *	$0.00	0 *	$0.00	0 *	$6,374.81	13 *
TOTAL NET BAD DEBT	$25,882.26	744 *	$143,492.99	492 *	$73,271.23	50 *	$186,699.44	45 *	$249,588.52	5 *	$678,934.44	1336 *
DOLLARS BUDGETED											$792,102.00	

* Net total of accounts do not include recoveries

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1987 THROUGH DECEMBER 1987

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	139,497.53	241	325,141.34	47	464,638.87	288
Bad Debt (702) Charity Care	46,822.11	57	217,657.14	30	264,479.25	87
Total	186,319.64	298	542,798.48	77	729,118.12	375
Recoveries	(3,483.99)	28	(000.00)	0	(3,483.99)	28
Net Total	$ 182,835.65	298*	$ 542,798.48	77*	$ 725,634.13	375*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 11,894.26	31	$ 472,944.34	15	$ 484,838.60	46
Bad Debt (701) Write-Offs	273,585.75	2121	59,126.94	15	332,712.69	2136
Bad Debt (702) Charity Care	70,825.62	360	13,840.50	5	84,666.12	365
Total	356,305.63	2512	545,911.78	35	902,217.41	2547
Recoveries	(10,283.58)	104	(2,231.35)	1	(12,514.93)	105
Net Total	$ 346,022.05	2512*	$ 543,680.43	35*	$ 889,702.48	2547*
INPATIENT AND OUTPATIENT TOTAL	$ 528,857.70	2810*	$1,086,478.91	112*	$1,615,336.61	2922*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 6,079.23	11	$ 000.00	0	$ 6,079.23	11
Outpatient (710)	1,534.58	5	.00	0	1,534.58	5
Total	7,613.81	16	000.00	0	7,613.81	16
Recoveries	(1,864.66)	2	(000.00)	0	(1,864.66)	2
Net Total	$ 5,749.15	16*	$ 000.00	0	$ 5,749.15	16*
TOTAL NET BAD DEBT	$ 534,606.85	2826*	$1,086,478.91	112*	$1,621,085.76	2938*

NOTE: More than $2,000 amount includes legal settlements totaling $27,492.77

DOLLARS [illegible]ETED **$1,651.570.00**

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1987 THROUGH DECEMBER 1987

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$2,204.13	55	$61,744.73	134	$75,548.67	52	$160,998.69	40	$164,142.65	7	$464,638.87	288
Bad Debt (702) Charity Care	$144.11	5	$11,170.21	28	$35,507.79	24	$111,960.96	26	$105,696.18	4	$264,479.25	87
Total	$2,348.24	60	$72,914.94	162	$111,056.46	76	$272,959.65	66	$269,838.83	11	$729,118.12	375
Recoveries	($715.52)	21	($1,165.92)	6	($1,602.55)	1	$0.00	0	0.00	0	($3,483.99)	28
Net Total	$1,632.72	60 *	$71,749.02	162 *	$109,453.91	76 *	$272,959.65	66 *	$269,838.83	11 *	$725,634.13	375 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$438.82	9	$6,720.78	19	$4,677.66	3	$47,409.19	10	$425,535.15	5	$484,838.60	46
Bad Debt (710) Write-Offs	$49,026.24	1377	$135,336.72	722	$29,222.79	22	$59,126.94	15	$0.00	0	$332,712.69	2136
Bad Debt (702) Charity Care	$7,940.65	194	$46,503.69	155	$16,381.28	11	$13,840.50	5	$0.00	0	$84,666.12	365
Total	$57,405.71	1580	$248,561.19	896	$50,281.73	36	$120,376.63	30	$425,535.15	5	$902,217.41	2547
Recoveries	($1,976.47)	70	($8,307.11)	34	$0.00	0	($2,231.35)	1	$0.00	0	($12,514.93)	105
Net Total	$55,486.24	1580 *	$240,254.08	896 *	$50,281.73	36 *	$118,145.28	30 *	$425,535.15	5 *	$889,702.48	2547 *
INPATIENT AND OUTPATIENT TOTAL	$57,118.96	1640 *	$312,003.10	1058 *	$159,735.64	112 *	$391,104.93	96 *	$695,373.98	16 *	$1,615,336.61	2922 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$4,479.23	10	$1,600.00	1	$0.00	0	$0.00	0	$6,079.23	11
Outpatient (710)	$98.97	3	$1,435.61	2	$0.00	0	$0.00	0	$0.00	0	$1,534.58	5
Total	$98.97	3	$5,914.84	12	$1,600.00	1	$0.00	0	$0.00	0	$7,613.81	16
Recoveries	($64.66)	1	$0.00	0	($1,800.00)	1	$0.00	0	$0.00	0	($1,864.66)	2
Net Total	$34.31	3 *	$5,914.84	12 *	($200.00)	1 *	$0.00	0 *	$0.00	0 *	$5,749.15	16 *
TOTAL NET BAD DEBT	$57,153.27	1643 *	$317,917.94	1070 *	$159,535.64	113 *	$391,104.93	96 *	$695,373.98	16 *	$1,621,085.76	2938 *
DOLLARS BUDGETED											$1,651,570.00	

* Net total of accounts do no include recoveries.

SECOND QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY SERVICE

ADMITTING SERVICE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Anesthesiology				
Clinical Research	3	2,319.25	4	4,306.06
Dentistry			2	1,839.17
Dermatology				
Family Practice				
OB	1	687.80	1	687.80
NB	1	123.07	1	123.07
GYN	1	2,935.62	9	14,524.42
GYN-Oncology	4	6,290.27	9	6,707.05
Lab Medicine & Pathology				
Medicine-Blue	3	1,030.74	8	8,684.80
Green	4	1,843.43	11	3,942.20
Masonic(onc)	15	26,838.78	24	78,189.03
Purple	3	5,436.84	3	5,436.84
Red A			3	8,593.66
Red B	1	648.23	1	648.23
Rose A	1	816.11	5	2,828.33
Rose B				
White A	6	5,006.18	12	10,650.68
White B	7	1,800.69	11	9,818.01
Yellow A	3	2,965.83	8	23,398.00
Yellow B	3	797.70	4	3,027.64
Neurology	6	11,089.15	11	17,143.60
Neuro-epilepsy			2	3,031.64
Neurosurgery	12	36,744.85	19	67,063.49
New Born-General	2	853.40	6	2,356.93
Obstetrics-General	1	2,278.34	9	13,070.08
-Midwife			1	1,756.73
Opthalmology	1	521.25	6	4,277.67
Orthopaedic Surgery	9	10,646.52	20	55,762.51
Otolaryngology	1	2,200.76	9	6,665.00
Pediatrics-General	8	10,518.70	28	45,850.28
Neurology			1	12,175.23
Neurosurgery	1	3,222.95	3	4,244.75
Opthalmology				
Orthopaedics			2	4,635.52
Otolaryngology	1	1,702.36	2	2,080.14
Surgery Green			2	2,513.42
Surgery Orange	1	49.10	1	49.10
Surg. Transplant	1	108.31	1	108.31
Urology	3	309.04	7	9,210.09
Physical Med. & Rehab.	3	40,646.92	7	44,391.94
Psychiatry-Child	2	2,045.20	2	2,045.20
Adult	12	32,534.88	20	49,496.98
Radiology				

SECOND QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY SERVICE
Page Two

ADMITTING SERVICE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Surgery-Blue	13	11,538.13	27	97,217.23
Orange			4	1,623.34
Purple	3	3,105.67	8	9,913.97
Red	10	16,815.17	14	21,567.97
White	6	19,907.75	22	28,933.45
Therapeutic Radiology				
Urology	8	8,584.54	22	22,315.21
Unknown			14	23,012.58
Outpatient	1143	183,028.89	2493	386,880.42
Total	1303	$457,992.42	2879	$1,122,077.77
Control Accounts		220,942.02		499,007.99
GRAND TOTAL		$678,934.44		$1,621,085.76

SECOND QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY STATE

STATE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT[1]	TOTAL FSY NUMBER	TOTAL FSY AMOUNT[1]
Alabama				
Alaska	1	28.96	1	28.96
Arizona	1	21.00	4	405.83
Arkansas	2	911.20	2	911.20
California			5	1,629.86
Colorado	1	79.80	7	364.00
Connecticut	1	1,182.00	3	1,556.60
Delaware				
Dist. of Columbia				
Florida	7	530.43	9	1,047.51
Georgia			2	299.00
Hawaii			1	83.99
Idaho				
Illinois	6	4,345.89	39	60,115.16
Indiana	4	1,242.18	4	1,242.18
Iowa	7	724.58	29	15,134.25
Kansas			6	400.12
Kentucky			1	122.90
Louisiana	1	887.07	3	1,397.20
Maine				
Maryland				
Massachusetts			2	347.07
Michigan	17	16,931.87	27	26,945.67
Minnesota	1141	317,710.91	2469	688,679.09
Mississippi				
Missouri	2	2,317.01	2	2,317.01
Montana	1	1,161.80	2	3,207.36
Nebraska			1	236.34
Nevada				
New Hampshire	1	19.00	1	19.00
New Jersey			2	556.10
New Mexico			1	2,515.35
New York			2	223.21
North Carolina	12	6,973.59	13	7,071.82
North Dakota	12	5,195.10	44	20,367.75
Ohio	1	207.38	1	207.38
Oklahoma	2	1,359.91	2	1,359.91
Oregon	1	12.36	5	1,214.37
Pennsylvania	5	1,700.51	7	1,915.51
Puerto Rico				

SECOND QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS
BY STATE
Page Two

STATE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT[1]	TOTAL FSY NUMBER	TOTAL FSY AMOUNT[1]
Rhode Island				
South Carolina			1	240.92
South Dakota	21	71,055.23	51	130,457.78
Tennessee	1	2,250.00	1	2,250.00
Texas	4	1,658.82	14	5,411.44
Utah				
Vermont				
Virginia			2	84,824.39
Washington	4	1,425.65	9	2,089.74
West Virginia				
Wisconsin	43	17,827.43	90	50,477.14
Wyoming	2	182.12	2	182.12
Out-of-Country	2	50.62	12	4,222.54
Total	1303	$457,992.42	2879	$1,122,077.77
Control Accounts		220,942.02		499,007.99
GRAND TOTAL		$678,934.44		$1,621,085.76

Board of Directors

C. Wesley Eisele, M.D.
John Horty, LL.B.
Charles F. Petet, D.D.
Vergil N. Slee, M.D.
Toma C. Wilson, M.P.A.
Richard E. YaDeau, M.D.

ESTES PARK INSTITUTE
P.O. Box 400
Englewood, Colorado 80151
(303) 761-7709
(800) 223-4430 (Outside Colorado)

Where emerging issues are treated.

Estes Park Institute

Presents

THE 100TH NATIONAL

HOSPITAL MEDICAL STAFF AND TRUSTEE CONFERENCE

WILLIAMSBURG, VIRGINIA
MAY 29 - JUNE 2, 1988

What is the Estes Park Institute?

The Estes Park Institute is a non-profit educational organization dedicated to strengthening the relationships, roles and responsibilities of hospital medical staffs, governing boards and administrations. The primary mission has been and continues to be the definition of current and emerging issues that impact upon the delivery of high quality healthcare.

Estes Park Institute was incorporated on July 1, 1974. The initial purpose was to perpetuate the Hospital Medical Staff Conferences originated by C. Wesley Eisele, M.D., at Estes Park in 1964. The conferences were later offered nationally but the name of Estes Park continued to be synonymous with the conferences and therefore is incorporated into the name of the organization.

The conferences were the first to offer opportunities for physicians, administrators and trustees to meet together in pleasant surroundings and to communicate with others from across the country.

The Hospital Medical Staff and Trustee Conferences

The Estes Park Institute (EPI) has concentrated upon emerging issues in healthcare since 1964. Each year EPI offers six national four-day Hospital Medical Staff and Trustee Conferences to provide an overview on social, legal, medical and managerial trends affecting healthcare organizations. Additional focused seminars are presented on related issues. A unique founding principle among all EPI conferences is their appeal to the conjoint participation of the hospital leadership team, i.e., chief executive officers, board members and medical staff leaders. Each of the six national Conferences typically includes several hundred leaders representing as many as 80 to 100 healthcare organizations across the United States.

The core curriculum presented at these conferences is essentially the same or similar to that presented at recent prior conferences in this series. Therefore, attendance by the same individual repeatedly may be of limited value.

Williamsburg, Virginia

This is the 100th Hospital Medical Staff and Trustee Conference!

All sessions will be presented at the Williamsburg Lodge and Conference Center, located in the restored area of Colonial Williamsburg. The Rockefeller Foundation restored the historic village to its original charm as Virginia's eighteenth-century capitol. Williamsburg has many attractions, both historic and contemporary, to enjoy during the hours when the conference is not in session.

Richmond, Norfolk and Newport News are gateway cities to Williamsburg with a variety of airlines and schedules. Limousine service is available from all three airports.

Credit

The Estes Park Institute is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. These activities meet the criteria for 30 Category I credits which may be submitted to any organization that recognizes Category I credit.

Conference Founder

The founder of these Conferences is C. Wesley Eisele, M.D., President Emeritus of the Estes Park Institute. He is Emeritus Professor of Medicine and Former Associate Dean for Postgraduate Medical Education at the University of Colorado School of Medicine. He originated the annual Hospital Medical Staff Conference at Estes Park in 1964 and has presided at 99 similar conferences.

Healthcare Seminar for spouses

A Healthcare Seminar designed especially for spouses is offered in conjunction with the Hospital Medical Staff and Trustee Conferences, but not the Focused Seminars. The Spouses' session runs concurrently with the large Conference on Monday, Tuesday, and Wednesday. Topics are taken from the healthcare field and are of broad general interest. There is no fee.

Tuition and registration

Registration tends to reach capacity at an early date; therefore, application for admission should be made early. Estes Park Institute reserves the right to limit registration.

The tuition fee for the Hospital Medical Staff and Trustee Conference is $500 per person. Tuition includes a non-refundable administration fee of $50.

The refund policy is as follows:

- All cancellations must be made in writing. Cancellations received by Estes Park seven (7) or more days prior to the opening of the seminar will receive a full refund except for the registration fee of $50.
- Cancellations received by Estes Park within six (6) days of the opening of the seminar are not eligible for a refund.
- There is no refund for "no-shows".

Registrations may be transferred to other Estes Park conferences offered within 12 months provided space is available at the time. It is to the hospital's benefit to transfer or seek substitutes rather than to request cancellation.

Housing

Registrants and hospital groups are expected to make their own housing reservations unless otherwise specified.

A block of rooms has been reserved for our group. The rates range form $103 to $156 single or double occupancy and accommodations range from lodge rooms to the deluxe Williamsburg Inn. THE DEADLINE FOR HOUSING RESERVATIONS IS APRIL 28, 1988.

Conference schedule

The Conference registration will open on Sunday afternoon, May 29 from 2:00 to 5:00 p.m. From 5:00 p.m. to 7:00 p.m., a special keynote session will be presented, featuring an eminent panel of healthcare experts. Panelists include Cliff Graham, head of the British National Health Service; Uwe Reinhardt, noted health economist from Princeton University; John Iglehart, well-known author and editor, among others.

The Conference will adjourn on Thursday, June 2, 1988 at noon. In addition to the plenary sessions offered during the week, multiple concurrent sessions for instruction and discussion are presented.

A Conference symposium will be presented from 6:30 p.m. to 7:30 p.m. on Monday, May 30 so that registrants and their spouses may participate in informal conversations and exchange ideas with the faculty and other registrants.

PLEASE CONTACT KAY FUECKER

AT 626-6222 IF YOU ARE INTERESTED

IN ATTENDING THIS PROGRAM.

Some faculty members

William R. Fifer, M.D.
Minneapolis, Minnesota
Sandra L. Gill
Westmont, Illinois
Hugh P. Greeley
Salem, Wisconsin
John Horty, LL.B.
Pittsburgh, Pennsylvania
Leland R. Kaiser, Ph.D.
Denver, Colorado
Spence Meighan, M.D.
Portland, Oregon
Jeffrey O'Connell, J.D.
Charlottesville, Virginia
Vergil N. Slee, M.D.
Brevard, North Carolina
Eric W. Springer, LL.B.
Pittsburgh, Pennsylvania
Richard E. YaDeau, M.D.
St. Paul, Minnesota

Some topics to be considered

Here Comes "Quality" Again
Accessing Capital
Health Care Costs
Medical Staff Bylaws
Emerging Antitrust Issues
Board, Medical Staff and Administrative Relationships
Performance-Based Physician Credentialing
Alternative Delivery Systems
Innovation in the Hospital
Techniques for Responsible Governance
The JCAH Medical Staff Standards
The Evolving Relationship of Doctors and Hospitals
Hospital and Physician Liability
Risk Management
CEO Contracts
Strategic Planning
Malpractice Issues

11th Annual AHA Trustee Forum

Health Care at the Crossroads:

Challenge to Hospital Governance

June 2-4, 1988
San Francisco, California

American Hospital Association

AHA

In cooperation with *Trustee*,
the magazine for hospital governing boards and the
California Association of Hospitals and Health Systems

Developed under the leadership of the
National Congress of Hospital Governing Boards

Health Care at the Crossroads: Challenge to Hospital Governance

Never before has the need for clear, decisive, and powerful action on the part of trustees been more needed than today. Hospitals are under tremendous strains from economic restrictions, industry-restructuring alternate delivery systems, competition, manpower shortages, taxation threats, new disease entities like AIDS, and continuingly restrictive legislation at both the state and federal levels.

In order to deal with this almost crushing agenda, individual trustees and boards as a whole must function at the highest possible level. In solving economic problems, trustees are needed to guard the values and integrity of their institutions. In dealing with taxation, manpower shortages, and legislation at the state and local levels, only the clear and present voice of trustees can communicate the issues and essential messages of the hospital community.

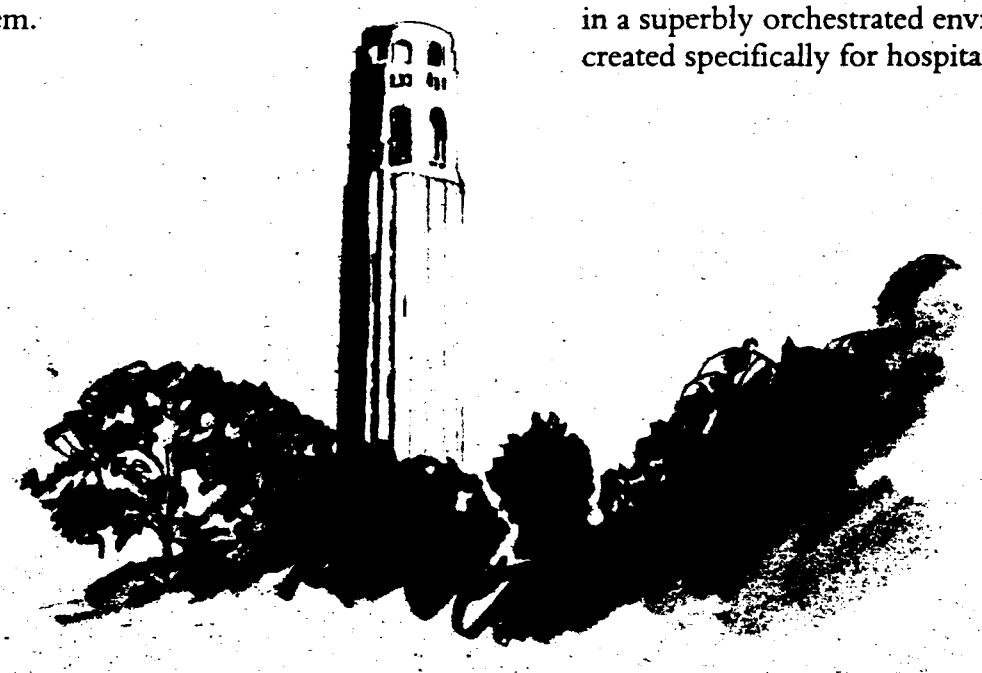
This year's program has been carefully designed to deal with the most critical and pressing issues confronting trustees. It also provides several outstanding sessions that deal with the organization of hospital governing boards so that they will be in a powerful position to respond to the increasing demands of trusteeship. This program will be one of the most powerful opportunities available this year to chief executives, trustees, and physician leaders to confront the most pressing health care issues and determine how to address them.

Who Should Attend?

The Forum is primarily designed for hospital trustees. However, teams of trustees, senior administrative officers, and physician leaders are encouraged to attend. The issues and concerns of these three groups are so closely intertwined that working and learning together at a conference such as the Trustee Forum can be a tremendous aid toward implementing change when the team returns to their institution.

Special Program Features

1. Five plenary sessions featuring distinguished speakers
2. Eight workshops covering critical issues and essential skills
3. Five sightseeing tours for spouses and participants and a vacation package
4. An opportunity for dialogue with outstanding trustees from throughout the country
5. San Francisco in the Spring and the amenities of the Meridien Hotel
6. An extensive conference materials package
7. Special Event: An Exploratorium reception, evening of entertainment and hors d'oeuvres as dinner exclusively for Forum attendees and their guests
8. A truly outstanding opportunity to learn from peers and some of the nation's leading experts in the development of health policy in a superbly orchestrated environment, created specifically for hospital trustees



Program Schedule

Wednesday, June 1, 1988

5:00 p.m.-7:00 p.m.
Early Registration and Reception

Dinner and evening on own

Thursday, June 2, 1988

9:00 a.m.-11:00 a.m.
Registration and Informal Discussion Groups

11:00 a.m.-12:30 p.m.
Opening Keynote Session

"The Aging of America: Implications for American Hospitals"
Ken Dychtwald, Ph.D.

12:30 p.m.-1:45 p.m.
Lunch

1:45 p.m.-3:15 p.m.
Workshops, Round 1

3:15 p.m.-3:30 p.m.
Break

3:30 p.m.-5:00 p.m.
Workshops, Round 2

6:15 p.m.
Leave for Exploratorium Special Event: Reception, dinner, and entertainment

Friday, June 3, 1988

7:30 a.m.-8:30 a.m.
Continental Breakfast

8:30 a.m.-10:00 a.m.
Opening Plenary Session

"National Health Policy: Do Lemons Still Make Lemonade?"
Faculty: Carol M. McCarthy, J.D., Ph.D.

10:00 a.m.-10:15 a.m.
Break

10:15 a.m.-11:45 a.m.
Workshops, Round 3

11:45 a.m.-1:45 p.m.
Lunch and Presentation

"Transplantation and High-Tech Medicine: A Personal Perspective and Implications for Governance"
Faculty: Monsignor Andrew J. McGowan

1:45 p.m.-3:15 p.m.
Workshops, Round 4

3:15 p.m.-3:30 p.m.
Break

3:30 p.m.-5:00 p.m.
Plenary Session

"AIDS—Dealing with the Growing Epidemic"
Faculty: Mervyn F. Silverman, M.D., M.P.H.

5:30 p.m.
Reception

Evening and dinner on own

Saturday, June 4, 1988

7:30 a.m.-8:30 a.m.
Continental Breakfast

8:30 a.m.-10:00 a.m.
Workshops, Round 5

10:00 a.m.-10:15 a.m.
Break

10:15 a.m.-11:30 a.m.
Closing Plenary Session

"Working with Government and Getting Your Message Across"
Faculty: Senator J. Glenn Beall, Jr.

11:30 a.m.
Evaluation and Closing Comments

12:00 p.m.
Conference Concludes

Plenary Session

"The Aging of America: Implications for American Hospitals"

For the first time in history, our demographic composition is shifting from a population of young people to one of middle-aged and older adults. This transition will radically reshape how hospitals deliver care and the kind of care they deliver. This presentation will review the dramatic effects of the aging of America and its impact on the delivery of care. Content will include emerging health care technologies, predictions regarding future health care services for the aged, and key strategies and technologies for meeting the unique needs of the emerging American "gerontocracy."

Ken Dychtwald, Ph.D., is a psychologist, gerontologist, lecturer, author, and outspoken figure in the field of human aging, health promotion, and high performance behavior. He is widely viewed as the nation's leading authority on the social, economic, and lifestyle implications of the aging of America. He is the founder and president of Age Wave. Dr. Dychtwald frequently appears on national television and radio shows throughout North America. His publications include *Bodymind, Millennium: Glimpses Into the 21st Century, The Keys to a Healthy Lifestyle, Wellness and Health Promotion for the Elderly, The Role of the Hospital in an Aging Society,* and forthcoming, *The Age Wave.*

"Influencing National Health Care Policy: Do Lemons Still Make Lemonade?"

Hospitals increasingly face an uncertain, changeable environment in which to deliver care. How will financing and delivery change over the next few years? How will hospitals react and how will trustees help hospitals and communities maintain high quality, accessible care? Dr. McCarthy will look at current and prospective national health policy issues and the expanding role of trustees in shaping the ever-changing health care environment.

Carol M. McCarthy, Ph.D., J.D., is president of the American Hospital Association. Prior to that she served as president of the Massachusetts Hospital Association, president of the Delaware Valley Hospital Council in Philadelphia, and executive vice-president and chief executive officer of the Association of Hospitals, Long Island, New York. Dr. McCarthy holds a master's degree in Health Services Administration, a Ph.D. with a concentration in Health Care Economics, and a law degree. She has authored numerous articles on health and hospital service and is well-versed in areas of health care administration, planning, finance, and policy.

"AIDS: Dealing with the Growing Epidemic"

AIDS is one of the most frightening diseases that modern health care has had to deal with. What is the prognosis for the spread of the disease and what is the most powerful role for hospitals to take as the epidemic unfolds? This session will provide an update regarding demographics of the disease and will look at critical questions, such as the role of the hospital as coordinator of comprehensive care in the community. The program will address the need to provide a continuum of care in the most economical, efficient, and humane manner, using inpatient, outpatient, and home care resources. Dr. Silverman will discuss the San Francisco model, which is now being replicated in the Robert Wood Johnson Foundation's AIDS Health Services program. The program will also address what information trustees should be reviewing regarding AIDS treatment, policies, and procedures within their own institutions.

Mervyn F. Silverman, M.D., M.P.H., is one of the nation's leading experts in public health and the battle against AIDS. Dr. Silverman is currently director of the Robert Wood Johnson Foundation's AIDS program and president of the American Foundation for AIDS research. Prior to his present position, Dr. Silverman was director of the San Francisco Department of Health, a position he held for eight years. During his tenure, Silverman was instrumental in launching San Francisco's program to combat the growing AIDS epidemic. The program soon became a model for others to follow.

Plenary Sessions

"Working with Government and Getting Your Message Across"

Never has there been a greater need for hospitals to be heard with a clear voice in the formation of law and policy at both the federal and state levels. In this session Senator Beall will relate his experience on what it takes to get the hospital's message across to legislators and governments. He brings the unique perspective of serving as a United States Senator, a member of the United States House of Representatives, and a state senator from Maryland. The program will focus on ways that trustees can ensure that legislators understand their position and the mission of the hospital. Beall will discuss the need for hospitals to be seen as ethical institutions that have positive images in the community. Methods will be discussed for working with state and federal legislatures to help ensure that hospitals will be heard and understood.

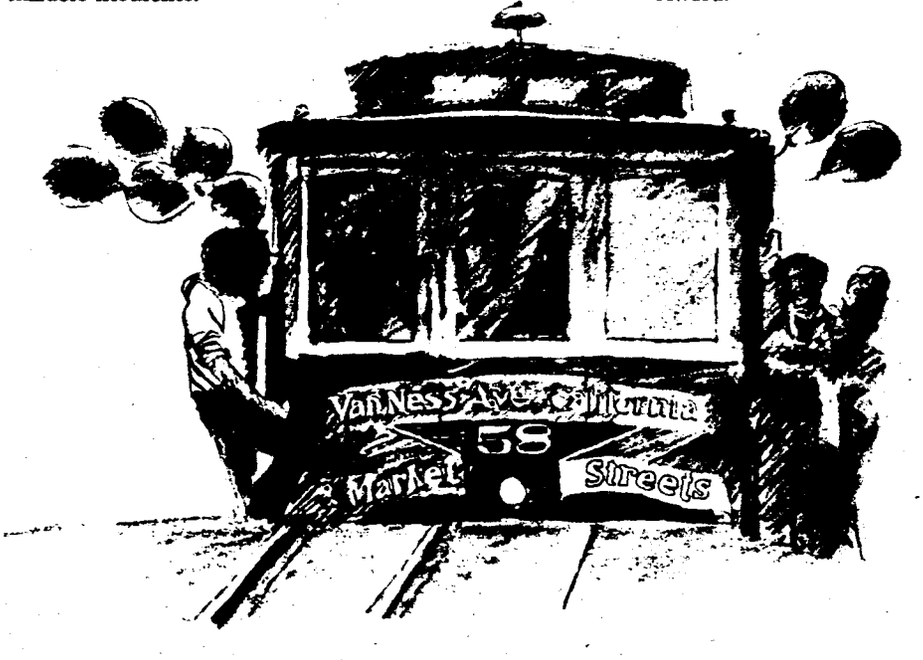
Senator J. Glenn Beall, Jr. is a former United States Senator from Maryland. He also served as a member of the U.S. House of Representatives and the Maryland General Assembly. Senator Beall served for nearly 20 years on the Lay Advisory Board of Sacred Heart Hospital in Cumberland, Maryland. He is currently serving his third term as chairman of the Maryland Hospital Association Board of Trustees. The Association's board is composed of hospital trustees drawn from its 68-member community acute care and specialty hospitals. He has served on the boards of dozens of civic and business groups and is currently a director of the Maryland Chamber of Commerce and the Allegheny Region of the First National Bank of Maryland.

Luncheon Presentation

"Transplantation and High-Tech Medicine: A Personal Perspective and Implications for Governance"

William C. McGowan, Chairman, founder, and Chief Executive Officer of MCI, Incorporated, was deathly ill with a condition that could be successfully treated only by a heart transplant. His brother, Monsignor Andrew McGowan, a hospital trustee, will share with us the experiences of William McGowan and his family in having to wait for a heart. Father McGowan's talk will include how hospitals participate in organ donation programs and the need for improved understanding, systems, and policies to govern and manage transplantation processes. He will also speak specifically to the role that trustees can play within the context of "miracle medicine."

Monsignor Andrew J. McGowan is director of community relations, Mercy Hospital, Scranton, Pennsylvania; diocesan director of community affairs, and director of Catholic Health Care Facilities and Catholic Institutions of Higher Learning. He has extensive experience as a trustee in hospitals and educaitonal settings, including having served as vice-chairman and chairman of several boards. Monsignor McGowan was Chairman of the Hospital Trustee Association of Pennsylvania, of which he is currently a member. He is the recipient of a number of awards, including the Hospital Association of Pennsylvania's Distinguished Service Award.



"The Effective Management of Hospital Boards"

Outstanding hospitals boards have some common characteristics. They have a sense of strategic mission, use outside experts when it's called for, give support to their administrative structure, act decisively, assure quality of care, understand and monitor the organizations's values, exert influence outside of the hospital, and review their own performance. In order to achieve board excellence, boards have to have excellence as a goal and know how to develop and monitor essential functions. This session will explore what factors lead to outstanding boards. The session will also help participants to evaluate the effectiveness of their own board and to identify steps that can be taken to strengthen their board's impact.

Barry S. Bader is president of Bader and Associates, Inc. He is a consultant and author specializing in hospital governance and quality assurance. Since founding his own firm in 1980, he has worked with more than 100 hospitals and health systems. Much of his work focuses on governing board self-evaluation, board retreats, TAP relations bylaws, and the development of governing board manuals. Bader numbers among his trustee publications *The Three Waves of Change: Hospital Board Responsibility in the New Healthcare Environment*, 1986, *The Complete Guide to Self-Evaluation of Hospital Governing Boards, The Trustee Resource Book—What Hospital Board Members Need to Know About Prospective Pricing*, and *Keys to Better Hospital Governance through Better Information.*

"Indicators of Hospitals in Distress and What You Can Do About It"

The focus of this workshop will be to provide an overview of how a hospital board can assess and govern an institution in distress. The session will review key financial indicators, the organization's culture, and its operating and regulatory environment. Also, this session will take a look at strategic options for improving performance, such as affiliations, incentive programs, conversions, partnerships, and downsizing. Selling or closing a facility and seeking protection under Chapter 11 will also be briefly reviewed. Finally, the issue of establishing board priorities under pressure while keeping and gaining committed trustees will be reviewed.

Michael F. Anthony is senior vice-president of legal affairs for the American Hospital Association. In this position, he is responsible for the Association's divisions of corporate legal affairs and legal advocacy, as well as for the American Academy of Hospital Attorneys. Mr. Anthony joined AHA in 1987. In previous positions he served as a hospital administrator at The Johns Hopkins Hospital and its affiliate, the Henry Phipps Psychiatric Clinic in Baltimore, and as partner in charge of the Chicago health law department for the law firm of McDermott, Will, and Emery. He received bachelor's and master's degrees from Xavier University, Cincinnati, Ohio, and his J.D. from the University of Baltimore School of Law.

Robert H. Rosenfield, LL.D., LL.M. is a partner in the Los Angeles office of McDermott, Will, and Emery. Mr. Rosenfield was recently identified as one of the prominent health care attorneys in the United States in a survey conducted by the National Law Journal. His practice has specialized in areas such as hospital-physician joint ventures, new legal structures, venture capital companies, hospital-affiliated group practices, physician employment relationships, and physician incentive programs. Rosenfield received his LL.D. degree from Harvard Law School and his LL.M. degree from the London School of Economics and Political Science.

"The Board's Role in Assuring Quality"

Attention is being increasingly focused on the crucial role of hospital governing boards in assuring the provision of high-quality care. This session will provide a comprehensive overview of the board's critical role in quality assurance. It will examine the quality assurance process, the board's role in that process, and the type of quality-related information the board should receive and review. How the board can use quality assurance processes and information to determine what constitutes quality and how quality can be evaluated, maintained, and improved in their hospitals will also be covered.

James E. Orlikoff is director of the Division of Hospital Governance of the American Hospital Association and Director of the Institute on Quality of Care and Patterns of Practice of the AHA's Hospital Research and Educational Trust. Prior to his current position, he was an independent consultant in the area of quality assurance and risk management. Mr. Orlikoff has been involved in quality assurance issues for more than 10 years. He has designed and implemented hospital quality assurance programs in four countries and since 1985 has been working with hospital governing boards to strengthen their involvement in and oversight of the quality assurance process. He is the primary author of the AHA book, *Malpractice Prevention and Liability Control for Hospitals.*

"Nursing and Other Manpower Shortages: A Flash in the Pan or Here to Stay?"

The shortage of nursing and other clinical manpower nationally has become a dramatic problem. It has forced hospitals to close wings, reduce services, transfer patients, and otherwise curtail their capability to deliver care. Just how bad is the problem and will it get better or worse? What's at the root of the problem? How are hospitals coping? What strategies are working? What can we expect in the next few years and beyond? These questions and others will be explored in depth along with key information that boards should be monitoring in their own institutions.

Elizabeth J. Kurzcynski, R.N., D.N.S., is corporate director of nursing—Pacific Division, Sutter Health Systems, Sacramento, CA. She has held a wide range of clinical and nursing management positions, including charge nurse, assistant head nurse, head nurse, and assistant and associate director of nursing. She received her Doctor of Nursing Science degree from the University of California, San Francisco in 1977. Kurzcynski has a diverse background that includes responsibility for organizational restructuring, work with multihospital systems, reorganization of nursing divisions, the development and marketing of new hospital services, and the development of quality assurance systems.

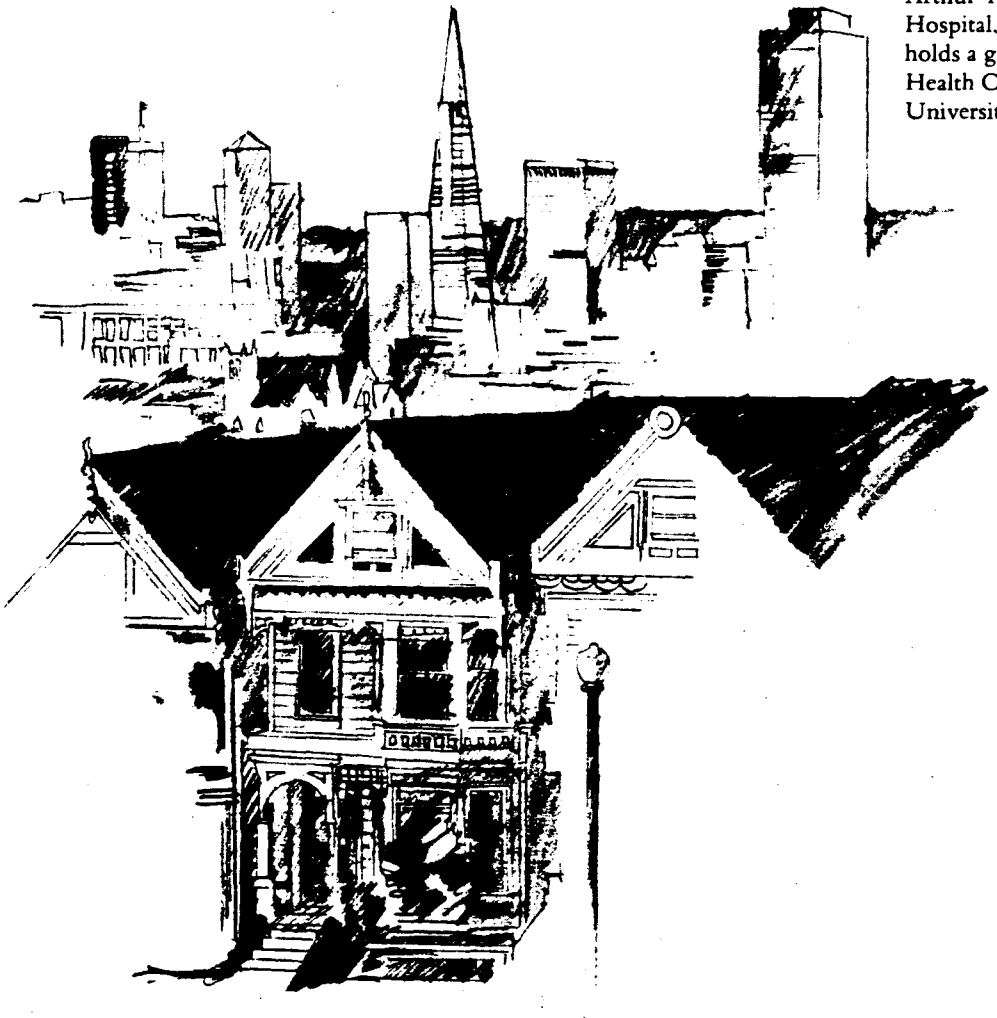
Karen Logsdon, R.N., M.N.A., is senior vice-president for the California Association of Hospitals and Health Systems. She is responsible for managing issues related to a variety of clinical, medical staff, human resources, and other areas. Her clinical background includes intensive care, emergency, coronary, and public health nursing. She has served in senior executive positions within hospitals and as President of the California Society of Nursing Services Administrators. She holds a master's degree in Nursing Administration from the University of California, San Francisco, where she also serves as assistant professor.

"CEO Evaluation, Incentives, Contracts, and Compensation: Or the Care and Feeding of Chief Executive Officers"

As the health care environment becomes increasingly complex and difficult, organizational leadership is more important than ever before. The chief executive is key to the success of any organization in a fast-paced environment. This seminar will focus on how to appraise chief executive officer performance, as well as how to use compensation, fringe benefits, and incentives effectively. It will demonstrate how an integrated, carefully designed package will help retain and provide security to executive officers, while spurring them to greater achievement and leadership. The role of executive contracts will also be discussed.

J. Pierce Culver III is vice-president of the Croner Company. Mr. Culver is in charge of the firm's health caer consulting practice and focuses in such areas as executive incentives and physician-based compensation for not-for-profit hospitals. Prior to his work with the Croner Company, Mr. Culver was a manager at Arthur Young and Company. He is a frequent seminar presenter and has written most recently with emphasis on incentive plans, physician compensation, and hospital executive attitudes and outlooks. Mr. Culver holds an M.B.A. from the Harvard Graduate School of Business.

James N. Heuerman is managing vice-president of Corn/Ferry International's Health Care practice. Prior to joining this firm he was vice-president and partner of Booz, Allen & Hamilton, where he was responsible for their health care consulting practice in the western United States. While with Booz, Allen & Hamilton, he worked extensively with boards, senior management, and physicians in areas of strategic planning, organizational structure, and staffing. He has also held positions with Arthur Young & Co., IBM, Evanston Hospital, and Fairview Hospital. He holds a graduate degree in Hospital and Health Care Administration from the University of Minnesota.

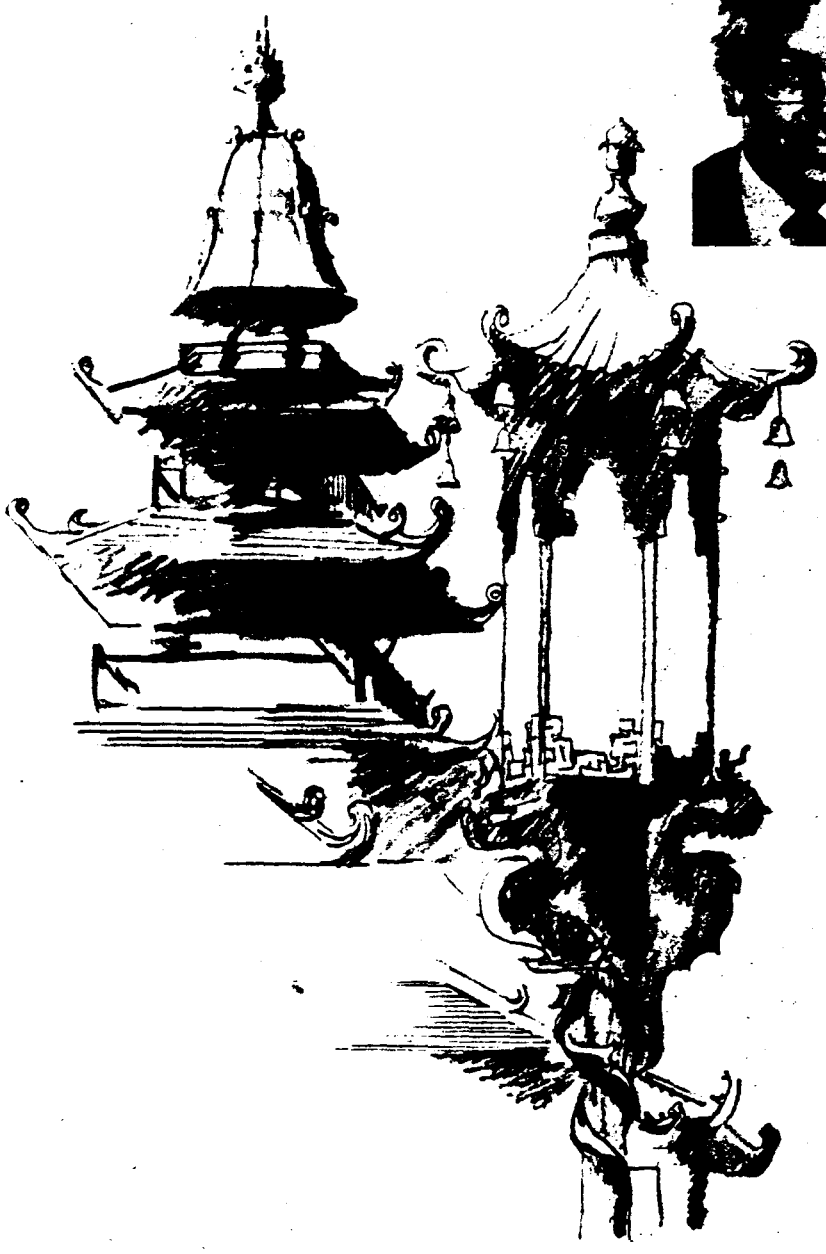


"Taxation of Not-for-Profit Hospitals"

n recent years a number of states have aggressively attempted to tax not-for-profit hospitals. This reverses the law prevailing in every state for a century or more, during which not-for-profit hospials were deemed to be charitable and, therefore, exempt from taxes. Utah was the first jurisdiction to strike out on this new course. Others have followed across the country with varying degrees of success. The issue of taxation, even in states whre ithas not become an active topic of conversation, requires that hospitals re-examine a number of curcial elements, inlcuding their role in the community, the role of volunteer trustees, the structure of business enterprises to the hospital, and the institution's relationship with local, state, and national officials. The program will review the threat to and case for the charitable exemption in light of modern health care realities.

Douglas John Hammer, J.D., is vice-president and general counsel of Intermountain Healthcare, Inc., a multi-hospital system. He has worked extensivelyt in Utah on the property tax issue over the last six years. His experience in this matter inludes work with the Utah Supreme Court, the Utah State Tax Commission, the Utah State Legislature, a public referendum, and 12 county boards of equalization. Hammer is also clinical assistant professor at the University of Utah, and adjunct professor at Brigham Young University and Webster State College. He received his Juris Doctor degree from the University of Utah in 1976.

Alan L. Sullivan, J.D., is a partner in the Salt Lake City law firm of Van Cott, Bagley, Cornwall & McCarthy. Mr. Sullivan clerked for the Honorable David T. Lewis, Chief Judge of the United States Court of Appeals for the Tenth Circuit. He has represented the Hospitals of Intermountain Health Care, Inc. for eight years in their disputes relating to property tax exemption. He presently serves as chairman of the Utah Supreme Court Advisory Committee on Civil Procedure and is a member of the Utah Administrative Law Advisory Committee. Mr. Sullivan is a graduate of Columbia University with honors and the University of Utah Law School.



Workshops

"Alternate Delivery Systems"

Alternate delivery systems, such as HMOs and PPOs, have grown at a rate that few in the industry could have predicted. Changes in the type, form, distribution, and importance of HMOs have dramatically altered since 1980. This program will review the impact of HMOs on hospitals and will include how a board can evaluate the profitability, quality, product design, and structure of an alternate delivery system with which it is seeking to affiliate. The program will also review the impact alternative health systems have had on physician behavior and the relationship of physicians to hospitals. The development of physician-hospital organizations and the roles they are beginning to play will be presented. A summary of the main trends in the managed care industry and their likely impact on hospitals of varying sizes and geographic locations will also be discussed.

Gail L. Warden is currently president and chief executive officer of Group Health Cooperative of Puget Sound, the largest health maintenance organization in the northwest United States. He has recently been appointed president and chief executive officer of Henry Ford Healthcare Corporation in Detroit and will assumes those duties in April. Mr. Warden serves as chairman-elect of the Governing Council of the membership section for multihospital systems of AHA and is a member of the board of the Group Health Association of America, where he chairs three of its operating committees. Prior to joining Group Health Cooperative, he was executive vice-president of the American Hospital Association. Mr. Warden has also been executive vice-president of Rush Presbyterian St. Luke's Medical Center in Chicago.

"For New Trustees: A Political and Environmental Briefing"

Radical change in the last 10 years has virtually reshaped the health care industry. These changes have included the restructuring of reimbursement systems, the development of multihospital systems, more competition and regulation, growth in for-profit health care, development of horizontal and vertical health care corporations, hospital closings and downsizings, physicians' strikes, and dramatic advances in life-sustaining technology. This session is specifically designed for new trustees and will introduce them to the structure of the health care industry, basic reimbursement issues, and other factors driving health care.

C. Duane Dauner is president and chief executive officer of the California Association of Hospitals and Health Systems. Prior to joining CAHHS, he was president of the Missouri Hospital Association. He has been active in both the American Hospital Association and the American Association of Health Care Executives. Mr. Dauner currently serves as chairman of the AHA Political Action Committee and as a member of the ACHE Public Policy Committee. He has served as assistant professor at Washburn University, Topeka, Kansas.

Special Event—An Exploratorium Evening for Conference Participants and Their Guests

The Exploratorium: Hors d'oeuvre dinner, ntertainment, and reception

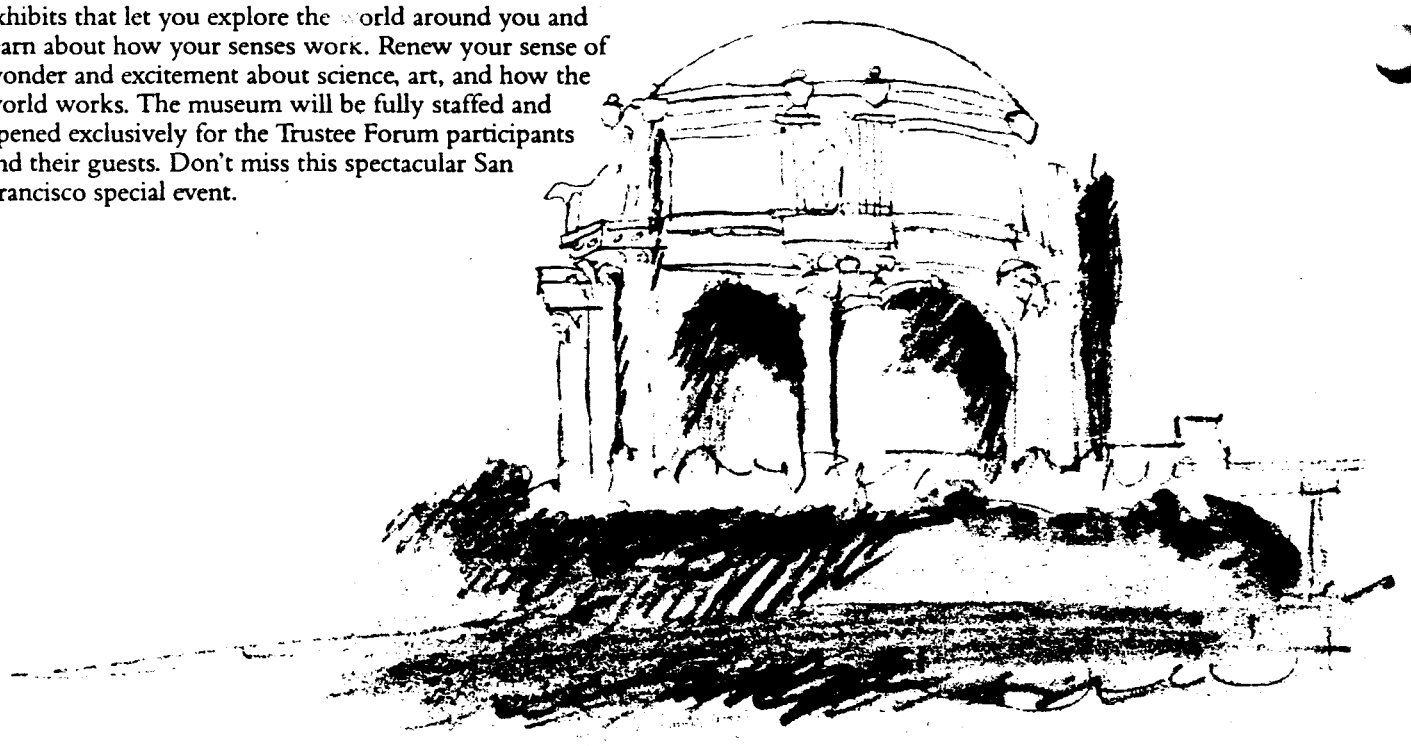
Thursday, June 2, 1988
6:15-9:30 p.m.

The Trustee Forum participants and their guests will have a unique opportunity to explore "one of the best science museums in the world." The Exploratorium is located in San Francisco's wondrous Palace of Fine Arts, which was created for the 1915 Panama-Pacific International Exposition. The architectural theme is a Roman ruin. This magnificent edifice alone is one of San Francisco's sites that must not be missed, but there is much more.

You will be transported to and from the hotel by motor coach and will enjoy a buffet-hors d'oeuvre dinner, which will include country ham, Mediterranean chicken, roast turkey, torta rustica, crab tortellini, and fabulous desserts. You will be entertained by a band featuring the renowned vocalist Morning Nichols, who will have guests dancing to show tunes and musical hits.

This hands-on museum of science, art, and technology is based on the theme of human perception, including light, sound, hearing, touch, and smell. The museum demonstrates that in nature there is no sharp edge between science and art. There are more than 600 exhibits that let you explore the world around you and learn about how your senses work. Renew your sense of wonder and excitement about science, art, and how the world works. The museum will be fully staffed and opened exclusively for the Trustee Forum participants and their guests. Don't miss this spectacular San Francisco special event.

Fee: $65 per person. This special event is not included in the program registration fee. To participate in this special event, please check off the appropriate location on the registration form.



Spouse Events, Special Tours, and Wine Country Weekend

1. San Francisco City Tour
Thursday, June 2, 1988, 1:00-4:30 p.m.

Come along! Learn what makes San Francisco what it is: a mosaic of cities within a city. Travel by deluxe motor coach through the Spanish Settlement, Chinatown, Italy's North Beach, and Japantown. View the luxury of Nob Hill and the Financial District. Visit Golden Gate Park with its more than one thousand acres of nature and some of the finest museums in the West. And finally, circle the city via the waterfront prior to returning to your hotel. **Fee: $18 per person.**

2. Muir Woods/Sausalito Excursion
Friday, June 3, 1988, 10:00 a.m.-3:30 p.m.

Our excursion will take you to two of Marin County's most attractive locations: Muir Woods National Monument and the village of Sausalito. You will travel by motor coach to Muir Woods, a 550-acre preserve of California coastal redwoods, where ample opportunity will be provided for a self-guided walk. Then visit Sausalito, an old fishing town and quaint artists' colony perched on the edge of the bay. You will lunch on your own at any of the charming restaurants, cafes, or delis in this riviera-like atmosphere. Ample time will be provided for shopping, browsing, and exploring the town on your own. When you are through shopping, you will return to San Francisco by bus. **Fee: $19 per person.**

3. Chinatown Walking Tour
Friday, June 3, 1988, 1:00-4:00 p.m.

A closeup experience of San Francisco's fabled Chinatown, the largest Chinese settlement outside of China. You will arrive at Chinatown by motor coach for a guided walking tour in groups of 10 to 12 people, each led by an experienced tour guide. The tour takes you along Grant Avenue where you will explore the back alleys that make up the heart of this fascinating community. You will see and selectively visit gift shops, jewelry stores, fine Chinese restaurants, herb pharmacists, acupuncturists, and shops filled with fine silks and jade. Then, on to Waverly Place and Ross Alley where you will stop along the way for tea and cookies. After your small group walking tour, you will return to the hotel by motor coach. **Fee: $25 per person.**

4. San Francisco Bay Cruise and Tiburon Dinner
Friday, June 3, 1988—Departs from hotel 6:45 p.m.
(This tour is limited to 55 participants, so those wishing to participate should register early.)

You will leave your hotel by motor coach and go to the historic ferry building where you will board a high-speed catamaran for a scenic 20-minute ride across San Francisco Bay. You will dine in one of Tiburon's exclusive restaurants on the bay and select from a menu of steak, fresh red snapper, or sesame chicken. After dinner a deluxe motor coach will drive through the colorful artists' colony of Sausalito, returning to San Francisco via the famous Golden Gate Bridge for another breathtaking view of the city. You continue along quaint Union Street with it restored Victorian homes and elegant boutiques. To complete this evening, your motor coach will wind its way through the Italian neighborhood of North Beach as you return to your hotel. **Fee: $50 per person.**

5. Alcatraz
Saturday, June 4, 1988—12:45-4:30 p.m.

You will depart the hotel via motor coach. Your tour guide will give you basic information and background about one of San Francisco's most unique attractions, Alcatraz Island. Upon arrival at Pier 44, you will board your ferryboat for the short trip to the island, site of the notorious federal prison. Your tour guide will conduct you on this educational and entertaining walking tour of the island. Inside the main cell block, National Park Service personnel will relate stories of the island. Before returning to the mainland, you may visit the museum slide show and gift shop. Upon arriving back at Pier 44, you may return to your hotel via motor coach, or you may wish to linger to browse and shop at Fisherman's Wharf. **Fee: $22 per person.**

6. Wine Country Weekend Tour
Saturday, June 4, 1988—Depart at 1:15 p.m.
Return Sunday, June 5, 1988 at 4:00 p.m.
(This tour is limited to 50 participants, so those wishing to participate should register early.)

You will travel by motor coach through the rolling hills of Marin and Sonoma Counties to the fertile Napa Valley vineyards. As you travel through the valley, the vineyards will stretch as far as your eye can see. Your first winery visit and tasting will be at the Gloria Ferrer Champagne Cellars. A late afternoon stop is also planned at historic Sonoma Plaza, cradle of California independence and site of the Bear Flag Revolt of June 1846. Then it's on to Napa Valley for your overnight stay and dinner at the Embassy Suites Hotel. A prime rib dinner will be served to all guests in the hotel's Fireplace Room. You will start Sunday with a leisurely complimentary full breakfast. Then, after checking out of the hotel, you will have a private visit to one of Napa Valleys' prestigious and historic wineries. Following your winery visit, you will travel by motor coach to Vintage 1870, a unique collection of restaurants, specialty, crafts and antique shops, where you will have lunch on your own and an opportunity to browse. Your motor coach will then travel back to San Francisco via the East Bay. Return to San Francisco will be at 4:00 p.m. on Sunday. **Fee: $165 double occupancy; $135 single occupancy.** Fee includes transportation, hotel (based on double occupancy), complimentary cocktails, full breakfast and dinner, two wine tastings, tour guide, and tax and gratuities. The tour bus, upon returning to San Francisco, will drop tour participants at either the Meridien Hotel or the San Francisco International Airport.

General Information

Fees

$495—AHA institutional and personal members
750—Nonmembers
$445—Additional registrant from the same member institution
$700—Additional registrant from the same nonmember institution

Fee includes three continental breakfasts, two luncheons, two hosted receptions, and comprehensive program materials.

How to register

Complete the attached registration form and mail it, with your check, to the American Hospital Association/ITS P.O. Box 825, Deerfield, IL 60015. Or register by phone by calling 312/940-2138.

All phone registrations must be charged to VISA, MasterCard, or American Express. When calling in a registration, please have the meeting code number #8509 available.

Hotel Accommodation

Meridien Hotel
53rd Street
San Francisco, CA 94103
415/974-6400
Single and Double—$130

A block of rooms at special rates has been reserved for this program. These rooms will be held until May 5 at the special rate. After that time, reservations will be accepted on a space availability basis. To ensure your accommodations, complete and mail the hotel reservation form below today. If you register by telephone, in order to receive the special conference rate, you must identify yourself as registering for the American Hospital Association Trustee Forum.

Discounted Air Transportation

Special discounted fares on United and Delta Airlines are available through International Travel Service (ITS), the AHA's official travel coordinator. For information and reservations, call ITS toll-free at 800/621-1083 (in Illinois, 312/940-1176) between 9 a.m. and 5 p.m. CDT Monday through Friday. Please give the event number to the sales agent to expedite your call.

Registrants booking air fare on the special 40% convention air discount will obtain full refund if the meeting is cancelled. Registrants who purchase restrictive fares are responsible for all penalties, whether they are the result of personal changes or of the cancellation of the meeting.

PLEASE CONTACT KAY FUECKER

AT 626-6222 IF YOU ARE INTERESTED

IN ATTENDING THIS PROGRAM.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUARTERLY REPORT TO THE BOARD OF REGENTS

MARCH 11, 1988

INTRODUCTION:

Chairman Lebedoff, President Keller, members of the Board of Regents, I am pleased to briefly highlight activities at The University of Minnesota Hospital and Clinic during the months of December, 1987 through February, 1988.

COMMUNITY UNIVERSITY HEALTH CARE CENTER:

The Community University Health Care Center (CUHCC) was established by the University of Minnesota in 1966 and became a satellite clinic of The University of Minnesota Hospital and Clinic in June, 1984. CUHCC provides primary medical, dental and mental health services to a low income population in south Minneapolis.

The building in which CUHCC is housed is in poor condition. The Board of Governors devoted a considerable amount of time discussing CUHCC's mission, service offerings, role in educating medical professionals, facility needs,

and financial position. We also evaluated our commitment to caring for this low income population.

In conclusion, we renewed our commitment to CUHCC's program and mission and will be recommending the replacement of the CUHCC building to you this month.

TECHNOLOGY UPDATE:

In December, 1987, the Board of Governors approved the acquisition of a second Magnetic Resonance Imaging unit for the Hospital. As you know, magnetic resonance imaging is a noninvasive diagnostic imaging technique that is used to obtain images of body tissues and monitor body chemistry without the use of ionizing radiation.

The Hospital first acquired a MRI unit in 1984. The technology quickly became an important method for imaging the brain, brain stem and spinal cord. Ten MRI exams are done, on average, each day. An exam takes 60-90 minutes to complete so that the machine is operational 12-14 hours per day. About 80% of the current exams are of the brain and spine. A second unit will allow physicians to employ this imaging technique in several other important areas.

The Board is also keeping abreast of changing lithotripsy technology. The Hospital first acquired an extracorporeal shock wave lithotripter in 1985. The lithotripter sends carefully calibrated and directed shock waves at kidney stones to disintegrate the stones so that they may be passed easily. At the inception of the program we had anticipated 300 kidney stone lithotripsy cases

a year. Volumes have met or exceeded original projections. This experience was shared by most hospitals who acquired kidney stone lithotripters.

The Food and Drug Administration (FDA) is currently being asked to approve clinical trials using lithotripsy to treat gall stones. Biliary lithotripsy will be an important new technology and the Hospital is actively exploring the potential acquisition of a biliary lithotripter.

TRANSPLANTATION:

You may have read in early December that two of our very well known transplant surgeons left The University of Minnesota Hospital and Clinic. Dr. Nancy Ascher, best known for her liver transplant work, went to the University of California at San Francisco. Dr. Steves Ring, best known for heart transplantation, went to the University of Texas Southwestern Medical Center at Dallas. Both physicians are a loss to our Hospital but we are extremely proud of the fact that they will both be directing transplant programs at these centers.

The talent and leadership among our physicians, both tenured and newly recruited, allows us to anticipate that the University of Minnesota Transplant Program will continue to thrive. University surgeons have been transplanting human organs for nearly three decades. In that time, the following transplants have been done: 2,693 kidney transplants, 2,400 corneas, 841 bone marrow transplants, 211 pancreas transplants, 148 livers and 148 heart

transplants and 5 heart-lung transplants. On January 1, 1988 a Plymouth man became the first person to undergo a double lung transplant at The University of Minnesota Hospital and Clinic. The patient is at home now and continues to do well.

VALIDATION SURVEY:

In early February, 1988, an eight member survey team from the Minnesota Department of Health conducted a comprehensive review of our Hospital. This was an unusual event in that we are customarily surveyed by an independent accreditation agency for hospitals, the Joint Commission on Accreditation of Healthcare Organizations, rather than the State Department of Health. The federal government does, however, ask state departments of health to survey a small random sampling of hospitals each year as a way of verifying Joint Commission survey findings.

The team spent four days inspecting our facilities, reading policies and records, observing staff at work, and even interviewing patients. Official findings are expected shortly. The preliminary verbal report was generally positive and, on balance, the suggestions for improvement were useful.

UTILIZATION LEVELS:

Through Janaury, 1988 the Hospital's admissions were approximately 4% over budget (11,123 actual versus 10,700 budgeted admissions). We are also pleased that we have been able to reduce our average length of stay by almost 6%

during this same time period. Although a shorter length of stay resulted in patient days being slightly below budget, this improvement in efficiency is an important change under the admissions oriented reimbursement system. Outpatient visits for the first 7 months of this year are approximately 1.5% above budget (149,080 actual versus 147,022 budgeted).

SELF-EVALUATION SURVEY FINDINGS:

In December, 1987, the Board of Governors conducted its third annual self-evaluation. A 27 question survey solicited feedback from Board members in three general areas: assessment of structure and composition, assessment of process, and assessment of performance. The responses were positive, but there were also several constructive suggestions for improvement. For example, the Board wants to continue to explore how it can better appreciate the complexities of being an academic health center affiliated hospital. The Board also hopes to employ organizational objectives more heavily in weighing individual decisions during the coming years.

OTHER:

In the purchasing period from July to September, 1987, 8701 purchase orders were processed with a total dollar value of $12.5 million. Very similar volumes and dollar levels were reported in the October through December, 1987 purchasing period.

The Hospital is currently completing a facility master planning process which includes planning for future utilization of the Mayo facility. Facility requirements are being assessed for areas not included in the new hospital and for areas within which we anticipate growth over the next ten years. The Board of Governors will be reviewing these requirements this spring.

Robert Nickoloff and I will continue as Vice Chairman and Chairman of the Board for 1988. The Board of Governors welcomed your appointment of Sally Booth as our new student representative. We are looking forward to working with Ms. Booth.

Thank you for the opportunity to update the Board of Regents on the activities at The University of Minnesota Hospital and Clinic.

Respectfully submitted,

Robert Latz
Chairman
Board of Governors

The Minnesota Daily

Thursday, February 25, 1988

Phillips area may get new clinic building with U's help

By **Delores Lutz**
Staff Writer

A new Community University Health Care Center will be built adjacent to the overcrowded clinic's site near Franklin and Bloomington avenues, the University Hospital Board of Governors decided Wednesday.

If the regents endorse the plan, CUHCC will remain in the Phillips Neighborhood of south Minneapolis, where residents have lobbied to keep a clinic that serves one of the city's poorest areas.

The board authorized up to $1.5 million for the project, but hospital officials said the new clinic will be built only if the city provides $150,000 in assistance and the promise of continued health department grant suppo[illegible]

See **Clinic** *page 10*

Clinic *from 1*

Minneapolis City Council Member Brian Coyle (DFL-Ward 6) supports the plan.

"We have offered financial incentives," Coyle said. "We want to insure that those who are getting service will continue to get it."

Currently, the clinic has 5,500 patients, about half of whom are eligible for medical assistance.

But access to health care is not the only issue involved, according to hospital officials.

"People believe that if CUHCC anchors one end of the avenue, it will be uplifted (economically)," said Dr. Amos Deinard, CUHCC's director.

Franklin Avenue's appearance "is of great concern," said officials at the Minneapolis Community Development Agency in a letter Tuesday to University Hospital officials. Therefore, CUHCC will be expected to spruce up a nearby building it plans to buy and hold for future expansion, the letter stated.

In December, the hospital board endorsed a plan to build a new facility, but delayed further action while administrators explored the possibility of relocating the clinic to other sites, including one on Lake Street.

The decision to keep CUHCC near its present location, 2016 16th Ave. S., was made after several weeks of meetings with community groups. Negotiations also involved state legislators and city officials, said Robert Dickler, general director of University Hospital.

CUHCC was founded in 1966 to provide health care to Phillips Neighborhood children, who were at high risk for health problems, Deinard said. Over the years, it expanded services to adult patients, offering dental care and mental-health services as well as medical care. The clinic has a staff of 65.

The 101-year-old converted apartment building is not accessible to the handicapped, and it is too small and outmoded to remodel, Deinard said.

Along with members of the Peavey Neighborhood Action Group who were present at the board meeting Wednesday, Deinard was pleased with the decision to build a new facility.

"I'm tired of having the toilet on the second floor flushed and drip water on my desk below," he said. "And our dentist cannot run the sterilizer and air conditioner at the same time because it will blow a fuse."

Minneapolis/'U' hospital plans new clinic

The University of Minnesota Hospital and Clinic, which for 22 years has operated a clinic in one of Minneapolis' poorer neighborhoods, has decided to remain in the neighborhood by building a new clinic adjacent to the present facility.

The decision Wednesday by the hospital's board of governors, though still needing approval from the university's board of regents, came after an intense lobbying effort by Phillips neighborhood leaders.

"It's a big victory. It's a victory of people," said Jim Graham, a neighborhood activist.

The Community University Health Care Center, with 56 employees and 48,000 patient visits annually, is at 2016 16th Av. S., near Franklin Av.

The new building, which will be the only neighborhood clinic of that type in Minneapolis run by the university, is expected to cost $1.5 million.

Star Tribune/Thursday/March 3/1988

Smoking bans put into effect at about 45 state hospitals

Despite habit, Fairview Ridges nurse assisted in writing policy

By Diana Ettel Gonzalez
Staff Writer

Every workday, at the end of her shift as an emergency room nurse at Fairview Ridges Hospital in Burnsville, Bev Doeden rushes to her car in the parking lot and lights up a cigarette.

Even though she smokes one to 1½ packs a day, Doeden backs a smoke-free policy that began at Fairview Ridges this week, when the hospital became one of a handful in the Twin Cities to ban smoking.

Doeden was part of a task force that helped write the hospital's policy, which allows smoking only for its chemical dependency patients and won't allow others to smoke anywhere on hospital property, even outdoors.

"We are a health organization, and it's a real dichotomy if you see health workers smoking and you're exposed to their smoke," she said.

Fairview is among about 45 hospitals in the state to ban smoking, according to Judy Knapp, who directs the Smoke Free Hospitals for 1990 project on behalf of the Smoke Free 2000 Coalition.

Under a law passed last year by the Legislature, smoking will be outlawed in all Minnesota hospitals by 1990. The law, which includes clinics and many other health care facilities, exempts patients in chemical dependency and mental health units if the hospital provides a separate, well-ventilated area where they may smoke. It also allows smoking if a patient obtains written permission to smoke from the attending physician, according to Kathleen Berntson, community coordinator for Smoke Free 2000, a coalition that includes about 36 organizations ranging from corporations to state agencies.

Those hospitals in the metropolitan area that have total smoking bans are Shriners Hospital for Crippled Children, Waconia Ridgeview Hospital and Methodist Hospital, according to the Smoke Free 2000 Coalition. In special cases, patients there are allowed to smoke with written approval from their doctors. The Veterans Administration Hospital at Fort Snelling plans to be smoke-free by April 1.

St. Paul-Ramsey Medical Center instituted a ban on smoking Tuesday that exempts some of its patients. Several hospitals have instituted partial bans or are considering the issue, Knapp said. For example, Minneapolis Children's Medical Center bans smoking except in unusual cases involving parents of critically ill patients, she said.

The coalition does not consider hospitals such as Hennepin County Medical Center — which allows smoking in one lounge — to be smoke-free, Knapp said. North Memorial Medical Center, one of the first in the metropolitan area to consider the issue, has two smoking lounges. Abbott Northwestern and Fairview Southdale hospitals are among some that have appointed task forces to study smoking bans.

"They're all making progress — that's the important thing," Knapp said.

In Burnsville, Fairview Ridges began exploring the issue after visitors and employees complained about smoking in the hospital's front lobby and cafeteria, said Brian Knapp, assistant administrator at the hospital and chairman of the its smoke-free task force.

A survey of employees, patients, physicians and visitors found that 87 percent of respondents favored a smoking ban, and that only 12 percent of those working or volunteering at the hospital smoked, he said.

The hospital began offering a series of quit-smoking programs, offering to reimburse employees for successful completion of such programs, Knapp said. Fairview Ridges also undertook other health education efforts before putting into place last November an interim policy allowing smoking in one lounge, he said.

The interim policy has helped some smokers adjust to the ban, Doeden said.

"It helped smokers break the habit of smoking in certain places. I used to smoke in our break room right in the emergency room. Patients couldn't see it, but they could certainly smell it," she said.

She got used to not smoking in the hospital because she thought the lounge was too smoky and too far away from the emergency room.

Some smokers have felt their rights have been violated by the policy, but they have accepted the ban, she said.

Employees have not complained about the new policy to hospital administrators, said Brian Knapp.

"A surprising number of employees that I've talked to have made their own efforts to quit," he said. "There was a housekeeping employee who quit smoking and started running on Feb. 14. A number of people within the last 48 or 72 hours have said, 'Well, it's time to quit. I can't smoke at the hospital.' "

Doeden, who has smoked for about 28 years, said she too wishes she could quit.

"I would certainly like to, but it's one of those things that takes a lot of desire and mental preparation. I hope I'm taking the first step toward it" by not smoking at work, she said.

Most hospitals that have put interim policies in place and allowed employees to adjust to policy changes before enforcing total smoking bans have been generally satisfied, Judy Knapp said. But other factors also influence the success of a new policy, she said.

"Sometimes, the smoothness of the (policy change) has a lot to do with particular hospital culture. If that hospital usually has problems passing any kind of policy, they will probably have difficulties," she said.

Some hospitals have decided to wait for the state law to take effect in 1990, she said.

"Most hospitals anticipate revolution," she said. "But the day comes, they become smoke-free and the sun sets and rises as it did the day before."

AIDS virus carriers help test drug treatment at U

St. Paul Pioneer Press Dispatch
Sunday, March 6, 1988

By Walter Parker
Staff Writer

Once a month, a healthy and hearty-looking Phil S. slips through the nondescript doors to the AIDS clinic in the University of Minnesota hospital complex basement for an update on the silent war inside his body.

Nurses draw his blood and examine him, as does Dr. Frank Rhame, one of the university's top AIDS experts. The blood will be analyzed closely for clues to what is happening on the cellular front.

Are Phil's immune system "guards," the helper T4 cells, declining? What are his white and red blood cells doing? Is his body properly processing the powerful anti-AIDS drug AZT that he's taking, or is it backing up to potentially toxic levels in his liver?

None of this is particularly unusual for an AIDS patient. But Phil (a pseudonym), a 33-year-old, full-time health care worker from Minneapolis, does not have AIDS.

He's an AIDS virus carrier. Except for a recurrent herpes infection and a loss of 10 pounds he has since recovered, Phil feels fine. He has ever since he learned in October 1985 that he was infected with the virus.

Nonetheless, he made a bet with fate eight months ago. He signed up then to participate in a national study of the effects of AZT on symptom-free carriers and on people with AIDS-related complex, or ARC, which often deteriorates into the lethal condition of AIDS. He's now one of 132 men, none of whom has AIDS, who visit the the U of M AIDS Clinical Trial Unit at least once a month as part of the study, which is coordinated with 34 other centers by the National Institutes of Health.

Doctors told Phil that the study is potentially one of the most important in medical history. It could show that AZT helps prevent carriers — of which there are an estimated 1.5 million nationally — from getting AIDS itself. Nothing else available is known to be able to do that.

That was the good part. He could help himself by getting free treatments worth thousands of dollars, while also doing a public service.

The doctors also laid out the down side. AZT's effects on healthy people were unknown; there was the theoretical chance that the drug could hasten his decline or make him extremely sick, although he'd be watched closely. And because the study is a double-blind, controlled trial, there was also a 1/3 chance that he wouldn't get the drug, but a placebo instead.

"It's absolutely unknowable that the drug recipients are going to win in this trial," Rhame said. "It's a very important question and it's absolutely not obvious."

Earlier controlled studies have shown that over a year or more, AZT appears to prolong the lives and improve the condition of many patients severely ill with AIDS. But it's a "big leap," Rhame said, to go from that to giving a toxic cancer drug to AIDS carriers who may have at least three to five years — and maybe many more years — of healthy time if they never took the drug.

The times demand that some people make that leap, however.

■ ■ ■

The facts in Phil's case were slightly different. He had a recurrent herpes virus infection and a 10-pound weight loss, and was classified as an "early ARC" patient.

Neither Phil, Rhame nor Phil's doctor in St. Paul know for sure if he's getting placebos or AZT. Phil, however, believes he is receiving the drug. And he's encouraged, though with the caution of one who watched a friend suddenly become sick and die of AIDS in two weeks last summer.

He's gained his weight back and hasn't had nausea or headaches since the first six weeks he was in the study. Key indices of his underlying condition — "helper cell" counts, hemoglobin — are stable, and both have risen since the study started.

"I believe I'm taking an active role now, taking responsibility for sustaining my life," he said in an interview at the apartment he shares with his partner of the past five years, who also is antibody-positive. "There's a side benefit, psychologically, in that this is gaining knowledge that will help more than just me.

"I knew I was dealing with a very lethal and volatile virus. I know people who have died and I didn't want to be another one at all."

As a health care worker, he has a good mental picture of what his treatment is about, but he said Rhame and the clinic's nurses take plenty of time to explain things to all the patients in the study.

"Seropositivity (the status of being antibody-positive) is such a weird place," Phil said. "You're not sick and you're not well. Going to the clinic, he gets a regular, detailed update on what is happening to his body, which for him is far better than living with uncertainty. "If you're sicker you don't want to hear, but if you're stable or better it feels good."

■ ■ ■

Carved out of an assortment of pre-existing university hospital operations, the AIDS Clinical Trial Unit is a $1.5 million-a-year, federally sponsored operation with 25 people working full and part time. Its director is Dr. Henry Balfour, 47, a pediatrician and nationally prominent specialist in viral diseases.

The unit includes a spacious outpatient clinic area where study participants — as well as AIDS patients treated by university doctors but not part of any studies — go for testing and treatment.

Elsewhere in the university health complex is a lab for culturing AIDS viruses for use in assorted laboratory studies. A separate virology lab is directed by Barbara Chinnock, 39, a medical technologist with extensive research experience in the development of antiviral drugs.

The total of 112 active asymptomatic men participating in the study at the university is the third highest among the 35 clinical trial units set up across the country by the federal government.

(More asymptomatic AIDS carriers and ARC patients are needed to volunteer, however, to help fill out the national ranks necessary to finish the study. National recruitment for study subjects with full-blown AIDS has been completed. Balfour said he encourages volunteers to ask their own doctors about getting involved in the study. They can ask a doctor for an AIDS antibody blood test, or get one at Room 111 in St. Paul or the Red Door Clinic in Minneapolis. The study's phone number is 625-1462.)

Balfour and other doctors in the study, proud of the enrollment rate here, in a state with a low AIDS incidence, attribute the high par-

OVER

ticipation rate to the cooperation of Twin Cities doctors and to the fact that the pool of potential subjects here seems to include a large number of thoughtful, civic-minded individuals.

Drs. Keith Henry of St. Paul and Margaret Simpson of Minneapolis, who work out of Room 111 and the Red Door, respectively, and have many AIDS patients in their practices, are both active research partners and key referral sources, Balfour said.

Since the university's AZT program began Feb. 2, 1987, 175 AIDS patients or carriers have been treated at the unit. Of those, 152 are still coming. The others stopped either for personal reasons or because the drugs apparently caused an overly toxic reaction, Balfour said. No one has died while on the program, though some did after leaving.

Balfour and others are careful not to oversell the benefits of AZT, nor to underestimate its significance as the best available weapon against AIDS. It's not a curative, they point out, and at best will probably maintain patients in the same way high blood pressure medication does. The drug is expensive, costing about $8,000 per year for the drugs alone, not counting the physician, nursing and lab time that necessarily goes with it.

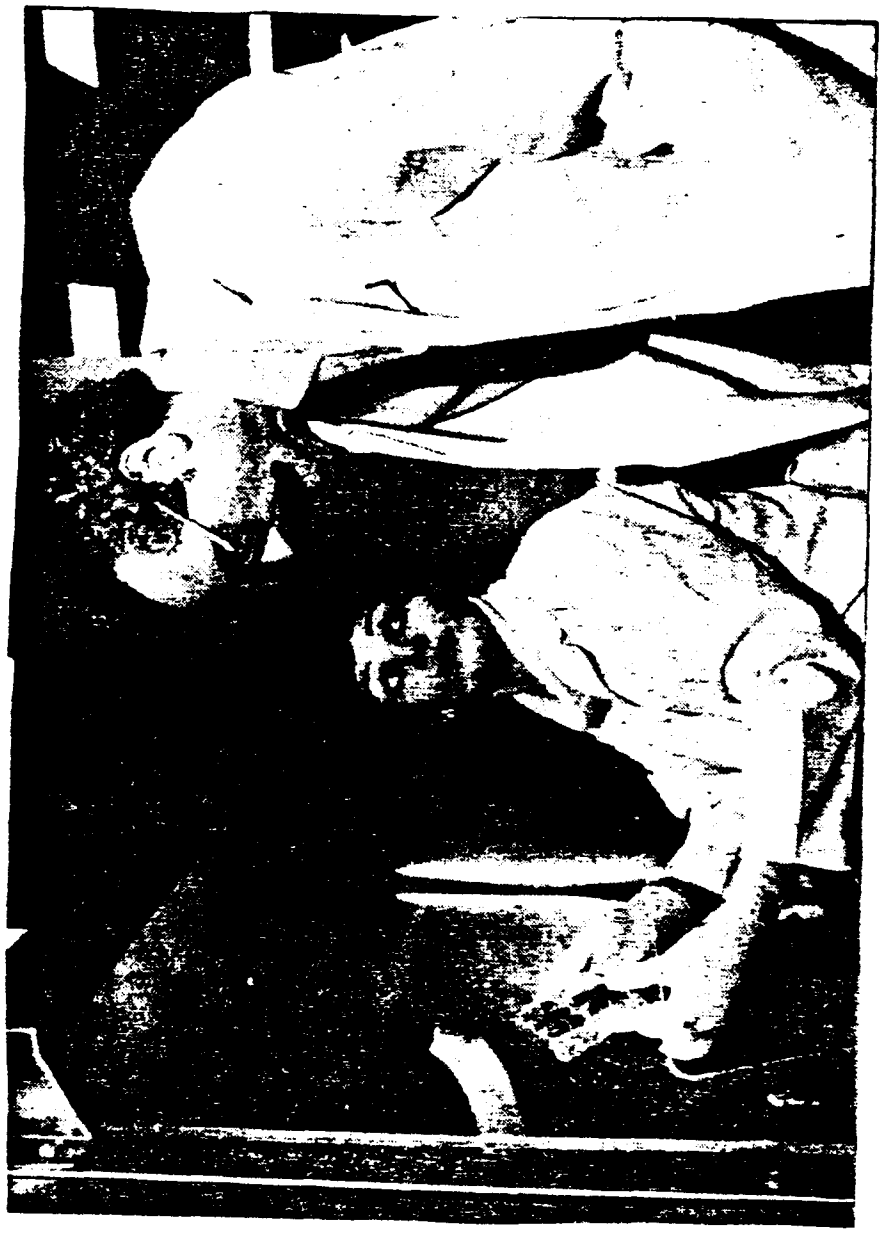
AIDS experts also have worried about the toxic effects of AZT since the earliest experiments, which caused as many as 25 percent of patients to reduce their dose or drop it entirely during the course of a year.

But in every controlled study, comparable patients who got the drug on the whole lived longer and better than those who did not. As researchers learn more about the drug, Balfour said, evidence is growing that its toxicity varies with the patient's degree of illness: the sicker he is, the more toxic the drug.

A major, exciting question, he said, is whether healthier patients who start taking AZT while they have relatively strong reserves of blood-producing bone marrow can withstand its toxic effects better than sick patients, and over a longer term.

The other piece of that puzzle, of course, is whether they do better than matched healthy AIDS carriers who do not get the drug. That part of the national study, known as Protocol 019, is scheduled to run for three years. If clear advantages or problems emerge before that, however, the study will be stopped.

Balfour said other studies are under way or planned, at the university and elsewhere, to see if AZT can be combined with other drugs. The idea would be to create a one-two punch, attacking the AIDS virus at different stages of its reproduction inside the cell, Balfour said.



Joe Oden/Staff Photographer

University lab supervisor Barbara Chinnock reviews data generated by a beta scintillation counter with Dr. Henry Balfour, medical director of the clinical virology program.

Star Tribune/Thursday/March 10/1988

Opponents of 'U' Focus plan head for hearing

By Howard Sinker
Staff Writer

Hearings on the University of Minnesota's Commitment to Focus recommendations — academic policies that have been overshadowed by the university's recent fiscal problems — will open this morning with 22 speakers on the schedule, including Dilit Lahiri, consul general of India.

Because of the number of speakers, at least two days of hearings before the Board of Regents may be scheduled in April, said Barbara Muesing, regents secretary.

In the month since President Kenneth Keller's 95-page document of recommendations was released, Commitment to Focus hasn't received the attention expected because of the furor over the $1.5 million remodeling of Eastcliff, the president's residence, and several other projects.

Keller and Roger Benjamin, vice president for academic affairs, are among those worried about the controversy's effect on state financing for Commitment to Focus. The plan calls for an extra $35.2 million per year by 1993, including about $25 million in new money from the Legislature.

"I hope the argument that we've come too far to turn back prevails," Benjamin said. "I believe that if we did not deliver something right now, there would be significant disappointment. We've created some expectations, and we'd better deliver."

Opposition is expected in at least four areas:

■ Several people, including Lahiri, are scheduled to protest closing the Department of South and Southwest Asian Studies. Tenured professors would be dispersed to other departments and, said Benjamin, undergraduate majors still would be offered through interdisciplinary programs.

■ Supporters of radio station KUOM and the MacPhail Center for the Arts are unhappy with plans to reduce their financing by 1993. MacPhail's directors passed a resolution in favor of keeping ties with the university, adding that if financing is cut, the center would need more than five years to come up with alternatives.

■ Some colleges slated to lose money or students are hoping those changes will be scrapped. Regents will be presented today with a petition from the College of Education, protesting a scheduled $500,000 budget cut, and several letters from people unhappy with proposed cuts in nursing programs.

■ Debate over changing to a semester system will be rekindled. Keller believes that the proposal will lead to better curriculum development and will put the university on the same schedule as most other universities. Many students and faculty members traditionally have opposed the idea.

Others have offered more general criticisms of Commitment to Focus, saying it is elitist because of its planned 21 percent cut in undergraduate enrollment and increased preparation requirements. The university expects a decline in the pool of college-age students to account for most of the decline, with the community college system picking up others who would have attended the university.

Among those scheduled to speak to the regents for five minutes are Camillo De Sante, chairman of the KUOM advisory committee; Judy Grew, president of the Minnesota Student Association; Dale Olseth, chairman of the University Foundation, and Robert Dunlop, dean of the College of Veterinary Medicine.

A task force report last June recommended that Veterinary Medicine be closed. It also suggested closing the School of Dentistry. Keller and the regents came out against those proposals, but Dunlop has indicated that his college needs more than its present rate of funding to survive. "We can't survive for five years without an enrichment of resources," he said.

Keller resigns as president, hoping to save Focus plan

He apologizes for Eastcliff mistakes

By Chuck Haga and Betty Wilson
Staff Writers

Kenneth Keller resigned as president of the University of Minnesota Sunday night.

Clearly frustrated by public preoccupation with controversy over renovation of his official residence and office, Keller said he will step down to try to save his Commitment to Focus, an extensive plan to make the university one of the best in the nation.

Reading from a prepared statement shortly after 10 p.m., Keller said the $1.5 million renovation of Eastcliff, the presidential mansion, was a "mismanaged" project that had claimed the public's attention at the expense of more significant and more positive matters.

"I bear a key responsibility for it," he said. "I have said before and I repeat now that I am profoundly embarrassed and profoundly sorry for it."

Inside

- The university is getting a chance to return to substance over style, columnist Doug Grow writes. **9A.**
- Possible successors to Keller. **9A.**
- A chronology of the Keller presidency. **8A.**
- Text of Keller's statement. **9A.**

Details, Pages 8,9A.

Senate Majority Leader Roger Moe said that the $23 million funding proposal for Commitment to Focus still should be postponed a year.

"That would allow a cooling-off period and give the university time to regain public confidence," Moe said. Keller's ability to remain as president

Keller continued on page 8A

Keller fought public's perception of elitism

By Bruce Benidt
Staff Writer

Ken Keller rose fast through the forcefulness of his vision and ideas. He fell when people perceived that he liked too well the heights he'd gained.

He was a respected teacher who saw beyond the narrow confines of his own field to a larger university that worked together to advance knowledge and find practical applications to human problems. When he rose to a position where he could propose change that would remake the university, he took such full advantage of it that he was

laden institutions, having gotten many people in the Legislature, the university community and the state at large to agree with his aims, when he was snared by an expensive set of details he hadn't paid enough attention to.

Through these last weeks, Keller was burdened with terms such as arrogance and elitism that for many people added up to a feeling he was too impressed with himself — a victim of hubris. Even the name of the rock his ship foundered on had a Shakespearean resonance to it — Eastcliff.

Rutherford Aris, a university regents

Staff Photo by David Brewster

Analysis

Departure may help Focus in long run

By David Peterson
Staff Writer

Commitment to Focus has something in common with the Edina High School hockey team.

Not long ago, Edina lost its leading scorer. And when its coach was asked, after the team became state champion, how it survived such a calamity, he replied that at times such a loss galvanizes the rest of the team.

Kenneth Keller could not have imposed Commitment to Focus upon an unwilling state. The Board of Regents appeared to have chosen him because of it. He was able to raise more than $300 million because the people who have that kind of money supported it. And, presumably, the Capitol remained so patient for the past few weeks precisely because political leaders believed in it.

None of that has changed simply because the team's leading scorer has placed himself on the disabled list. Commitment to Focus — and a decision as to whether to proceed — remains.

"A lot of people were using Eastcliff as a smokescreen because they don't want to come out and say that they're opposed to Commitment to Focus," said Judy Grew, president of the Minnesota Student Association. "That's one positive thing. Now if they don't like Commitment to Focus, they're going to have to say so and they're going to have to say what their alternative will be."

Keller

Continued from page 1A

of the university had been a matter of speculation for weeks, especially since the release last week of audit reports examining the $1.5 million remodeling of Eastcliff, the president's official residence.

Keller could remain at the university as a professor of chemical enginering because he is a tenured faculty member.

At Gov. Rudy Perpich's request, Keller met with the governor for about 1½ hours yesterday afternoon at the governor's residence.

Perpich was not available for comment. Aides had said that Perpich did not know what Keller planned to say last night, and that to their knowledge, the governor did not ask Keller to resign. The governor has scheduled a press conference at noon today on the university.

Perpich has been the leading champion of Keller's Commitment to Focus plan, and he recommended $23 million for its funding in his 1988 budget.

Initial reaction from regents, legislators and others generally held that Keller's departure had become inevitable. There was disagreement what that means for Focus.

"The situation had really deteriorated the last week," said House Majority Leader Ann Wynia, DFL-St. Paul. "The level of criticism seemed to be getting more severe."

She said many legislators were expecting more decisive action from the regents to restore public and legislative trust in the university administration. The regents met with Keller Friday and approved a package of recommendations he made to tighten financial management at the institution.

That was "really not what we were looking for," Wynia said.

She said Commitment to Focus "still has great potential," if faculty and the regents get behind it. "If it's a good idea, a good program, clearly the loss of one person doesn't mean the end of that program," Wynia said.

But Microbiology Professor Martin Dworkin, a close friend of Keller's, accused the regents of folding under pressure and failing to protect Keller.

As a result, he said, Commitment to Focus has been traded for "commitment to mediocrity."

Dworkin said, "I think that there has been something like 40 days of headlines focusing on an issue that I think was far less important than the positive things that he has done. I think it has generated a mood among people, who are not intimately familiar with

Chronology of events at 'U' under Keller

Here are some of the important events since Kenneth Keller became interim president and then president of the University of Minnesota.

Aug. 10, 1984: Keller is selected interim president, replacing C. Peter Magrath, who left to become president of the University of Missouri. Keller said he did not intend to become a candidate for the presidency.

Oct. 26, 1984: Gov. Rudy Perpich chastised university regents for not doing a good job of managing the school's finances after regents told him state support of instructional funding at the university is among the lowest in the Big Ten. He suggested that the system for selecting regents should be changed.

Feb. 8, 1985: Keller proposes a major institutional overhaul called Commitment to Focus, which he said would make the university among the top five public schools in the nation by reducing the number of undergraduates, emphasizing research, shifting two-year programs to state universities and community colleges and developing tougher admission standards.

March 1985: Largely on the strength of his plan for Commitment to Focus, Keller is chosen by regents to head the university, even though he had earlier agreed not to be a candidate.

Nov. 15, 1985: Keller is inaugurated as president.

Jan. 27, 1986: Hours after three Gopher basketball players are charged in Madison, Wis., with sexual assault, Keller announces that the basketball season will continue, but under the direction of assistant coach Jimmy Williams instead of Jim Dutcher, who resigned Jan. 24. Keller said he would create a task force to investigate intercollegiate athletics and would devote more resources to dealing with sexual violence on campus.

Feb. 7, 1988: Keller makes public the administration's final recommendation for a six-year Commitment to Focus plan. It would cost $35.2 million annually when in place, requiring about a 7 percent increase in state funding.

Feb. 8: Keller acknowledges publicly for the first time that the University of Minnesota's men's athletic program has broken NCAA rules. The majority of the violations are related to the basketball program between 1984 and 1986.

Staff Photo by Mike Zerby

On Nov. 15, 1985, Kenneth Keller spoke at his inauguration as University of Minnesota president.

Feb. 21: Keller wrestles with fallout from news reports that $1.5 million was spent to remodel Eastcliff, the St. Paul residence of the university president, more than twice the budgeted cost.

Feb. 23: University of Minnesota officials say that nearly $200,000 was spent to remodel Keller's office suite after he took the job in 1985. Although university policy requires that expenses of more than $100,000 be approved by regents, the remodeling budget was not presented to regents for a vote because it was done in piecemeal fashion rather than as one project.

Feb. 26: A news report shows that a new university telecommunications system cost about $33 million, about $9 million over budget.

Feb. 27: Legislative leaders agree to conduct a major audit of the physical plant operations of the University of Minnesota, in addition to the mansion and office remodeling projects.

March 2: Keller apologizes "for not paying closer attention" to finances, but says he is confident that auditors will find that he did nothing illegal. Another disclosure reveals that about $100,000 was spent to remodel the University of Minnesota's Office of Academic Affairs from 1980 to 1984, when Keller was academic vice president. Keller says the remodeling was "absolutely essential" for the functioning of the office.

March 5: University of Minnesota officials failed to comply with university procedures when they approved expenses to renovate Eastcliff, according to an interim audit by an outside firm hired by the university.

March 8: The NCAA infractions committee places the University of Minnesota's men's basketball program on two years' probation with two minor sanctions. The action came after an 18-month investigation.

March 10: David Lilly, 71, the university's vice president for finance, resigns as of June 30 because of what he says are age and health considerations. Lilly was named in a legislative auditor's report as one of several university officials at fault for not seeking regents' approval for extraordinary costs for renovation at Eastcliff.

March 10: The legislative auditor reports that most cost overruns at Eastcliff occurred because Keller and his closest associates authorized more work on the presidential mansion than regents knew about.

March 12: Keller vows to remain president of the university, despite an "uphill battle" to regain public confidence.

March 13: Keller announces his resignation.

Focus

Continued from page 1A

Eastcliff — and by extension, its tenant — had become not merely an incidental obstacle to Commitment to Focus, but a symbol of it.

Keller justified the lavish renovation partly on the grounds that a first-class university needed to *be* first-class in every important respect, including the place where its guests and contributors would be entertained.

But in so doing, he created in miniature, just the sort of thing to which many objected in a larger sense: A place that lent itself to being caricatured as a palace for the few, excluding the many.

There was also the way he went about it. The public found out about the renovation of Eastcliff in the fall of 1985, several months after Keller and the regents had informally agreed, and indeed begun, to undertake it. That alone caused no controversy at the time; nor did the fact that it would cost hundreds of thousands of dollars.

But when you're up to anything as touchy as shaking ol' State U by the collar and trying to make it an elite, if not elitist, institution, presentation is important. First you persuade; then you build. And when it turned out that Eastcliff had been done up in the dark, it was an invitation to wonder what else was going on in Morrill Hall.

Keller had about him an air of almost swaggering boldness that was perhaps necessary at the beginning of Commitment to Focus. Like all innovations, it needed an entrepreneur. But the same qualities can be dangerous in government.

Ann Wynia, majority leader of the Minnesota House, said last night that given the trouble Keller would have had at the Legislature selling Commitment to Focus, "its future may be enhanced" by his departure.

"I do think there will be some who see this as an opportunity to either stop or slow down Commitment to Focus," she said, "but the incidents that brought Keller down were not really related to Commitment to Focus." After the raising of the endowment and the other signs of progress, she said, it would be a mistake to turn back. She urged regents "to shoulder the leadership."

Presidents before Keller had hoped to do something with Eastcliff and had been afraid to do so. Others, too, had hoped to overhaul the University of Minnesota. There was talk in the 1970s of a Commitment to Excellence, talk that drew from Garrison Keillor the comment that before it worried about excellence, the university should aim to be "good."

Keller "may have coined the phrase," said David Graven, presi-

has generated a mood among people, who are not intimately familiar with what was happening at the university. That mood was translated to their legislators, who responded in a political fashion."

Keller had said as recently as Saturday that he would not resign, but he apparently changed his mind sometime yesterday. He drafted his statement at Eastcliff last night.

"I thought I could learn from mistakes at Eastcliff, improve the management of the university where it's needed, and get on with the important job of completing Commitment to Focus," Keller said.

He had promised several times "that if I thought my presence would hurt more than help," he would resign. "As painful as it is for me to say, I now believe that to be the case, and I am informing the Board of Regents this evening that I am prepared to step aside as president as soon as they can arrange for an interim replacement."

He said many friends had asked him to stay on as president despite the mounting criticism "because they believe I am vital" to Commitment to Focus.

He said, however, that Focus "has always been the work of many people, and if it is as right and as timely as I believe it to be, its momentum should carry it forward."

Keller did not take questions from reporters who assembled in the president's office in Morrill Hall.

Regent M. Elizabeth Craig said Keller's resignation was unexpected. "I didn't think he would do it tonight," she said. "It was a very big surprise because he was so positive on Friday when talked at the Board of Regents meeting."

Regent Charles H. Casey predicted that an interim president of the university might be chosen in a week or two, but said the search for a permanent president would take several months.

"I think he made the right decision for himself and the university," said Regent Wendell R. Anderson. "It was a very difficult one, but his Commitment to Focus that he believes in very strongly will be better served by the decision he has made." The regents, he added, "want to move quickly to fill the vacuum."

Anderson said Keller has left behind a university legacy of more than 100 new professor positions and about $327 million raised. "That's incredibly significant, and I think overshadows the troubles of the last month."

Faculty leader W. Phillips Shively would not say whether he favored or opposed the resignation, but he said he was saddened by it and feared for the future of Commitment to Focus.

To save the plan, he said, it will be necessary for the regents to give it strong support and choose an interim president who has the ability to carry it forward.

"We have to complete that process or we'll never get the university moving in a systematic, progressive way again, at least in a long time," said Shively, chairman of the university senate consultative committee, the top elective faculty position.

Shively said the plan is "utterly critical" to faculty morale, which he described as being at a low ebb because of the controversy. "The whole business has torn people apart," he said.

"We are losing a great president," said David Lebedoff, chairman of the regents, "but we must not lose his great program. Ken showed tonight his total dedication to our university. Now it is our job to match that dedication with our own. I will ask the board to renew its strong support of Commitment to Focus. That program must live"

Lebedoff said he hoped the regents will schedule a meeting this week.

"I think it's very important for the regents to move swiftly and decisively to find an interim president of great competence and who shares a strong commitment to Commitment to Focus and the academic priorities we have been discussing," Lebedoff said.

Dave Roe, who urged at the regents meeting Friday that Keller consider resigning, said that on Friday there were seven regents and possibly eight who were ready to move to ask for Keller's resignation. Roe said last night that "It saddens me and I'm sure it saddens others that he had to resign. Under the circumstances, of course, I think he had no alternative. I think the office of the president of the university warranted a decision other than a dismissal.

He said that former Vice President Walter Mondale has been suggested as an interim president, and Roe said he would not consider him for that post but would be pleased to consider him as a candidate for the permanent presidency.

"One of the things we will insist on, and this time make it stick, is that the interim president will not be a candidate for the permanent position," Roe said. He recalled that Keller was the interim president in 1984 and became the permanent president. It was a controversial development at the time.

The university is asking for a total of $38.4 million this session for its operating budget, including improvements called for in Commitment to Focus, and for special projects including a Supercomputer Institute.

The first post-resignation test of the Legislature's mood toward the university will come Wednesday, when the higher education division of the House Appropriations Committee begins deciding how many dollars of a very tight legislative budget to allocate to the university.

Several legislators had called for Keller's resignation, saying his continued leadership could damage the university's prospects in the current session. One of the final blows came Saturday, when the chairman of the House Higher Education Committee said Keller should go or risk further damaging the institution's stature at the Capitol and around Minnesota.

Other lawmakers have suggested the university still faces problems at the Capitol.

"My sense is his resignation will not detract from the sentiment widespread in the public and the Legislature that the university has some tremendous soft spots in the way it controls itself," said Rep. Phillip Riveness, chairman of the Legislative Audit Commission.

Keller was named president of the university in March 1985. He served as vice president for academic affairs at the university from June 1980 until November 1984, when he was named interim president.

He served in a number of administrative posts, including acting dean of the graduate school in 1974-75 and head of the Department of Chemical Engineering and Materials Science from 1978 to 1980.

He is the 12th president of the university. The previous president, C. Peter Magrath, served from 1974 to 1984.

Commitment to Focus should move ahead without delay, said Regent Stanley Sahlstrom of Crookston. "The university has tremendous leadership within and without, and this change will not stop the progress of the university," he said.

Jack Grahek of Ely said Focus "has great potential. I may not agree with everything about it, but the general concept is good."

Senate Finance Chairman Gene Merriam, DFL-Coon Rapids, defended Keller, saying, "It would be a mistake for anybody to assume the problems of the university are entirely the fault of President Keller, and that they will go away when he's gone. That's obviously not the case."

House Appropriations Committee Chairman Glen Anderson, DFL-Bellingham, also said Keller is not the only one responsible for the university's financial disarray.

"I frankly am a little sorry to see him take the dive. I think he kind of inherited a mess that had evolved over the years." The regents should have detected what was going on as well as Keller, Anderson said.

"A lot of people were using Eastcliff as a smokescreen because they don't want to come out and say that they're opposed to Commitment to Focus, according to Judy Grew, president of the Minnesota Student Association. "That's one positive thing. Now if they don't like Commitment to Focus, they're going to have to say so and they're going to have to say what their alternative will be."

Grew said that while Keller provided leadership in the initial phases of Commitment to Focus, the process of rethinking the university's mission and adjusting its direction is already so far under way that most of it will be implemented without Keller.

"But that flavor of his leadership and his push to get things done will not be there," Grew said.

Regents Professor John Turner, a political scientist, said, "It's too bad that we have to lose a leader who has set a new direction for the university. And it's too bad, after we made those gains, all of a sudden we have to be struck down on an issue like refurbishing a public building, particularly when all of the facts have not been made available to the public."

Turner, who had joined other senior faculty members in signing a petition in support of Keller, said the university has made "enormous progress" under Keller in raising capital funds, increasing research money, setting about to improve undergraduate and graduate education and reordering higher education in the state.

A petition was circulated at the university last week, signed by 16 regents professors and several hundred professors, urging "continued support" in the new direction for university programs. The petition, addressed to the regents, was to have been published in an advertisement in the Minnesota Daily, the student newspaper, this week.

Commitment to Focus is not exclusively Keller's idea, so it will not die with Keller, according to David Graven, president of the Citizen's League. Keller "may have coined the phrase, but he is really the spokesman for a large group of faculty that for at least 10 years has been concerned with quality at the university," Graven said.

Legislative leaders bought into Commitment to Focus last session, Graven said, and some changes proposed under the Keller plan are already starting. "I find it difficult to think that's going to be reversed unless you get really cowardly and evasive action by the regents, which I do not expect."

Staff Writers Bruce Benidt, Randy Furst, Howard Sinker, Joe Rigert, Gregor W. Pinney and Steve Gross contributed to this article.

Minnesota Daily prints 'extra' on resignation

The Minnesota Daily was expected to print an "extra" edition today on the resignation Sunday of University of Minnesota President Kenneth Keller.

There was to have been no Daily today, because like other students, Daily students needed time to prepare for final examinations, which begin today.

But as early as last week, Daily editors and staff decided they would print an "extra" if and when Keller stepped down. "We wanted to complete a story we started," said John Engen, editor of the Daily.

It was the Daily that first reported the story on cost overruns in the remodeling of the president's home.

"I got an anonymous bill mailed to me," Engen said last night. "There was a note that said, 'thought you might be interested in this.' The bill was for $600,000. We looked at it and thought, 'this is going to be a great story.' Our first story was that $700,000 had been spent for Eastcliff. But it was funny because even noted Keller-haters were saying, 'He's the president, it's reasonable.'"

But outrage increased as the real cost of remodeling Eastcliff became clearer.

"We've had a contingency plan for publishing an extra for the last couple of weeks," Engen said. "When the audits came out last week, we were pretty sure we might be publishing an extra edition."

professor and a friend of Keller's for as long as Keller has been at the university, said last night, "He was certainly at fault for not perceiving what the public perception would be" over the expenditures on his office and official residence, Eastcliff. But Aris said, "I don't think it's rooted in a disdain so much as perhaps a preoccupation with other things."

Keller was never a man interested in personal aggrandizement, Aris said. But his personality has some harsh edges, and another supporter of Keller's said at week's end that what the public has perceived as the extravagance of Eastcliff and Keller's office played into the public view of Keller as elitist.

Keller, 54, is a confident and smart man. "We tend to be a little uncomfortable with someone so bright," Aris said. "It's probably one of his faults that he hasn't learned to conceal his quickness. I think it rubs a lot of people the wrong way and may be part of the root of the antipathy to him," Aris said. "Perhaps, as I've said, he hasn't suffered fools gladly enough," Aris said.

Keller's philosophy as revealed in Commitment to Focus was that the university could no longer be all things to all people. If it was to be a great university — and Keller did not want to be president of only a good university — it had to narrow its focus, throw some programs overboard to concentrate on improving those that remain.

That view gored many an ox, and the cries from the wounded were loud. The toughness of Commitment to Focus — exemplified by the recommendation that the Dental School be cut in a state where the governor was a dentist — became softer as committees worked it over and people hurt by it lobbied for change.

But by forcefully proposing a bold plan, then letting the system deal with the specifics of putting it into effect, Keller succeeded in making Commitment to Focus a fact that might be changed but wouldn't be rejected completely.

Until Eastcliff.

Ken Keller grew up in Brooklyn, part of the marvelous mix that is New York, his family of Eastern European Jewish heritage. Keller would call himself "a typical overachieving New York kid." He would rise above his lower-middle class beginnings through the education and intellectual achievements his family valued.

He earned degrees in liberal arts and chemical engineering from Columbia University in 1956 and 1957, then

Staff Photo by David Brewster

Ken Keller, speaking at a press conference Sunday at the University of Minnesota: "While I am very proud of the role I've played in the Commitment to Focus, it's always been the work of many people, and if it's as right and as timely as I believe it to be, its momentum should carry it."

spent four years in the Navy working on a land-based nuclear power plant. Next came master's and doctoral degrees in chemical engineering at Johns Hopkins University in Baltimore.

In 1964 he came to the University of Minnesota, a school that already had a good reputation for engineers. "I knew what it was, but not where it was," Keller later said. Aris was in the chemical engineering department when Keller came to interview, and they have remained friends since then. He recalls Keller from the beginning as "obviously very bright and articulate.

Keller had a larger view of the university from the beginning because his interests were not limited by a narrow academic field, Aris said.

Although Keller was in chemical engineering, he did research that touched on biochemistry, biomedicine, bacteriology and mechanical engineering. Keller did research on how material passed through cell membranes, and saw application of his work in finding how red blood cells were damaged during the bypassing of the blood supply in early heart surgery. This showed how Keller was "interdisciplinary in his approach" from the beginning, Aris said.

In 1978 Keller became head of the department. Along the way he had put on other hats that looked good on an ambitious member of the university community; he was chairman of the All-University Consultative Committee, vice chairman of the university Senate, acting dean of the Graduate School, faculty lobbyist at the Legislature.

In 1980 he became vice president for academic affairs, a position of power for a serious man of ideas. When C. Peter Magrath resigned as president of the university, Keller was named interim president on Aug. 9, 1984. It was an opening Keller made good use of.

He put together a plan to bring the university into line with the top public universities in the nation, a plan that would be known as Commitment to Focus. It toughened academic standards at the university and stiffened entrance requirements, thus sending a signal to public schools and colleges that fed students to the university that the quality of education had to rise there, too.

The plan also proposed closing General College, which had been a place where students not academically prepared to enter the full university could go to get remedial work to bring them into the university mainstream. This, more than anything, brought charges of elitism.

Keller had told the Board of Regents that he would not be a candidate for the presidency. But that promise faded away when the regents became enamored of the plan and then decided they wanted the man who drew it up to come aboard and make it work.

So Keller became president with a mandate for change. But he brought more controversy to the university than change.

When Keller was inaugurated as president on Nov. 15, 1985, after a year as interim president, protesters objecting to Keller's Commitment to Focus plan and the way he became president chanted "Keller off campus."

Randy Kamrath, then an Independent-Republican state senator, objected to what he called the "outrageous and obscene" cost of the president's inauguration — $30,000. "I'm from a farm district and right now spending $30,000 on reception wine and little cocktail wienies seems almost criminal," Kamrath said.

His habits of taking the broad view and of heading straight into a problem rather than running from it were shown when three Gopher basketball players were arrested in Madison, Wis., on rape charges in January 1986. Keller wanted not just to deal with three ball players but with what part athletics should play in the life of the university.

Keller formed a task force that he hoped would "bring honor to the university" by tying athletics more closely to the classroom and getting more athletes to graduate. He raised the heretical point that athletics should be pursued only if they are consistent with the central goals of the university, which are learning and the personal and physical development of the student-athlete.

Keller's goal was larger than just avoiding a public relations disaster for the university when the rape charges coincided with a report from the Big Ten that the university had the lowest graduation rate for scholarship athletes in the conference between 1978 and 1983. He wanted the task force report completed in time to make recommendations to a meeting of Big Ten college presidents on how the whole conference might make reforms.

"I do not believe we should overlook ways in which Minnesota or the Big Ten can take a leadership role in change," Keller said at the time.

Although no huge changes came about, Keller's tough stance in canceling a Gopher basketball game after the rape charges were filed resulted in the resignation of coach Jim Dutcher. The resulting process of finding a replacement included measures that put the student athletes closer to the books than they had been in the past.

Keller liked being called tough, and added adjectives such as fair and intense when asked to describe himself. He said in a 1985 interview, "I'd like to think I'm not defined so much by what I do as by who I am, by my human qualities, how sensitive you can be to people's needs and not be too absorbed in the externals of life."

In the end, he was judged by who he is, or by who the people of Minnesota and the state's legislators and journalists thought he is. That view of Ken Keller had become defined by externals — by desks, by fences, by a house named Eastcliff.

focus, it's always been the work of many people, and if it's as right and as timely as I believe it to be, its momentum should carry it forward. I hope that each of you, each of you who supported me, will continue to work for the completion of that task as I can assure you that I will in whatever way that I can. Indeed, nothing would ease the difficulty of this decision for me in the future more than seeing the university and higher education in Minnesota thrive as I think it can if we continue on the course we have set.

To the Board of Regents and to the Legislature of our state, let me say that I hope that you can now work to refocus the discussion on the central issues of the university and its future. If we can provide adequate public support and can reach final agreement on a well-defined, carefully focused mission, we can build new strength that will affect the state for decades to come.

Let me end on that hopeful note, and let me say that it's been a privilege and an honor to serve this state and this university, both of which I love very deeply. Thank you.

Several mentioned as possible successors

By Gregor W. Planey
Staff Writer

The regents of the University of Minnesota will have no shortage of names as they begin their search for a new president to succeed Kenneth Keller.

Even before Keller quit Sunday night, speculation about successors had begun.

Among those mentioned:

Jon Wefald, president of Kansas State University at Manhattan and former chancellor of the Minnesota State University System (completely separate from the University of Minnesota) until he took the Kansas job in 1986. Wefald, once a history professor at Gustavus Adolphus College in Minnesota and an unsuccessful candidate for Congress in 1970, was state commissioner of agriculture under former Gov. Wendell Anderson, now a member of the Board of Regents. When the regents were looking for a president in early 1985, a coalition of 10 state agricultural organizations lobbied regents to appoint Wefald.

According to a rumor at the Capitol Friday, the regents wanted Keller to remain on the job until they could line up Wefald to return to Minnesota as university president. But Wefald, reached in Kansas City Friday, said he had not been approached and hadn't even heard the rumor.

Robert Carothers, the present chancellor of the State University System and formerly president of Southwest State University at Marshall, Minn. Carothers, 45, said he had not been approached about the University of Minnesota job.

Roger Benjamin, provost and vice president for academic affairs at the University of Minnesota and formerly associate dean at the College of Liberal Arts, the university's largest division. The academic vice president ordinarily is considered the second-highest ranking officer at the university and thus Benjamin is a natural candidate for interim president and likewise would automatically be a possibility for the top job. He has the disadvantage, however, of being closely associated with Keller, who brought him back to the university last year after a tour as provost at the University of Pittsburgh. He further has figured in criticism recently of an arrangement he made with Keller to receive university-paid travel expenses for returning regularly to Pittsburgh to visit his family, which has remained there.

Robert Stein, dean of the university Law School and recently one of four finalists for president of the University of Iowa.

Stein, who had been one of four invited to Iowa for interviews, withdrew because it would be inappropriate to leave the Minnesota Law School in the midst of the school's Endowment for Excellence drive that had raised $14 million, he said.

Lattie Coor, president of the University of Vermont and the regents' reported No. 2 choice at the time Keller was selected in 1985.

Gordon Donhowe, chief executive of the Fairview Hospitals and former commissioner of finance for Minnesota. It was Donhowe who accompanied Gov. Rudy Perpich to at least one meeting with the regents in 1984 to press the board for better definition of the university's program. Although an appointee of DFLer Perpich, Donhowe was mentioned as a presidential candidate last week by House Independent-Republican leader Bill Schreiber. But reached last night, Donhowe said, "I think I'd be manifestly unsuitable for the job."

Nils Hasselmo, provost of the University of Arizona since 1983 and vice president for planning and administration at the University of Minnesota until he left for Arizona. Hasselmo, 56, was a finalist for the University of Iowa job, but withdrew in December.

Staff Writer Howard Sinker contributed to this article.

Keller's statement

I wanted to speak tonight directly to the people of Minnesota, a state in which I have lived happily and been fulfilled for 24 years; a state in which I have raised my children; a state at whose university I have spent my entire academic career. And I hope you'll forgive me if I read this statement. I've tried to choose my words carefully because what I have to say is serious.

Over the past few weeks, you and I have lived with stories about Eastcliff renovations and repairs. The stories have not been good ones. It was a project that was mismanaged, and I bear a key responsibility for it. I have said it before and I repeat now that I am profoundly embarrassed and profoundly sorry for it.

What makes me most unhappy is that this very bad story has completely taken attention away from a very good story: the university's attempt to focus its activities, to build its academic strengths, and to work cooperatively with the rest of higher education to provide Minnesotans with opportunity, with choice, and with quality in post-secondary education.

I have said recently that I thought I could learn from the mistakes of Eastcliff, I could improve the management of the university where it's needed, and we could get on with the important job of completing Commitment to Focus. I have also said that if I felt my presence would hurt more than help in accomplishing that task I'd step aside. As painful as it is for me to say, I now believe that to be the case, and I am informing the Board of Regents this evening that I am prepared to step aside as president as soon as they can arrange for an interim replacement.

There are many good friends who have asked me not to do this, who asked me to stay on because they believe I am vital to the completion of our planning process. To them, let me say that while I am very proud of the role I've played in the Commitment to Focus, it's always been the work of many people, and if it's as right and as timely as I believe it to be, its momentum should carry it forward. I hope that each of you, each

Doomsayers need not fret over Ken Keller's departure

Can anything save us now? Can anything save us from being just another rust-bucket state with a mediocre university and a .500 football team? Can anything save us now that Ken Keller is leaving as president of the University of Minnesota and taking his plan and good tastes with him?

Woe, Minnesota? Doomed, Minnesota? Have we tossed out the baby with the bathwater? Have we thrown out our salvation — Commitment to Focus — with the pretty desk and the $41,000 picket fence? Is all lost now, Minnesota?

Certainly, there have been a number of people, smart people, who have said that those who wanted Keller out have failed to see the forest for the very expensive trees that were planted at Eastcliff.

Just last week, a number of university professors wrote letters to the Minnesota Daily supporting Keller and his baby, Commitment to Focus. Others, too, have warned that something so relatively minor as cost overruns and secret $50 million funds shouldn't bring down Keller and Focus. Some regents, some legislators and some newspaper editorial writers have argued that citizens should take the good, Keller's grand scheme, with the bad, the university paid $1,535 just to

Doug Grow

have blinds hung on the second floor at Eastcliff.

And perhaps they are right.

But with Keller's departure, maybe Minnesota is getting something more important than Commitment to Focus. Maybe it is being given a chance to reclaim its university from mentality long on style, short on substance.

The president, the plan, the times were a perfect fit. Eastcliff and the remodeled presidential office, complete with a $9,535 conference table as a symbol of Commitment to Focus. Commitment to Focus as a metaphor of the 1980s.

With the encouragement of a governor capable of saying little, except "Brainpower State," education and economics under Keller have become twisted together in a perverted way. Why, one of the main defenses of Keller in his final days was that he was the man who was able to pry $300 million from various wealthy individuals and companies.

But does the light of knowledge lead to or pour from a bank vault?

Consider, for a moment, a strange professor named Muhammad Barker. He works out of a six-professor department called South and Southwest Asian Studies, a department slated to be wiped out under Commitment to Focus.

From a strictly economic standpoint, perhaps it is hard to justify the department of South and Southwest Asian Studies. And from a strictly economic standpoint perhaps it is hard to justify the work of a man such as Muhammad Barker. Barker does such things as write books about a language called Urdu.

And if, from a black-ink point of view, that seems a waste of time, maybe, before tossing out the department and the professor who teaches the language with the funny name, maybe we should listen to Barker.

"The language," he says, "is the language of 90 million Pakistanis."

He talks, emotionally, of how the language has been his life's work. Of how no one in the nation knows more about the language than he. Of how his books have been read by operatives of both the CIA and the KGB.

"Can you get a better recommendation than that?" he asks. Then, laughing, he says, "Besides, can 90 million Pakistanis be wrong?" And beyond the 90 million Pakistanis who speak this language with the funny name, Barker points out that the department, South and Southwest Asian Studies, a department that costs the university $240,000 a year, teaches courses that cover roughly a third of the world's population.

Maybe, Barker suggests from a messy, formica sort of office, a great university has a department devoted to a third of the world's population, even if you can't put that knowledge in the bank tomorrow.

"A great university," Barker said, before Keller's departure, "must cover the waterfront."

Consider, too, some of the early planning in Commitment to Focus. Consider the Keller-created committee that decided that the University of Minnesota no longer needed a school of veterinary medicine.

When the roars of protest reached his office with the nice desk, Keller said he wasn't a supporter of all of the committee's findings. In fact, he said, he wouldn't want to throw out the school of veterinary medicine. However, he said, it was good that debate had been stimulated.

But the question that never was really debated is how could the university get so far removed from its roots that a committee of its faculty members would consider dumping veterinary medicine.

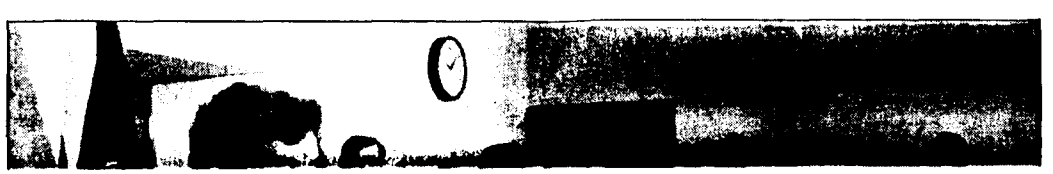
All of this doesn't mean that nothing should change at the university. Clearly, for example, it would be a good time to change a bunch of vice presidents whose strange accounting practices got their boss in so much trouble. Presumably, there also can be some tightening here, some sprucing up over there and maybe even a little remodeling in some of the departments.

But the university never again should be focused on something so shallow as rankings and prestige. Maybe Minnesota hasn't been doomed by Keller's decision. Maybe it has been given a reprieve.

Career

Continued from page 1A

professor and a friend of Keller's for as long as Keller has been at the university, said last night, "He was certainly at fault for not perceiving what the public perception would be"



St. Paul Pioneer Dispatch
March 17, 1988

Sauer selected interim U president

By Anne Bratass
Staff Writer

Richard J. Sauer, a man whose academic specialty is spiders, was chosen Wednesday to restore public trust in the leadership of the University of Minnesota as its interim president.

It is an apt background, he joked, for someone charged with disentangling the university from a web of events that have alienated lawmakers and the public.

■ As interim president of the University of Minnesota, Richard Sauer will be a man on a mission. Profile on Page 8A.

"One could say I've moved from spiders to spider webs," he said shortly after being chosen during a special meeting of the Board of Regents to replace former President Kenneth Keller.

Keller resigned Sunday because of controversy over the $1.5 million renovation of Eastcliff, the president's official residence, and other allegations of fiscal mismanagement.

Sauer, 48, has been vice president of the university's Institute of Agriculture, Forestry and Home Economics for nearly three years.

Regent Charles H. Casey nominated Sauer, noting his statewide involvement in agricultural issues, skill at communicating with the Minnesota Legislature and ability to work with a variety of constituencies. He said these talents will be vital to carrying through Commitment to Focus, the plan devised by Keller to improve the university.

Gov. Rudy Perpich on Monday said he was withdrawing his request to give the university $23 million this year for Commitment to Focus and suggested the university's newly revealed reserve fund might have to be tapped instead. As a result, regents wanted to fill the interim president's post as quickly as possible with an adept manager to salvage the program and restore credibility to the institution.

The search for a permanent president will take six months or more, and probably involve a fessional search firm. In the r time, Sauer said he will as full responsibilities of the offi

"While some may view an

Please see Sauer/9A

Joe Oden/Staff Photograp

Dr. Robert Stein, left, dean of the University of Minnesota Law School, congratulates Richard J. Sauer, who was named interim university president Wednesday the Board of Regents.

Sauer

Continued from Page 1A

im president as a custodian of the status quo, or even a lame duck, I do not intend to act like one," he said.

Instead, he envisons making "bold but necessary decisions" that may involve staff reassignments or firings. He declined to elaborate, saying only that some could be unpopular moves that would be difficult for the next president to take early in his or her term.

Sauer said he does not plan to be a candidate for the permanent position.

The only other nominee for the interim presidency was Robert Stein, dean of the university's law school. He was nominated by Regent Charles F. McGuiggan, who described Stein as an able leader who has "really brought that law school up to date."

The regents voted 10-2 in Sauer's favor, with McGuiggan and Regent Mary Schertler of St. Paul backing Stein. The board later agreed to make the vote unanimous in favor of Sauer.

Board chairman David Lebedoff said that when he first approached Sauer about the job — about 20 minutes after seeing Keller resign on the 10 p.m. news — Sauer's "first response was to say in a choked voice — he was very choked up — 'No. I don't want to advance in life at the expense of another's misfortune.'"

Lebedoff said he was touched and impressed by the sensitivity of the response. He was further impressed by the faculty reaction to Sauer. "They spoke with such glowing enthusiasm," he said.

Sauer said he initially declined for two reasons. One was the time and energy the job would take away from his personal life. The second was his reluctance to profit from Keller's problems.

Richard J. Sauer

Quote

"While some may view an interim president as a custodian of the status quo, or even a lame duck, I do not intend to act like one. And because I do not intend to be a candidate for the permanent position, I can make some bold but necessary decisions that might not be possible for the next president, at least not early in his or her term."

Professional

As interim president of the University of Minnesota, Sauer assumes the leadership of one of the largest higher education institutions in the country, with a total student enrollment of about 75,048. ... Its total annual budget is about $1.2 billion. ... The University of Minnesota was ranked seventh in academics among public institutions, and 17th among public and private schools, according to 1987 data from the National Academy of Sciences. ... A former vice president for agriculture, forestry and home economics at the University of Minnesota, Sauer has been with the university since March 1980 when he became director of the agricultural experiment station.

Personal

Age 48 ... Born in Wahpeton, Minn. An entomologist whose specialty is crab spiders, Sauer earned his bachelor's degree in biology from St. John's University, Collegeville; his master's in zoology from the University of Michigan, Ann Arbor; his Ph.D. in entomology from North Dakota State University, Fargo. ... Before he did, Sauer was married with his wife, Elizabeth. ... Has children ages 19 to

Handout at Meeting

IMPROVED PROGNOSIS FOR LOW-BIRTH-WEIGHT INFANTS

Theodore R. Thompson, M.D.

I. Definitions

A. Perinatal Period: 20th week of gestation to first 28 days of age

B. Perinatal Mortality Rate: $\frac{\text{Fetal deaths (>20 weeks) + neonatal deaths}}{\text{Fetal deaths + live births}} \times 1000$

C. Neonatal Period: First 28 days of age

D. Neonatal Mortality Rate: $\frac{\text{Neonatal Deaths}}{\text{Live births}} \times 1000$

E. Preterm (premature): Gestation below 38 weeks

F. Full Term: Gestation 38-42 weeks

G. Post Term: Gestation above 42 weeks

H. Low Birth Weight: Below 2500 grams birth weight

II. Survival Rates for Newborn Infants

A. Minnesota Neonatal and Perinatal Mortality Rates

Neonatal Mortality Rate			Perinatal Mortality Rate	
1970	14.2		24.1	
1976	10.0	62% ↓	18.6	51% ↓
1985	5.4		11.9	

Infant Mortality Rate - Minnesota: 18.0 (1970) 8.7 (1985)
USA: 29.2 (1950) 10.6 (1985)

B. 1985 Minnesota Statistics
1. Live births: 66,715; 50% metropolitan region
2. Below 37 weeks: 6.1%
3. Below 2500 grams (LBW): 4.9%; 75% of deaths
4. Below 1500 grams (VLBW): 0.9%; 50% of deaths
5. Prenatal care (none or third trimester): 3.2%
6. High risk (maternal, neonatal): 19%
7. Congenital anomalies at birth: 1.3%

C. Neonatal-Postneonatal Mortality Rates
1. Low birth weight (<2500 grams): 7% live births
   a. 67% neonatal deaths
   b. 20% postneonatal deaths
2. Very low birth weight (<1500 grams): 1% live births
   a. 50% neonatal deaths
   b. 25-30% postneonatal deaths

D. NICU at UMHC - 1986 Overall Survival Rates by Birth Weight

Birth Weight (gm)	No.	% Survival
<1000	20	85
<1500	64	86
1500-1999	65	92
2000-2499	56	89
<2500	185	89
≥2500	210	93
Total	396	91

E. NICU at UMHC - 1986 Overall Survival Rates by Gestational Age

Gestational Age (wks)	No.	% Survival
≤24	7	86
25-26	6	67
27-28	19	74
29-30	32	94
31-33	61	93
34-35	54	93
36-37	42	93
≥38	174	93
Total	396	91

F. NICU at UMHC - 1986 Overall Surival Rates for VLBW Infants

Birth Weight (gm)	No.	% Survival
500-599	4	100
600-899	6	67
900-999	10	90
<1000	20	85
1000-1249	23	87
1250-1499	21	86
<1500	64	86

G. Comparison of Survival Rates for Infants Admitted to the NICU at UMHC

	1976		1983-1984	
Category	No.	%S	No.	%S
<1000 grams	15	7	50	64
(750-1000)	--	--	(41)	(73)
<1500 grams	65	38	172	80
(1000-1500)	(40)	(60)	(163)	(83)
Severe RDS	77	45	102*	73*
			89**	88**

*Less than 1500 grams only for 1983-1984; all birth weights 1976
**1986 all birth weights

H. Survival Rates for Very Low Birth Weight Infants - 1976-1978

Birth Weight (gm)	Hammersmith	Cambridge	Cleveland	New York
501-1000	26%	64%	47%	30%
501-750	-	50%	20%	0%
751-1000	-	65%	56%	50%
1001-1500	75%	76%	81%	86%
1000-1250	-	65%	73%	83%
1251-1500	-	89%	87%	89%
Total	61%	73%	69%	69%

I. Overall Survival Rates for VLBW Infants (Vermont-New Hampshire)

Years	Birth Weight (gm)		
	500-1000	1000-1500	<1500
1960s	9%	56%	38%
Early 1970s	15%	70%	57%
Late 1970s	42%	82%	60%
1976-1979	38%	82%	69%

From: Philip AGS, et al. Pediatrics 68:122, 1981

J. Survival Rates for LBW Infants (Cleveland, Ohio - 1982-1985)

Birth Weight (gm)	No.	Survival Rate
1500-2499	874	98%
1000-1499	216	86%
750-999	73	67%
500-749	77	26%
<500	21	0%

From: Hack M, Fanaroff AA. NEJM 314:660, 1986

K. Mortality and Morbidity of Infants Below 1000 Grams Birth Weight (Rhode Island 1977-1981)

Birth Weight (gm)	No.	Survival Rate	Moderately or Severely Handicapped
500-599	15	0%	--
600-699	38	3%	100%
700-799	79	24%	37%
800-899	50	38%	43%
900-999	65	60%	12%
Total	247	32%	26%

Modified from: Walker DJB. Pediatrics 74:20, 1984

L. Survival Rates and Morbidity for Infants <800 Grams Birth Weight - 1977-1984

Year of Birth	Population	Birth Weight (gm)	Survival	Neurodevelopmental Handicap
1977-1980	Regional	500-800	29%	34%
1977-1980	Inborn/Outborn	500-800	20%	25%
1977-1980	Inborn/Outborn	500-800	44%	35%
1977-1980	Inborn/Outborn	500-750	42%	27%
1975-1980	Inborn/Outborn	500-750	40%	32%
1982-1984	Inborn	500-750	26%	33%

Modified from Hack M, Fanaroff AA. NEJM 314:660, 1986

M. Prognosis for Infants at 23-28 Weeks' Duration 1977-1984

Gestation (Weeks)	No.	Mean Birth Weight (grams)	% Survival	% with Impairment*	% Major Disability**
23	27	616	7	50	50
24	40	619	33	14	8
25	43	759	26	45	27
26	58	929	60	26	20
27	83	1033	76	14	10
28	91	1112	75	15	7
Total	342	932	56	19	12

*Impairment: cerebral palsy, mental retardation, blindness, deafness
**Interference with normal lifestyle

Modified from Yu VYH. Brit Med J 293:1200, 1986

N. Overall Survival Rates of Newborn Infants with Severe RDS (positive-pressure ventilation)

Birth Weight (gm)	Survival Rate (%)
<1000	40-60
1000-1499	60-95
<1500	60-80
1500-2000	85-95
>2000	90-95
Overall	85-95

O. Summary
1. Gestational age or birth weight is the major determinant of neonatal mortality
2. What are the current limits
   a. Gestational age: below 23-34 weeks
   and b. Birth weight: below 500-600 grams
   plus c. Discussion with parents: risks, benefits
   d. Intensive care therapy
      (1) Comfort
      (2) Warmth
      (3) Fluids-nutrition
      (4) Oxygen

3. Very-low-birth-weight infants
   a. Survival rate: 80-90% below 1500 grams
   b. Survival rate: 75-90% below 28 weeks' gestational age
   c. Survival rate remains low below 600 grams, 24 weeks' gestation
4. Relative risk of neonatal death among low-birth-weight infants
   a. Normal birth weight (2500-4000 grams): 1
   b. <2500 grams: 40-fold risk
   c. <1500 grams: 200-fold risk

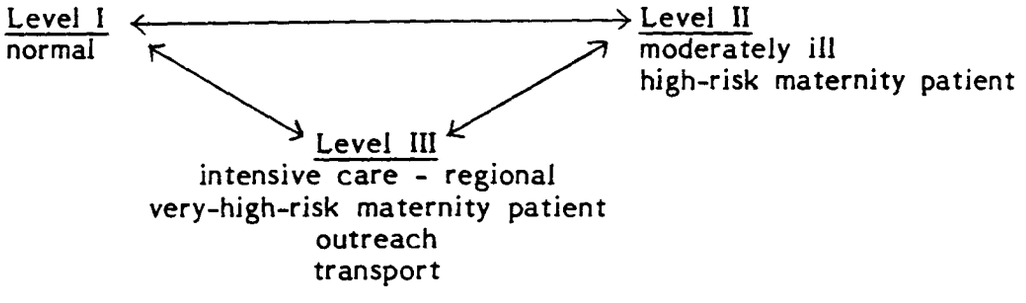
III. Suggested Reasons for Improved Survival Rates for LBW Infants

A. Regionalization - Perinatal Emphasis

1. Definition: Regionalization is a systems approach to the development within a geographic area of a cooperative system of perinatal health care whereby mutual agreements between physicians and hospitals and based on population needs, the Intensity of perinatal care each hospital should be capable of delivering is identified so that Optimal care can be delivered to perinatal patients with maximal utilizaiton of personnel and facilities

2. Objectives of regionalization of perinatal care
   a. Quality care to all pregnant women, newborn infants
   b. Maximal utilization of highly trained perinatal personnel and intensive care facilities
   c. Assurance of reasonable cost effectiveness

3. NICU care: Factors in decreased mortality of LBW infants
   a. Neonatal mortality decrease with only slight decline in proportion of LBW births
   b. Progressive decrease in neonatal mortality for VLBW infants
   c. Decrease in neonatal mortality for geographic regions after NICU introduction
   d. Improved survival of LBW infants born at tertiary care center
   e. Decrease in neonatal mortality in geographic regions where increase in LBW and VLBW infants born at tertiary care centers

4. 

B. Obstetric Care
1. Earlier identification of high-risk women
   a. Premature labor
   b. Other
2. Maternal transport
3. Fetal monitoring
4. Maternal corticosteroids (betamethasone)
5. Improved tocolytic agents

6. Cesarean sections - more liberal education
7. Ultrasonography
8. Rh immunoglobulin prophylaxis
9. Amniocentesis
   a. Genetic
   b. L/S ratio, phosphatidylglycerol
10. Genetic counseling
11. Family planning programs

C. Neonatal Care
1. Improved identification, stabilization of ill newborn infants
2. Intensive care therapy - transport, NICU
3. Improved assisted ventilation, monitoring
   a. Continuous positive airway pressure (CPAP)
   b. Mechanical ventilation with positive end-expiratory pressure (PEEP)
   c. High-frequency ventilation
   d. ECMO
   e. Oximetry
   f. Blood pressure
4. Improved resuscitation
5. Increased attention to adequate nutrition
   a. Breast milk
   b. Parenteral nutrition
   c. Fat emulsion
6. Improved surgical techniques
7. Surfactant administration
8. Ultrasonography (cardiac, CNS, renal)
9. Increased attention to parent-infant bonding

IV. Follow-Up Evaluation of LBW Survivors

A. CNS Morbidity Has Decreased With Mortality
1. Major and minor handicapping condition (mental, neurologic)

Pre-intensive care	Intensive care era
40-90%	10-35%
	(majority with minor handicaps)

   a. Major or severe deficits include developmental quotient below 80 and/or hydrocephalus, spastic quadriplegia, hemiplegia or diplegia
   b. Minor handicaps include attention span disorders, poor coordination, behavioral problems, learning difficulties and irritability.

B. Major Factors Associated with Later Neurologic and/or Mental Morbidity
1. Birth weight below 750 grams
2. Gestational age below 24-25 weeks
3. Intraventricular hemorrhage - parenchymal, ventricular dilatation
4. Severe perinatal distress with seizures, abnormal tone
5. Meningitis (viral - TORCHES, bacterial)
6. Severe, recurrent, symptomatic hypoglycemia
7. Severe chronic lung disease (bronchopulmonary dysplasia)
8. Chromosomal abnormality

C. Follow-Up at Seven Years Necessary for Learning Disabilities, Behavioral Disorders

D. Chronic Lung Disease (bronchopulmonary dysplasia - BPD): 5-30%
   a. Limited to infants requiring extended positive-pressure ventilation and oxygen
   b. Increased incidence of respiratory infections for 1-2 years, asthma
   c. Abnormal radiographs
   d. Many are asymptomatic by school age

E. Growth Patterns
   a. Normal or nearly normal for appropriate-for-gestational-age premature infants
   b. Small-for-gestational-age infants may have subnormal growth

F. Visual Deficits
   a. Retinopathy of prematurity - below 1000 grams primarily
      1. Incidence: 75%
      2. Blindness: 5-10%

G. Hearing Deficits: 0-10% in Premature Infants
   a. Diuretics
   b. Antibiotics
   c. Positive-pressure ventilation (endotracheal tube)
   d. NICU noise
   e. Cytomegalovirus

H. Speech, Dentition Disorders
   a. Intubation
   b. Endotracheal tube

I. Child Abuse/Neglect
   1. The LBW infant is at least three times more likely to be subjected to physical abuse and neglect, compared with the full-term, AGA infant
   2. Risk factors include inadequate support structure, family history of child abuse, serious marital problems, inadequate child spacing, inadequate child care arrangements, unplanned or unwanted pregnancy, and apathetic and dependent personality types

V. Major Causes of Neonatal Morbidity, Mortality

A. Birth Weight Below 750 Grams
B. Congenital Malformations
C. Respiratory Distress Syndrome
D. Perinatal Distress
E. Bacterial or Viral (TORCHES) Infection
F. Intraventricular Parenchymal Hemorrhage
G. Intrauterine Growth Retardation

VI. Future Goals, Directions

A. Reduction in LBW Birth Rates
   1. Early identification of pregnant women at risk for premature labor (see #6 below)
      a. May permit advancement of fetal age
      b. Determination of mechanism(s) of labor, rupture of fetal membranes
   2. Early identification of other high-risk pregnant women
   3. Early identification of intrauterine fetal growth retardation

4. Improved nutrition, socioeconomic status
5. Increased prenatal care
6. Premature labor high-risk factors
   a. Average pregnant woman has a 6-7% chance (1 in 15) of premature delivery

Risk Factors	Multiple by Which Risk is Increased	Estimated Chance for Premature Delivery
Iatrogenic premature deliveries (elective Cesarean section, labor induction)	—	—
Placenta previa	10-13x	1 in 1-2
Incompetent cervix	10x	1 in 2
Multifetal gestation	5x	1 in 3
Severe preeclampsia	4x	1 in 4
Repeated abortion (2nd trimester)	4x	1 in 4
Vaginal spotting (1st or 2nd trimester)	4x	1 in 4
Previous premature infant	3x	1 in 5
Abdominal surgery	3x	1 in 5
Acute pyelonephritis	3x	1 in 5
Polyhydramnios	?	?
Uncorrected uterine anomaly	?	?

B. Prevention of Perinatal Asphyxia
   1. Fetal monitoring
   2. Ultrasonography
   3. Mode of presentation - delivery
   4. Prompt, effective delivery room resuscitation

C. Prevention of Respiratory Distress Syndrome
   1. Lecithin/sphingomyelin ratio, phosphatidylglycerol determination
   2. Antenatal corticosteroid therapy: 26-34 weeks' gestation
   3. Surfactant administrtion postnatally

D. Prevention of Intracranial Hemorrhage
   1. Prevent hypotension, hypoxia, hypercarbia, acidosis
   2. Measurement of intracranial pressure, blood flow

E. Improvement in Nutritional Techniques for the Newborn

F. Improvement in Capabilities to Provide and Monitor Ventilation and Oxygenation

G. Prevention of Congenital Anomalies

H. Improvement of Parent-Infant Bonding

VII. Perinatal Dilemmas

A. Reduction of LBW Rate

B. Limits - Birth Weight, Gestational Age ?

C. Intraventricular Hemorrhage - Prevention, Treatment

D. Retinopathy of Prematurity - Prevention, Treatment

E. Chronic Lung Disease

F. Perinatal Distress - Antenatal, Intrapartum

G. Transplantation (e.g., cardiac)

H. DRGs, HMOs

I. Deregionalization

J. Follow-Up Care

K. Ethical Issues (e.g., malformation, gestational age, hemorrhage)

L. Genetic Screening Tests

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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

APRIL 27, 1988

TABLE OF CONTENTS

*** OTHER ATTACHMENTS ***

"Anencephalic Babies", Discover, April 1988
"The Trauma of EBS (The Empty-Bed Syndrome: Twin Cities Hospitals in Crisis)" Twin Cities, April, 1988, pp. 62-75
"Regents Approve New Building for CUHCC", Minnesota Daily, April 11, 1988
"Sauer Seeks Plan to Improve University's Public Relations", Star Tribune, April 13, 1988

The University of Minnesota Hospital and Clinic
Board of Governors
April 27, 1988
2:30 P.M.
555 Diehl Hall

AGENDA

I.	Approval of March 23, 1988 Minutes	Approval
II.	Chairman's Report - Mr. Robert Nickoloff	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Committee Reports:	
	A. Planning and Development Committee - Ms. Kris Johnson	
	1. Capital Expenditure Policy	Information
	2. Capital Budget	Information
	3. Lithotripsy Update	Information
	B. Joint Conference Committee - Mr. Robert Dickler	
	1. Joint Commission Follow-Up	Information
	C. Finance Committee - Mr. Robert Nickoloff	
	1. 1988-89 Budget	Approval
	2. March Year-To-Date Financial Statements	Information
	3. Third Quarter, Fiscal Year 1988 Bad Debts	Approval
V.	Other Business	
VI.	Adjournment	

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

MARCH 23, 1988

CALL TO ORDER:

Chairman Robert Latz called the March 23, 1988 meeting of the Board of Governors to order at 2:35 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias
	Sally Booth
	Shelley Chou, M.D.
	Robert Dickler
	Phyllis Ellis
	George Heenan
	Kris Johnson
	Robert Latz
	Barbara O'Grady
	Neal Vanselow, M.D.
Not Present:	David Brown, M.D.
	Al Hanser
	David Lilly
	Jerry Meilahn
	James Moller, M.D.
	Robert Nickoloff

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the February 24, 1988 meeting as written.

CHAIRMAN'S REPORT:

Mr. Latz noted that the Board of Governors Quarterly Report to the Board of Regents was included in the agenda packet. The report was reviewed by the Board of Regents on March 11, 1988.

Mr. Latz asked members to note two upcoming meetings. A 100th Annual Medical Staff and Trustee Conference, sponsored by the Estes Park Institute, will be held May 29-June 2, 1988 in Williamsburg, Virginia. The American Hospital Association will sponsor the Challenge to Hospital Governance June 2-4, 1988 in San Francisco. Please contact Kay Fuecker in the Board of Governors Office if any of these meetings are of interest.

SPECIAL PRESENTATION: ADVANCES IN THE CARE OF THE CRITICALLY ILL NEWBORN INFANT: MEDICAL, LEGAL AND ETHICAL ISSUES

Mr. Robert Dickler introduced Dr. Theodore Thompson, Professor of Pediatrics, Professor of Obstetrics and Gynecology and Professor and Consultant for Research Program, Department of Family Practice and Community Health. Dr. Thompson, Mr. Dickler reported, has been a staff member since 1969, Director of the Newborn Intensive Care Unit since 1984, and more recently, was named co-Director of the Medical Outreach program. Dr. Thompson is also the Co-chair of the Biomedical Ethics Committee.

Dr. Thompson summarized the marked decline in infant mortality this century. He explained that the decline is attributable to both improved care of infants and of mothers. Today, 94% of all neonatal infants admitted to the UMHC Intensive Care Unit (ICU) survive. Dramatic improvements have occurred in the last decade in the care of the very small infant. Seventy-five percent of babies under 1000 grams now survive. Twenty-four weeks gestation and 600 grams seem to represent today's critical minimums for survival. As birthweight and gestation period decline, Dr. Thompson added, the occurrence of motor and mental handicaps do increase.

Occupancy in our NICU has remained relatively stable over the last decade, despite the fact that a growing number of hospitals are opening similar units. There are 6 other units in the metro area, 2 in LaCrosse, 2 in Sioux Falls, 2 in Fargo, 1 in Rochester and 1 in Duluth.

Ethical issues associated with caring for this patient population are many. Dr. Thompson reviewed several cases involving ethical decision-making and explained the process undertaken to resolve such issues. Special care is taken, he noted, to involve families and staff in making decisions about an infant's care.

HOSPITAL DIRECTOR'S REPORT:

Mr. Greg Hart reported that the conditions approved by the Board for CUHCC's continued presence in the Phillips neighborhood, capital funding from MCDA and grant stability, are under negotiation. If discussions are satisfactorily concluded, the CUHCC building project will be placed on the Board of Regents April agenda for approval.

Mr. Robert Dickler reported that members of the Administrative Staff will be meeting with the Education Division of the House Appropriations Committee on March 24th to review the sources and uses of the hospital's reserves.

Dr. Vanselow reported that Interim President Sauer and Regent Chairman Lebedoff had withdrawn the University's supplemental request from the legislature and recommended committing up to $40 Million from the central reserves as operating income and income for capital improvements. A special Regents meeting had been scheduled for March 24, 1988 to formally endorse the plan.

Mr. Al Dees reported briefly on the current issues being discussed at the Legislature. They include a bill that would eliminate the requirement of the Board of Medical Examiners to send notices to the media regarding disciplinary action involving physicians when chemical dependency abuse is the sole basis for the disciplinary action. The bill would also require hospitals to provide more detailed information on disciplinary action to the Board. A bill that would require HMO's to provide replacement insurance for groups of individuals whose insurance coverage is dropped by an HMO is also under review. One significant change has also been made to the HMO solvency bill: HMO's would be required to maintain a reserve account in case of an HMO bankruptcy. The proposed open meeting law remains in committee.

The Dermatology Expansion proposal, Mr. Dickler reported, will be discussed by the Planning and Development Committee after the bidding process has been completed.

The year-to-date census, Mr. Dickler noted, continues to be strong. Admissions are ahead of budget for the year; the length of stay is below budget. Census began rising the beginning of March and remains high.

Mr. Dickler reported that discussions continue internally on a number of planning issues relating to facilities and capital planning. These items have been discussed in various committees and will be presented to the Board for approval in the next couple of months.

JOINT CONFERENCE COMMITTEE REPORT:

Mr. George Heenan reported that the Committee had reviewed and discussed the End Stage Renal Disease (ESRD) Policies. The new policies: formalize the responsibility for professional communication regarding patient care in Patient Team Rounds and Care conferences; assure accountability of professionals of the Medical Advisory Committee to comply with Joint Commission standards for medical integration into unit activities; address the termination of treatment to comply with Joint Commission standards; develop guidelines to establish clear lines of authority and accountability in preparing and connecting equipment for continuous arterio-venus hemofiltration; and institute guidelines for employing universal blood and body substance technique. There were minor changes to a number of policies which reflect conformation with existing policies and procedures.

The Board of Governors seconded and passed a motion to approve the End Stage Renal Disease Policies as presented.

Mr. Heenan noted that the Joint Conference Committee had reviewed two proposed revisions to the Rules and Regulations of the Medical and Dental Staff. One change allowed for malpractice insurance deductibles; the other reflects a change in medical record policies consistent with policies approved by the Medical Staff-Hospital Council. The Committee endorsed these changes. The Board of Governors seconded and passed a motion to approve the revisions to the rules and Regulations of the Medical and Dental Staff as presented.

Mr. Heenan presented for the Board approval the Medical Staff-Hospital Council Credentials Committee recommendations endorsed by the Joint Conference Committee on February 10, 1988. The Board of Governors seconded and passed a motion to approve the Medical Staff-Hospital Council's credentials report and recommendations as presented.

Lastly, Mr. Heenan reported that the hospital had received the November, 1987 Joint Commission findings. The Joint Conference Committee will discuss them in detail at an up-coming meeting. A number of recommendations were issued along with the accreditation renewal.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reported that the Hospital's operations through the month of February continued to reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. In addition, we experienced ancillary service utilization that was higher than anticipated.

Mr. Fearing and Mr. Rode reviewed the Second Quarter, Fiscal Year 1988 Bad Debts. Bad debts totalled $689,621.74, representing 1,336 accounts. Recoveries amounted to $10,687.30, leaving a net charge-off of $678,934.44, representing 1.09% of gross charges.

Mr. Fearing informed the Board that guidelines are under development for approval of out-of-state patients in an effort to reduce the bad debts. This policy, when completed, will be presented to the Board for its approval.

The Board of Governors seconded and passed a motion to approve the Second Quarter, Fiscal Year 1988 Bad Debts in the amount of $678,934,44.

ADJOURNMENT:

There being no further business, the March 23, 1988 meeting of the Board of Governors adjourned at 3:45 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Board of Governors Office

MINUTES
Planning and Development Committee
April 12, 1988

CALL TO ORDER
Mr. Robert Dickler called the April 12, 1988 meeting of the Planning and Development Committee to order at 3:10 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Leonard Bienias Robert Dickler S. Albert Hanser Clint Hewitt William Jacott, M.D. Geoff Kaufmann Ted Thompson, M.D.
	Absent	Peter Lynch, M.D.
	Staff	Cliff Fearing Greg Hart Mark Koenig John LaBree, M.D. Lisa McDonald
	Guests	Sharon Farsht

UMHC UPDATE
Mr. Hart read Dr. Lynch's report in his absence. UMCA has resolved repayment terms with UMHC for the PCN debt. Secondly, UMCA is in the process of resolving its billing difficulties with PHP. They have also experienced billing difficulties with one other HMO. The difficulties with the HMOs have led to cash flow problems for UMCA.

Mr. Fearing reported that UMHC is working with PHP to settle their outstanding claims.

OUTREACH UPDATE
Mr. Kaufmann reported that the existing affiliations are going very well and that discussions are progressing with several other sites.

Mr. Kaufmann also reported on UMHC's international efforts. UMHC has hosted 7-8 international visitors from the Americas. Several of them have spent a week doing mini-fellowships.

Dr. Thompson reported on his progress at several outreach sites. He also updated the committee on programs in development or expansion phases which include physician placement services, mini-fellowships and on-site CME programs.

Mr. Kaufmann summarized efforts to date on a comprehensive physical program aimed at corporations.

Mr. Dickler reported that preliminary discussions have occurred with the Veterans Administration about developing an outreach program in conjunction with their faculty. Also, UMHC has entered into an agreement with Fairview Riverside and Group Health to provide coordinated cardiac services.

U-ACCESS PHYSICIAN CONSULTATION AND REFERRAL SYSTEM

Dr. Thompson explained U-ACCESS (the physician consultation and referral center) which is a communication system whose goal is to simplify communication and increase referrals.

Ms. Farsht informed the committee about the U-ACCESS directory, tracking system and future programs. Ms. McDonald detailed the marketing plan whose goal is to make referring and UMHC physicians aware of the U-Access system and to get them to use it.

PROPOSED REVISION OF THE CAPITAL EXPENDITURE POLICY

Mr. Koenig and Mr. Dickler discussed the capital expenditure approval process and proposed a revised policy. The policy has been drafted based on what has been the practice between the Board of Governors and the Regents. Suggested changes are as follows:

1. Add a third category for major capital expenditures between $100,000 to $600,000 which have not previously been reported on a formal basis.
2. Bring recurring and major capital expenditures over 3% of the approved capital budget to the Board for supplemental approval.
3. Review all special projects that exceed the approved budget by 10% of the total budget with the Board of Governors.

Mr. Dickler informed the committee that the information is being presented for discussion.

Mr. Hart stated that the proposed policy does not change what is brought to the Board of Regents. It does change what goes to the Board of Governors.

Mr. Dickler and Mr. Hewitt discussed the difference between the Board of Governors and the Regents policies.

Mr. Dickler concluded that the current Board of Governors policy has worked well, but that clarifications were needed. Further discussion may be needed on how project overruns would be reported to the Board of Governors. Mr. Dickler said that the proposed policy should not require additional time from the Board. The Finance Committee will review the proposed policy on 4/13/88.

APPROVAL OF MINUTES

The minutes of the February 10, 1988 meeting were approved as distributed.

CAPITAL BUDGET

Mr. Hart discussed the capital approval process. UMHC is in the process of narrowing $18MM in capital requests to $8MM for 1988-89. The committee was provided a list of the $18MM in requests. The final list will be brought to the committee in June. The Mayo remodeling project is not included in the budget and is funded from the hospital reserves. Ms. Johnson inquired about how the requests were evaluated. Mr. Dickler responded that anything that is not for replacement or maintenance receives a financial review. Mr. Fearing concluded that all new and major projects receive a thorough financial evaluation.

OTHER BUSINESS

Biliary Lithotripter

Mr. Hart updated the committee on the biliary lithotripsy acquisition for clinical trials. A committee of physicians has been reviewing 5 different biliary lithotripters. The committee has decided on Siemens based on their financial stability, clinical efficiency and financial considerations. Siemens will lease their machine for one year at $100,000 and will allow UMHC to return it if they are not satisfied.

Pending FDA approval the machine could be delivered in mid-May. The Board of Governors will be presented the proposal in April when plans and terms are finalized.

Census

Mr. Dickler reported that in the last two weeks the census has been up considerably.

ADJOURNMENT

Mr. Dickler adjourned The Planning and Development Committee at 4:44 p.m.

Respectfully submitted,

Lisa G. McDonald

Lisa G. McDonald
Assistant Director
Planning and Marketing

MINUTES
Joint Conference Committee
Board of Governors
April 13, 1988

CALL TO ORDER:

Chairman Heenan called the April 13, 1988 meeting of the Joint Conference Committee to order at 4:37 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Robert Dickler
Patricia Ferrieri, M.D.
George Heenan
James Moller, M.D.

Absent:
Sally Booth
Phyllis Ellis
Michael Popkin, M.D.
Bruce Work, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Michael Steffes, M.D.
Jan Brockway

APPROVAL OF MINUTES:

The minutes of the March 9, 1988 meeting were approved with some minor wording amendments.

CLINICAL CHIEFS REPORT:

Robert Dickler, Hospital Director, noted that in the most recent Chiefs' meetings capital planning has been the primary topic of discussion.

Medical Staff - Hospital Council Report

Dr. James Moller indicated that there was no report for this meeting, beyond the cost evaluation report presented by Dr. Steffes.

Cost Evaluation Committee Report

Dr. Michael Steffes, Chairman of the Cost Evaluation Committee, supported by Jan Brockway, Director of Quality Assurance, described the findings and recommendations of the Committee's final report. He noted that one of the greatest difficulties in the study had been the adequacy of casemixe and severity measures. The measure used in the report is based on the DRG casemix index which is widely accepted as one of the most reliable measures. In general he noted that the casemix index has increased and UMHC's use of FTE's per casemix adjusted and outpatient adjusted discharges, has declined slightly over the four year (FY's 83-86) analysis period. He also noted that UMHC's weighted average charge per discharge has remained relatively constant over the period, though some areas such as Respiratory Care and Pharmacy demonstrated marked increases.

The Committee made seven recommendations which essentially centered either on education of both physicians and staff of the Hospital to improve the control of utilization and, thereby, decrease UMHC's costs or a Hospital-wide effort to enhance the quality and accessibility of utilization information based on casemix adjusted analysis of improved patient and cost data.

Discussion ensued concerning the course of action that should be pursued relative to the recommendations. Chairman Heenan suggested that we focus on a number of limited areas such as Respiratory Therapy or Pharmacy initially, but also noted that some of the recommendations call for long-term institutional value changes that must be developed over time.

Joint Commission Follow-Up

Nancy Janda, Associate Director, distributed a document that briefly summarized the 75 findings from UMHC's November JCAHO site visit and the responses that are now being implemented to address those findings. Ms. Janda elaborated on a number of specific examples. The Committee focused on the recommendations concerning Hospital oversight of quality assurance activities. Chairman Heenan questioned if it would be appropriate for the Committee to review quarterly summaries of Departmental QA reports and minutes. There was also concern expressed that there was not an adequate mechanism in place to assure that Clinical Chiefs take responsibility for this function. It was suggested that a clearer job description should be developed for the clinical chief role, and that Chiefs should be held more strictly accountable for the job requirements by the Board of Governors.

Future Work Plan

Chairman Heenan presented a Joint Conference Committee - Preliminary Work Plan for 1988. The list included three types of work: "Routine" Items, Issue Development and Monitoring, and a Major Focus Area - Quality Assurance. Mr Heenan asked for feed back and additions to the list. It was suggested that "other items as needed" be included on the list as well as Don Wegmiller's litany on QA for discussion at one of the meetings. The Chairman asked that any other items that members thought appropriate be communicated to him.

Other Business

No other business was conducted.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:20 P.M.

Respectfully Submitted:

Theodore J. Yank

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

DATE: April 21, 1988

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Associate Director and
Secretary to the Board of Governors

REGARDING: Joint Commission Findings

As you know, our hospital was surveyed by the Joint Commission on Accreditation of Healthcare Organizations last November. We received the results of that survey in mid-March. The Joint Commission renewed our accreditation for the maximum available accreditation term, three years.

With the renewal of our accreditation we received seventy-five recommendations for change or improvement. The Joint Commission's report and our responses to the report were reviewed by the Joint Conference Committee this month. A copy of the document used by the Committee is attached. I will be summarizing this information for you on Wednesday, April 27, 1988.

Thank you.

NCJ/kff

Attachment

JCAH Communique

The University of Minnesota Hospital and Clinic

NOVEMBER 13-16, 1987 SITE VISIT
THREE YEAR ACCREDITATION AWARDED

SUMMARY OF RESPONSES TO FINDINGS

ANESTHESIA

1. **Fabrics permissible for use as outer garments or blankets in anesthetizing areas were not specified in writing.**

   A policy outlining the content of the fabrics for garments and blankets permissible in anesthetizing locations has been drafted and will be in place by June 1, 1988.

2. **Postanesthetic visits were not consistently documented. Not postanesthesia notes reviewed included a date and a time that the visit was made.**

   Anesthesia residents have recently been made responsible for making and appropriately documenting postanesthesia visits.

3. **Indicators for all important clinical aspects of care were not included in the department's monitoring activities.**

   The department's monitoring activities have been expanded so that major clinical indicators for assessing care, such as critical complications and mortality, are included.

EMERGENCY SERVICES

4. **Emergency Room policies did not specifically state that patients in restraints should be attended to at least every 15 minutes.**

   Emergency Room policies are being modified to reflect current practice: patients in restraints receive close observation, either 1:1 nursing or checks at least every 15 minutes.

5. **Documentation regarding the patients condition upon discharge was deemed inadequate. Five of six records reviewed noted condition as "same".**

The emergency room staff will use more descriptive language for summarizing conditions upon discharge.

6. **Indicators for all important clinical aspects of care were not included in the department's monitoring activities.**

The department's monitoring activities have been expanded so that specific indicators for patients with chest pain, asthma, lacerations and abdominal pain are included. Additional indicators will be developed by the medical staff in 1988.

GOVERNING BODY

7. **The process that ensures individuals who provide patient care services but who are not subject to the medical staff privileges delineation process is not always reviewed with the Board of Governors.**

Non-physicians who are not employees of The University of Minnesota Hospital and Clinic are credentialled individually by the Board of Governors as non-hospital ancillary personnel. All hospital employees are governed by the hospital's personnel policies and procedures, which are also approved by the Board.

8. **The Board of Governors documentation of quality assurance reviews was limited.**

(C) The Joint Conference Committee will review quality assurance activities more regularly. Emphasis will be placed on evaluating findings and improvements in care resulting from quality assurance reviews; reviews will be documented accordingly.

HOME CARE SERVICES

9. **Indicators for all important clinical aspects of care were not included in the department's monitoring activities. Specifically, monitoring activities address nursing care provided but not care provided by physical therapy, respiratory therapy, dietary, social work or home heath aides.**

Specific criteria have been developed for all disciplines providing Home Health Care and are incorporated into a departmental quarterly record review.

10. **The annual reappraisal of the Home Health Department's quality assurance activities did not include an appraisal of care provided by non-registered nursing personnel.**

Mechanisms to appraise the quality assurance activities for all disciplines have been established.

HOSPITAL SPONSORED AMBULATORY CARE SERVICES

11. **Neither of the ambulatory care buildings were accessible to the handicapped.**

All outpatient clinics are handicapped accessible except the CUHCC clinic. Plans for replacing the CUHCC facility are currently being finalized.

12. **Patients auditory privacy was not ensured in the clinic reception areas.**

Clinics are designed with one or two check-in windows and one or two check out windows. As a matter of practice, private or sensitive issues are not discussed at these windows. Discussions of a clinical nature take place in the exam rooms while finances are discussed in private areas in outpatient registration. Clinic staffs were recently reminded of the importance of patient privacy.

13. **Medical records did not routinely include complete summary sheets.**

(C) Summary sheets will be included in every medical record by July 1, 1988. The Outpatient Committee will evaluate the use of these summary sheets.

14. **Indicators only minimally address the appropriateness of services offered. Further, documented activities are limited to administrative and documentation concerns and do not address clinical aspects of care provided.**

Some clinically significant indicators are now in place in Endoscopy and the Masonic Day Hospital. Nursing monitors are also conducted to determine compliance with nursing standards of care. Additional clinical indicators are being selected for monitoring.

15. **Although information about important aspects of ambulatory care was collected, it was not done on a routine basis.**

Information is collected and distributed on the clinic census, staffing ratios, cancel or no-show rates, Patient Relations Department

contacts, incident reports and unplanned admissions. Additional information will be collected and evaluated as new indicators are developed.

16. **Identification of problems or opportunities to improve care had been limited, thus limiting actions taken. The effectiveness of actions taken should be evaluated more thoroughly.**

(CC) A number of actions taken to improve care were available at the time of the survey. Staff will continue to take and document action in response to problems identified. As new indicators are developed and new data is gathered, new opportunities to improve care will be sought.

INFECTION CONTROL

17. **Record of infections among hospital personnel were not systematically maintained. Records of patient infections were systematically maintained, but there was no evidence that the Infection Control Committee was reviewing or discussing infections on a regular basis. Discussion was initiated only if there was an unusual or interesting case.**

The Employee Health Service maintains a log of personnel illnesses. The Infection Control Committee will review infection rates among patients on a regular basis as appropriate to infection rates.

18. **Corrective actions taken in response to infections among hospital personnel should be documented more clearly.**

The Employee Health Service, Emergency Department and Infection Control Department will begin documenting and evaluating corrective action taken in response to employee illness.

19. **The Infection Control Committee authority statement had not been reviewed or approved since 1981.**

The Infection Control Committee authority statement has been revised and will be presented to administration and the Chief of Staff for approval.

20. **There were no infection control policies relating specifically to the four Psychiatry units, the cafeteria, the Emergency Room, Rehabilitation, the Medical Intensive Care unit and the Surgical Intensive Care unit.**

The hospital policy and procedure manual includes twenty-one infection control policies that apply to all areas. Infection control

policies specific to the cafeteria have been in place since 1984 and were recently reviewed by the Infection Control staff. Rehabilitation has policies for the therapy areas. Policies are being developed for the Rehab inpatient unit. Policies are also under development for Psychiatry, the Emergency Room, the Medical Intensive Care Unit and the Surgical Intensive Care Unit.

CENTRAL STERILE PROCESSING

21. **Documentation of educational programs on sterile supply processing and handling techniques was limited for 1986 and unavailable for 1987.**

In January, 1988 an indexing system was created that documents CSP's educational programs for each employee.

22. **Autoclave spore test documentation was unavailable for the period prior to June, 1987.**

At the time of the survey, spore test results for only six months were kept on site; the remainder were kept in the storehouse. As of January, 1988 records will be stored at the hospital from Joint Commission survey to Joint Commission survey.

23. **Uncovered clean linen carts were observed on several floors. Additionally, other supplies are stored in the clean linen storage room where linen is also uncovered.**

Clean and soiled linen carts are now covered. Coats were being stored in clean linen rooms on two units. Alternative arrangements are being made for coat storage.

MEDICAL RECORDS

24. **Five of nineteen records reviewed did not include documentation of a comprehensive physical assessment that included a pelvic and rectal exam. Two of four records reviewed did not include a physician's stop order for newborn infant's oxygen. Clinical summaries written at discharge did not address diet in six of twelve records and did not prescribe allowable activities in sixteen of twenty-four records. Lastly, eight of twenty-four records did not include a description of patient status upon discharge; condition was simply stated as "improved" or "good".**

Medical staff on each service found to have charting deficiencies will be asked to formulate corrective actions. Forms listing the

required components of histories and physicals and discharge summaries will be developed and incorporated into the medical record for use by physicians. The Medical Record Committee will monitor records for improvement in the areas cited as being deficient.

25. **Entries in the medical record should always be dated; provisional necropsy protocols were not always dated.**

Pathologists performing autopsies have been apprised of this finding. Autopsy reports will be audited periodically to ensure that they are being dated.

26. **Abbreviations observed during the medical record review were not always listed in the medical record abbreviations policy.**

The medical records abbreviation policy will be updated periodically to include new abbreviations being used in the records.

27. **The hospital did not have a policy defining when medical records can be declared complete for the purposes of filing.**

A policy that defines when a record is complete and ready for filing has been drafted for consideration by the Medical Records Committee in May.

28. **The hospital did not have a policy stating that medical staff members cannot complete a medical record on an unfamiliar patient.**

A policy that confirms the inappropriateness of completing a medical record on an unfamiliar patient has been drafted for consideration by the Medical Records Committee in May.

29. **The role of medical records personnel in the hospital's overall quality assurance program and related committee functions was not defined.**

The role of medical record personnel in the hospital's quality assurance program will be defined as part of the annual quality assurance plan.

MEDICAL STAFF

30. **Criteria outlined in the medical staff bylaws for granting medical staff membership did not include health status.**

Medical Staff Bylaws will be changed to reflect information currently utilized on medical staff appointment applications, including information on health status.

31. **The period of time in which the governing body must make the final decision on each completed application for medical staff membership was not specified in the medical staff bylaws.**

Board Bylaws indicate that applications will be acted upon at the next regular Board meeting. Medical Staff Bylaws will be changed to include this same statement.

32. **A time-limited order from a physician should be written within twelve hours after the critical use of restraint or seclusion. Because the time of the authentication of verbal orders was not always written in the chart, compliance with this standard was difficult to determine.**

The need to document time of verbal order authorization for seclusion/restraint will be re-emphasized and monitored.

33. **The medical staff bylaws did not specify how frequently bylaws and rules and regulations are reviewed.**

A statement will be added to the Medical Staff Bylaws requiring annual review of Bylaws and Rules and Regulations.

34. **The Medical Staff-Hospital Council did not review or act upon the findings of the clinical and hospital departments.**

(C) The Quality Assurance Steering Committee will develop guidelines and sample meeting minutes for use by clinical departments. Departments will, in turn, submit minutes to the Quality Assurance Department for review by the Quality Assurance Steering Committee. The Committee will determine if minutes adequately document findings, conclusions, recommendations and actions resulting from the department's consideration of monitoring and evaluation activities. Quarterly summary reports will be reviewed by the Medical Staff-Hospital Council. The quality assurance programs of departments, periodic progress reports and reports summarizing priority issues will be reviewed by the Joint Conference Committee.

35. **Clinical departments did not uniformly hold monthly meetings to consider quality assurance findings. Minutes of the clinical departmental monthly meetings rarely document conclusions, recommendations, actions and evaluations of actions taken.**

(CC) Please see response to recommendation #34.

36. **The responsibility of the clinical chiefs for recomending criteria for privileges was not specified in the medical staff bylaws.**

An addition will be made to Medical Staff Bylaws referencing department chairmen responsibility for recommending criteria for clinical privileges.

37. **There was no evidence that peer recommendations were utilized in the delineation of clinical privileges.**

The Credentials Committee of the Medical/Dental Staff includes peers of applicants for appointment/reappointment. We view this as being in compliance with the Joint Commission's peer review requirement.

38. **There was no evidence that quality assurance findings were utilized in the reappraisal process.**

The Quality Assurance system will be refined to provide data on a physician-by-physician basis for use in reappraisal/reappointment. Some elements of that system are already being utilized; expansion will occur over the next twelve months.

39. **There was no evidence that peer recommendations were utilized in the reappraisal process.**

Please see #37.

40. **Indicators had not been developed for all major clinical aspects of care provided by all departments.**

A basic set of outcome indicators (by deaths, outliers and major complications) as well as appropriateness of care indicators (e.g., rate of surgery on day of admission) were developed for every clinical service prior to the November, 1987 survey. The Quality Assurance Steering Committee and Quality Assurance Services are now in the process of assisting departments in the development of additional indicators where the basic set has not identified problems or opportunities to improve patient care.

MEDICAL STAFF/SURGICAL CASE REVIEW

41. **The Tissue and Procedure Review Committee meets every other month rather than every month. Documentation did not consistently indicate that all cases were reviewed at the meetings.**

(C) To improve our compliance level we will develop a surgical case review program description. It will clarify the relationship between the two committees doing surgical case review, the Tissue and Procedure Committee and the Endoscopy Committee. The Tissue and Procedure Committee, which will retain responsibility for coordinating and overseeing surgical case review activities, will develop an annual work program that will include a minimum of twelve criteria based evaluations of high volume or high risk procedures. The work of the two committees will be coordinated to ensure twelve meetings a year.

MEDICAL STAFF/DRUG USAGE REVIEW

42. **Results of drug usage review were not used in the reappointment process.**

Drug usage review information is now collected and analyzed on an aggregate basis. The Department of Pharmaceutical Services will begin breaking that information down on a physician-by-physician basis for review by the Pharmacy and Therapeutics Committee.

MEDICAL STAFF/MEDICAL RECORD REVIEW

43. **Review of medical records for clinical pertinence was initiated only recently except for the review of Rehabilitation, Psychiatry, Emergency Room, Home Health, and Kidney Transplant records.**

(CC) The surveyor did not find the Medical Record Committee's plan for reviewing and taking action on the findings of reviews done by the Medical Records staff to be acceptable. Therefore, an alternative plan based on the surveyors verbal recommendations will be pursued. Records from a specific service will be reviewed each month by a physician from the service, a nurse, a physician member of the Medical Records Committee and a Medical Record Department staff member.

MEDICAL STAFF/BLOOD USAGE REVIEW

44. **Blood usage review activities addressed only the ordering practices of platelets. Blood usage review activities did not include criteria for the review of cases involving whole blood. Criteria for the review of cases involving use of cryoprecipitates, fresh frozen plasma, and red blood cells had been developed but not implemented.**

(CC) Platelet reviews were instituted in 1987 as a pilot test for monitoring major blood component usage. Monitoring of cryoprecipitates, fresh frozen plasma, and red blood cells will be implemented by July 1, 1988. Less than twenty units of whole blood are used at UMHC annually.

Based on that volume, the Transfusion and Therapeutics Committee had deemed monitoring of whole blood unnecessary. Given the Joint Commission citation, monitoring criteria will be developed and implemented.

NUCLEAR MEDICINE

45. **There was no evidence that the physician director had assumed responsibility for implementation of the monitoring and evaluation process.**

At UMHC the Nuclear Medicine Department is a service within the Diagnostic Radiology Department. The quality assurance monitoring and evaluation plan for Nuclear Medicine had been part of the more general Diagnostic Radiology plan. This approach was deemed unacceptable by the Joint Commission surveyor. A new comprehensive monitoring and evaluation plan will be designed and implemented for Nuclear Medicine.

46. **The indicators should be expanded to include all major clinical functions of the department. Specifically, the activities did not address issues such as the medical necessity of ordering practices or the accuracy of interpretations.**

Please see response to recommendation #45.

47. **There was no evidence of periodic assessment of monitoring information.**

Please see response to recommendation #45.

48. **There were no criteria addressing issues such as the medical necessity of ordering practices or the accuracy of interpretation.**

Please see response to recommendation #45.

49. **Actions taken to improve care were not sufficiently documented. Evaluation of the effectiveness of actions taken as part of Nuclear Medicine's quality assurance activities was not documented.**

(CC) Please see response to recommendation #45.

50. **There was no documentation that findings were reported.**

(C) Please see response to recommendation #45.

51. **There was no documentation of an annual reappraisal of the department's quality assurance program.**

Please see response to recommendation #45.

NURSING SERVICES

52. **Standards of nursing care were written as standards of practice and performance.**

Nursing standards of care will be rewritten as an aspect of care that all patients can expect to receive. Standards of care will be rewritten by July, 1988.

53. **Performance appraisals did not relate to standards of performance specified in job descriptions for staff working in specialty care areas, such as the intensive care units.**

Area specific standards of performance will be incorporated into the 1989 appraisal process.

OPERATING ROOMS

54. **50% of the records reviewed indicated that a non-registered nurse was assigned to the circulating nurse position in the Operating Room.**

(C) The 1987 Joint Commission standard requires that "only qualified registered nurses are assigned to head nurse/supervisor and circulating nurse positions in the surgical and obstetrical suites". The standard goes on to say, "an operating room technician may assist in circulating duties under the direct supervision of a qualified registered nurse."

A registered nurse has the overall responsibility as head nurse for supervision of the Operating Rooms. The Operating Rooms are staffed so that a team leader, who is always an R.N., oversees any non-registered nurse assigned to circulating duties. Data from local and national sources is currently being gathered to assess interpretation of these standards. Any operational adjustments will be made after this information is reviewed and additional clarification from the JCAH is sought.

NURSING SERVICES

55. **Each patient's nursing needs should be assessed by an R.N. at the time of admission. Of twenty-nine open and twenty-five closed records reviewed,**

twelve did not include a complete physical assessment, nineteen did not include a psychosocial assessment, twenty-four did not include educational needs of the patient and forty did not include discharge planning needs.

Needed changes will be made to the current manual documentation system to meet the requirements and will be incorporated into a computerized nursing information system in late 1989.

56. **Twenty-three of fifty-three care plans did not indicate that goals were mutually set with the patient and/or family.**

Please see response to recommendation #55.

57. **Standardized patient care plans were used on some units. Twenty-five of fifty-four records reviewed contained standardized plans; Eleven of those were not individualized to the patient.**

Please see response to recommendation #55.

58. **Thirty-five of fifty-four charts did not document that care plans had been followed. Evaluation of nursing intervention was not evidenced in 31 of the records reviewed. Nine of fourteen transfers did not address the patient's status in relation to the nursing process. Seventeen of twenty-five records reviewed did not evidence the patient's understanding of instructions.**

Please see response to recommendation #55.

PATHOLOGY AND LABORATORY MEDICINE

59. **Quality assurance indicators should be expanded to include all major clinical functions of the department.**

Indicators used in monitoring and evaluation will be expanded to more fully address the scope of care provided.

PLANT, TECHNOLOGY AND SAFETY MANAGEMENT

60. **The family rooms on the fourth and fifth floors of the University Hospital do not have doors separating them from corridors. Two utility rooms on Rehab 4 and six doors on Mayo 7 slide closed and should swing to ensure a tight closure. Employee lockers on the first floor of Mayo are**

not protected by one hour fire resistant construction. There is a dead end corridor on the sixth floor of the Rehabilitation Building.

(C) We interpret the National Fire Protection Act (NFPA) to read that we do not need doors on family waiting areas. We interpret NFPA to read that we do not need swing doors on Rehab 4 or two rooms on Mayo 7 because they are bathrooms or sink rooms. The remaining doors on Mayo 7 have not been converted to swing doors because the corridor is narrow and swing doors would make passage by a handicapped patient or employee difficult. Removal or relocation of the employee lockers on Mayo 1 will be explored. We interpret NFPA to exempt dead end corridors on floors where patients are not housed overnight.

61. **The effectiveness of the safety program was not assessed annually.**

The Safety Committee will be using their October meeting each year to evaluate all pertinent records and reports.

62. **The Safety Committee authority statement had not been approved by the Medical Staff.**

The Chief of Staff will sign the Safety Committee authority statement.

63. **Organized safety education programs were not reviewed annually for effectiveness.**

The Safety Committee will review organized safety education programs for effectiveness every October.

64. **1987 emergency preparedness drills were not conducted at six month intervals. Neither of the drills conducted during 1987 involved an influx of patients from outside the hospital.**

(CC) Three emergency drills were held in 1987. April and June drills apparently did not meet the surveyors definition of semi-annual. A third drill that did involve an influx of patients was held in December, 1987.

65. **Although the hospital had a system which included automatic transmission to the fire department, some components of the system had a five minute delay prior to transmission.**

A five minute delay was installed on transmissions triggered by smoke detectors at the request of the fire authority having jurisdiction. This system was acknowledged by the Minneapolis Fire Department. It is intended to minimize false alarms. When a sprinkler goes off, a pull

station is activated, or a call is made to the fire department, responses are immediate.

66. **Although weekly generator exercises had been conducted, the emergency generator had not been tested under full load.**

(C) We consider actual power outages, which occur once or twice each year, to be tests of the generator under full load conditions. Test in other than actual emergencies present unnecessary risks to the safe operation of critical patient care equipment. Tests under partial load conditions are conducted weekly.

67. **One of the seclusion rooms on the Psychiatric Unit had only a peep hole for observation, which is inadequate to fully see the interior of the room. Grab bars in the toilet and bathing areas in Psychiatry were removable.**

The viewing hole in the door of the seclusion room will be enlarged to allow for full visualization of the room. Grab bars in Psychiatry toilet and bathing areas are removable only with a Phillips head screw driver. When the Psychiatry facilities are renovated or replaced, permanently attached grab bars will be installed.

RESPIRATORY CARE SERVICES

68. **Respiratory care prescriptions did not include type of diluent in two of six records reviewed.**

The type of diluent is now specifically solicited on the Respiratory Care order sheet. Ordering physicians complete the order sheets.

69. **Quality assurance indicators should be expanded to include all major clinical functions of the department.**

Scope of care has been reviewed and critical indicators added to the review process. These include but are not limited to patient reactions, referrals, and equipment malfunctions. Appropriateness of ordering practices have been monitored and evaluated for ten years.

SPECIAL CARE UNITS

70. **There were no specific safety policies and procedures for the bone marrow transplant unit.**

Safety policies and procedures will be developed for the Bone Marrow Transplant Unit by June, 1988.

71. **Direct visual observation was not always possible in the intensive care units.**

Although it is not always possible to visualize all patients in all of the intensive care units from a central location, staffing and windows between units facilitate continuous observation.

72. **Evidence that the physicians directors have assumed responsibility for implementation of the monitoring and evaluation process may be in question.**

Response pending verification of finding.

73. **The quality assurance indicators should be explored to include all major clinical functions of the units. Medical staff monitoring activities in the Medical Intensive Care Unit and the Surgical Infection Control Unit had not resulted in the identification and correction of problems.**

The MICU and SICU medical directors have met to discuss the need to expand their quality assurance activities. They have already taken steps to improve their evaluation of monitoring findings (e.g., deaths, complications). Additionally, Quality Assurance Services will assist all units in clarifying and improving their documentation of monitoring and evaluation activities.

74. **Documentation of actions taken was minimal.**

Documentation of actions taken will be expanded.

75. **Documentation of an annual reappraisal of the departments quality assurance program may be in question.**

Response pending verification of finding.

MINUTES

BOARD OF GOVERNORS FINANCE COMMITTEE

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

April 13, 1988

CALL TO ORDER:

Mr. Robert Nickoloff called the April 13, 1988 meeting of the Finance Committee to order at 10:14 A.M. in the Board Room.

ATTENDANCE:

Present:	Carol Campbell Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Jerry Meilahn Robert Nickoloff
Absent:	Elwin Fraley, M.D. Barbara O'Grady Vic Vikmanis
Staff:	Kay Fuecker Nels Larson Barbara Tebbitt

1988-89 BUDGET:

Mr. Robert Dickler reported that the rate increase for UMHC is higher than in the past, but below 10%. The price increase will be 9.8%.

The University's general administrative allocation to the Hospital, Mr. Dickler reported, has been reduced from $6,471,000 in 1987-88 to $244,000 in 198-89. This will result in a lower net revenue over expense by $6.2 million.

Accelerated Comparable Worth funding, Mr. Dickler reported, has been supported by the Board of Regents. The 1988-89 budget reflects UMHC's fourth year of the plan. At the end of that time UMHC will be within 5% of it's target while the University will be within 7% of their target. No discussions have been scheduled to determine how to budget the final 5% and 7% respectively.

Mr. Fearing reported that the 1988-89 budget has been developed with the following set of assumptions:

1) 1987-88 Budget Base - Inpatient census for 1988-89 has been budgeted at 18,700 admissions and 143,700 patient days. We are projecting an average daily census of 394 as compared to 418 this year. Ancillary Services will be budgeted at a 9.4% overall increase, $182 per inpatient and $200 per outpatient. Moderate increases are expected in other operating revenues, particularly food services, parking services, pro fees and interest income on bonds.

FTE's - During 1987-88 there was an increase of 188.8 FTE's based on changes in admissions, program and intensity changes, workload, and new positions. The additions were 107 in ancillary departments, 44 in nursing, 24 in administrative departments, and 10 in support service departments. A net decrease of 60 FTE's is budgeted for 1988-89.

Pay Plan - The pay plan built into the 1988-89 budget includes: (1) an effective 2.3% change for all across-the-board increases. We have budgeted for a 2.0% across-the-board increase for all non-bargaining unit classifications and have budgeted a 3.0% increase for bargaining unit classifications in accordance with current contracts. (2) An effective 1.0% for step increases (applies to bargaining units, GSN's, Pharmacists, radiology techs, CRNA's). (3) An effective 0.6% change for merit-based progression increases. This increase is equal to 1.5% of the base for non-step/non-student classifications. (4) An effective 0.6% increase for pay equity changes and (5) an effective 0.3% change for marketplace range changes.

The pay equity amount included in the budget for Hospital dominated classifications reflects the fourth year of our four year plan. The pay equity amount included for University dominated classifications reflects the University's accelerated three year plan.

Non-Operating Revenue - Projected inflationary increases on appropriation are 2.2% and assuming that the appropriations will no longer earn interest income for UMHC. This year the amount of interest income earned on the appropriation was $319,000.

Deductions from Charges - The fiscal 1988-89 projection is based on current experience as well as pending legislative and regulatory changes relating to the Medicare and Medicaid programs. The greatest increases in the budget year are in Medicare and Medical Assistance. They are due to changes in the regulations, reductions in reimbursement for pass-throughs, and the impact of the rate increase. All other changes in deductions are related to volume and/or other minor contractual adjustments.

2) Fiscal Year 1988-89 Price and Revenue Increases - An increase of 9.8% is planned resulting in total patient charges to $281,419,000.

3) Capital Expenditures - A limit of $8,000,000 is being budgeted from operating cash flows for recurring equipment replacement and minor remodeling. Additionally, $3,905,000 will be budgeted for debt

service on equipment, bonds and parking ramp amortization. A detailed capital expenditure plan will be presented to the Finance and Planning and Development Committees in May. Additional funds totaling $7,500,000 to $11,500,000 are budgeted for planning stage for replacement of facilities of those clinical programs that did not relocate to Unit J.

Mr. Fearing reviewed in detail the UMHC Board Designated Fund activity for 1987-88, noting the current level of the reserves at $63,000,000. In addition there is $40,000,000 in Trustee Health Assets (funds borrowed for construction projects), of which UMHC cannot touch approximately $20,000,000 because it is for bond holder protection. An additional $4.5 - $5 Million in restricted endowments is also available for various purposes. Mr. Fearing reminded the Committee that the Hospital is 95% self-supported and 5% state supported. A document that was shared with the legislature when Mr. Robert Dickler and Mr. Robert Latz testified concerning UMHC central reserves will be included in the April, 1988 Board packet.

A reserve policy for The University of Minnesota Hospital and Clinic will be discussed after the current budget process has been completed. A target date for completion will be September, 1988.

The Finance Committee seconded and passed a motion to approve the 1988-89 Budget as presented.

CAPITAL EXPENDITURE POLICY:

Mr. Robert Dickler reviewed the proposed changes to the Board of Governors Policy on Capital Expenditures for the Committee's information. No action is expected at this time. The proposed changes include: defining recurring capital expenditures ($500 - $100,000), major capital expenditures ($100,000 to $600,000) and special projects (over $600,000), the approval procedures involved in each, and procedures to deal with cost overruns, which were not covered by the Board of Governors policy in the past.

ADJOURNMENT:

There being no further business, the April 13, 1988 meeting of the Finance Committee was adjourned at 12:30 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

April 18, 1988

TO: Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: 1988-89 Operating Budget for University of Minnesota Hospital and Clinic

Enclosed for your review are the operating budget schedules for the 1988-89 fiscal year. These budget projections are the results of the Hospital budget process which has involved all levels of management preparing a projection of activity, costs, reserve, revenue deductions and capital needs required to operate University Hospital and Clinic in fiscal year 1988-89. The annual equipment and renovation budget will be presented to the Planning and Development Committee in their April 12, 1988 meeting for information.

The amount of funding for the capital budget is consistent with our long range financial planning at a total of $8,000,000. This does not include principal payments of $3,905,000 or 1988-89, and/or major facility projects for 1988-89. The major facility projects will be presented separately to the Board of Governors and funded from sources other than 1988-89 operating funds.

The 1988-89 operating budget includes two significant financial statement presentation changes. First, the University General Administrative allocation of University costs assigned to UMHC has been reduced from $6,471,000 in 1987-88 to $244,000 in 1988-89. As you know this has historically been a non cash expense shown on UMHC's financial statements in accordance with National Institute of Health (NIH) allocation guidelines (UMHC pays the University $100,000 for these services). Central Administration has been negotiating with the NIH to change this methodology to improve the University's cost recovery on NIH grants and contracts and have been successful in these negotiations. At this time we do not foresee any negative financial implications in reimbursement from this change nor will it change our cash flow outcomes. However this will change the financial results on our operating statement significantly showing a lower net revenue over expense by $6.2 million.

The second change is that we are dedicating the interest income on reserves for our long range capital programs. This does not change our financial outcomes since we have normally spent more on capital than we earned on reserves. We are making this change to more accurately reflect how the reserves and the interest income thereon are utilized.

The attached schedules provide a fairly detailed description of the projected operating budget outcomes for 1988-89. The highlights of the operating budget are 9.8% price increase, bringing estimated gross patient charges to $281,419,000; an average increase in costs of 5.4% increasing operating costs to $258,476,000. Cash flows from operations for 1988-89 will provide the resources necessary to fund principal and interest payments on our outstanding debt, provide $8,000,000 for equipment and renovation, and reserve interest income of $5,258,000 for major capitol projects.

We believe this budget is consistent with our budget objectives and incorporates all known variables that will impact UMHC in fiscal 1988-89.

The budget was approved by the Finance Committee in a special budget meeting on April 13, 1988.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BUDGET LETTER
1988-89 BUDGET

The 1988-89 Budget has been developed with the following set of assumptions:

* 1987-88 Budget Base

  In projecting the 1988-89 fiscal year budget elements, the current experience in each category was used as the starting point to determine expected 1988-89 results. As described below and shown in the attached schedules, forecast admissions, patient days, clinic visits, expenses, revenues, and revenue deductions have been made based on current year experience. Current year experience has then been adjusted for changes in projected volume, mix, and intensity of services, and new and pending reimbursement regulations. The following are general descriptions of how the major elements in the 1988-89 budget were projected:

  - Demand Analysis:

    For the 1987-88 fiscal year we had developed a budget of 18,350 admissions and 153,000 patient days. Using our actual experience through December, 1987, we are projecting 19,336 admissions and 152,965 patient days. While the increase in admission levels occurred throughout the majority of clinical service areas, Medicine, Orthopaedics, and Surgery experienced the greatest increases.

    The 1988-89 census projections reflect a slight decline in demand because of the general HMO/PPO influence on competition as well as continued emphasis on same-day surgery admissions and efforts to reduce low-acuity patient days. Inpatient census for 1988-89 has been budgeted at 18,700 admissions and 143,700 patient days.

Schedules I, II, and III summarize the demand forecasts for 1987-88 and 1988-89.

- Ancillary Service Utilization

  While the 1988-89 budget for ancillary service revenue reflects the projected decline in inpatient admission levels, it also reflects a slightly higher average utilization level due to changes in the mix of our patient population. Inpatient ancillary revenue has averaged $7,182 per admission March year-to-date compared to the budgeted average of $7,220. Outpatient revenue per clinic visit has averaged $189 compared to the budgeted average of $184. For 1988-89, we are budgeting $7,270 per admission and $205 per visit before price increase.

  In the 1988-89 budget year we anticipate continued growth in several new programs, including Wound Healing and Home Nutrition, and a continued increase in several outpatient clinics, specifically, Diabetes Center, Day Hospital, and Comprehensive Cancer Care.

- Deductions from Charges

  Schedule IV is a summary of the expected deductions from revenue for fiscal years 1987-88 and 1988-89. For 1987-88, there were several significant variances from budget. The major ones occurred in Medicare ($3,903,000 due to greater than anticipated reimbursement for indirect medical education), Medical Assistance ($1,534,000 due to an increase in payment rates) and HMO's (-$1,456,000 related to volume).

  The fiscal 1988-89 projection is based on current experience as well as pending legislative and regulatory changes relating to the Medicare and Medicaid programs. The greatest increases in the budget year are in Medicare and Medical Assistance. They are due to changes in the regulations ($3,186,000 for Medicare, $294,800 for Medical Assistance), reductions in reimbursement for pass-throughs ($1,026,000 reduction), and the impact of the rate increase ($3,292,000). All

other changes in deductions are related to volume and/or other minor contractual adjustments.

- Other Operating Revenue

  Schedule V is a summary of projected operating revenues from sources other than patient care. The increase in other operating revenue projected for the 1987-88 fiscal year is primarily due to an increase in the interest earned on the bond proceeds over the original 1987-88 budget levels. No significant changes are expected in the 1988-89 budget year.

- Full-Time Equivalent Summary

  Schedules VI through IX reference changes in full-time equivalents. From a 1987-88 budget base of 3797 FTE's, there has been an increase in full-time equivalent utilization to 3985.8 FTE's projected for year-end 1987-88, or an increase of 188.8 FTE's. A decreased use of FTE's is budgeted for 1988-89, to a level of 3927 FTE's.

  Schedules VII through IX provide "reasonableness checks" at a hospital-wide productivity level, incorporating changes in admissions and clinic visits, programs and intensity changes, FTE's which are not actual cost additions (accounting changes), and FTE's added due to external environmental changes.

- Expenditure Summary

  Schedule X is a comparative summary of expenditures projected for 1987-88 and budgeted for 1988-89. The expenditure levels have been determined using December, 1987, year-to-date actual experience as a basis for projection. Although pay plans for employees have not been finalized, we have incorporated salary and wage increases that appear consistent with those in the community and the University pay plans. Schedule X(a) is a narrative description of budget variances for 1987-88 and unusual expense changes for 1988-89. The following inflationary assumptions were used in budgeting 1988-89:

	Inflation %
Salaries:	
July 1, 1988 across-the-board	2.3%
Step increases (Bargaining units, GSN's, Pharmacists, Rad. Tech's, CRNA's)	1.0%
Merit-based progression increases (Increase to equal 1.5% of the base for non-step/non-student classifications)	0.6%
Pay equity	0.6%
Marketplace range adjustments	0.3%
	4.8%
Fringe Benefits	11.1% a
Academic/Resident Contract	4.1%
Physician Compensation	5.5%
Other Contracts	4.0%
Utilities	3.6%
Insurance	30.7% b
Campus G & A	5.0%
Drugs	4.8%
Blood	4.7%
Medical Supplies	4.0%
Food	6.0%
Laundry and Linen	5.0%
Rental	2.9%
Maintenance	5.5%
General Supplies and Expense	3.6%

a) This increase is due to anticipated increases in health insurance costs.
b) This increase primarily relates to $290,000 of liability premium increases.

- Non-Operating Revenue

Schedule XI is a summary of expected appropriations and other non-patient revenues for fiscal years 1987-88 and 1988-89. The projection for inflationary increases on the appropriations is 2.2%. We are also assuming that in the 1988-89 fiscal year the appropriations will no longer earn interest income for the Hospital. The

appropriations will be received by the Hospital on a monthly basis rather than being received in total on July 1. This change reduces our revenues by approximately $319,000 in the budget year.

* Fiscal Year 1988-89 Price and Revenue Increases

Although we have been able to keep our annual rate increase to 2.9% each of the last three years, the price increase planned for 1988-89 is 9.8%. It results in an increase in patient charges of approximately $25,117,500, bringing total patient charges to $281,419,000.

Major factors in the price increase include our budgeting a reduction in revenues because of the expected decline in inpatient volumes ($1,047,000), budgeting an increase in our deductions from charges due to changes in the regulations ($3,480,900) and our implementing a price increase over and above what third party payors will reimburse ($3,292,000), and budgeting an increase in our capital obligations. We are budgeting a $2,017,000 increase in equipment and renovation purchases, and we are committing an additional $2,852,000 to future capital expenditures.

The Comparative Statement of Operations and Operating Cash Flow on Schedule XII summarizes our projected position for the 1988-89 fiscal year.

* Capital Expenditures

Capital expenditures that will be provided from operating cash flows in 1988-89 for recurring equipment replacement and minor remodeling will be $8,000,000. In addition, there are several projects which exceed the Board of Governors approval threshold of $600,000. They are such things as the biliary lithotripter and the possible upgrade of the Neuroradiology area. These projects will be brought to the Board for approval as they occur. Finally, $3,905,000 will be spent for principal payments on equipment, the Unit J bonds, and the parking ramp.

In addition to these equipment and remodeling items, UMHC is currently in the planning stage for replacement of facilities for those clinical programs that did not relocate to Unit J. For 1988-89,

planning and construction costs are currently estimated to be between $7,500,000 and $11,500,000. These costs could vary substantially based on the ultimate decision regarding this project and its timing. As usual, all major facilities, renovation, and equipment purchases will be brought to the Board for approval.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
COMPARATIVE DEMAND ANALYSIS
INPATIENT ADMISSIONS

SCHEDULE I

ADMISSIONS	1987-88 PLANNED BUDGET	1987-88 PROJECTION	1988-89 BUDGET
CLINICAL RESEARCH	445	475	465
DENTISTRY	66	58	57
DERMATOLOGY	16	16	16
FAMILY PRACTICE	24	16	16
GYNECOLOGY	1,374	1,359	1,332
MEDICINE	3,683	4,363	4,276
NEUROLOGY	356	341	334
NEUROSURGERY	829	866	849
NEWBORN	354	313	307
NUCLEAR MEDICINE	6	0	0
OBSTETRICS	599	565	553
OPHTHALMOLOGY	956	1,029	935
ORTHOPAEDICS	1,068	1,235	1,206
OTOLARYNGOLOGY	455	424	416
PEDIATRICS	3,206	3,136	2,969
PM & R	160	165	162
PSYCHIATRY - ADULT	762	824	770
PSYCHIATRY - CHILD	63	103	85
RADIOLOGY	0	1	1
RADIATION THERAPY	0	3	3
SURGERY	2,903	3,182	3,103
UROLOGY	1,025	862	845
TOTAL	18,350	19,336	18,700

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
COMPARATIVE DEMAND ANALYSIS
PATIENT DAYS

SCHEDULE II

PATIENT DAYS	1987-88 PLANNED BUDGET	1987-88 PROJECTION	1988-89 BUDGET
CLINICAL RESEARCH	2,254	1,560	1,490
DENTISTRY	119	114	109
DERMATOLOGY	206	156	149
FAMILY PRACTICE	149	64	61
GYNECOLOGY	5,903	6,527	6,235
MEDICINE	31,771	32,750	31,298
NEUROLOGY	2,527	2,056	1,963
NEUROSURGERY	5,967	6,668	6,369
NEWBORN	1,098	1,084	1,036
NUCLEAR MEDICINE	6	0	0
OBSTETRICS	2,586	2,697	2,577
OPHTHALMOLOGY	2,963	3,184	2,822
ORTHOPAEDICS	7,259	7,677	7,333
OTOLARYNGOLOGY	1,910	1,756	1,677
PEDIATRICS	34,079	32,904	30,222
PM & R	3,519	3,413	3,260
PSYCHIATRY - ADULT	16,908	15,534	14,140
PSYCHIATRY - CHILD	2,141	2,150	1,728
RADIOLOGY	0	1	1
RADIATION THERAPY	0	6	6
SURGERY	27,742	29,262	27,975
UROLOGY	3,893	3,402	3,249
TOTAL	153,000	152,965	143,700

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
COMPARATIVE DEMAND ANALYSIS
CLINIC VISITS

SCHEDULE III

AMBULATORY CARE	1987-88 PLANNED BUDGET	1987-88 PROJECTION	1988-89 BUDGET
CLINIC VISITS	218,739	227,459	228,272
EMERGENCY ROOM VISITS	16,212	15,716	15,716
THERAPEUTIC RADIOLOGY VISITS	16,917	18,537	18,537
AMBULATORY SURGERY VISITS	3,792	4,004	3,575
TOTAL	255,660	265,716	266,100
COMMUNITY UNIVERSITY HEALTH CARE CENTER	48,000	50,000	50,000
HOME HEALTH	9,269	8,792	9,600

University of Minnesota Hospital and Clinic
Deductions from Charges
For Fiscal Years 1987-88 and 1988-89

SCHEDULE IV

	1987-88 PLANNED BUDGET	1987-88 PROJECTION	1988-89 BUDGET
Billing Adjustments (a)	$8,960,000	$9,984,000	$10,863,000
HMO/PPO Discounts (b)	6,465,000	9,020,000	8,966,000 (d)
Government Contractual Adjustments (c)	26,564,000	18,496,000	24,850,000
Provision for Uncollectables	3,312,000	3,665,000	3,992,000
TOTAL	$45,301,000	$41,165,000	$48,671,000

a) Includes Reference Lab billings, Kidney Acquisition adjustments, Charitable Care and other miscellaneous billing adjustments.

b) Includes HMO's and BCBSM.

c) Includes Medicare, Medical Assistance, GAMC, and other government program writeoffs.

d) Decline essentially based on anticipated volume reductions.

University of Minnesota Hospital and Clinic
Other Operating Revenue Summary
For Fiscal Years 1987-88 and 1988-89

Schedule V

	1987-88 Planned Budget	1987-88 Projection	1988-89 Budget
Food Services	$1,348,000	$1,491,000	$1,528,000
Parking Services	500,000	576,000	576,000
Department Non-Patient	79,000	73,000	48,000
CUHCC Grants	1,067,000	1,168,000	1,105,000
Reference Lab Income	1,544,000	1,547,000	1,4[illegible]00
Pro Fees -- Net Revenue	1,352,000	1,477,000	1,5[illegible]
X-Ray Silver Salvage	0	217,000	0
Donations to Operations from Restricted Funds	0	20,000	0
Interest Income on Construction Fund Held By First Nat'l Bank	1,576,000	2,232,000	2,407,000
Writedown of Current Assets	0	(121,000)	0
TOTAL	$7,466,000	$8,680,000	$8,684,000

'NIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
FTE SUMMARY

SCHEDULE VI

1987-88 Budget	1987-88 Projected	1988-89 Budget
3797.0	3985.8 *	3927.0

* Major increases include 107 FTE increase in ancillary departments (laboratory, pharmacy, heart cath, etc.), 44 FTE increase in nursing, 24 FTE increase in administrative departments (primarily information systems and finance), and 10 FTE increase in support service departments.

NIVERSITY OF MINNESOTA HOSPITAL & CLINIC
OR FISCAL YEARS 1987-[illegible] AND 1988-89
HOSPITAL-WIDE PRODUCTI[illegible]TY ANALYSIS

SCHEDULE VII

1987-88 Budget	3797 FTE
1988-89 Budget	3927 FTE
Net Increase	130 FTE

Factor	Percentage	Impact
Increase in Admissions/ Clinic Visits	2.5%	47.5* FTE
Program/Intensity Changes	3.6%	68.3* FTE
Contract cost shifts/Offsets	NA	23.9 FTE
		139.7 FTE
External/Regulatory Impact		6.5 FTE
		146.2

*50% fixed cost, 50% variable cost used

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
HOSPITAL-WIDE PRODUCTIVITY ANALYSIS

SCHEDULE VIII

1987-88 Budget	3797.0 FTE
1987-88 Projected	3985.8 FTE
Net Increase	188.8 FTE

Factor	Percentage	Impact
Increase in Admissions/ Clinic Visits	5.0%	95.0*
Program/Intensity Changes	-.6%	-11.4*
Contract Cost Shifts/Offsets	NA	8.5
		92.1

*50% fixed cost, 50% variable cost used

'NIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
FOR FISCAL YEARS 1987-88 AND 1988-89
HOSPITAL-WIDE PRODUCTIVITY ANALYSIS

SCHEDULE I

1987-88 Projected	3985.8	FTE
1988-89 Budget	3927.0	FTE
Net Decrease	58.8	FTE

Factor	Percentage	Impact
Decrease in Admissions	-3.3%	-65.8* FTE
Intensity/Program Changes	+5.0%	+99.6* FTE
Contract Cost Shifts/Offsets	NA	+15.4 FTE
Net		+49.2 FTE
External Regulatory Impact		6.5 FTE
		+55.7

*50% fixed cost, 50% variable cost used

University of Minnesota Hospital & Clinic
Expenditure Summary: 1987-88 Projection vs 1988-89 Budget
For Fiscal Years 1987-88 and 1988-89

Schedule X

	1987-88 Planned Budget	1987-88 Projection	Variance	Percent Variance	1988-89 Budget	Increase/ (Decrease)	Percent Change
Expenditures							
Salaries	$101,075,000	$104,669,000	$3,594,000	3.6%	$106,821,000	$2,152,000	2.1%
Fringe Benefits	19,140,000	21,613,000	2,473,000	12.9%	24,605,000	2,992,000	13.8%
Academic Contracts	1,960,000	2,041,000	81,000	4.1%	2,128,000	87,000	4.3%
Resident Contracts	5,533,000	5,681,000	148,000	2.7%	5,907,000	226,000	4.0%
Physician Compensation	2,683,000	2,898,000	215,000	8.0%	3,056,000	158,000	5.5%
Total Salary, F.B. & Fees	$130,391,000	$136,902,000	$6,511,000	5.0%	$142,517,000	$5,615,000	4.1%
Laundry & Linen	$2,106,000	$2,291,000	$185,000	8.8%	$2,418,000	$127,000	5.5%
Raw Food	1,688,000	1,680,000	(8,000)	-0.5%	1,760,000	80,000	4.8%
Drugs	20,236,000	18,089,000	(2,147,000)	-10.6%	19,414,000	1,325,000	7.3%
Blood & Blood Derivatives	5,853,000	7,375,000	1,522,000	26.0%	8,255,000	880,000	11.9%
Medical Supplies	13,940,000	15,003,000	1,063,000	7.6%	16,404,000	1,401,000	9.3%
Utilities	4,255,000	4,006,000	(249,000)	-5.9%	4,143,000	137,000	3.4%
Insurance	1,008,000	1,186,000	178,000	17.7%	1,383,000	197,000	16.6%
Rental	2,902,000	3,445,000	543,000	18.7%	3,700,000	255,000	7.4%
Maintenance & Repair	4,252,000	3,858,000	(394,000)	-9.3%	4,475,000	617,000	16.0%
Communications	1,476,000	1,754,000	278,000	18.8%	1,780,000	26,000	1.5%
Campus Administration Expense	6,471,000	244,000	(6,227,000)	-96.2%	256,000	12,000	5.0%
Depreciation	16,694,000	17,353,000	659,000	3.9%	17,918,000	565,000	3.3%
Interest	12,005,000	12,216,000	211,000	1.8%	12,005,000	(211,000)	-1.7%
General Supplies & Expense	17,596,000	19,844,000	2,248,000	12.8%	22,048,000	2,204,000	11.1%
Total Supplies & Expense	$110,482,000	$108,344,000	($2,138,000)	-1.9%	$115,959,000	$7,615,000	7.0%
Total Expenditures	$240,873,000	$245,246,000	$4,373,000	1.8%	$258,476,000	$13,230,000	5.4%

University of Minnesota Hospital & Clinic
Explanation of Variances and Budgeted Increases
For Fiscal Years 1987-88 and 1988-89

Schedule X (a)

1. Physician Compensation	Variance in current year 1987-88 is due to an increase in the malpractice insurance premium for the labs physicians. The increase in the budget year is primarily inflation.
2. Laundry & Linen	Variance is due to greater usage, much of it in AIDS-related areas.
3. Drugs	Variance is due to three factors: (a) cost savings associated with membership in the University Hospital Consortium, (b) budgeted volume increase of 12% in outpatient pharmacy was not realized, and (c) we have received most of the AZT for AIDS patients at no cost. Increase in the budget year is due to inflation and the purchase of new drugs (i.e., AZT, TPA).
4. Blood & Blood Derivatives	Variance is primarily due to high usage of blood derivatives for BMT patients. Increase in budget year is because of inflation ($370,000) and the new wound healing clinic ($560,000).
5. Medical Supplies	Variance is primarily volume and program related: (a) $611,000 for Home Nutrition Program, (b) $550,000 in the Operating Rooms and Heart Catheterization Lab. Increase in budget year is primarily inflation ($630,000) and Home Nutrition Program ($650,000).
Insurance	Variance is due to a one-time payment of $163,000 for Renewal Project completed coverage policy. Increase in the budget year is primarily in the liability premium.
7. Rental	Variance is due to implementation of the PCA system for self-administration of medications and a multichannel infusion pump program for chemotherapy patients. Also, we have seen increased rental of Kin-air and Clinitron beds.
8. Maintenance & Repair	Increase in the budget year is due to an increase in the number of service contracts for equipment items coming off warranties: (a) Computer Services $125,000, (b) Labs $100,000, (c) Radiology $230,000.
9. Communications	Variance is due to higher phone costs in nursing and the communications center, and the unbudgeted expense for the U-ACCESS program ($100,000).
10. Campus Administration Expense	Variance is the result of using a new methodology for allocating campus administrative expense.
11. General Supplies & Expense	Variance is primarily due to the increase in contracts in the following areas: (a) BMT contract with the National Registry, $443,000, (b) perfusionist contract, related to patient volume, $198,000, (c) start-up costs for Home Nutrition program, $118,000, (d) temporary nurses, $305,000, (e) advertising, $106,500, and several lab contracts, $475,000. In addition, there was an increase in travel of $177,000 related to computer training, systems evaluation, and conferences. Increase in the budget year is due to inflation ($760,000), purchased software ($210,000), patient transportation ($250,000), physician recruitment ($498,000), and contracting for an entire year with the National Registry for BMT ($478,000).

University of Minnesota Hospital & Clinic
Non-Operating Revenue Summary
For Fiscal Years 1987-88 and 1988-89

Schedule XI

	1987-88 Planned Budget		1987-88 Projection		1988-89 Budget	
Appropriations	$14,414,000		$14,409,000		$14,725,000	
Interest on Appropriations	0		319,000		0	
Interest Income on Reserves	5,518,000		6,685,000	a	5,258,000	a
Shared Services	383,000		118,000		101,000	
Interest Income on Debt-Service Reserve Fund	1,808,000		2,605,000	b	1,094,000	b
Total	$22,123,000		$24,136,000		$21,178,000	

a) Interest Income on Reserves:
   (i) Variance in 87-88 is due to earning a higher rate of interest on the reserve balance than was budgeted.
   (ii) Decrease in budget year is from spending down our reserve balance on capital and other projects.

b) Interest Income on Debt Service Reserve Fund:
   (i) Variance reflects the gain of $1,118,000 on the sale of the Treasury Bill.
   (ii) Decrease in the budget year is due to maturing of bank note and, subsequently, earning a lower rate of interest on those funds.

University of Minnesota Hospital and Clinic
Summary Statement of Operations and Operating Cash Flow
For Fiscal Years 1987-88 and 1988-89

SCHEDULE XII

	1987-88 B O G	1987-88 Projection	1988-89 Budget
Gross Patient Charges	$ 249,618,000	$ 257,348,000	$ 281,419,000
Deductions from Charges	45,301,000	41,165,000	48,671,000
Other Operating Revenue	7,466,000	8,680,000	8,684,000
Total Revenue from Operations	$ 211,783,000	$ 224,863,000	$ 241,432,000
Expenditures			
Salaries	$ 101,075,000	$ 104,669,000	$ 106,821,000
Fringe Benefits	19,140,000	21,613,000	24,605,000
Contract Compensation	10,176,000	10,620,000	11,091,000
Medical Supplies, Drugs, Blood	40,029,000	40,467,000	44,073,000
Campus Administration Expense	6,471,000	244,000 a	256,000 a
Depreciation	16,694,000	17,353,000	17,918,000
Interest	12,005,000	12,216,000	12,005,000
General Supplies & Expense	35,283,000	38,064,000	41,707,000
Total Expenditures	$ 240,873,000	$ 245,246,000	$ 258,476,000
Net Revenue from Operations	$ (29,090,000)	$ (20,383,000)	$ (17,044,000)
Total Non-Operating Revenue	$ 22,123,000	$ 24,136,000	$ 21,178,000
Revenue Over/-Under Expenses	$ (6,967,000)	$ 3,753,000	$ 4,134,000
Add Non-Cash Outlays:			
Depreciation	$ 16,694,000	$ 17,353,000	$ 17,918,000
Campus Administration Expense	6,371,000	144,000 a	156,000 a
K.E. Utilities	139,000	175,000	144,000
Net Increase/(Decrease) to Working Capital	(2,624,000)	(3,403,000)	862,000
Transfer for PCN Liability Payment	0	1,058,000 b	0
Total Funds Provided	$ 13,613,000	$ 19,080,000	$ 23,214,000
Funds Applied			
Increase in Accounts Receivable	$ 2,797,000	$ 6,626,000	$ 5,891,000
Capital Obligations:			
Architectural Fees	0	465,000 c	0
Principal Payment on Bonds	2,799,000	2,706,000	2,891,000
Principal Payment on Equipment	1,265,000	1,169,000	1,014,000
Recurring Equipment and Renovation	5,452,000	4,623,000	8,000,000
Reserves for Equipment Rollforward	0	925,000 d	0
Interest Income Committed to Capital Plan	0	0	5,258,000 e
Total Funds Applied	$ 12,313,000	$ 16,514,000	$ 23,054,000
Total Cash Available from Operations	$ 1,300,000	$ 2,566,000	$ 160,000

NOTES TO CASH FLOW

a) The Campus Administration Expense allocation has been significantly reduced as a result of changes in allocation methods for University overhead that were approved by the Department of Health and Human Services. This will increase the amount of funds received by the university from federal contracts and grants. The Hospital pays $100,000 of the total allocated expense in cash.

b) The $1,058,268 transfer for PCN Liability is to pay off outstanding loan guarantees for Primary Care Network. The cash for the payment was transferred out of Board Designated Reserves. The liability for this was recognized in June of the 1986-87 fiscal year.

c) The $464,753 in Architectural fees is part of the $1,100,000 budgeted for Mayo Remodeling planning and design. The $1,100,000 was originally budgeted against the Renewal Project Construction Fund. $854,666 was charged to the Construction Fund before it was closed to any further activity.

d) The $925,054 identified in Reserves for Equipment Rollforward is for budgeted capital expenditures that we anticipate will not be paid for by June 30, 1988 and are therefore encumbering those dollars to provide for the payments in the 1988-89 fiscal year.

e) In the 1988-89 budget year we are planning to set aside the Investment Income earned on our Board Designated Reserves for Capital Expenditures as part of the long range Capital facilities planning. These funds will be dedicated toward capital expenditures and will not be used to offset operating costs.

UMHC Board Designated Fund Activity
6-30-87 through 2-29-88

	Unspecified	Specified	Total
Balance 6-30-87	$57,048,000	$ 8,511,000	$65,559,000
Interest Income on Reserves and Appropriations	5,006,000	-0-	5,006,000
Net Transfers from Trustee for Equipment, Renovation Expenses, and Debt Service Costs	10,281,000	-0-	10,281,000
Payment of Primary Care Network Loan Guarantees	<1,058,000>	-0-	<1,058,000>
Transfer of Cash for Abandonment Cost Note Payable	-0-	<2,500,000>	<2,500,000>
Transfer for:			
Community University Health Care Center	<1,500,000>	1,500,000	-0-
MRI-2	<3,600,000>	3,600,000	-0-
Architect Fees	<465,000>	465,000	-0-
Dermatology Clinic Space	<400,000>	400,000	-0-
Eye Clinic	<40,000>	40,000	-0-
Closed Plant Funds	155,000	<155,000>	-0-
Expenditures Against Equipment Rollforward Reserve		<109,000>	<109,000>
Expenditures Against Plant Funds		<259,000>	<259,000>
Transfer from Operations - Capital Encumbrances		53,000	53,000
Balance at 2-29-88	$65,427,000	$11,546,000	$76,973,000 *

*In addition to these funds, there is approximately $20,000,000 of borrowed funds remaining in the Unit J construction trustee held account which can be used for capital expenditures or debt retirement.

UMHC Board Designated Fund Activity
Projected 2-29-88 Through 6-30-88

	Unspecified	Specified	Total
Balance 2-29-88	$65,427,000	$11,546,000	$76,973,000
Investment Income on Reserves and Appropriations	1,998,000		1,998,000
Transfers for:			
Community University Health Care Center	150,000	<150,000>	
Dermatology Clinic Space	<230,000>	230,000	
Closed Plant Funds	93,000	<93,000>	
Orthopaedic Surgery Loan		<513,000>	<513,000>
Projected Expenditures:			
Community University Health Care Center		<350,000>	<350,000>
MRI-2		<117,000>	<117,000>
Architectural Fees		<465,000>	<465,000>
Plant Funds		<230,000>	<230,000>
Biliary Lithotripter - Lease Expense	<8,000>		<8,000>
Equipment Rollforward Reserve:			
Projected Expenditures Against 1986-87 Reserve		<776,000>	<776,000>
Transfer of Unexpended 1986-87 Reserve	238,000	<238,000>	
Transfer for 1987-88 Reserve		925,000	925,000
Projected Net Operating Subsidy	<4,742,000>		<4,742,000>
Projected Balance at 6-30-88	$62,926,000	$ 9,769,000	$72,695,000 *

*In addition to these funds, there is approximately $20,000,000 of borrowed funds remaining in the Unit J construction trustee held account which can be used for capital expenditures or debt retirement.

UMHC Board Designated Fund Activity
Projected 7-1-88 through 6-30-89

	Unspecified	Specified	Total
Balance 6-30-88	$62,926,000	$ 9,769,000	$72,695,000
Investment Income on Reserves	5,258,000		5,258,000
Transfer of Cash for Abandonment Cost Not Payable		<2,500,000>	<2,500,000>
Expenditures:			
Community University Health Care Center		<1,000,000>	<1,000,000>
MRI-2		<3,483,000>	<3,483,000>
Planning & Architecture Fees	<9,200,000>		<9,200,000>
Computer Hardware	<850,000>		<850,000>
Hyperthermia Equipment	<500,000>		<500,000>
Lithotripter I Upgrade	<400,000>		<400,000>
Operating Rooms	<250,000>		<250,000>
Biliary Lithotripter -			
Lease Expense	<92,000>		<92,000>
Purchase Cost	<1,100,000>		<1,100,000>
Projected Balance at 6-30-89	$55,792,000	$ 2,786,000	$58,578,000 *

*In addition to these funds, there is approximately $20,000,000 of borrowed funds remaining in the Unit J construction trustee held account which can be used for capital expenditures or debt retirement.

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

April 27, 1988

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period July 1, 1987 through March 31, 1988

The Hospital's operations through the month of March continued to reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. In addition, we experienced ancillary service utilization that was higher than anticipated. To highlight our position:

Inpatient Census: For the month of March, inpatient admissions totaled 1,632 or 76 above budgeted admissions of 1,556. Our overall average length of stay for the month was 8.2 days. Patient days for March totaled 13,193 and were 283 days over budget. The increase in admission levels over budget is primarily in the area of Medicine.

To recap our year-to-date inpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Admissions	14,170	13,666	14,237	571	4.2
Avg. Lnth. of Stay	8.3	8.4	8.0	-.4	-4.8
Patient Days	115,809	115,277	113,708	-1,569	-1.4
Avg. Daily Census	422.7	419.2	413.5	-5.7	-1.4
Percent Occupancy	71.9	72.0	71.3	-0.7	-0.9

Outpatient Census: Clinic visits for the month of March totaled 23,805 or 2,836 (13.5%) above budgeted visits of 20,969. Areas which experienced actual visits with large increases over budget were Ophthalmology, Psychology, and A.T.E.U. Community University Health Care Center (CUHCC) visits for the month of March totaled 4,235 or 45 (1.0%) above budgeted visits of 4,190, while Home Health visits of 949 for the month were 162 (20.5%) above budgeted visits of 787.

To recap our year-to-date outpatient census:

	1986-87 Actual	1987-88 Budget	1987-88 Actual	Variance	% Variance
Clinic Visits	182,947	187,610	194,130	6,520	3.5
CUHCC Visits	35,280	35,810	36,228	418	1.2
HHA Visits	7,305	6,958	6,874	-84	-1.2

Financial Operations: The Hospital's Statement of Operations shows total expenses over revenues of $1,252,354, a favorable variance of $4,865,828.

Patient care charges through March totaled $ 190,540,316 and were 2.4% over budget. Routine revenue was 2.2% under budget and reflected our year to date favorable patient day variance. Ancillary revenue was approximately $138,965,480 (4.3%) above budget and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $7,182 per admission compared to the budgeted average of $7,220 per admission. Outpatient revenue per clinic visit has averaged $189 compared to the budgeted average of $184.

Operating expenditures through March totaled $184,210,799 and were approximately $4,629,466 (2.6%) over budgeted levels. The overall variance relates to increased salary and fringe benefit costs.

Accounts Receivable: The balance in patient accounts receivable as of March, 1988 totaled $72,932,450 and represented 100.24 days of revenue outstanding. The overall decrease in our patient receivables in March of 12.82 days occurred due to large payments received from Medicare, Minnesota MA and Commercial Insurance.

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

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1987 TO MARCH 31, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$185,993,118	$190,540,316	$4,547,198	2.4%
Deductions from Charges	-33,781,151	-31,206,976	2,574,175	7.6%
Other Operating Revenue	4,412,625	4,817,278	404,653	9.2%
Total Operating Revenue	156,624,592	164,150,618	7,526,026	4.8%
Total Expenditures	-179,581,333	-184,210,799	-4,629,466	-2.6%
Net Operating Revenue	-22,956,741	-20,060,181	2,896,560	
Non-Operating Revenue and Expenses	16,838,559	18,807,827	1,969,268	11.7%
Revenue over Expense	($6,118,182)	($1,252,354)	$4,865,828	(1)

(1) Variance equals 2.8% of total budgeted revenue.

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Admissions	13,666	14,237	571	4.2%
Patient Days	115,277	113,708	-1,569	-1.4%
Average Daily Census	419.2	413.5	-5.7	-1.4%
Average Length of Stay	8.5	8.0	-0.5	-5.9%
Percentage Occupancy	72.0%	71.3%	-0.7	0.9%
Outpatient Clinic Visits	187,610	194,130	6,520	3.5%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

STATEMENT OF OPERATIONS

FOR THE PERIOD JULY 1, 1987 TO MARCH 31, 1988

	Budgeted	Actual	Variance Over/-Under Budget	Variance %
Gross Patient Charges	$185,993,118	$190,540,316	$4,547,198	2.4%
Deductions from Charges	33,781,151	31,206,976	-2,574,175	-7.6%
Other Operating Revenue	4,412,625	4,817,278	404,653	9.2%
Total Revenue from Operations	$156,624,592	$164,150,618	$7,526,026	4.8%
Expenditures				
Salaries	$76,157,443	$79,103,033	$2,945,590	3.9%
Fringe Benefits	14,421,200	16,061,481	1,640,281	11.4
Contract Compensation	7,599,239	7,863,136	263,897	3.5
Medical Supplies, Drugs, Blood	29,705,582	29,092,534	-613,048	-2.1
Campus Administration Expense	4,862,391	4,862,391	0	
Depreciation and Amortization	12,502,046	13,022,828	520,782	4.2
General Supplies & Expense	34,333,432	34,205,396	-128,036	-0.4
Total Expenditures	$179,581,333	$184,210,799	$4,629,466	2.6%
Net Revenue from Operations	($22,956,741)	($20,060,181)	$2,896,560	
Non-Operating Revenues and Expenses				
Appropriations	$10,830,417	$10,826,475	($3,942)	
Interest Income on Reserves	4,364,744	5,545,499	1,180,755	27.1
Shared Services	287,398	125,185	-162,213	-56.4
Investment Income on Trustee Held Assets	1,356,000	2,310,668	954,668	70.4
Total Non-Operating Revenues and Expenses	$16,838,559	$18,807,827	$1,969,268	11.7%
Revenue Over Expense	($6,118,182)	($1,252,354)	$4,865,828	(1)

(1) Variance equals 2.8% of total budgeted revenue.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

BALANCE SHEETS

MARCH 31, 1988 AND JUNE 30, 1987

ASSETS

	3/31/88	6/30/87
CURRENT ASSETS		
Operating Cash	($796,089)	$34,475
Reserve Cash- Third Party Payable	8,689,424	14,305,751
Unrealized Appropriation Cash	3,426,225	0
Reserve Cash- Short Term Debt	2,500,000	2,500,000
Reserve Cash-Bond Int. & Prin. Pay.	2,376,651	4,214,376
Accounts Receivable		
Patient Receivables	72,932,450	72,366,775
Other Receivables	2,553,923	2,018,472
	75,486,373	74,385,247
Less Allowances for Losses in Collection	-5,813,140	-5,577,999
Less Allowances for Discounts to Third Party Payors	-11,678,859	-13,623,861
	57,994,374	55,183,387
Trustee Held Assets	0	1,020,755
Inventories of Drugs & Supplies	4,773,670	4,863,369
Prepaid Expenses	459,121	393,145
Silver Flake	216,753	0
TOTAL CURRENT ASSETS	$79,640,129	$82,515,258
BOARD DESIGNATED ASSETS:		
Board Designated Assets Available for Assignment		
Cash & Investments	$63,943,441	$56,442,424
Accrued Interest	2,143,595	605,020
	66,087,036	57,047,444
Assigned Cash & Investments	11,409,895	8,508,004
TOTAL BOARD DESIGNATED ASSETS	$77,496,931	$65,555,448
DEFERRED THIRD PARTY REIMBURSEMENT	$9,591,390	$10,172,239
OTHER ASSETS	258,189	258,189
LAND, BUILDINGS & EQUIPMENT		
Land, Buildings & Improvements	$182,563,795	$180,359,060
Equipment	73,696,137	68,008,620
	256,259,932	248,367,680
Less Accumulated Depreciation	-78,685,190	-67,640,664
	177,574,742	180,727,016
Construction in Progress	5,484,536	8,210,281
TOTAL LAND, BUILDINGS & EQUIPMENT	$183,059,278	$188,937,297
TRUSTEE HELD ASSETS	$41,558,190	$51,195,164
DEFERRED DEBT EXPENSE	$1,899,968	$2,023,259
	$393,504,075	$400,656,854

LIABILITIES AND FUND BALANCES

	3/31/88	6/30/87
CURRENT LIABILITIES		
Accounts Payable	$4,392,227	$6,101,90
Payable to Third Party Contr. Payors	8,689,424	14,305,75
Salaries, Wages and Payroll Taxes	6,659,146	7,080,11
Accrued Vacation	7,256,468	6,706,16
Accrued Professional Fees and Physician Compensation	2,242,607	1,625,51
Contracts Payable	1,441,862	2,36
Construction Retainages	0	918,37
Interest Payable	1,947,106	4,263,16
Current Portion of Long-Term Debt	3,976,886	3,796,44
Promissory Notes Payable	2,500,000	2,500,00
TOTAL CURRENT LIABILITIES	$39,105,726	$47,299,79
LONG-TERM DEBT, LESS CURRENT PORTION	$176,800,583	$182,896,90
UNRESTRICTED FUND BALANCE	$177,597,766	$170,460,15
	$393,504,075	$400,656,85

RESTRICTED ASSETS

Cash and Investments	$5,711,397	$4,856,396

RESTRICTED FUND BALANCES

Fund Balances		
Endowment Funds	$1,920,650	$1,846,7
Gift Funds	3,790,747	3,009,6
	$5,711,397	$4,856,3

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

March 20, 1988

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

SUBJECT: Bad Debts - Third Quarter, Fiscal Year 1988

The total amount recommended for bad debt for Hospitals and Clinics accounts receivable during the third quarter of 1987-88 is $682,453.25, represented by 1,710 accounts. Bad debt recoveries during the period amounted to $11,413.55 (63 accounts), leaving a net charge-off of $671,039.70.

The net bad debts of $671,039.70 for the third quarter were 1.06% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($816,463.00)

A statistical summary is attached along with a detailed description of losses over $2000.00 and recoveries over $200 for each month of the third quarter.

Year-to-date bad debts have amounted to $2,321,402.59, represented by 4,648 accounts. Recoveries during these three quarters amounted to $29,277.13 (198 accounts), leaving a net charge-off of $2,292,125.46.

The net bad debts of $2,292,125.46, for the three quarters were 1.20% of gross charges. This compares to a budgeted level of bad debts of 1.33% ($2,468,033.00).

Along with a year-to-date statistical summary, we have also included reports with a break down of bad debts by residence and the admitting clinical service.

attachments

CPF:hhm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JANUARY 1988 THROUGH MARCH 1988

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	43,223.60	95	99,780.37	17	143,003.97	112
Bad Debt (702) Charity Care	32,914.56	67	44,520.41	10	77,434.97	77
Total	76,138.16	162	144,300.78	27	220,438.94	189
Recoveries	(1,509.78)	10	(6,481.69)	1	(7,991.47)	11
Net Total	$ 74,628.38	162*	$ 137,819.09	27*	$ 212,447.47	189*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 9,304.56	24	$ 219,305.70	7	$ 228,610.26	31
Bad Debt (701) Write-Offs	120,322.45	1110	41,638.26	5	161,960.71	1115
Bad Debt (702) Charity Care	57,273.13	370	14,170.21	5	71,443.34	375
Total	186,900.14	1504	275,114.17	17	462,014.31	1521
Recoveries	(3,422.08)	52	(000.00)	0	(3,422.08)	52
Net Total	$ 183,478.06	1504*	$ 275,114.17	17*	$ 458,592.23	1521*
INPATIENT AND OUTPATIENT TOTAL	$ 258,106.44	1666*	$ 412,933.26	44*	$ 671,039.70	1710*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 000.00	0	$ 000.00	0	$ 000.00	0
Outpatient (710)	000.00	0	.00	0	000.00	0
Total	000.00	0	000.00	0	000.00	0
Recoveries	(000.00)	0	(000.00)	0	(000.00)	0
Net Total	$ 000.00	0*	$ 000.00	0*	$ 000.00	0*
TOTAL NET BAD DEBT	$ 258,106.44	1666*	$ 412,933.26	44*	$ 671,039.70	1710*

NOTE: More than $2,000 amount includes legal settlements totaling $31,026.98

DOLLARS BUDGETED **$ 816,463.00**

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JANUARY 1988 THROUGH MARCH 1988

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$1,537.76	34	19,788.70	46	21,897.14	15	46,488.73	14	53,291.64	3	143,003.97	112
Bad Debt (702) Charity Care	$783.68	15	$17,293.00	41	$14,837.88	11	$31,929.81	9	$12,590.60	1	$77,434.97	77
Total	$2,321.44	49	$37,081.70	87	$36,735.02	26	$78,418.54	23	$65,882.24	4	$220,438.94	189
Recoveries	($125.22)	5	($1,384.56)	5	$0.00	0	($6,481.69)	1	0.00	0	($7,991.47)	11
Net Total	$2,196.22	49 *	$35,697.14	87 *	$36,735.02	26 *	$71,936.85	23 *	$65,882.24	4 *	$212,447.47	189 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$340.32	7	$7,220.44	16	$1,743.80	1	$23,142.14	4	$196,163.56	3	$228,610.26	31
BAD DEBT (701) WRITE-OFFS	$26,528.91	759	$87,428.60	346	$6,364.94	5	$18,984.55	4	$22,653.71	1	$161,960.71	1115
Bad Debt (702) Charity Care	$9,674.91	232	$34,895.21	130	$12,703.01	8	$14,170.21	5	$0.00	0	$71,443.34	375
Total	$36,544.14	998	$129,544.25	492	$20,811.75	14	$56,296.90	13	$218,817.27	4	$462,014.31	1521
Recoveries	($1,861.80)	42	($2,360.28)	10	$0.00	0	$0.00	0	$0.00	0	($3,422.08)	52
Net Total	$35,482.34	998 *	$127,183.97	492 *	$20,811.75	14 *	$56,296.90	13 *	$218,817.27	4 *	$458,592.23	1521 *
INPATIENT AND OUTPATIENT TOTAL	$37,678.56	1047 *	$162,881.11	579 *	$57,546.77	40 *	$128,233.75	36 *	$284,699.51	8 *	$671,039.70	1710 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Outpatient (710)	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Total	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Recoveries	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Net Total	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *	$0.00	0 *
TOTAL NET BAD DEBT	$37,678.56	1047 *	$162,881.11	579 *	$57,546.77	40 *	$128,233.75	36 *	$284,699.51	8 *	$671,039.70	1710 *
DOLLARS BUDGETED											$816,463.00	

* Net total of accounts do not include recoveries

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1987 THROUGH MARCH 1988

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Medicare (610) Non-Recoverable	$ --	--	$ --	--	$ --	--
Bad Debt (701) Write-Offs	182,721.13	336	424,921.71	64	607,642.84	400
Bad Debt (702) Charity Care	79,736.67	124	262,177.55	40	341,914.22	164
Total	262,457.80	460	687,099.26	104	949,557.06	564
Recoveries	(4,993.77)	38	(6,481.69)	1	(11,475.46)	39
Net Total	$ 257,464.03	460*	$ 680,617.57	104*	$ 938,081.60	564*
OUTPATIENT						
Medicare (610) Non-Recoverable	$ 21,198.82	55	$ 692,250.04	22	$ 713,448.86	77
Bad Debt (701) Write-Offs	393,908.20	3231	100,765.20	20	494,673.40	3251
Bad Debt (702) Charity Care	128,098.75	730	28,010.71	10	156,109.46	740
Total	543,205.77	4016	821,025.95	52	1,364,231.72	4068
Recoveries	(13,705.66)	156	(2,231.35)	1	(15,937.01)	157
Net Total	$ 529,500.11	4016*	$ 818,794.60	52*	$1,348,294.71	4068*
INPATIENT AND OUTPATIENT TOTAL	$ 786,964.14	4476*	$1,499,412.17	156*	$2,286,376.31	4632*
MEDICARE BAD DEBTS						
Inpatient (710)	$ 6,079.23	11	$ 000.00	0	$ 6,079.23	11
Outpatient (710)	1,534.58	5	.00	0	1,534.58	5
Total	7,613.81	16	000.00	0	7,613.81	16
Recoveries	(1,864.66)	1	(000.00)	0	(1,864.66)	2
Net Total	$ 5,749.15	16*	$ 000.00	0*	$ 5,749.15	16*
TOTAL NET BAD DEBT	$ 792,713.29	4492*	$1,499,412.17	156*	$2,292,125.46	4648*

NOTE: More than $2,000 amount includes legal settlements totaling $58,519.75

DOLLARS BUDGETED **$2,468,033.00**

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1987 THROUGH MARCH 1988

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Medicare (610) Non-Recoverable	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0
Bad Debt (701) Write-Offs	$3,741.89	89	81,533.43	180	97,445.81	67	207,487.42	54	217,434.29	10	607,642.84	400
Bad Debt (702) Charity Care	$927.79	20	$28,463.21	69	$50,345.67	69	$143,890.77	35	$118,286.78	5	$341,914.22	164
Total	$4,669.68	109	$109,996.64	249	$147,791.48	136	$351,378.19	89	$335,721.07	15	$949,557.06	564
Recoveries	($840.74)	26	($2,550.48)	11	($1,602.55)	1	($6,481.69)	1	$0.00	0	($11,475.46)	39
Net Total	$3,828.94	109 *	$107,446.16	249 *	$146,188.93	136 *	$344,896.50	89 *	$335,721.07	15 *	$938,081.60	564 *
OUTPATIENT												
Medicare (610) Non-Recoverable	$836.14	16	$13,941.22	35	$6,421.46	4	$70,551.33	14	$621,698.71	8	$713,448.86	77
BAD DEBT (701) WRITE-OFFS	$75,555.15	2136	$282,765.32	1068	$35,587.73	27	$78,111.49	19	$22,653.71	1	$494,673.40	3251
Bad Debt (702) Charity Care	$17,615.56	426	$81,398.98	285	$29,084.29	19	$28,010.71	10	$0.00	0	$156,109.46	740
Total	$94,006.85	2578	$378,105.44	1388	$71,093.48	50	$176,673.53	43	$644,352.42	9	$1,364,231.72	4068
Recoveries	($3,038.27)	112	($10,667.39)	44	$0.00	0	($2,231.35)	1	$0.00	0	($15,937.01)	157
Net Total	$90,968.58	2578 *	$367,438.05	1388 *	$71,093.48	50 *	$174,442.18	43 *	$644,352.42	9 *	$1,348,294.71	4068 *
INPATIENT AND OUTPATIENT TOTAL	$94,797.52	2687 *	$474,884.21	1637 *	$217,282.41	186 *	$519,338.68	132 *	$980,073.49	24 *	$2,286,376.31	4632 *
MEDICARE BAD DEBTS												
Inpatient (710)	$0.00	0	$4,479.23	10	$1,600.00	1	$0.00	0	$0.00	0	$6,079.23	11
Outpatient (710)	$98.97	3	$1,435.61	2	$0.00	0	$0.00	0	$0.00	0	$1,534.58	5
Total	$98.97	3	$5,914.84	12	$1,600.00	1	$0.00	0	$0.00	0	$7,613.81	16
Recoveries	($64.66)	1	$0.00	0	($1,800.00)	1	$0.00	0	$0.00	0	($1,864.66)	2
Net Total	$34.31	3 *	$5,914.84	12 *	($200.00)	1 *	$0.00	0 *	$0.00	0 *	$5,749.15	16 *
TOTAL NET BAD DEBT	$94,831.83	2690 *	$480,799.05	1649 *	$217,082.41	187 *	$519,338.68	132 *	$980,073.49	24 *	$2,292,125.46	4648 *
DOLLARS BUDGETED											$2,468,033.00	

* Net total of accounts do not include recoveries

THIRD QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS

BY STATE

STATE	THIRD QUARTER NUMBER	THIRD QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Alabama	1	50.00	1	50.00
Alaska			1	28.96
Arizona	7	1,359.26	11	1,765.09
Arkansas	11	2,032.17	13	2,943.37
California	13	7,399.16	18	9,029.02
Colorado			7	364.00
Connecticut			3	1,556.60
Delaware				
Dist. of Colombia	1	223.60	1	223.60
Florida	4	246.30	13	1,293.81
Georgia			2	299.00
Hawaii			1	83.99
Idaho				
Illinois	16	4,224.97	55	64,340.13
Indiana	8	1,278.97	12	2,521.15
Iowa	10	1,172.65	39	16,306.90
Kansas	2	552.12	8	952.24
Kentucky			1	122.90
Louisiana	3	132.32	6	1,529.52
Maine				
Maryland				
Massachusetts	1	136.88	3	483.95
Michigan	17	6,449.09	44	33,394.76
Minnesota	1342	305,997.84	3810	994,657.93
Mississippi				
Missouri	4	1,228.09	6	3,545.10
Montana	3	634.80	5	3,842.16
Nebraska			1	236.34
Nevada				
New Hampshire			1	19.00
New Jersey	3	1,127.19	5	1,683.29
New Mexico	1	106.40	2	2,621.75
New York	12	3,307.61	14	3,530.82
North Carolina			13	7,071.82
North Dakota	26	10,575.56	70	30,943.31
Ohio	2	1,663.63	3	1,871.01
Oklahoma	1	271.00	3	1,630.91
Oregon	1	30.40	6	1,244.77
Pennsylvania	3	177.97	10	2,093.48
Puerto Rico				

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THIRD QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS

BY STATE/Page Two

STATE	THIRD QUARTER NUMBER	THIRD QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Rhode Island	1	61.00	1	61.00
South Carolina			1	240.92
South Dakota	46	24,638.16	96	155,086.94
Tennessee			1	2,250.00
Texas	4	5,285.30	18	10,696.74
Utah	4	332.01	4	332.01
Vermont				
Virginia			2	84,824.39
Washington	10	1,219.20	19	3,308.94
West Virginia	1	424.09	1	424.09
Wisconsin	109	38,792.73	199	89,269.87
Wyoming			2	182.12
Out-of-Country	6	1,036.45	20	5,286.99
Total	1673	422,166.92	4552	1,544,244.69
Control		260,286.33		777,157.90
GRAND TOTAL		682,453.25		2,321,402.59

THIRD QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS

BY SERVICE

ADMITTING SERVICE	THIRD QUARTER NUMBER	THIRD QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Anesthesiology				
Clinical Research	4	2,304.04	8	6,610.10
Dentistry	2	3,041.02	4	4,880.19
Dermatology	1	599.00	1	599.00
Family Practice				
OB			1	687.80
NB			1	123.07
GYN	3	3,142.03	12	17,666.45
GYN-Oncology	7	13,946.56	16	20,653.61
Lab Medicine & Pathology				
Medicine-Blue	6	34,565.65	14	43,250.45
Green	3	2,592.78	14	6,534.98
Masonic (Onc)	16	21,386.37	40	99,575.40
Purple			3	5,436.84
Red A	2	692.44	5	9,286.10
Red B			1	648.23
Rose A	3	4,474.45	8	7,302.78
Rose B				
White A	11	17,618.58	23	28,269.26
White B	3	741.38	14	10,559.39
Yellow A	3	370.26	11	23,768.26
Yellow B			4	3,027.64
Neurology	4	1,877.41	15	19,021.01
Neuro-epilepsy	2	376.39	4	3,408.03
Neurosurgery	13	9,855.28	32	76,918.77
New Born-General	2	1,381.92	8	3,738.85
Obstetrics-General	6	3,641.80	15	16,711.88
-Midwife			1	1,756.73
Opthamology	9	5,722.96	15	10,000.63
Orthopaedic Surgery	7	8,349.87	27	64,112.38
Otolaryngology	3	2,197.18	12	8,862.18
Pediatrics-General	17	20,987.64	45	66,837.92
Neurology			1	12,175.23
Neurosurgery	4	8,356.19	7	12,600.94
Opthalmology	2	413.03	2	413.03
Orthopaedics	1	549.80	3	5,185.32
Otolaryngology	3	3,538.73	5	5,618.87
Surgery Green			2	2,513.42
Surgery Orange			1	49.10
Surg. Transplant	1	1,001.61	2	1,109.92
Urology			7	9,210.09
Physical Med. & Rehab.			7	44,391.94
Psychiatry-Child	1	24.50	3	2,069.70
-Adult	7	5,205.18	27	54,702.16
Radiology				

continued on next page

THIRD QUARTER FISCAL YEAR - 1988
and YEAR-TO-DATE BAD DEBTS

BY SERVICE/Page Two

ADMITTING SERVICE	THIRD QUARTER NUMBER	THIRD QUARTER AMOUNT	TOTAL FSY 88 NUMBER	TOTAL FSY 88 AMOUNT
Surgery-Blue	11	8,543.92	38	105,761.15
Orange	1	287.89	5	1,911.23
Purple	6	2,266.44	14	11,460.41
Red	8	11,196.37	22	32,764.34
White	3	2,260.77	25	31,194.22
Therapeutic Radiology				
Urology	9	8,405.56	31	30,720.77
Unknown	5	8,523.94	19	31,536.52
Outpatient	1484	201,727.98	3977	588,608.40
Total	1673	422,166.92	4552	1,544,244.69
Control Accounts		260,286.33		777,157.90
GRAND TOTAL		682,453.25		2,321,402.59

BAD DE[illegible]RITEOFF (CONTROL) ACCOUNTS
1ST HA[illegible] J87-88

610 MEDICARE NON-RECOVERABLE

ACCT #	NAME OF ACCOUNT	JULY	AUGUST	SEPTEMBER	1ST QTR TOTAL	OCTOBER	NOVEMBER	DECEMBER	2ND QTR TOTAL
6901987	MEDI: DIALYSIS N/A RAD	356.00			356.00				
6901995	MEDI: DIALYSIS N/A CL FEE			50.10	50.10	-279.50	-15.50	31.00	-264.00
6902092	MEDI: DIALYSIS N/A PHARM	8,066.91		5,565.47	13,632.38	1,945.36	2,394.33	4,684.32	9,024.01
6907950	MED DENIED - HOSP LIABLE	-661.69	116.88	-36.00	-580.81	1,319.20	470.00	6,416.29	8,205.49
6914337	MEDI: CAPD N/A CLINIC FEE			423.00	423.00		31.00	168.00	199.00
6914485	MEDI: DIALYSIS N/A SUPP	650.85		249.65	900.50		182.20	670.40	852.60
6915169	MEDI: PMR-NO RECORD				0.00		5,671.67	51.07	5,722.74
6916639	MED - ESRD FUND	392.00	198.64	102.21	692.85	79.92	184.65	32.93	297.50
6919914	MHCS-MEDICARE DENIAL W/O			325.00	325.00	252.00	298.00		550.00
6925093	MED-DIALYSIS:ROUTINE LAB	2,254.45	2,019.80	856.60	5,130.85	1,413.10	-2,231.35	3,722.20	2,903.95
6925101	MED-DIALYSIS:COMPOSITE	113,533.24	72,619.32	61,050.30	247,202.86	55,987.30	6,613.75	122,344.99	184,946.04
6925119	MED-DIALYSIS:OXYGEN	583.90	99.40	60.20	743.50	60.20		240.80	301.00
701	BAD DEBT WRITEOFFS				0.00				
6906549	LEGAL SETTLEMENTS	3,036.60	5,021.08	6,467.68	14,525.36	7,735.47	1,644.92	915.83	10,296.22
6910301	BAD DEBT AGCY UND $50	-96.71	-5.63	381.38	279.04	66.24	4.00	126.29	196.53
6912802	REFUNDS - UNLOCATABLE	-19.50			-19.50				
6910608	BAD DEBT - MED NC CHGS		761.59		761.59	5,231.94	639.95		5,871.89
	TOTAL	128,096.05	80,831.08	75,495.59	284,422.72	73,811.23	15,887.62	139,404.12	229,102.97

2ND HALF 1987-88

610 MEDICARE NON-RECOVERABLE

ACCT#	NAME OF ACCOUNT	JANUARY	FEBRUARY	MARCH	3RD QTR TOTAL	APRIL	MAY	JUNE	4TH QTR TOTAL
6901987	MEDI: DIALYSIS N/A RAD	82.10	57.20	622.10	761.40				
6901995	MEDI: DIALYSIS N/A CL FEE	18.00			18.00				
6902092	MEDI: DIALYSIS N/A PHARM	986.03	446.02	5,684.73	7,116.78				
6907950	MED DENIED - HOSP LIABLE	660.38	741.12	7,581.36	8,982.86				
6914337	MEDI: CAPD N/A CLINIC FEE			206.00	206.00				
6914485	MEDI: DIALYSIS N/A SUPP		38.00	577.15	615.15				
6915169	MEDI: PMR-NO RECORD	47.52			47.52				
6916639	MED - ESRD FUND	242.43	231.91		474.34				
6916761	MEDI:DIAL JUSTIF UNVAILA		148.60		148.60				
6919336	MEDI: DIALYSIS N/A ECG	32.50		631.50	664.00				
6919914	MHCS-MEDICARE DENIAL W/O	231.00	533.00	65.00	829.00				
6925093	MED-DIALYSIS:ROUTINE LAB	1,743.80	7,677.95	2,198.10	11,619.85				
6925101	MED-DIALYSIS:COMPOSITE	58,824.43	87,339.69	49,999.44	196,163.56				
6925119	MED-DIALYSIS:OXYGEN	270.90	481.60	210.70	963.20				
701	BAD DEBT WRITEOFFS				0.00				
6906549	LEGAL SETTLEMENTS	3,435.90	22,653.71	4,937.37	31,026.98				
6910301	BAD DEBT AGCY UND $50	16.71	36.00	596.38	649.09				
6912802	REFUNDS - UNLOCATABLE								
6910608	BAD DEBT - MED NC CHGS								
	TOTAL	66,591.70	120,384.80	73,309.83	260,286.33	0.00	0.00	0.00	

		CREDITS	TOTAL
	1ST QUARTER TOTAL	284,422.72	819.53	285,242.25
	2ND QUARTER TOTAL	229,102.97	2,526.35	231,629.32
	3RD QUARTER TOTAL	260,286.33	0.00	260,286.33
	4TH QUARTER TOTAL			0.00
	TOTAL	773,812.02	3,345.88	777,157.90

cepted for publication. The requirement that there be no advance publicity (beyond that associated with presentations at scientific meetings) ensures that all claims will be accompanied by the evidence on which they are based.

The aspirin report was a case in point. Some critics maintain that the results of the aspirin study were too important to withhold from the public — even for only the five weeks required to review and publish it. But the full data in that report showed that the results needed medical interpretation and could not safely be assumed to apply to the general population. The untoward consequences of widespread ill-advised use of aspirin might have done more harm than good. How can one weigh the human cost of the hemorrhagic strokes and gastrointestinal hemorrhages that might have been caused by aspirin against that of the myocardial infarctions that might have been prevented? Even though it requires no prescription, long-term prophylaxis with aspirin should clearly be initiated only on the advice of a physician, and to give such advice the physician needs to have the full report at hand.

The dissemination of medical reports in the media before all the evidence is available seldom benefits the public, and complicates the task of the physician. It also encourages self-promotion and commercial manipulation, and increases the likelihood of exaggerated or even false claims. There are rare instances in which early publicity is in the public interest; we acknowledge such exceptions and are willing in those cases to alter our policies accordingly. Otherwise, we ask that would-be authors abide by our longstanding policy against prior publicity.[3]

In a forthcoming issue we will review the details of that policy in an effort to eliminate any ambiguities and misunderstandings.

ARNOLD S. RELMAN, M.D.

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SOUNDING BOARD

BEYOND GMENAC — ANOTHER PHYSICIAN SHORTAGE FROM 2010 TO 2030?

SINCE publication of the 1981 report of the Graduate Medical Education National Advisory Committee (GMENAC),[1] much attention has been focused on the current and future supply of physicians in the United States. The following analysis will suggest that the policy debate over the supply of physicians has been shortsighted and that important demographic, social, and economic shifts between now and the year 2010 could affect the supply of doctors dramatically, resulting in a shortage.

The GMENAC report suggested that by the year 2000 there will be 144,700 too many physicians, or a ratio of 247 doctors to every 100,000 persons, as compared with 171 per 100,000 in 1978. The report recommended an ideal ratio of physicians to population of 191 to 100,000.[1]

In 1985 the Bureau of Health Professions, using a different method and set of assumptions, came out with a more pessimistic set of projections about the physician surplus, revising upward the earlier GMENAC projections of physician supply. The Bureau of Health Professions projected a total physician population of 706,500 in the year 2000, or a ratio of 260 doctors to every 100,000 persons.[2]

The ensuing debate about the impending surplus of physicians has focused mostly on the GMENAC study. For example, several authors suggest that the GMENAC projections are too conservative in light of physician productivity in health maintenance organizations and the phenomenal growth of those organizations during the past few years.[3-5] On the basis of the current experience of health maintenance organizations, Steinwachs et al. have suggested that in 1990, 20 percent fewer primary care physicians will be needed for children, and 50 percent fewer for adults, than was projected by GMENAC.[5]

More recently, Schwartz et al. have suggested that the GMENAC projections underestimate the need for subspecialists.[6] Other objections center on the nature of the models themselves[7] or criticize the studies for failing to account for variables such as the acquired immunodeficiency syndrome (AIDS), which was unknown when the GMENAC study was undertaken,[8] or societal trends that affect the physician work force.[9]

In 1985 there was a decrease in the number of persons entering medical school,[10] and some policy makers have heralded this as the beginning of an appropriate adjustment in the supply of physicians.[11] Some of that decline can be attributed to a reduction in federal aid for medical education as a result of the policy debate over the physician surplus.[11] The American Medical Association, the American Hospital Association, and the American Association of Medical Colleges — although they have not moved vigorously — have endorsed certain proposed methods of limiting the supply of physicians, such as curtailing Medicare support of residency programs for graduates of foreign medical schools.[12]

To date, none of the discussions of the future supply of physicians have looked beyond the year 2000 — now only 12 years away. What has not been recognized is that although there may be a physician surplus in the short run, it is entirely possible that for the majority of people who are alive today, there may be

stories without fear of being scooped by competitors. This so-called embargo arrangement is used by many other scientific and medical journals and is generally well accepted by the media. Over the years there have been very few intentional violations of the *Journal*'s embargo.

On this occasion, however, rumors about the study had begun to circulate in medical and business circles even before the *Journal* came off the press. Brief nonspecific references to the study appeared in a few business news-wire dispatches. On Tuesday, January 26, the Reuters news agency released the full story through their wire service. Although they had already received their advance copy of the *Journal* and therefore had all the details available to them, they claimed not to have broken their embargo agreement with us; one of their reporters, they said, had obtained the story from another source. Once a news story is released, the rest of the media feel free to ignore the embargo, so the Reuters dispatch was promptly followed by an avalanche of media publicity on Tuesday evening and Wednesday morning (accompanied by a television advertising blitz from the aspirin industry, which had obviously been gearing up for some time).

That week the public heard the headline news about aspirin before most of our subscribers had received their copies of the *Journal* and were in a position to interpret the report to their patients. Judging from newspaper reports of rapidly emptying drugstore shelves, millions of people must have rushed to medicate themselves without the benefit of medical advice — a potentially dangerous practice warned against by the report itself, the accompanying editorial, and more recently, the FDA.

Two letters published in today's Correspondence section are examples of the numerous complaints we receive from physicians whenever stories about new medical developments are circulated to the public before subscribers have had an opportunity to study the evidence for themselves. Many subscribers, annoyed at finding themselves unable to respond to their patients' questions, think we promote the advance release of information to the media. On the contrary, we send out no press releases and hold no press conferences. Our embargo policy is intended to achieve just the opposite — that is, to ensure that any stories the media may choose to write about our articles are released in an orderly manner, at the time the *Journal* is published. We have no power to prevent publicity on or after Thursday, so our release time of Wednesday at 6 p.m. Eastern time (which allows newspapers to publish their stories on Thursday morning) makes only a six-hour concession to the electronic media.

The alternative to our embargo policy would be to have no special arrangement with the media. They would then be able to receive the *Journal* by regular second-class mail, just as all other subscribers do, and would be free to publish their stories whenever they wished. Since copies are delivered to some parts of the country several days before the publication date, enterprising reporters in those places would always manage to publish their stories a few days before the majority of subscribers had received their copies — a situation we have wanted to prevent if possible.

Our research articles, after all, are technical communications intended to be read by physicians. For the most part they concern procedures or tests that can be prescribed only by physicians, or they present data on the cause and natural history of disease that can best be interpreted for patients by their physicians. No physician can be expected to make professional decisions or offer advice simply on the basis of broadcast news or newspaper stories circulated before an article appears in a medical journal. That is why we believe most physicians support our embargo policy. To verify that impression, we are preparing to send a questionnaire to a large random sample of readers. Unless the response to that questionnaire sends us a very clear message to the contrary, we will stand by our embargo and try to persuade representatives of the media to do the same.

The embargo is an agreement between the *Journal* and the representatives of the media to whom we send copies by first-class mail. Opposition to the embargo policy comes primarily from a few news agencies (e.g., Reuters) that serve investors and stock market analysts. An increasing number of *Journal* articles concern drugs or other products of commercial importance; publication of such articles often affects stock prices. Investors and analysts insist on prompt access to this kind of information and see no reason to abide by our embargo rules. We understand their concern, but our first obligation is to serve the needs of our physician readers and all those who depend on them for timely and fully informed medical advice. As long as physicians want us to maintain the embargo, we will not abandon it simply for the benefit of investors and their market analysts.

Most of the criticism in the press of our handling of the aspirin report was concerned not with what happened after the article came off the press, but before. We were accused of having withheld information that should have been released to the public promptly, as soon as the investigators decided to terminate their study. In this case, however, the decision not to disseminate the news until the participants had been notified and the report published in a peer-reviewed scientific journal was made by the investigators themselves, with the concurrence of the National Institutes of Health, which was funding the study. We supported that decision fully, because it was consistent with our usual policy.

In general, we ask investigators not to publicize their work before it has been published. We exempt presentations at scientific meetings and press coverage of such meetings, because meetings are necessary for communication among scientists. The careful peer review and revision required by most reputable journals discourage the submission of shoddy work, screen out reports of dubious validity, and generally improve the quality of the reports ultimately ac-

another shortage just when they will need doctors the most — after 2011, the year in which the first of the baby boom generation will turn 65 and enter their retirement years.

The baby boom generation (those born between 1946 and 1964) is an unprecedented demographic phenomenon in U.S. history, and its impact on American society has been remarkable.[13] Highly educated (25 percent have college degrees[13]) and the products of a relatively affluent era, baby boomers have also gone to medical school in unprecedented numbers. This was facilitated by U.S. government policies that encouraged the increase in the supply of physicians through grants to medical schools and loans and grants to students.[14]

The GMENAC report projects that 642,950 physicians will be in practice in the year 2000 — a surplus of 144,700 doctors.[1] That would represent a ratio of 247 physicians to every 100,000 persons.[1] If this projected number of physicians for the year 2000 were to remain constant through 2030, the number of physicians for every 100,000 persons would fall to 227 in 2010, 217 in 2020, and 211 in 2030, on the basis of population growth alone. (This assumes that the number of new physicians [graduates of American and foreign medical schools] entering the field would equal the number leaving it as a result of retirement or death.) These figures are still above the "ideal" GMENAC ratio of 191 doctors for every 10,000 Americans and mean that there would continue to be a surplus of 61,000 physicians through the year 2030 (Table 1).

However, maintaining the supply of physicians at the level projected for the year 2000 would require a substantial increase in the number of graduates of U.S. and foreign medical schools. In 1985, 54 percent of all physicians were under the age of 45.[15] By 2000, demographics alone suggest that most physicians will be of the baby boom generation. These physicians will begin to reach the age of 65 in 2011, and some will presumably retire from the profession, although they may retire at a later age than doctors of previous generations.[13]

If we further assume that government policies to reduce the number of graduates of medical schools and current market forces will help achieve GMENAC's ideal ratio of 191 to 100,000 by the year 2000, and that the GMENAC's projected ideal number of physicians[1] for that year (498,520) can be held constant through 2030, we can anticipate a shortage of 42,480 doctors in 2010, increasing to a shortage of 82,296 physicians in 2030 (Table 1).

To make matters worse, the population of the United States is aging rapidly — a trend that will accelerate into the next century as the baby boom generation ages. By 2030, it is projected that 21 percent of all persons will be over the age of 65, as compared with 12 percent in 1985.[16] By applying estimates of age-specific physician visits per population from the 1985 National Health Interview Survey[17] to the age-specific population projections of the Bureau of the Census,[16] we have determined that the number of visits per person will increase from 5.3 in 1985 to 5.7 in 2030. This will result in 128.5 million more physician visits in 2030 than if the age structure of the population were to remain as it was in 1985 (Table 2).

Table 1. Estimates of Indicators of Physician Supply through the Year 2030.

Estimates	Year		
	2010	2020	2030
Population (millions)[16]	283.2	296.6	304.8
Ideal GMENAC ratio of physicians to population (per 100,000)[1]	191	191	191
Ratio of physicians to population (per 100,000), assuming GMENAC projected supply for the year 2000[1]	227	217	211
Difference between ideal ratio and projected supply ratio for the year 2000	36	26	20
Physician surplus (thousands)	102.0	77.1	61.0
Ratio of physicians to population (per 100,000), assuming GMENAC ideal supply for the year 2000	176	168	164
Difference between ideal ratio and ideal supply ratio for the year 2000	15	23	27
Physician shortage (thousands)	42.5	68.2	82.3

The GMENAC report acknowledged a current and projected lack of primary care physicians, particularly geriatricians.[1] Adjustment of the GMENAC ratios for the dramatically shifting age structure of the population beyond the year 2000 suggests that there is potential for an even greater shortage in future years.

A number of other trends may exacerbate the problem. Russell[13] and Supple[18] have both anticipated an overall reduction in the labor force after 1990 because of the "baby bust" generation resulting from the decrease in fertility rates after 1965. In the United States in 1985, there were 43.1 million persons between 20 and 29 years of age — the pool of potential medical school candidates.[16] By the year 2000, that age cohort will decrease by 20 percent, to 34.5 million.[16] This means the available pool of potential physicians will be smaller than it was during the baby boom years.

The influx of women into the profession can also be expected to have an effect on the future supply

Table 2. Projected Effect of the Aging U.S. Population on Total Numbers of Physician Visits in the Years 2010 through 2030.

Index	Year		
	2010	2020	2030
Population (millions)[16]	283.2	296.6	304.8
Age-adjusted annual physician visits per person	5.5	5.6	5.7
Total visits (millions)	1559.2	1662.5	1743.9
Visits based on 1985 rate (5.3) (millions)[17]	1501.0	1572.0	1615.4
Additional visits, reflecting aging of population (millions)	58.2	90.5	128.5

of physicians. Women accounted for 12 percent of the profession in 1981 and will constitute 20 percent of practicing physicians by the year 2000.[2] Already in 1985, 24 percent of all physicians under the age of 35 were women.[15] Female physicians' productivity is lower than that of their male counterparts, although the extent to which this is related to the demands of child raising as opposed to other factors is unclear.[19]

There has been an overall decline in the number of hours worked by physicians, partly because of the increased value placed on leisure time.[20] This reflects a general trend among professionals in their 30s and 40s, who value more free time and less work.[13]

Although medicine has historically been a prestigious profession, several economic factors may make it less attractive in the future. First, medical training is expensive, and there has been a recent decline in federal aid, with a concomitant increase in student debt.[7,14] Second, physicians' real income (accounting for inflation) has not increased between 1975 and 1985.[21] Third, financial issues such as the high cost of malpractice insurance are (at least in the short run) causing physicians to leave practice.[14]

Jacobsen and Rimm have adjusted the GMENAC projections to account for the effects of declining enrollments in medical schools, the increase in the number of female physicians, and declines in physician productivity. On that basis, they project a surplus of only 6000 physicians in the year 2000, excluding foreign medical graduates, or a ratio of 194 physicians to every 100,000 persons (close to the GMENAC figures for the ideal supply).[9] Because of the aging of the population, that surplus could quickly turn into a deficit after the turn of the century.

On the positive side, other factors may help mitigate the impact of the trends noted above — factors such as large enrollment of baby boomers in health maintenance organizations, the increased use of nurse practitioners and physicians' assistants, a new influx of foreign medical graduates, the positive effects of health-promotion and disease-prevention programs, and the possibility that many baby boomers may not retire at the age of 65. However, whether such factors may offset the effects of any declines in the available supply of physicians is unknown.

In summary, general population growth, the aging of the baby boom generation, declining enrollments in medical schools, the shrinking labor pool, lower physician productivity, and the increasing unattractiveness of medicine as compared with other professions suggest that we may be headed for another shortage of physicians in the next 30 years. Current manpower-planning policy may be too shortsighted to avert this potential crisis and needs to focus on the longer term, taking into account the important variables discussed in this cursory analysis.

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CORRESPONDENCE

THE ASPIRIN–HEART STUDY AND THE *JOURNAL*'S EMBARGO POLICY

To the Editor: The recent turmoil between the *Journal* and the press concerning the embargo on the release of information before publication compels me to voice my long-smoldering annoyance regarding the priority in mailing the *Journal* to its subscribers. Even though I chair a department of medicine at a medical school, I usually receive my copy of the *Journal* some five to seven days after the publication date. Subsequently, I find it downright embarrassing to be "one-upped" on rounds by students and house staff who have read the latest articles days before we make rounds together. In a very unscientific poll, I found that I am not alone in this humiliation but share it with chairpersons not only of departments of medicine

ANENCEPHALIC BABIES

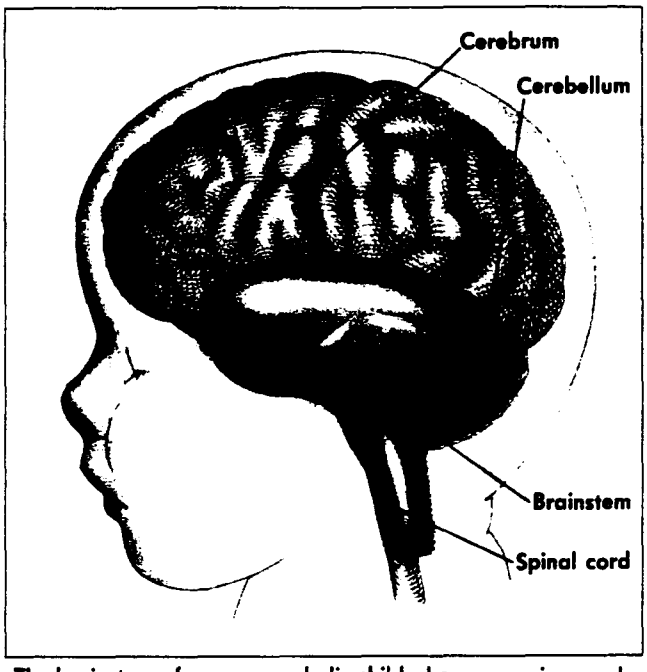
Brenda Winner was five and a half months pregnant when she learned from a routine sonogram that her baby was anencephalic—missing most of its brain. With no hope for life, such fetuses frequently are aborted, even late in pregnancy. But Winner wanted some good to come of her child's doomed existence: she wanted to donate the baby's healthy organs so that another child might live. Last December Loma Linda University Medical Center in California agreed to help the Winners and other parents like them carry out their wishes.

As it turned out, the Winners' daughter was stillborn; her organs (except for the heart valves and corneas) could not be used for transplantation. But the case sparked wide debate over whether the hospital—a pioneer in infant heart transplants—was trampling on the rights of this baby in order to harvest her organs.

Each year about 3,000 babies in this country are born with anencephaly, a fatal congenital brain defect. Diagnosis is usually incidental. Amniocentesis may reveal high levels of alpha fetoprotein leaking from the baby's defective brain, or the condition may be detected when a sonogram is done to date the pregnancy. More than half these babies are stillborn. Those that survive are given comfort care: they're kept warm and fed until their death, which usually occurs within a week.

Donating the organs of these children, however, is fraught with ethical and legal problems. By law, all organ donors must be brain dead—that is, they can't have any detectable brain activity, including brainstem reflexes. Startling at a loud noise, blinking at a bright light, and, most important, breathing, are signs that the brainstem is still functioning. Anencephalics don't meet brain-death criteria, at least not initially.

Anencephalic children lack a cerebrum, a cerebellum, and the skin and bone that normally covers them—virtually everything above the eyebrows. But these babies *do* have a functioning brainstem. For their brief few days of life, this stalk of nerve fibers regulates their breathing, their waking and sleeping, and lets them suck and cry. (Whether they feel pain is not known, although it's highly unlikely that they experience pain as we know it, says Joyce Peabody, chief of neonatology at Loma Linda. An anencephalic infant might "sense" a pinprick in its finger, but since the higher brain is missing, the signal can never reach the sites that turn the nerve signal into the "experience" of pain.)



The brainstem of an anencephalic child, shown superimposed over a normal child's upper brain, remains undeveloped.

As long as an anencephalic's brainstem is still active, removing its organs is against the law and, to many people, morally repugnant. But retrieving them after the baby's death is pointless because of the way these babies die. As their brainstems cease functioning, they sporadically stop breathing, starving their organs of oxygen. By the time they die naturally their major organs are no longer viable as transplants.

Moved by the pleas of parents like the Winners, however, a number of doctors and ethicists in Canada and the United States have devised guidelines that they think get around the dilemma. In accordance with these guidelines, the donor baby is kept on a respirator to keep its organs healthy. Periodically, however, the baby is taken off the respirator to see if it's still breathing on its own. Only when the baby has ceased to breathe and shows no other signs of brainstem function is it considered legally dead. It is then returned to the respirator so its organs can be preserved for donation.

The procedure is controversial, however. Critics argue that the anencephalic infant is being used purely as an incubator for its own organs. From the moment it's born, the baby is kept breathing not for its own sake but for the sake of someone else. As the critics see it, the procedure is morally questionable, and it blurs the lines between life and death.

Supporters of the guidelines disagree. "By going through the procedure of putting the child on a respirator, attempting to wean it off, and seeing if it stops breathing, we're trying as best we can to determine death," says Arthur Caplan, director of the Center for Biomedical Ethics at the University of Minnesota. Peabody stresses that Loma Linda's primary intent is to help the parents: it must be they who approach the hospital, not the other way around.

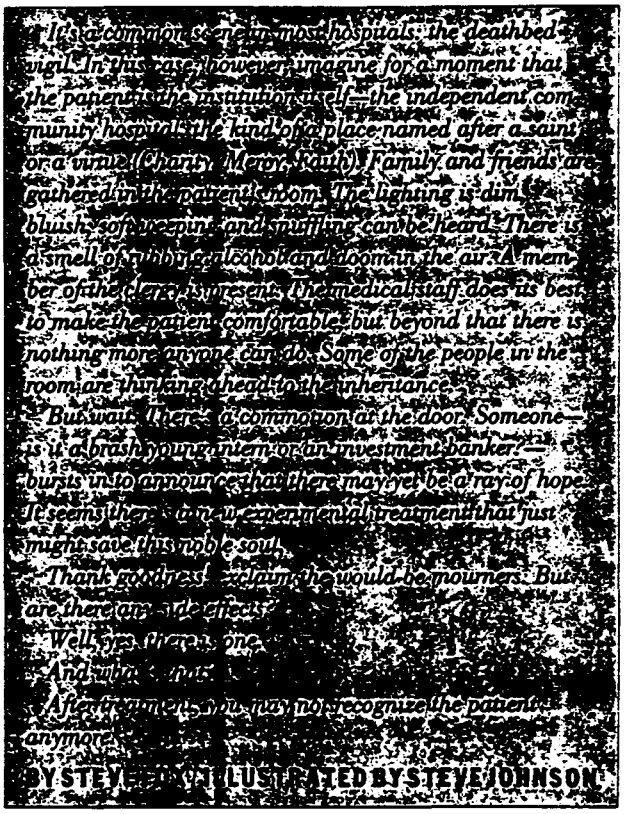
"We're not saying all anencephalics should have their organs donated," says Brenda Winner. "We're asking that parents have the choice. Those who want to donate should be able to do so."

—Shawna Vogel

ILLUSTRATION BY LEWIS C. CALVERT

THE TRAUMA OF EBS

The Empty-Bed Syndrome: Twin Cities hospitals in crisis.



It's a common scene in most hospitals: the deathbed vigil. In this case, however, imagine for a moment that the patient is the institution itself—the independent community hospital, the kind of a place named after a saint or a virtue (Charity, Mercy, Faith). Family and friends are gathered in the patient's room. The lighting is dim. Subdued sobs, soft weeping and sniffling can be heard. There is a smell of rubbing alcohol and doom in the air. A member of the clergy is present. The medical staff does its best to make the patient comfortable, but beyond that there is nothing more anyone can do. Some of the people in the room are thinking ahead to the inheritance.

But wait. There's a commotion at the door. Someone—is it a brash young intern or an investment banker?—bursts in to announce that there may yet be a ray of hope. It seems there's a new experimental treatment that just might save this noble soul.

"Thank goodness!" exclaim the would-be mourners. But are there any side effects?

Well, yes, there is one.

And what's that?

After treatment, you may not recognize the patient anymore.

BY STEVE FOX / ILLUSTRATED BY STEVE JOHNSON

IT IS CALLED THE "NEW HOSpital corporation," and it is regarded by many to be a strategic necessity for hospitals trying to survive in an inhospitable economic environment. But for some health care providers—particularly community-based hospitals with sectarian origins—it represents a poisonous financial pill.

Whatever it is, and it is many different things to many different people, it is now the treatment of last resort for Minnesota's troubled hospital industry, an industry in which roughly one of every two providers lost money last year. In the Twin Cities, considered one of the country's premier medical communities, two-thirds of the hospitals are estimated to have lost money in 1987, to the collective tune of more than $20 million.

The overwhelming economic fact of life for many hospitals operating in the 1980s is that they may not be in business in the 1990s, at least not in their current form, with their current management structures and their current full slate of acute-care services. The hospitals of the future, the ones that survive the economic shakeout now buffeting the industry, will be subunits within corporate-controlled chains of health care providers.

The familiar names will be gone, either supplanted by or subordinated to the new multihospital operating systems. The casualty list already reads like a Biblical account of fallen angels—St. John's Eastside, Samaritan, and Mounds Park in St. Paul. That was 1987. Over the past five years, more than 20 metropolitan hospitals have closed or merged with others. Currently, there are but four independent hospitals of stature left in the market, and three—Ramsey, Hennepin, and University—are government-controlled (the VA Hospital is not included because of its special admission requirements).

The rest of the major hospitals, the 19 still technically classified as acute-care hospitals within the inner metro market, are affiliated with one of the "new hospital corporations," the multihospital holding companies that now dominate the health care system. The creation of these corporations is both an old and a new story, but their future impact on the cost and delivery of health care in the Twin Cities is very much an unknown.

In many respects, what is transpiring here is a test: Can hospitals function—profitably but economically—within a relatively "free" and "competitive" market environment? Or will there be a movement toward a much more government-regulated, if not actually government-controlled, health care delivery system?

Crucial to that determination is whether the "new health corporation" delivers on its promises of providing economies of scale and superior management, making hospitals more efficient and effective providers of health care services.

There is a danger, of course, of overstating Minnesota's import to the rest of the country, but when it comes to health care, the state traditionally has been a closely watched and frequently emulated trendsetter. As *Hospital* magazine put it in a November 1987 story on the financial condition of health care providers here, "Hospitals, beware. As Minneapolis goes, so goes the nation."

As things are going in the Twin Cities, hospitals, indeed, should beware, because there is widespread financial trouble in the seven-county metro area. The overall occupancy rate on a licensed-bed basis is about 47 percent; some institutions operate with about one in three beds occupied on any given day. Operating margins overall fell about 250 percent in 1986, with some of the market's best-known and most respected hospitals reporting successive multimillion-dollar losses over the past few years. Some multihospital systems, in fact, are so highly leveraged that there has been concern over the possibility that a reversal in revenues might cause a technical default on bond obligations.

By just about any financial measure, there has been a system-wide deterioration in the economic health of the industry. An x-ray of the Twin Cities market today would reveal a system in severe distress, suffering from several acute maladies with potentially terminal implications for health care providers, practitioners, and patients.

Steve Fox is a consulting editor of TWIN CITIES.

Consider this: At a time when health insurance premium costs, locally, are rising at least three to four times faster than inflation, and at a time when health care costs generally have exceeded overall inflation levels by as much as 700 percent, the majority of players in this market are still losing money. Last year, for example, the majority of HMOs in the state lost money, as did the majority of hospitals, and most doctors report that their real incomes were stagnant or went down. Moreover, it is likely that a major medical clinic in the Twin Cities could declare bankruptcy within the next year.

In a true Euripidean irony, the health care system grows sicker as it consumes more and more of the economy. Health care now represents 11.4 percent of the nation's GNP—up from nearly 6 percent in 1965. By the year 2000, health care expenditures are expected to increase their share of the GNP to 15 percent.

Since hospitals constitute no small part of the total cost of the national health care bill, they have been the focus of several cost-containment initiatives, all of which have forced hospitals to change the way they conduct their affairs. But change has come ever so slowly, more often wrought by irresistible economic forces—the imminent threat of bankruptcy, in many instances—than by foresight or community stewardship.

Any understanding of the current problem requires an appreciation of the antecedents that have brought the system to a near-crisis state. If any word could capture the causative factors affecting the hospital industry, *tradition* would surely head the list.

Religious Roots, Market Pressures

THE HISTORY OF NONPROFIT HOSPITALS IN THE TWIN CITIES IS inextricably linked with that of the area's various religious communities. Hospitals were, and many still are, extensions of the church, created out of a religious concern to care for the sick, the debilitated, the aged members of the community.

Each denomination measured its caring spirit by the hospital system it supported on an almost exclusive basis for followers of its particular faith. Catholics went to facilities managed by Catholic orders, staffed by Catholic doctors, and funded by Catholic donations. Baptists and Lutherans and Methodists did the same, often further separating their identities ethnically—hospitals for the Germans, for the Norwegians, for the Swedes, and for the newly blended cultures falling under the Protestant umbrella. Jews, however, were excluded; Jewish doctors were often denied staff privileges in Christian hospitals. So, the Jewish community built its own.

The scene was set for the law of unintended results to start undermining a system built on ingrained religious and ethnocentric considerations, not on market demand or medical need.

Every hospital operated independently, providing care from the cradle to the grave, the full spectrum of medical procedures, regardless of whether the Lutheran or Catholic or Jewish hospital down the street was offering identical services. The system was able to function, not necessarily efficiently or economically, as long as the cost of care was never competitively priced. No matter how high the fixed overhead or how expensive the treatment, hospitals just passed the cost of community pride on to third-party payers, primarily business and government.

This approach became suspect back in the early 1960s, when it appeared that the health care system had expanded far beyond what demand would ever warrant.

One study at the time, conducted by the Citizens League, found that the Twin Cities were operating twice as many beds as another comparable metropolitan area of similar size and demographic make-up. Further studies revealed that Minnesota had one of the highest ratios of beds to populations in the country and one of the highest hospital utilization rates per capita, despite the fact that medical indices showed Minnesotans generally to be in better-than-average health. (Minnesotans, in fact, enjoy the highest life expectancy in the continental United States.)

Belatedly, after decades of unrestricted and unquestioned growth, the issue of hospital overbuilding, excess capacity, and costly duplication of services was placed on the public agenda, with the initial objective being to bring planning and order to a system that was clearly out of control. Almost a decade went by before the state finally began regulating hospitals, via certificate-of-need legislation passed in 1971, which mandated the licensing of hospital beds and government approval of expansion and new construction.

It didn't work. The industry tenaciously resisted change, fighting attempts at transforming independent hospitals into a quasi-utility system. Besides, the infrastructure was already in place, the buildings already built, the beds already staffed.

The only way to deal with the overcapacity problem, it seemed, was to force some hospitals out of operation, a step the Metropolitan Health Planning Board tried to take when it suggested in the early 1980s that several Twin Cities hospitals should evaluate whether they were serving a legitimate mission. Six hospitals responded by suing the board. "That was kind of the last straw, because it was now clear that politically we were never going to close a hospital, and therefore the only way we were going to do it was to bankrupt them into the process of closing," recalls Harry Sutton, a health care consultant with Tillinghast, a division of the nationally recognized consulting firm Towers, Perrin, Forster & Crosby.

And, indeed, the specter of bankruptcy did effect the changes that government initiatives could not. The six litigant hospitals—Lutheran Deaconess, Samaritan, Golden Valley Health Center, Mount Sinai, St. Joseph's, and Divine Redeemer—have either closed or merged (mainly under financial duress) with other hospitals.

In the end, market pressures prevailed because the market altered the manner by which hospitals were reimbursed for services rendered. No longer could hospitals operate on the traditional "cost-plus" pricing mechanism; instead, government and business introduced competitive pressures to the industry by adopting several alternative payment systems.

For the first time, economic forces were exposing hospitals to the realities of the market. But, again, hospitals resisted change until the system literally bludgeoned them into adopting a different business plan, a plan based more on commercial demands than church or community loyalties. "The competitive price squeeze has done more to advance ecumenism than anything else," says Walter McClure, president of the Minneapolis-based Center for Policy Studies, a nonprofit organization with the self-described mission of "reforming the American health care system."

The price squeeze to which McClure refers is composed of several economic elements, the two most important being the cost-control systems imposed by federal and state governments on the

Medicare and Medicaid programs, and what are now generally known—in a variety of forms—as health maintenance organizations.

Does HMO Stand for "Hospitals Missed Out"?

GIVEN THE SIZE AND UNREGULATED GROWTH OF THE HEALTH care system in the Twin Cities market, it was only fitting that the HMO movement originated here. Conceived by Paul Ellwood of InterStudy, a think tank for the health care industry, and formally adopted on a national level in 1973 with the HMO Act, the movement away from traditional indemnity insurance to prepayment coverage has arguably done more to change the local health care delivery system than anything else. There is no doubt, however, that HMOs have been the financial nemesis of hospitals, even though HMOs themselves have not been the cost-control panacea they were once envisioned to be. In fact, HMOs may now be contributing to the runaway cost of health care.

Nonetheless, in the Twin Cities, where almost 56 percent of the population is covered under some type of HMO plan, the rules of the game have shifted in favor of payers, with providers such as doctors and hospitals practicing a new form of medicine called damage control. The HMOs so dominate the market that they have engaged in what is labeled a "provider bashing strategy," whereby they use their market leverage to extract the lowest possible prices by playing competing hospitals against one another.

For hospitals, the payment squeeze problem is largely self-inflicted, and it's largely due to the fact that traditionalism impaired business judgment. The HMO situation is probably one of the most telling examples of how hospitals misread what the future had in store. "There was a general feeling over the years that things really would not change that much, but things have happened much quicker, with much more of an impact, than some people wanted to believe," says Malcolm Mitchell, director of the Metropolitan Health Planning Board.

What happened in this instance is that Twin Cities hospitals had an opportunity to significantly influence and slightly profit from the HMO movement by becoming more vertically integrated operations that would, in effect, not only provide health care, but also finance it through ownership of an HMO plan or what is called a preferred provider organization (PPO).

"Back in the mid- to late Seventies, the hospitals had an opportunity to spawn, if you will, the HMO movement; basically, where the hospitals would get into the financing of the health care business," says Allan Johnson, president of the Council of Hospital Corporations, a trade organization representing Twin Cities hospitals. "But the hospitals said that was not really part of our mission. What that did was really give birth to the HMO movement, which has turned out to be a mistake on the part of the hospitals."

The situation nationally is much different. In many areas, HMOs and PPOs are built around hospital systems, providing those hospitals with a guaranteed patient population and revenue diversification.

Hindsight also shows that Twin Cities hospitals compounded the strategic misstep of not adapting readily to the HMO movement by blithely maintaining beds for which there was progressively less need. Even today, more than two decades after HMOs began to alter the medical payment system, hospitals still have not sufficiently addressed the fiscal liability of staffing too many

WHO'S GOT THE BUSINESS

Twin Cities hospitals ranked by market share.

Hospital	Percentage of market
Abbott Northwestern Hospital	9.65
North Memorial Medical Center	7.12
Methodist Hospital	6.76
Hennepin County Medical Center	5.96
Fairview Southdale Hospital	5.91
University of Minnesota Hospital and Clinic	5.86
United Hospital	5.10
Fairview Riverside Hospital	5.02*
St. Paul–Ramsey Medical Center	4.90
Mercy Medical Center	4.51
Metropolitan Medical Center	4.14**
St. John's Northeast Hospital	4.10
Unity Medical Center	3.92
St. Mary's Hospital	3.49*
St. Joseph's Hospital	3.06
Midway Hospital	2.91
Fairview Ridges Hospital	2.71
Children's Hospital of St. Paul	2.[illegible]
Bethesda Lutheran Medical Center	2.33
Waconia Ridgeview Hospital	1.73
Mount Sinai Hospital	1.70**
Minneapolis Children's Medical Center	1.63
Lakeview Memorial Hospital	1.36
St. Francis Regional Medical Center	1.20
Golden Valley Medical Center	.73
Divine Redeemer Memorial Hospital	.64
Mounds Park Hospital	.46
Fairview Deaconess Center	.39*
Gillette Children's Hospital	.24

Source: Council of Hospital Corporations. Market share has been calculated on the basis of total patient discharges from Twin Cities hospitals in the first half of 1987.

**Since this study, Fairview Riverside Hospital/Fairview Deaconess Center and St. Mary's Hospital have entered into a joint operating agreement as Riverside Medical Center, which, based on these figures, would have a market share of 8.9 percent.*

***Metropolitan Medical Center and Mount Sinai Hospital recently merged, giving the new Metropolitan/Mount Sinai Medical Center a market share of 5.84 percent.*

hospital beds.

Such folly has cost them millions, and will cost them millions more until the market reaches a state of equilibrium, if ever such a condition can be reached in the volatile health care industry.

A major factor that disrupted the demand side of the equation was hospital reimbursement procedures, principally those instituted by HMOs and PPOs and the government.

The basic concept behind HMOs is prepaid care for members. There are variations in prepayment provisions, but a common element is an incentive to control costs by fixing fees to providers for the care they render. Thus, doctors began responding to the incentives by limiting their use of hospitals, both by curtailing their patients' average length of stay and by performing more procedures on an outpatient basis.

Hospitals, similarly, had incentives to release patients quicker—and a little sicker—because of contractual provisions with HMOs and because the federal government had instituted cost-control measures of its own. The Medicare system shifted in the early 1980s to a reimbursement policy based on classifying diagnoses for hospital-treated illnesses according to groups, with predetermined amounts established for particular groups.

Hospitals absorbed the losses caused by difficult or long-term cases and pocketed profits from efficiently administered treatments.

The payers had pinpointed hospitals for cost control because roughly 50 percent of health insurance payouts are associated with hospital care.

From the standpoint of correcting hospital overutilization—and from that standpoint alone—the new reimbursement and payment systems have been dramatically successful. According to statistics from the Council of Hospital Corporations, there has been a 36.5-percent decline in total hospital utilization in the Twin Cities since 1980. The figure becomes even more meaningful when juxtaposed with a 6-percent population increase during that time.

The true impact of how difficult the situation has become can be measured by overall patient-day rates—the number of patient-days in the seven-county area per 1,000 population. That index has declined 42 percent in six years.

What it all means is that fewer people are being hospitalized, and when they are, they stay for far shorter periods of time—the average hospital stay, for example, has been shortened by 25 percent during the 1980–86 period.

The declines, unfortunately, are not attributable to a sudden wellness movement among Twin Citians. Rather, more medical care is handled on an outpatient, same-day basis. But even on that account the good old days are gone for Twin Cities hospitals. Outpatient utilization dropped almost 10 percent between 1980 and '85, although the trend line indicates the business is starting to return.

Still, patient care has shifted more to clinics and back to the physician's office, where procedures are unregulated and—some would say—quality-less assured.

While hospitals may be the preferred setting for many outpatient procedures, their main book of business is providing acute-care services. And that part of their business is what has suffered most and what is unlikely to ever return to the days when payers unquestioningly picked up the patient-care tab.

Overall occupancy rates for licensed beds in the Twin Cities market, for example, have plummeted by a third in six years, more in the case of certain hospitals. Up until just last year, there were even a couple of hospitals operating at about 15 percent of licensed-bed capacity before their life support systems were mercifully turned off. (Note: The term "licensed beds" refers to the maximum number of beds allowed by law in a given hospital. The term "staffed beds," often used by hospitals themselves, means the number of beds that are set up and available for patients and for which nursing staff is or will be made available. These days, most hospitals staff fewer beds than they are licensed to operate. Obviously, using the smaller number to calculate occupancy rates produces a higher-looking result.)

But economic euthanasia remains an anathema to hospital boards and administrators. The standard rules of business do not always apply to not-for-profit institutions (85 percent of the nation's hospitals are nonprofits). As Harry Sutton observes, "Nothing has a longer life than a not-for-profit institution."

Long, though not indefinite.

The excess capacity in the system is like cancer; either it's removed or it consumes the victim.

Hospitals have been so desperate to fill beds that they have underpriced their product just to attract patients, sometimes at rates barely covering their marginal costs. "The HMOs have divided and conquered the hospitals," says Dr. Richard Reece, editor-in-chief of *Minnesota Medicine*, the monthly journal of the Minnesota Medical Association, and also publisher of the independent *Reece Report* newsletter. "The HMOs have really played that to their advantage by forcing hospitals to deeply discount their contracts, with each hospital trying to underbid the other. But all of them lost in the aggregate."

The HMOs themselves were waging a price war to attract enrollees and gain market share, with competing groups slashing prices to such an extent that the majority lost money on their health care contracts. HMOs then tried to make up some of their losses by shifting costs onto hospitals and extracting even more concessions, sometimes through extended contracts with which hospitals must now live for the next couple of years.

Some hospitals fared better than others in the rate negotiations, but none fared very well. A survey of hospital operating margins reveals that 1987 will go down as the worst year on record. Of the minority of hospitals that managed to make money, a few did so because of nonoperating income—the revenues received from interest on investments and philanthropic support. Such nonoperating funds also helped mask the magnitude of losses by many of the hospitals that finished in the red.

It was a bad year, to be sure, but the real watershed year is 1988.

This will be the year when the newly aligned multihospital holding companies begin to discover the strategic wisdom of their respective business plans. What transpires in this market over the next few years will make a statement about whether a relatively competitive economic model is appropriate for the delivery of health care; if things go badly, the Twin Cities experience could very well be cited as one example of why health care is much too important a public service to be left to the vagaries of an unregulated market.

A social experiment this is not. But it is an adjustment process of some import, and it will have ramifications beyond the Twin Cities market. Since just 1980, for example, there has been a

25-percent increase nationally in the number of hospitals that belong to multihospital systems. By 1990, according to one industry estimate, almost half of all hospitals will be part of a system. If these systems fail to deliver economical, effective care, or if a few of them outright fail, there will be increased public pressure for more regulation.

In terms of multihospital systems, the metro area is far more concentrated than the rest of the country, with more than three-fourths of Twin Cities hospitals aligned with a nonprofit corporation. This corporatization of care has been sudden in one respect, yet decades in the making in another.

Hospitals today, says one analyst, "need a market share large enough so [they] can negotiate toe to toe, jaw to jaw, and belly to belly with the HMOs."

Multihospital Systems: Something Old, Something New

THE LARGEST MULTIHOSPITAL system, Health One, with 21 percent of the acute-care hospital admissions, is but a year old this month, while another system, Fairview Hospitals, was a pioneer in the movement more than two decades ago. In fact, in a 1972 issue of the *Harvard Business Review*, Carl Platou, then CEO of Fairview Hospitals, co-authored a piece titled, perhaps still relevantly, "Thinking Ahead: Multihospital Holding Companies."

The benefits Platou outlined then remain valid today—that consolidation into multihospital systems offers economies of scale, a wider variety of services, improved capital resources, and a stronger, more professional management structure. An even more compelling reason today is creating a unified front to negotiate with cost-conscious business purchasers and HMOs. "Individual hospitals in the past were not positioned very well to negotiate strongly with HMOs," observes Mark McGarraugh, who follows the hospital bond market as vice president of Piper, Jaffray & Hopwood's public finance department. "The HMOs would basically say, 'Accept this rate or we will not send any patients to your hospital.' Current theory is that you need a market share position sufficiently large enough so that you can negotiate toe to toe, jaw to jaw, and belly to belly with the HMOs."

The market share strategem has been aggressively pursued, even brashly pursued in one or more instances, by all the multihospital holding companies, each of which has added hospitals to its system in the past year.

The largest consolidation occurred just a year ago when Health Central, formed in 1970, merged with HealthOne (one word), a 1983 start-up, to become a united but orthographically separated Health One (two words). The new system encompasses, through outright ownership or management contracts, seven Twin Cities hospitals—United Hospital in St. Paul, Children's Hospital of St. Paul (managed), Mercy Medical Center in Coon Rapids, Unity Medical Center in Fridley, Golden Valley Health Center (limited to behavioral health and chemical dependency), and the newly merged Metropolitan Medical Center and Mount Sinai Hospital in Minneapolis. It is the only system with hospitals on both sides of the Mississippi River, a geographic boundary that delineates two distinct medical markets.

Additionally, Health One owns or manages several outstate and out-of-state hospitals and nursing homes, as well as diversified health care businesses such as dental centers (GreatTeeth), sen[illegible] and home health care services, medical transportation servi[illegible] and a PPO.

It epitomizes the term Health One has helped to coin: the "new hospital corporation," defined formally as "a regional health care system that is vertically and [illegible]zontally integrated to provide a full continuum of care, as well as alternative forms of health care financing."

Health One's size ranks it as the second-largest not-for-profit secular health care system in the country, with more than $500 million in revenues under management. Its ascendancy, however, has been achieved through mergers, not operational growth. Management must now prove that it has the acumen to profitably run a diversified multi-institutional health care system for which there are few templates. Even Health One acknowledges that the go-go days are over, and the grow-grow days have begun.

Being number one inevitably exposes Health One to criticism and second-guessing. The faultfinding focuses on whether Health One has grown beyond its capacities: Can it effectively manage a system that more than doubled almost overnight? There are attendant questions on just how synergistic some relationships are within the system.

An oft-cited example is the recent merger between Metropolitan Medical Center and nearby Mount Sinai Hospital, which was brought about by economic necessity, although the official line is that it was a "unique opportunity for Health One to strengthen its market presence."

The unofficial line is that Mount Sinai, an independent hospital established in 1951 by the Jewish community, needed to find an angel. Truth be told, "Mount Sinai should have been closed ten years ago," says Harry Sutton. Instead, it is an example of just how difficult it is to retire institutions, especially when benefactors refuse to let them die.

Licensed to operate 273 beds, Mount Sinai has experienced a steady deterioration in admissions, with only about 32 percent of its licensed beds occupied during 1986. Total admissions fell 22.5 percent from 1985 to '86. Equally significant is that the average length of stay increased by 35 percent—contrary to the trend of declining lengths of stay in Twin Cities hospitals.

Although Mount Sinai was accepting far fewer patients, the ones admitted were far more complicated cases. The hospital reported

that the resource needs of patients admitted during 1986 were 40 percent above the national average. Part of this can be explained by the hospital's disproportionate share of elderly patients—48 percent were age 65 or over, compared to the Twin Cities average of 24 percent.

The rule of thumb in health care today is that the more complicated the case and the longer the length of stay, the more money an institution loses. And Mount Sinai was losing millions. In fiscal 1987, there was an estimated $3.3-million operating income loss on revenues of about $32.5 million, and Sinai's ability to service its debt was significantly impaired.

A merger was mandatory. Whether what resulted was judicious is a matter of supposition. Cynics, however, regard it as a partnership among paupers.

Together, Mount Sinai and Metropolitan Medical Center lost an estimated $5 million last year. Both institutions also lost money in 1985. Like Mount Sinai, MMC operates at a capacity rate far below the Twin Cities average. In 1986, MMC reported a licensed-bed occupancy rate of 34.2 percent, down almost 10 percent from the year before. Other operating measures—admissions, daily census, and staffed-bed occupancy rates—were down almost an equal percentage rate.

Although MMC was already part of Health One, the question is why Health One would want to assume a liability such as Mount Sinai, a hospital with diminished inpatient prospects, high fixed overhead, and a history of poor financial performance.

Get Yourself a Magnet

THE ANSWER, IN PART, LIES IN WHAT HAS BEEN MOUNT SINAI'S comparative advantage in the medical community: the Phillips Eye Institute, considered among the nation's best. That asset fulfills a goal shared by virtually all the hospitals in the Twin Cities market. They are, by concentrating on one specialty or another, or even several, trying to position themselves as "centers of excellence."

Because of their unmatched superiority, these centers not only draw patients from across the metro market, but they also become magnets attracting patients throughout the Upper Midwest.

The Phillips Eye Institute does have drawing power, but it came with a lot of baggage, not the least of which is unneeded beds. And there are no current plans to take those beds out of the market. The short-range approach is to combine management operations of the two systems, now known as Metropolitan–Mount Sinai Medical Center, but still operate both facilities.

The viability of maintaining separate physical plants will depend on the economies that Health One can achieve by eliminating duplicative administrative functions and making similar belt-tightening moves. A consulting group predicts eventual savings of about $7 million annually from the merger. "That is a very significant savings when you look at total operating revenues of one hundred forty million dollars," says Donald Wegmiller, CEO of Health One and past chairman of the board of the American Hospital Association. "And in our judgment, we think the estimate is on the low side."

Wegmiller's judgment is based on the savings realized when Health Central, which he formerly headed, joined with the old HealthOne. He says that merger has netted a 35-percent savings, with more economies anticipated. But to date, the savings have not translated into a positive bottom line.

So far, the year-old Health One has refused to go public with its performance figures. Wegmiller will only say that, "In our first year of the merger, we clearly did not have good financial performance. Considering the circumstances, Health One had reasonable financial performance."

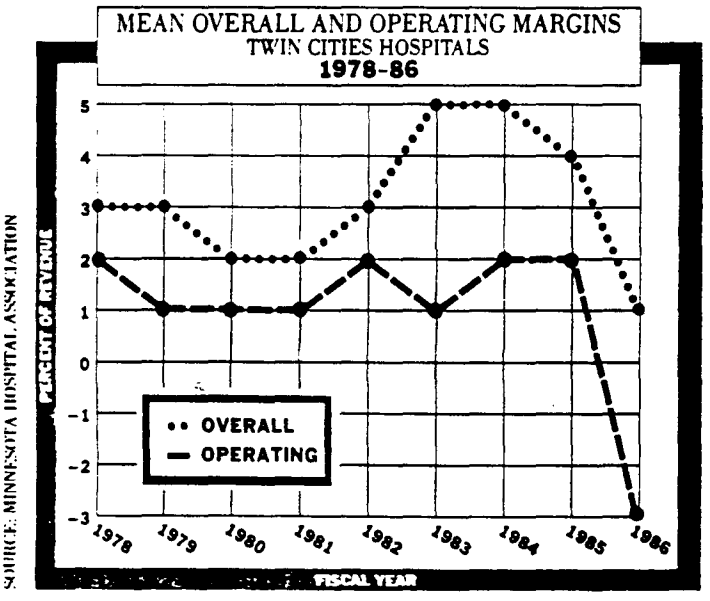
Against the backdrop of what it accomplished over the past year, "reasonable" is probably a fair assessment; until recently, it also seemed fair to say that Health One sustained a loss of about $4.4 million. That figure, obtained from a post-merger document circulated internally at Health One, is inflated, according to Wegmiller.

However, according to a credit report published by Standard & Poor on March 7, "Preliminary unaudited results for the fiscal year ended Dec. 31, 1987 indicate a $9.5 million loss for the new Health One Corp. . . . This has negative implications for $51.2 million of 'A' rated series 1985B and 1985C Health Central System Project bonds, issued by various cities and hospital districts. . . ."

More interesting—and perhaps more revealing—than these conflicting dollar figures is the reason Wegmiller is so reticent about talking specifics. Says he: "As long as we are in this very competitive market, we will not release financial information for two very justifiable reasons: We are in a competitive situation with other providers, and those financial statements are very revealing and very helpful if one is plotting strategy; secondly, we have some very significant and at times very difficult negotiations with payers. We don't intend to release to them overall financial material."

The statement is a reflection of just how much the hospital industry has changed in the past few years. As Mark McGarraugh of Piper, Jaffray & Hopwood succinctly says, "It's definitely become a much tougher ball game."

And the toughest ball game of all is being played on the diamond over on the east side of the river.



SOURCE: MINNESOTA HOSPITAL ASSOCIATION

The East Side Story

LAST YEAR THREE EAST METRO HOSPITALS STRUCK OUT. Mounds Park, Samaritan, and St. John's Eastside were finally closed, each forced ungracefully into retirement after years of diminished usefulness. Their demise was anything but surprising. Mounds Park and Samaritan had

both sustained admission decreases of more than 40 percent in 1986 alone.

The oversupply problem has always been most acute in St. Paul. "I used to laugh about the situation in St. Paul," says Bernard McDonagh, a health care/medical technology investment analyst with Piper, Jaffray & Hopwood. "If you ever had an accident in downtown St. Paul, there would probably be five ambulances from the hospitals in the downtown area ripping you apart limb from limb in an effort to get your business. It was just incredible—you had United, Bethesda, St. Joe's, Ramsey, and St. John's Eastside all within that area."

The situation has improved somewhat with the closing of St. John's Eastside, and it will improve even more once Bethesda is transformed from an acute-care facility to a specialty development center. It is all part of a strategic plan implemented by the new HealthEast multihospital system, an ecumenical amalgamation of Baptist, Catholic, and Lutheran interests.

In less than two years, HealthEast has emerged as the largest health care provider in St. Paul, with more than half of all inpatient admissions. Only three east metro hospitals—United and Children's, both Health One operations, and St. Paul–Ramsey—remain outside the HealthEast umbrella.

While HealthEast has rapidly achieved dominance by bringing formerly independent units together, it faces the formidable challenge of making the system profitable. Many market observers, in fact, consider it a high-risk gambit.

The numbers tell much of the story.

During fiscal 1987 the system lost an estimated $14 million; the forecast for this year is a loss of $11.5 million. The obligated HealthEast group is not expected to report a net income gain until fiscal 1989, at which time there is a projected $8-million profit. Achieving that goal, however, requires that HealthEast reduce its total operating expenses by $20 million in a one-year period; likewise, it can ill afford any shortfalls in revenue projections or incur any unexpected costs or alterations in patient care mix. HealthEast also enacted substantial price increases at its two major hospitals, ratcheting up rates ten percent at Midway and St. Joseph's during 1987.

"The strategies for each of the units within HealthEast will have to be right on the money for them to make it go," says McDonagh. "But the thing that I have learned is that nothing works quite as people expect it will."

Should the unexpected occur, HealthEast will have little room in which to maneuver.

In order to put the merger package together and to finance capital improvements at several of its hospital sites, HealthEast had to float a $137-million bond issue. Most of the issue was needed to consolidate and standardize debt obligations among the merged hospitals.

But the bond issue left HealthEast highly leveraged and weakened its credit rating in the financial community. The bonds, for example, carried a triple-B-minus rating. Although still an investment-grade issue, the rating is too low to allow commercial banks to purchase the paper for their portfolios. Instead, most of the issue was sold to so-called junk bond funds and investors who are willing to accept higher risk.

There is limited concern that some individual investors may not fully appreciate the level of risk they assumed. "Even though the ratings on those bonds reflect the risk, I don't think some of the purchasers of those bonds may have caught up with the changes that have taken place over the last few years, and they may not realize the level of risk that is there," says Malcolm Mitchell of the Metropolitan Health Planning Board.

The prospectus issued before the bonds were sold, however, carried the obligatory warning to investors. Those who read it must have appreciated how high a mountain HealthEast has to climb before it reaches the operating goals it needs in order to turn a troubled system around.

Regardless of whether investors did their homework, HealthEast's president of operations, John Reiling, says the organization is poised to benefit from the economies of consolidation and is thus a much better investment than its bond rating indicates. Moreover, HealthEast may be better positioned than some of its competitors and peers because it has already taken the difficult steps to eliminate excess capacity from its sytem. "We are confident that we are the leading health care provider here in St. Paul and we will continue to be the leading system in this area," says Reiling.

HealthEast has followed a familiar script to become the major health care provider in St. Paul. Like Health One, with which it competes head-on in the east metro market, it is a diversified health care corporation, with hospitals, long-term care centers, senior services, specialty clinics and programs, and transportation services. The nonhospital and development activities will produce a better bottom line than if HealthEast were just running acute-care facilities, says Reiling.

He, too, is touting the benefits, though not specifically using the name, of the "new hospital corporation."

HealthEast does fit the profile of the new hospital corporation—it is the product of mergers, a corporation vertically and horizontally integrated, a system with sufficient market share to buy right, negotiate effectively, and operate efficiently. In short, it's got all the right stuff.

Yet the new system is still composed of elements from the old days, with liabilities inherited from when the operative word was not synergism but sectarianism. That value system carried over into the new HealthEast. Reiling believes the religious heritage, though diverse, is a strength—that it actually solidifies the system. In any event, it will forever identify some units within the corporation. HealthEast's flagship hospital, St. Joseph's, for example, only agreed to join the system on the condition that it continue operating as a Catholic institution. Further, there are other provisions restricting management prerogatives.

More problematic than organizational issues of culture is the question of how strong some of the links in the corporate chain are. Harry Sutton's analysis, perhaps overstated, is that "HealthEast has a lot of cats and dogs in their system."

The odd mix at HealthEast raises the question of whether there is a good strategic fit among all the hospitals in the system. One of the most questionable elements is Divine Redeemer.

With only 130 licensed beds, Divine Redeemer is a relatively small hospital operating in a geographically isolated section of the metro area. Its current constituency is the South St. Paul area, but HealthEast is hoping to position the facility to take advantage of growth in the southeast quadrant of the Twin Cities. Whether that growth occurs to the extent that is envisioned within the anticipated time frame, and whether the growth benefits Divine Redeemer or a competitor, are questions that only time will

resolve. Says Mitchell: "I think Divine Redeemer is a high-risk strategy in the short term; the only [way] it makes sense is over the longer term—that they can obtain significant market share in that area as it grows."

In the meantime, HealthEast is betting millions that its positioning strategy will pay off. Like the most aggressive of the multihospital systems, HealthEast's philosophy seems to be to go for market share first and worry about margins later.

But even on the basis of buying market share, Divine Redeemer is questionable. According to figures compiled during the first half of 1987 by the Council of Hospital Corporations, Divine Redeemer's market share (as calculated on the basis of total patient discharges from Twin Cities hospitals) amounted to less than 1 percent. During 1986, it operated at only about 24 percent of licensed bed capacity.

Moreover, Divine Redeemer is one of the more expensive hospitals in the Twin Cities at which to be treated.

Although HealthEast picked up Divine Redeemer without a significant capital outlay, the financing of the transaction included promissory notes and a capital lease totaling $32 million. The deal also included the assets of Samaritan Hospital, but that facility had already closed prior to the purchase and there are no plans to find an alternative health care mission for the site.

As one of the main architects of the strategy, Reiling defends the deal as being an important element in providing HealthEast with a strategic geographic stake in the marketplace, and he says patient volume will increase at Divine Redeemer as some services are transferred there from other facilities that have been closed within the system.

Fewer people are being hospitalized, and when they are, they stay for far shorter periods of time. Thus, hospitals are battling for a steadily shrinking slice of business.

Fill Those Beds! (With Paying Customers)

ATTRACTING PATIENTS, HOWEVER, IS NOT JUST A FUNCTION OF location. To a large extent it's based on physician referrals. Doctors prescribe the treatments and determine where the treatments will be performed. Other factors, of course, including patient preference, drive the decision-making process. But patients tend to adhere to their healer's advice.

Hospitals know from where their business is actually derived, and they court the health care professionals who can put patients in their empty beds or admit clients to their programs.

It is common knowledge in the health care community that physician referrals are often based as much on financial considerations as on medical ones. The public received a slight glimpse of how the system really works when it learned that Methodist Hospital, one of the largest and most profitable facilities in the metro area, had paid $2.5 million to Park Nicollet Medical Center to guarantee a steady stream of referrals.

The revelation of hospitals paying cash for customers was just one more measure of how desperate some hospitals were to maintain their patient census. In practice, hospitals have been buying physicians' practices for some time as a defensive move to guarantee business. "All the major hospitals have been buying up practices as a funnel for future patients," says Dr. Richard Reece, who tracks the ever-changing relationships in his monthly newsletter. "They have not only been buying practices, they also have been setting them up."

And they also have been stealing them away.

Last year, Abbott Northwestern, the Twin Cities' largest hospital, with a licensed capacity of 980 beds and roughly a ten-percent market share, offered the Aspen Clinic a severely discounted contract to obtain its business.

The move was widely viewed as an ill-conceived attempt to buy market share, regardless of cost or how disruptive the medical realignments proved to be.

The doctors at Aspen changed their medical staff affiliations to Abbott Northwestern and ended their long-standing relationship with Fairview Southdale. Many patients, of course, followed the physician exodus to Abbott, leaving the Fairview group with about 7,000 fewer patient-days of business.

It was a lose-lose situation almost all the way around.

For Fairview Southdale, about eight percent of its business walked out the door; Abbott Northwestern reportedly lost money on every new patient it gained.

The two hospitals belong to separate multihospital corporations. Abbott Northwestern is the lead hospital for the LifeSpan system, while Fairview Southdale is part of the Fairview Hospitals group.

As the Aspen Clinic imbroglio attests, both systems are trying to carve out sections of pretty much the same market, albeit with considerably different approaches.

"Market share is not the strategic plan," says Gus Donhowe, CEO of Fairview Hospitals, which is perhaps one of the most closely studied and emulated multihospital systems in the country. It is, for example, the only hospital holding company that has been the subject of case studies by both Yale and Harvard. It was also one of the first three multihospital systems ever formed in the country; it is now more than two decades old.

Fairview qualifies as an "old hospital corporation." But it is every bit the vertically integrated and managerially sophisticated operation some of its upstart competitors are. More telling, it is the most profitable system operating in the Twin Cities market, with almost a 15-percent increase in net income from 1986 to 1987.

"We never promised anything with the Fairview system, but we raised the question of whether consolidation could provide

efficiencies and economies to the hospital industry; and for us, it certainly has," says Carl Platou, president of Fairview and the recognized dean of Twin Cities hospital administrators.

Since joining Fairview in 1952, Platou has directed the growth of a one-hospital operation into a multi-institutional system, with eight hospital affiliations in a three-state area, several medical clinics, ownership interests in a PPO, ambulatory health services, senior and home care, and behavioral and chemical dependency treatment programs. The system is currently expanding its facilities with new construction projects at Fairview Southdale and Fairview Ridges.

One of the more significant developments affecting the Fairview system was the affiliation in 1987 of Fairview Riverside and its neighbor, St. Mary's, into a joint operating company retitled Riverside Medical Center, now one of the largest medical campuses in the Twin Cities. That affiliation notwithstanding, Fairview espouses a wariness of the merger mania that seized the market in 1986–87.

Although Platou and Donhowe are circumspect about commenting on the strategies pursued by their rivals, it's clear they prefer stewardship over brinkmanship. When confronted with the choice of matching or bettering the terms Abbott offered to the Aspen Clinic, Fairview opted to forsake market share rather than jeopardize margins.

"We are not going to do something foolish and enter into a contract we consider an unacceptable discipline of pricing just to chase market share at any cost," says Donhowe, who is being groomed as Platou's replacement at the helm of the Fairview system. "From the standpoint of simple equity, we were not prepared to make the type of concessions Aspen demanded, because if we had done so we would have been obliged to reopen our contracts with our other clinics. We would have broken a pricing situation that would have been disastrous."

The situation has not necessarily been disastrous for Abbott Northwestern, but it has been costly. Just how costly is something that's blended into the consolidated operating statements. Besides its main hospital, Abbott Northwestern includes the operations of the Sister Kenny Institute and the old Eitel Hospital, now an inpatient child/adolescent psychiatric treatment facility renamed the Willow Street Center.

And Abbott Northwestern itself is just one of five hospitals and eight health service businesses under the holding company structure of LifeSpan. The newest member of the system, which was formed in 1982, is Methodist Hospital, which affiliated earlier this year. Besides Abbott and Methodist, considered to be two of the metro's best, LifeSpan's other hospitals in the Twin Cities include Minneapolis Children's Medical Center and Gillette Children's Hospital. Together, LifeSpan hospitals account for about 18 percent of admissions in the Twin Cities market.

Abbott alone accounts for about half that figure. But its size does not necessarily produce a better bottom line. While revenue has shown a steady and impressive increase over the past two years, operating income in 1987 was down almost 36 percent from 1985. Financial difficulties in mid-1987—net income for the first six months was $5 million below budget, with operating income at a razor-thin 0.1 percent of revenues—forced the hospital to access its line of credit for the first time since 1982 in order to meet expenses; in addition, it laid off about 200 employees and increased prices. These steps helped Abbott finish the year in the black, but net income was down almost 17 percent from the year before.

The Aspen Clinic situation contributed to Abbott's problems, but it has had the positive effect of forcing the hospital to re-evaluate its approach to attracting business.

Says Gordon Sprenger, who wears two hats as president and CEO of LifeSpan and president of Abbott Northwestern: "When you have excess capacity, you have to ask if you are better off having any business that will use some of your capacity if it's paying more than direct expense. But as you gather market share and use up excess capacity, you get to the point of selecting which block of business brings more of the full-cost payment to your institution versus another. We went after the Aspen Clinic because it brought us more than direct cost, and it was to our advantage to get that block of business. But now we have to start picking and choosing which block of business we want to keep. Because even though some blocks of business put patients in our beds, we are not able to change the economics enough [to] where it pays to perform that service, and we cannot afford to take care of certain patients. There is more selectivity now in what we are willing to do."

Not exactly a mea culpa, but nonetheless a signal that economics will keep further competitive excesses in check.

There are several other notable points in Sprenger's statement—among them the warning that hospitals can no longer afford to be in the charity business, to keep up the practice of accepting any patient who walks in their doors.

Donald Wegmiller of Health One predicts that cost-containment pressures will force hospitals to quit providing "free care" to underinsured and uninsured patients. He cites national figures estimating that about 37 million persons are without health care coverage. "We need to find more ways to make health care accessible to people," he says.

Private hospitals, however, are not and really have not been for quite some time in the business of charity, despite occasional public posturings of magnanimity. When Mount Sinai and Metropolitan Medical Center formally announced their merger, they noted that they would continue to provide about $600,000 worth of charitable care each year. A helpful gesture, granted, but it represents less than half of one percent of their revenues.

Poor people are treated primarily at the Twin Cities public hospitals—Hennepin and Ramsey.

Still, the fact does remain that a significant and worrisome number of persons are unable to obtain proper medical care. And Twin Cities hospitals are sensitive to the issue; it's a profound dilemma for all the hospitals operating in this market.

But the magnitude of the problem exceeds their ability to address it. Besides, a more immediate and proper concern for hospitals is to improve their own health.

Doing so gets back to the issue of whether the private hospital system here—and elsewhere—is operating efficiently and economically.

Medicare, Margins, Mecca

THE ECONOMICS OF THE TWIN CITIES MARKET CLEARLY SHOW that it is not. Economics alone, for example, would dictate that the system move closer to a supply-demand equilibrium. Instead, hospitals are still blaming many of their problems on an insufficient payment system.

The brunt of the complaint is often directed at the government's Medicare system, from which about 40 percent of overall hospital revenues are derived. The actual percentage varies widely among hospitals in different regions of the country.

In the Twin Cities market, the Medicare percentage is a little lower than the national average, but it's still significant, usually representing a full third or more of hospital revenues. On this book of business, hospitals insist their margins are just too thin and that this is a significant factor in their poor financial performance.

Not everyone buys that argument, though. "I'm surprised that Twin Cities hospitals are not doing that well with the program, because nationally speaking, hospitals are living with the Medicare payment system," says Roger Feldman, a professor of health services research and economics at the University of Minnesota.

According to a recent report by the U.S. Department of Health and Human Services, hospitals' average profit margin on Medicare business was about 9.6 percent in 1987—down from an average of 14.4 percent the year before, when 80 percent of hospitals reported making a profit off Medicare.

Although hospitals are not making as much money on Medicare, the majority are still reporting respectable margins. "Quite frankly, I don't understand what the problem is," says Feldman, who is participating in a national study on health care delivery issues. "If hospitals are not dealing with it in Minneapolis, it indicates one of two things: One, they have not been able to get their costs down, or two, other payers in the market are putting the squeeze on them. But I don't agree that all payers are squeezing them unnecessarily, at least on an individual basis."

The rejoinder from hospitals is that costs, driven ever higher by demands for the latest medical technology, are escalating much faster than the fees they receive from payers, not only from Medicare but from HMOs, Blue Cross and Blue Shield, and some commercial insurance plans. "There is no question that this industry needs to improve payment rates from third parties," says John Reiling of HealthEast. "The Twin Cities hospital industry is clearly underfunded and requires higher reimbursement payments."

The people who pay the bills adamantly disagree. "We do not in any way believe that high double-digit increases are warranted," says Patricia Drury, executive director of the Minnesota Coalition on Health Care Costs, which represents business and citizen interests on health care issues. "We suspect there is excess hospital capacity in total, and in no way do we want to pay for it."

The issue is more than whether hospitals are incurring high fixed costs because they maintain too many empty beds and thus pass the overhead expense on to the public. The surplus space can contribute to needless treatments and overutilization. "There is a lot of variability and discretion in medical care, and when a facility isn't full, it tends to be used," explains Drury. "As long as the capacity is there, the variability of procedures will keep the beds full."

Walter McClure, whose Center for Policy Studies has designed a "buy right" strategy to bring health care costs into line, believes the entire health care field is plagued by an oversupply problem—an oversupply of hospitals and doctors whose excessive numbers lead to medical overactivity. "At least fifty percent to seventy percent of the expansion in the medical field was a transfer of wealth, not a production of better health for the money," he says. "It was ineffective and inefficient. We could have, in fact, spent far less and received far more had the system performed differently."

The perversity of the oversupply problem can be partially gauged by the fact that by 1990 there will be more doctors graduating from medical schools than nurses from four-year institutions, according to a projection by *American Demographics* magazine. An interesting anomaly within a system bloated from excess is that the primary care-giver, the nurse, is in desperately short supply, so much so that some hospitals in the United States are facing such a critical shortage of nurses that they may have to limit elective treatment cases because they cannot staff the beds.

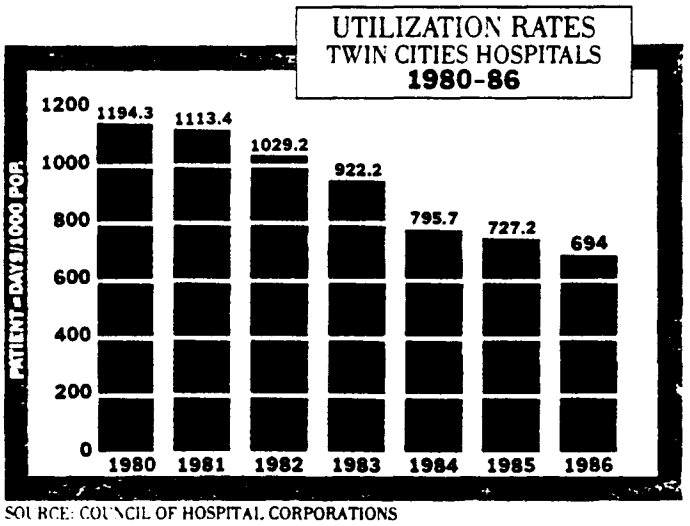
There is a significant shortage of nurses locally, too, but hospitals are doing anything but turning patients away. Just the opposite.

Hospitals are turning to alternative treatment programs to keep facilities operating. "They are creating demands that were not there before, like sports medicine," says Drury.

The big rage in the hospital business these days is behavorial medicine, chemical dependency treatment, and long-term care. Rather than shut down facilities, hospitals convert their operations into different functions. "The hospitals are glomming from one buzzword to another," says Harry Sutton. "The first thing they do is switch to mental health and chemical dependency. As I'm fond of saying, we [in Minnesota] have three percent of the population in the U.S. and fifteen percent of the chemical dependency treatment beds."

The old Eitel Hospital is an example of how facilities retain a lease on life long after their original mission has expired. The facility was renovated in 1985 and converted into an inpatient child and adolescent psychiatric treatment center with 144 licensed beds. Bethesda Hospital is another example. Although it will cease being a primary acute-care hospital, HealthEast plans to convert the 298-bed facility into a geriatric center and long-term care hospital. Even the old 213-bed Abbott Hospital was renovated and converted in 1983 into a specialized, skilled nursing facility.

"These things have a life that goes on forever whether they are needed or not," observes Sutton. He acknowledges the need for nursing homes, but questions the precipitous increase in inpatient chemical dependency treat-



SOURCE: COUNCIL OF HOSPITAL CORPORATIONS

ment programs, especially when there is considerable question about whether institutionalization is any more effective than outpatient care in the majority of cases. "But look what's happened. The number of beds for chemical dependency treatment increased by five hundred percent from the early 1970s to the early 1980s, because of the very liberal state laws passed in 1973 that required insurance companies to cover this treatment. The fact that there is money there to pay for it creates a huge use."

In fairness, a significant amount of that use is by out-of-state patients who are drawn to what are recognized as some of the best chemical dependency programs in the country. "Minnesota should actually be proud of its leadership position," says Carl Platou of Fairview Hospitals, whose chemical dependency treatment program at the former St. Mary's (now Riverside Medical Center) is well recognized. "We get teen-agers from New Jersey who come to a community hospital for treatment. What does that say about New Jersey?"

Or Minnesota?

For one thing, it says that Minnesota spends a lot of money on health care. The field is the state's largest employer and its fastest-growing sector for products and services. Minnesota is a mecca for health care and sophisticated medical procedures and technological innovations. The Minnesota Medical Alley Association was recently formed, for instance, to promote the state's health care industry.

And at the heart of the health care field are Twin Cities hospitals. Recognized as leaders, the hospitals here enjoy national reputations in key specialty areas, with among the most notable being transplants and the most notable among transplants being heart/lung operations.

Ya Gotta Do Hearts?

THE MINNEAPOLIS HEART INSTITUTE, AFFILIATED WITH ABBOTT Northwestern, is one of only a handful of facilities in the country approved by the FDA for experimental artificial heart transplants. The University of Minnesota holds equal—and intensely competitive—stature with the Minneapolis Heart Institute. They are joined by the Midwest Heart Institute, North Heart Institute, and St. Paul Heart & Lung Institute.

In all, there are about 15 hospitals in the Twin Cities that support major cardiology programs. It has become a big business for hospitals. At Abbott Northwestern, to cite just one example, cardiology accounts for almost 20 percent of admissions. "The most profitable market in today's environment is heart surgery," says Dr. Richard Reece. "I will bet you that Abbott Northwestern makes more than fifty percent of its profits on one procedure: coronary bypass."

Bets aside, there is no denying that an inordinate amount of activity is occurring in the area of cardiac surgery. There are concerns that some of the activity may be unwarranted. A recent research report published in the *New England Journal of Medicine* indicated that more than half the pacemakers implanted into patients may be unnecessary. Though criticized, the report does raise questions on practice patterns, the problem of physicians overtreating and hospitals overadmitting.

"There's a lot going on in medical care that is sloppy, that is simply inappropriate, and that's the problem that needs to be addressed," says Patricia Drury. "Hospitals cannot do it alone, but they are part of the problem and they have to be in concert with

WHO RUNS WHAT

Multihospital holding companies and their components, in the Twin Cities and beyond.

HealthEast

Midway Hospital
St. Joseph's Hospital
Divine Redeemer Hospital
St. John's Northeast Hospital

LifeSpan

Abbott Northwestern/Sister Kenny Institute
Methodist Hospital
Minneapolis Children's Medical Center/Gillette Children's Hospital in St. Paul
Memorial Hospital in Cambridge
Stevens Community Hospital in Morris

Fairview Hospitals

Riverside Medical Center*
Fairview Southdale Hospital
Fairview Ridges Hospital
Fairview Milaca Hospital
Fairview Princeton Hospital
Waseca Area Memorial Hospital
Iowa Lutheran Hospital in Des Moines, Iowa
Indianhead Medical Center in Shell Lake, Wisconsin

*Riverside Medical Center is a joint operating agreement between St. Mary's Hospital and Fairview Riverside Hospital/ Fairview Deaconess Center.

Health One

United Hospital
Children's Hospital of St. Paul*
Metropolitan/Mount Sinai Medical Center**
Mercy Medical Center of Coon Rapids
Unity Medical Center of Fridley
River Falls Area Hospital/ Kinnic Long-Term Care Unit
St. Croix Valley Memorial Hospital*
Dakota Midland Hospital in Aberdeen, South Dakota
Health Central of Owatonna
Sioux Valley Hospital of New Ulm
Granite Falls Municipal Hospital & Manor*
Ipswich Community Hospital of Ipswich, South Dakota*
Health Central of Buffalo
Long Prairie Memorial Hospital & Home
St. Mary's Hospital & Home of Winsted
Monticello–Big Lake Community Hospital & Nursing Home*
Central Michigan Community Hospital of Mt. Pleasant, Michigan*
Dakota Hospital–Southeastern Dakota Nursing Home of Vermillion, South Dakota*
Memorial Hospital of Manhattan, Kansas***
North Iowa Medical Center of Mason City, Iowa*
Prairie Lakes Health Care Center of Watertown, South Dakota*
Northeast Medical Center****

Facilities are managed by Health One.
**Metropolitan/Mount Sinai Medical Center is a merger between Metropolitan Medical Center and Mount Sinai Hospital.*
***Joint operating agreement.*
****Administrative support agreement.*

physicians to solve it."

The duplication-of-services issue is a deep-rooted one. The number of cardiology programs in the Twin Cities market is an example of excess. But hospitals loathe giving them up because of the prestige associated with offering the service. Moreover, the prestige helps in another very important area—keeping doctors associated with a hospital's medical staff.

The psychological reality of the situation is that egos drive hospital strategy every bit as much as economics. That's why those who run the institutions seem compelled to ornament their operations with all the technological doodads—right down to the emergency helicopters.

The multihospital systems are sensitive to the criticism. Yet no one is volunteering to close down their specialty centers so their competition can operate more efficiently. There is the question, too, of how much is too much.

"It's fair to say there's duplication," says Donald Wegmiller of Health One, whose own system is now developing a strategy of pinpointing the medical specialties in which it intends to excel. "But it gets very fuzzy in my mind where the line is between adequate access to care versus duplication. The ultimate in nonduplication, of course, is to have one service. Everyone agrees that's foolish. Then, it becomes a matter of judgment—is it two or three or what? And then should Minneapolis and St. Paul each have their own because of the market size, or should they each have two? Where is it? I don't know what that number is, and if someone does they should tell us."

Duplication-of-services is a deep-rooted issue. The number of cardiology programs in this market is an example of excess. But hospitals loathe giving them up.

The issue of accessibility of care, the convenience and comfort of having a hospital in every community's back yard, has as its counterpoint the more compelling issue of affordability. The independent stand-alone hospital, fully equipped with comprehensive diagnostic capabilities, is an economic anachronism. There is also the much more fundamental issue of quality. Who provides the best care, in what area, and at what price?

The public is generally unaware of the disparity that exists among hospitals, especially the sticker charges from one institution to the next.

Quality of care is generally considered a given here, thanks to a strong medical school and vigorous medical community that promotes high standards. But price variability is another story. A coronary bypass can range from an average of $22,353 at United Hospitals to $18,827 at Abbott Northwestern to $21,369 at Fairview Southdale to $23,399 at North Memorial to $15,149 at Methodist. The high-low spread amounts to $8,250, or a difference of almost 55 percent between Methodist and North Memorial. Admittedly, it's a procedure with a lot of variability, but the price ranges indicate an underlying difference in cost structure.

Even a less complicated procedure, such as childbirth, varies markedly in cost. A vaginal delivery without complications will vary from an average price of $1,056 at Waconia Ridgeview to $1,543 at St. Paul–Ramsey to $1,272 at St. Joseph's to $1,728 at Fairview Riverside to $1,177 at Methodist to $1,621 at Fairview Southdale. There is a $672 range in costs, or a difference of almost 64 percent.

Choosing Quality: How Can We Know?

PRICING MEDICAL CARE IS A DICEY BUSINESS, HOWEVER. AN important caveat is that price alone is an insufficient—in fact, probably the wrong—measure by which to rate hospitals. The preferred approach, advocated under the competitive "buy right" model put forth by Walter McClure and others, is to buy health care services based on quality and efficiency. "We must know who the winning teams are so we can reward them with business," says McClure. "Otherwise, if we cannot determine who is good, we buy on the cheap, and that will just benefit the second-rate providers."

The weakness in the "buy right" strategy is that it's hard to know how to measure quality and how to get providers to cooperate. There is no small problem with having hospitals expose themselves to litigation because they voluntarily released information that may reveal their performance shortcomings. No hospital operating today is so clean that it would not be compromised by quality disclosures.

Nonetheless, the quality measure is a *sine qua non* for the future of the health care industry. "It is essential that some of the information available on quality be made more public," says Malcolm Mitchell of the Metropolitan Health Planning Board. "At this point it's still very confidential. The argument has always been that it will be misleading and be misused. But as more information becomes available from a number of different sources, people will make pretty good and informed decisions about what they are buying and why they want to buy it."

Consumers cannot help but notice that "information" of a sort has been filtering out—in print and electronic advertisements. The message is uniformly soft, emphasizing a hospital's image but little of health care substance.

Hospital marketing has become a big business, with many hospitals spending more on advertising than on providing charity care. In 1986, according to a study by Chicago's SRI Gallup, hospital marketing expenditures increased 56 percent from 1985. "What we have is hospitals trying to build images, and I don't know whether building images is worth all the money spent to do it," says Mitchell.

Certain hospital systems have been more advertising-intensive than others. HealthEast has mounted a very aggressive television

image-building campaign. Unfortunately, most of the audience for that television campaign lives in a market—the west metro area of Minneapolis—that will never use HealthEast's services. Observes Gus Donhowe of Fairview Hospitals, which along with Health One is fairly stingy on spending for advertising, "There are a lot of advertising neophytes out there in the hospital field."

But legitimate health care information dissemination is an important public policy issue. Hospitals—good ones, that is—should benefit as much as consumers. Says Allan Jacobson of the Council of Hospital Corporations, which is one of the main data depositories on Twin Cities hospitals: "In the absence and/or ignorance of such issues as quality and the questionable ability to measure it, basically health care coverage is bought and sold here, as elsewhere, based on coverage and price. Those are the only two dimensions on which employers and consumers are making decisions. But as long as discussions remain focused on coverage and cost, the long-term future of the hospital industry looks pretty bleak."

Certainly the immediate future, the period over the next three to four years, promises to be a distressing time for providers. On a national scale, more than one out of every ten hospitals is expected to close by 1995, according to a study by Arthur Andersen & Company and the American College of Healthcare Executives.

Prognostications—most of which are made off the record when they concern specific institutions—call for fewer consolidations in the Twin Cities hospital industry but more outright closures. "In order to realize economies from a merger, you would not only have to take some of the beds out, but whole hospitals, because that's the only way you can really get rid of the fixed costs," points out Roger Feldman. "It's not enough to shut down ten beds one week in this hospital and ten beds the next week in another hospital and so on; what they have to do is take out the whole hospital."

A lot of what has been accomplished thus far, though important, has been a half step toward shutting facilities down. The consolidation process itself is really just an interlude. As McClure puts it, "These hospitals will not be shot through the eyes and destroyed; they first consolidate and then they disappear eventually. The only ones we want to survive are just the best and most efficient outfits."

The best are the hospitals that become what the industry labels "centers of excellence." All the multihospital systems are trying to establish those centers within their groups. But developing and maintaining these centers requires resources and high-paid personnel, both medical and administrative. As a consequence, during an era of increasingly scarcer resources, the multihospital systems will be forced to selectively starve the unpromising ventures so that their showcase hospitals not only survive, but thrive.

One example of this type of institution is Abbott Northwestern, which legitimately boasts premier services in such areas as rehabilitation, cancer, neurosciences, and cardiovascular treatment. Its pre-eminence in specific areas helps account for the fact that 28 percent of its patients come from outside the metro area. Its cardiology services are in such demand that last year it had to turn patients away because it was at capacity.

Abbott is by no means an exception. One could also cite the new Riverside Medical Center, United, North Memorial, University, Methodist, and several others as medical facilities with strong programs on which to sell themselves.

Conversely, there are other facilities whose missions are less compelling or whose comparative advantage is singular rather than plural. They are at risk, regardless of whether they are independent operations or divisions within the new hospital corporation. The future promises to be every bit as difficult as the past for hospitals trying to satisfy the public that they are worthy of support, confidence, and patronage.

In any summary discussion of the hospital industry's prospects in the near, medium, or long term, there is one point that deserves emphasis: an industry that fails to deal with its problems invites intervention. Excess capacity is clearly a problem. Not the only problem, to be sure, but enough of a problem that it has had a deleterious effect on the industry's financial well-being.

Government intervention, the layering of more controls and regulations on the industry, is widely viewed as undesirable, perhaps even ruinous to the system in the long run—as it has proven to be in the "public utility" model exemplified by Britain's National Health Service. Although Britain spends only 6 percent of its GNP on health care, compared to more than 11 percent in the United States, the tradeoff is questionable.

"We would merely spend less to get less, which is what the public utility model would provide, just like it has with our school system," says Walter McClure.

The preference is to allow the system to operate in as unregulated an environment as possible, with competition providing the impetus to re-form an unwieldy system. The new hospital corporation, with its promises of economies of scale, critical mass, and managerial sophistication, is part of that competitive model.

This story line, however, calls to mind another health care promise to which Minnesota gave birth. The HMO movement was hailed as an important step toward checking the explosive growth in health care costs and as a more affordable, free-enterprise means of providing coverage to unprotected patients. Now, with rising losses and insolvencies threatening HMOs, and with the recent revelations that HMOs were dumping senior citizen clients who live in rural areas of the state, there is public pressure to impose tougher government restrictions on HMOs.

What went wrong? Industry observers point to rapid HMO expansion, excessive competition that prompted rate cutting, and that familiar bogeyman, mismanagement.

So far, the hospital industry has seemed to parallel the HMO path, with rapid expansion of the multihospital holding companies, excessive competition among providers, and injudicious product discounting.

The last question, and the critical one, is whether the managers of the new hospital corporations are up to the task. Do they have in place strategic plans that will improve the efficiencies and economies of their systems?

"Clearly, some major actions have been taken by all those systems on their strategic plans; and in some situations, it has been fairly high-risk," says Malcolm Mitchell, who has seen the metropolitan hospital system move away from government regulations to quasi-deregulation.

"But I think the development of the multihospital system has really provided the opportunity to deal with the issue of economics and some of the other problems more effectively," he says.

"Whether some of their strategic plans work out, well, I think the jury is still out on that one." TC

The Minnesota Daily

Monday, April 11, 1988

Regents approve new building for CUHCC

The Community University Health Care Center, which serves the Phillips Neighborhood in south Minneapolis, will be replaced with a new building at Franklin and Bloomington avenues, the Board of Regents decided Friday.

The Minneapolis Community Development Agency and the City Council recently agreed to chip in $150,000 of the $1.5 million the project will cost. The University Hospital Board of Governors approved the plan in February, on the condition that city officials promise that CUHCC would retain some of its grant support in the future.

The clinic serves low- and moderate-income people and offers some health services which are partially subsidized by the Minneapolis health department.

Hospital officials at one point considered relocating the clinic. But after a series of community meetings throughout the winter, they decided to buy property at 1521 E. Franklin Avenue and keep CUHCC next door to its current location.

At a Minneapolis City Council meeting Apr. 1, Council Member Brian Coyle (DFL-Ward 6) called the decision "a real victory for the neighborhood." Council Member Tony Scallon (DFL-Ward 9), who had lobbied in favor of a Chicago Avenue site, said it is important to keep the clinic in its present neighborhood because, with a staff of 65, "it is the largest job generator on Franklin Avenue."

CUHCC's current building is 100 years old and lacks handicapped access. The space also must be increased by 62 percent, University officials said.

The clinic, which has an annual operating budget of $2 million, had 48,000 patient visits last year, according to University officials. The clinic also offers clinical training opportunities for about 30 students each year. Twelve research projects are in progress at CUHCC, according to clinic officials.

— Delores Lutz

Sauer seeks plan to improve university's public relations

By Howard Sinker
Staff Writer

Officials at the University of Minnesota know that what they're doing looks like closing the barn door after the horses are gone. But interim President Richard Sauer and others want a plan to help them handle public scrutiny and convey their message.

The concern stems largely from recent events: The Eastcliff remodeling that led to Kenneth Keller's resignation one month ago, controversies about the university's central reserve, a continuing legislative audit of the physical plant and the uncertain future of Commitment to Focus.

"I'm not in a position to speculate and say, 'Here's what should have been done — one, two, three,' like a Monday morning quarterback," Sauer said Tuesday. "It's my general sense that if one had thought about strategy from a public relations standpoint, some of our problems could have been minimized. Whether Ken Keller would still be president, I don't know.

"I can only judge from the eight years that I've been here, but this university has not given adequate attention to public relations."

Sauer has asked for a short-term strategy to improve the university's reputation and a long-range strategy for dealing with the news media and the public. Sally Howard, a former Minneapolis council member, has taken a leave from her public relations position at the university's hospital to oversee the effort.

"We need a document that says, 'If that happens, this is what we want to do,' " Howard said. "This is a very touchy thing to develop because you don't want to control anybody's freedom of speech. Nobody is thinking about a situation where you have to go to the teacher before you can leave the room. But if there was a failing on our part, it's that we didn't have anything in place that could be kicked into action. We're starting from scratch."

Said Rick Heydinger, vice president for external relations: "It's only in the last few years that public organizations have realized the importance of sound communications strategy. Private organizations have realized that for a long time. In the same way that marketing has become a good idea in higher education over the last decade, public relations and communication have become much more of a component in administering a large public research institution."

As much as anything else, the university must decide what constitutes proper effort and what would be misconstrued. "It's different than selling widgets," Heydinger said. "We're not talking about advertising. We're talking communications, and I do have concerns about public reaction. How much of this activity is appropriate? How much time, energy and money do we devote to it?"

Among those with doubts is Provost Roger Benjamin, the No. 2 administrator on the Twin Cities campus. He agrees that an immediate plan can help the university recover lost prestige, but doubts that a long-term plan will be worthwhile.

"I won't pretend that I don't have some negative views about some of the media, particularly the visual media," Benjamin said. "But you develop relations with journalists that are based on trust. That's the best strategy. Openness and candor generate a better chance of achieving the truth, and I don't know that any particular media plan can deal with that. . . . I think we're all going to suffer if we try to fine tune how to put the spin on something."

Sauer apparently will follow through on a plan to visit cities throughout Minnesota after the Legislature adjourns this month. That will allow him to use contacts made in his previous positions — vice president for Agriculture, Forestry and Home Economics and director of the Agricultural Experiment Station — and give him the chance to generate support.

"People in the metro area get so much of the university because there's a steady diet from the media," said D.J. Leary, a media consultant who will meet today with Heydinger and Howard. "But there's a whole segment of the population that's been overlooked. A kid from Renville County sees the university in the same way that his father and grandfather did. He's not thinking, 'Why don't they do something about the parking problems?' You have to reacquaint that constituency with the university. . . .

"It's not finger-pointing time because your finger would get tired. Now they should go out and do some things. Dick Sauer is the kind of guy who'll say, 'This is your university. We're changing things and we want to know what you think.' "

Howard has been interviewing administrators and plans to have a preliminary report next week.

Handout
4/27/88

UNIVERSITY OF MINNESOTA
TWIN CITIES

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

April 27, 1988

TO: Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Biliary Lithotripter

In January, 1988 we provided the Board with a two-year retrospective summary of activity and results from our kidney stone lithotripsy program. We also indicated at that time that we were investigating our possible involvement in the clinical trial phase of gallstone lithotripsy, and that we would likely be recommending a course of action in that regard to the Board in mid-1988.

Over the past several months we have had a task force of medical and administrative staff evaluating "second generation" lithotripsy. Two major steps forward in lithotripsy appear to be on the horizon. The first is the ability to treat gallstones (in addition to kidney stones) using lithotripsy technology. The second is the ability to treat both kidney stones and gallstones using lithotripsy without general anesthesia.

Neither of the above two steps or advantages are yet clinically proven; this is especially true with regard to gallstone treatment. Because our (and others) involvement with kidney stone lithotripsy has demonstrated the importance of early involvement in these technologies, we have expressed a desire to several vendors to be a clinical trial site for biliary (gallstone) lithotripsy.

We have, over the past several months, evaluated five vendors. One indicated that they could not consider us as a clinical trial site. The second has indicated that they are considering us, but cannot yet make any commitments. The three other vendors indicated they would wish to have UMHC participate in their clinical trials.

One of the three vendors does not appear to have a machine which uses only local or no anesthesia; we have, for this reason, not pursued serious discussions with that company (this vendor has, reportedly, located their machine at another Twin Cities hospital). The other vendors all appear to offer lithotripsy machines which have similar probabilities of being clinically effective. The costs to UMHC of participating in the clinical trials vary substantially, however.

Most of the clinical trial proposals we have received call for up-front payments of up to $900,000, with no recourse if the machine does not receive FDA approval. The competitive environment among hospitals is such that institutions have been willing to participate under these conditions.

Our negotiations with one of the manufacturers has led to a one-year lease arrangement. The costs involve a one-year lease of approximately $110,000; and a one-year maintenance contract of about $100,000. The vendor will pay us $100,000 in phases as we reach certain volume levels in our clinical trials. This is clearly the most advantageous arrangement available to us, and we are in the final stages of negotiating an agreement along those lines. Presuming the final details are worked out, we hope to take delivery in mid-May, begin treatment of kidney stones on this machine in early summer, and begin treatment of gallstones in mid-summer.

Because this level of expenditure does not require Board approval, no action from the Board is required. Because of the early-stage clinical trial participation, we thought it important that the Board be aware of this project. Further, we hope to generate some publicity relative to our clinical trial participation in the next several weeks, and wanted the Board to be aware of the project for this reason as well.

Please feel free to contact me with any questions.

GH/kj

Handout
4/27/88

1988 MINNESOTA LEGISLATIVE SESSION
SUMMARY OF HEALTHCARE AND UNIVERSITY RELATED ACTIONS
Prepared by: Al Dees
4/27/88

BILLS PASSED AND SIGNED

H.F. 1493 Tort Reform
Deletes the minimum statutory rate (8%) on verdicts. Requires court hearings where award of more than $100,000 in future damages are made. Limits joint and several liability of persons who are 15 per cent or less at fault (4 times fault). Creates a legislative study commission to study the civil justice system. Repeals Minnesota Statutes Section 604.07, which provided for discounting of future damage awards.

H.F. 1784 Nurse Midwife and other licensed/certified practitioner practice
Allows registered nurses nurses who are certified nurse-midwives to prescribe and administer drugs and therapeutic devices. Allows licensed and certified health care professionals, upon licensed practitioner authority, to prescribe and administer legend drugs and controlled substances.

H.F. 2559 Hearing Aid Sales and Repair
Extends the 30-day hearing aid guarantee to cover the first 30 days of possession by the buyer. Requires guarantees of hearing aid repairs to be in writing, as specified. Limits itemized repair bill requirement.

S.F. 335 Physical Therapist Practice
Requires continuing education for physical therapists. Permits physical therapists to provided treatment for an initial 30 day period without an order or referral by a licensed physician, chiropractor, podiatrist, or dentist. Extends persons authorized to order or refer persons for physical therapy to chiropractors, podiatrists and dentists. Amends standards for denial of certification of and prohibitions on physical therapists.

S.F. 752 Pharmacy Regulation
Modifies regulatory statutes governing pharmacies, drug manufacturers, and others, expanding authority of the Board of Pharmacy to inspect medical gases and veterinary drugs and devices.

S.F. 1861 HMO Coverage, Subscriber Rights, and Cancellation/Coverage
Requires HMO's to clearly define covered and noncovered services in subscriber contracts and to include the enrollee bill of rights. Also requires contracts to explain conditions under which coverage may be terminated and to explain continuation/conversion rights. Requires reporting of intent to cancel or discontinue contracts to the Commissioner of Health 120 days prior to effective date. Requires provision of replacement coverage if contracts discontinued or canceled. Extends authority of Commissioner of Health to mandate replacement coverage plans and to mediate HMO/provider disputes which could result in contract cancellations. Requires Commissioner to promulgate rules addressing issue of appropriate prior authorization requirements.

Provides for and details HMO financial responsibility for continuation coverage under Minnesota comprehensive health insurance plan (MCHA).

S.F. 1904 Board of Medical Examiners Amendments
Allows the Board to not publish disciplinary actions based solely on evidence of chemical and alcohol addiction, expands disciplinary actions grounds particularly with regard to fee splitting, Authorizes temporary physical therapist permits, and allows certain data transfers to other states.

S.F. 1958 Employee Restroom Breaks
Requires employers to allow employees adequate time in each four hour work period to use the nearest convenient restroom. Does not affect current collective bargaining agreement.

S.F. 1970 MA/GAMC Reimbursement
Modifies hospital payment rates, exempting computation of rates and relative value of diagnostic categories from Medicare routine service cost limitations, exempting Indian health service facilities from rate establishment methods, and specifying rates for out-of-state hospitals.

BILLS PASSED AND AWAITING SIGNATURE

H.F. 2122 Higher Education Appropriations Bill
Includes request that the Regents employ persons qualified to provide them with fiscal and policy information, oversight, and analysis on matters requiring regents' attention or action. Staff should be independent of the University's administration and responsible solely to the Regents. Requests report to chairs of Senate finance and House appropriations committees by 12/1/88. Establishes 24 member Regent Candidate Advisory Council to determine criteria for and to identify and recruit qualified candidates. Requires Board of Regents to make all available to the commissioner of finance all books, accounts, documents, and property the commissioner wishes to inspect.

H.F. 2126 Health & Human Services Omnibus Bill
Sets basis for MA payment rates after 10/1/88 for physician, dental, vision, podiatric, chiropractic, physical therapy, occupational therapy, speech pathology, audiology, mental health, psychology, public health, and independent lab and X-ray services as rates in affect on 6/30/87. Basis for OB care, however, is set at 10% above 6/30/87 rate base. Appropriates $700,000 for FY89 for AIDS prevention grants for high-risk populations including communities of color, adolescents and IV drug users. Extends MA Case Manager system to mental health care. Requires Commissioner to establish procedures to analyze and correct problems associated with MA, GAMC, and Children's health plan claims preparation and processing including designation of a full-time liaison to providers, provision of quarterly reports to hospitals of claims received and identification of and reasons for any suspended claims, and identification and prioritization of hospital claims that are in jeopardy of exceeding time factors that would eliminate payment. Requires the Commissioner of Human Services to develop implementation plan for the healthspan program to provide health coverage to the uninsured.

H.F. 2127 HMO Solvency

Requires new HMO's to show evidence of $500,000 deposit before certificate of authority will be issued and mandates subsequent deposits equal to the difference between the amount on deposit and 33% of uncovered expenditures in preceeding year. Requires net worth for new HMO of 8 1/3% (i.e. equal to 30 days of working capital) of all expenses expected in first 12 months of operation or $1.5 million, whichever is greater. After first year, requires net worth maintenance of 8 1/3% of prior year expenses or $1 million, whichever is greater. Phase-in period for compliance with net worth requirement extends to 12/31/93. Requires HMO's maintain a positive working capital and mandates development of correction plans approved by Commissioner of Health when negative position develops or net worth requirements not met. Requires submission of quarterly financial statements to Commissioner (only final, annual reports will be public data, however.) Prohibits providers from seeking payment from enrollees or their representatives and family members in the event of HMO nonpayment, insolvency or breach of contract but does not prohibit pursuit of payment from others such as employers etc. Requires providers to give HMO's 120 notice of intent to terminate participation agreement. Enables providers to notify Commissioner if an HMO's payments delayed beyond dates specified in contract. Defines rehabilitator/liquidator powers of Commissioner.

H.F. 2344 State Departments Appropriations Bill

Appropriates $100,000 to the legislative auditor to cover the cost of auditing the University's physical plant operations. The U is liable, however, to the auditor for the total cost and expenses of the audit. Appropriates $4,593,300 for transfer to the employee insurance trust fund to cover the Blue Cross losses the state is assuming but requires the Regents to pay $3,956,700 to the insurance trust fund from money previously appropriated for UM operations and maintenance.

H.F. 2590 Omnibus Tax Bill

Includes sales tax exemption for UMHC retrotroactive to June 1, 1987

S.F. 994 Extension of Workers' Comp. Definition of Occupational Disease

Extends definition to include infectious or communicable disease contracted by a police officer, firefighter, paramedic, emergency medical technician or nurse after exposure while providing emergency medical care outside of a hospital.

S.F. 1388 HMO Enrollee Bill of Rights

Establishes requirements regarding statements of exclusions and limitations in enrollee contracts. Establishes guidelines regarding marketing materials. Requires written statements regarding denial of service when requested by enrollees. Prohibits denial or limitation of coverage for service already received based solely on failure to obtain prior authorization or a second opinion if service normally covered, or for care provided by non-participating provider if care was ordered or recommended by a participating provider, the service would ordinarily be covered and the enrollee was not given prior written notice that service would not be covered. Prohibits withholding or threats of withholding services in attempting to collect delinquent accounts.

BILLS WHICH DID NOT PASS

H.F. 2240/S.F. 1995 Open Meeting Law Amendments
Would have enabled boards of public hospitals to hold closed sessions for strategic planning and trade secret discussions.

H.F. 2517/S.F. 1816 Adult Health Care Decisions Act (Living Will Bill)