

Board of Governors

Enrichment Speakers

1992

Gordon Ginder, M.D., Department of Oncology (January)

Kamil Ugurbil, Ph.D., Center for Magnetic Resonance Research (April)

Paul Abramowitz, Director of Pharmaceutical Services (May)

Richard Latchaw, M.D., Radiology and Neuroradiology (October)

Diverse Workforce Council (December)

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JANUARY 22, 1992

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
JANUARY 22, 1992
2:30 P.M.
555 DIEHL HALL

AGENDA

		<u>Page</u>
I.	<u>Approval of the December 18, 1991 Minutes</u>	Approval 1
II.	<u>Chairman's Report</u> -Ms. Kristine Johnson	Information
III.	<u>Hospital Director's Report</u> -Mr. Robert Dickler	Information
IV.	<u>Special Presentation: Gordon Ginder, M.D.</u> -Professor and Head Department of Oncology	Information 5
V.	<u>Committee Reports</u>	
A.	<u>Consent Items</u>	
	<u>Finance Committee</u>	
	1. December 18, 1991 Minutes	Information 14
	2. Second Quarter, 1991-92, Bad Debts	Information 17
	3. Orthopedic Clinic Remodeling	Information 51
B.	<u>Joint Conference Committee</u> - Robert Maxwell, M.D. - The Joint Conference Committee Did Not Meet	
	1. Medical Staff-Hospital Council Report Credentials Committee Recommendations	Approval 53
C.	<u>Planning and Development Committee</u> - The Planning and Development Committee Did Not Meet	

D. Finance Committee

- Mr. David Lentz

- | | | | |
|----|--|-------------|----|
| 1. | December 31, 1991 Financial Statements
(To be distributed at the meeting) | Information | |
| 2. | EMTEK System | Information | 57 |
| 3. | Magnetic Resonance Imager | Approval | 60 |

E. Nominating Committee

- Ms. Cherie Perlmutter

66

V. Other Business

VI. Adjournment

MINUTES

BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic

December 18, 1991

Call To Order

Ms. Kristine Johnson called the December 18, 1991 meeting of the Board of Governors to order at 2:40 p.m. in the East Wing of the Campus Club.

Attendance

Present: David Brown, M.D.
Robert Dickler
Robert Erickson
Kris Johnson
Nellie Johnson
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
Jerry Meilahn
Barbara O'Grady
Trudy Ohnsorg
Cherie Perlmutter
Roby Thompson, M.D.

Not Present: Leonard Bienias
Michael Dougherty
George Heenan
Robert Nickoloff
Jerry Olson

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the October 23, 1991 meeting as submitted.

Chairman's Report

Ms. Kris Johnson reported that the Board of Regents, at their December 13, 1991 meeting, have appointed four new Board of Governors members; Maria Gomez, Albert Hanser, John Morrison and Kristine Zualkernan (student). Two additional governors will be appointed in January to complete the terms of George Heenan and Gerald Olson.

Ms. Johnson informed the Board that the Board of Regents will be hosting a luncheon for the Board of Governors on January 9, 1992.

Ms. Johnson announced the appointment of the Board of Governors Nominating Committee; Cherie Perlmutter as Chair, Michael Dougherty and Nellie Johnson.

Ms. Johnson announced that there would be a closed session at the conclusion of the Board meeting to discuss marketing activities.

Ms. Johnson encouraged the Board members to attend the holiday party immediately following the Board meeting.

Directors Report

Mr. Bob Dickler introduced Joanne Disch, Senior Associate Director and Director of Nursing, to the Board.

Mr. Dickler commented and commended employees on their special efforts made during recent snowstorms.

Mr. Dickler reported on holiday activities which would be taking place such as holiday parties for patients.

Mr. Dickler reported that he expects to announce the appointment of a director of medical affairs by the January Board of Governors meeting.

Consent Agenda

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

- a. Quarterly Purchasing Report
- b. Quarterly Capital Expenditure Report
- c. Pediatric Radiographic/Fluoroscopic System
- d. Laboratory Computer System

The Medical Staff-Hospital Council Report, Credentials Committee Recommendations was moved from the consent agenda because the Joint Conference Committee Meeting was cancelled due to a power outage. This item was discussed during the Joint Conference Committee report.

Joint Conference Committee

In Mr. Heenan's absence, Ms. Barbara O'Grady called on Dr. Robert Maxwell to present the recommendations of the Credentials Committee which were endorsed by the Medical Staff Hospital Council on November 12, 1991. A motion to approve the recommendations of the Credentials Committee was passed unanimously.

Planning and Development Committee

In Mr. Nickoloff's absence, Ms. Nellie Johnson called on Mr. Al Dees to present the Magnetic Resonance Imager (MRI) proposal. UMHC is currently operating two MRI units: a 1.0 Tesla machine which UMHC began leasing and operating in January 1985, and a 1.5 Tesla machine acquired in 1989. Due to the significantly improved image quality, throughput, and increased versatility obtained, 1.5 Tesla has replaced 1.0 Tesla as state-of-the-art technology. Alternatives have been explored; (1) contract with another hospital or imaging center for off-site service, (2) purchase on-site, mobile service from an imaging services company, or (3) operate the existing 1.5 Tesla machine 24 hours per day on weekdays. UMHC's current 1.5 Tesla unit has a projected capability of supporting 3400 procedures annually when operated 16 hours per weekday. The proposal is to replace the 1.0 Tesla MRI machine with a new, state-of-the-art machine with a magnet strength of 1.5 Tesla or greater. The projected cost is \$2,400,000 for equipment and \$600,000 for installation. This item is brought to you for information and approval will be sought at the January Board meeting.

Finance Committee

Mr. Jerry Meilahn called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospitals's Statement of Operations for the period July 1, 1991 through November 30, 1991 shows expenses over revenues by \$1,768,000, an unfavorable variance of \$6,532,000. Patient care charges through August totaled \$153,042,000, which was 4.7% under budget.

Mr. Fearing reported inpatient admissions for November totaled 1,336 which was 179 below budgeted admissions of 1,515. Overall average length of stay for the month was 8.1 days. Outpatient clinic visits for the month of November totaled 24,810 which was 3,026, or 10.9% less than budgeted visits of 27,836.

Mr. Greg Hart gave the Board an update on the hospital labor relations. Collective bargaining agreements have been signed with Teamsters and the AFSCME unit 4. Negotiations continue between the University and AFSCME Unit 6.

Adjournment

There being no further business, the December 18, 1991 business meeting of the Board of Governors was adjourned at 3:55 p.m. A non-public executive session of the Board of Governors was called at 4:00 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

January 16, 1992

TO: Members of the Board of Governors
FROM: Shannon Lorbiecki
Secretary to the Board of Governors

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

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

CURRICULUM VITAE

Gordon Dean Ginder, M.D.

I. Personal Data

- A. Citizenship Status: U.S.A.
B. U.S. Social Security Number

II. Education

<u>Year</u>	<u>Position</u>	<u>Institution</u>
1971	B.S. (highest honors)	University of Illinois
1975	M.D.	The Johns Hopkins University School of Medicine

III. Post-Graduate Education

<u>Year</u>	<u>Position</u>	<u>Institution</u>
1975-76	Intern, Straight Medicine	University Hospitals of Cleveland Case-Western Reserve University
1976-77	Resident, Internal Medicine	University Hospitals of Cleveland Case-Western Reserve University
1977-79	Research Associate	Laboratory of Molecular Biology, NIH, NIAMDD
1979-80	Fellow, Hematology/ Oncology	University of Iowa, Iowa City, Iowa

IV. Academic Appointments

<u>Year</u>	<u>Position</u>	<u>Institution</u>
1979-1980	Associate, Internal Medicine	University of Iowa, Iowa City, Iowa
1980-1985	Assistant Professor Internal Medicine	University of Iowa, Iowa City, Iowa
1983-1990	Faculty, Inter-departmental Genetics PhD Program	University of Iowa, Iowa City, Iowa
1985-1989	Associate Professor Internal Medicine	University of Iowa, Iowa City, Iowa
1986-1990	Associate Director Division, Hematology/ Oncology	University of Iowa, Iowa City, Iowa
1989-1990	Professor, Internal Medicine	University of Iowa, Iowa City, Iowa
1990-Present	Professor, Institute of Human Genetics	University of Minnesota, Minneapolis
1990-Present	Director, Medical Oncology	University of Minnesota, Minneapolis, Minnesota

V. Certification and Licensure

A. <u>Board Certification</u>	<u>Date</u>	<u>Number</u>
National Board of Medical Examiners	7/1/76	160508
American Board of Internal Medicine	9/13/78	67369
American Board of Internal Medicine Subspecialty, Medical Oncology	11/9/81	67369

B. Licensure

<u>State</u>	<u>Date</u>	<u>Status</u>	<u>Number</u>	<u>Renewal Date</u>
Maryland	9/01/77	Permanent	D21491	9/30/87
Iowa	9/21/79	Permanent	21765	9/30/88
Minnesota	1/5/91	Permanent	34198	12/31/91

VI. Professional Affiliations and Offices Held

American Association for Cancer Research
American Association for the Advancement of Science
American Board of Internal Medicine, Diplomate
American College of Physicians, Associate
American Federation for Clinical Research
American Society of Clinical Investigation
American Society of Hematology, Committee on Training Programs 1992-94
American Society of Microbiology
Central Society for Clinical Research, Council
Johns Hopkins Medical and Surgical Association
Midwest Blood Club

VII. Areas of Research Interest

- . Gene Regulation During Normal and Abnormal Cell Differentiation
- . Control of DNA Methylation in Eukaryotic Cells
- . Regulation of HLA Class I Gene Expression in Normal and Malignant Cells
- . Allogeneic and Autologous Bone Marrow Transplantation

VIII. Honors and Awards

Alpha Omega Alpha
Bronze Table - University of Illinois
Established Investigatorship - American Heart Association
Henry Strong Dension Research Award, Johns Hopkins University
Phi Beta Kappa
Phi Eta Sigma
Phi Kappa Phi
Special Fellowship, Leukemia Society of America

IX. Postgraduate Students Supervised

Nancy Wandersee, Graduate Student, Genetics
Jeffrey Waring, Graduate Student, Genetics
Jane Little, Postdoctoral Fellow
Karen Gustafson, M.D./Ph.D. student

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
December 18, 1991

MINUTES

ATTENDANCE:

Present: Edward Ciriacy, M.D.
Robert Dickler
Leo Furcht, M.D.
David Lentz
Margaret Matalamaki
Jerry Meilahn
Roger Paschki
Vic Vikmanis

Staff: Giles Caver
Greg Hart
Nels Larson
Shannon Lorbiecki
Joanne Disch
Sharon Weiss

CALL TO ORDER:

The Finance Committee was called to order by Mr. Jerry Meilahn on December 18, 1991 at 12:00 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the October 23, 1991 meeting as written.

JULY 1, 1991 THROUGH NOVEMBER 30, 1991 FINANCIALS:

Mr. Nels Larson reported to the Finance Committee the month of November inpatient admissions totaled 1,336 which was 179 below budget; average length of stay was 8.1 days; patient days totaled 11,588 which were 554 days below budget. The November average daily census was 386, which was below the budgeted level of 405. Clinic visits for the month of November were reported to be 10.9% under budget.

The Hospital's year-to-date Statement of Operations showed expenses being greater than revenues by \$1,768,000, an unfavorable variance of \$6,532,000. Gross patient revenue was 4.7% below budget and operating expenditures through September were reported to be 3.9% below budget.

As of November 30, the balance of accounts receivable totaled \$105,927,000 and represented 102.6 days of revenue outstanding.

The Hospital's overall operating position shows a loss for the month and year-to-date.

1991-92 YEAR-END FINANCIAL PROJECTIONS:

Mr. Robert Dickler presented to the Committee for information a summary of the 1991-92 Financial Projections.

Two projections were developed for fiscal year 1991-92. The first assumed the average activity levels through November would set the pattern for the remainder of the year. The second assumed that the remainder of the year would have the same level of reduced activity that was seen in November. Both projections adjusted for seasonal variations and both projections assumed a further reduction in FTE's by April 1 to 3,500.

While the Hospital incurred a loss at year-end in both projections, the adjustments in expense resulted in a break even fourth quarter under the first scenario. Mr. Dickler noted that an actual decision, beyond the current hiring freeze, regarding workforce reductions would not occur until mid-January and will be dependent on activity levels.

Mr. Dickler also noted that significant components of the annual capital budget had been placed on hold. Decisions regarding potential reduction of capital commitments, if any, would be forthcoming later in the fiscal year.

MAJOR CAPITAL EXPENDITURES:

Laboratory Computer

Mr. Greg Hart reported to the Committee, for information, a proposal to purchase two Tandem VLX processor modules to upgrade the Clinical Laboratory Computer Systems at a cost of \$149,800.

Mr. Hart stated an increase in computer load is expected in the coming year due to new versions of the operating system, and new laboratory and hospital applications planned for implementation.

This project has been budgeted for in fiscal year 1991-92. The cost of \$149,800 is for reconditioned, Tandem maintenance certified, equipment which at this time can be obtained for about 40% of the retail price for new equipment.

Pediatric Radiographic/Fluoroscopic System

Mr. Al Dees reported to the Committee, for information, a proposal to purchase a digital radiographic/fluoroscopic system replacement for the Pediatric Section of Diagnostic Radiology at a cost of \$550,000.

Mr. Dees stated that the current equipment has required frequent repair and the quality has deteriorated to unacceptable levels during the past two years. In consulting with vendor personnel, it would take an additional expense of \$150,000 - \$175,000 to correct most of the problems with no guarantees. In considering these facts, a conclusion was reached that the most prudent action would be to replace the equipment.

The purchase of this equipment has been included in the fiscal year 1991-92 capital budget.

SPECIAL CAPITAL PROJECT:

Magnetic Resonance Imager

Mr. Al Dees introduced Dr. Arthur Stillman, Head of MRI Section of Radiology Department at UMHC, as a guest at today's Board of Governors Finance Committee meeting.

Mr. Dees reported to the Committee, for information, a proposal to purchase a 1.5 Tesla Magnetic Resonance Imager to replace a 1.0 Tesla Magnetic Resonance Imager in the MRI section of the Department of Radiology at a cost of \$2,400,000 for equipment and \$600,000 for installation.

Mr. Dees stated UMHC is currently operating two MRI units: a 1.0 Tesla machine which UMHC began leasing and operating in January, 1985, and a 1.5 Tesla machine acquired in 1989. The 1.0 Tesla machine is currently being used for only 30% of the procedure load due to its limitations in comparison with the 1.5 Tesla machine which has a superior image quality. The conclusion has been reached that the 1.0 Tesla machine is no longer worth the \$28,650 monthly (\$343,800 annual) lease cost.

The options considered were: (1) Operate the existing 1.5 Tesla machine 24 hours per day on weekdays; (2) Contract out for off-site service until UMHC's volume increases to a specific percentage of a 1.5 Tesla machines capacity; (3) Purchase on-site, mobile service from an imaging company until UMHC's volume reaches a specific percentage of one machine's capacity; or (4) Replace the existing 1.0 Tesla machine with a 1.5 Tesla unit on-site.

Based on examination of the pros and cons of each of the alternatives and projected future procedure volumes, the following action was proposed: Replace the 1.0 Tesla MRI machine with a new, state-of-the-art machine with a magnet strength of 1.5 Tesla or greater. This acquisition is included in UMHC's capital plan for the 1991-92 fiscal year.

Due to the lack of time, the remaining agenda items, External Relations and Labor Relations Update, will be deferred to the Wednesday, January 22, 1992 Board of Governors Finance meeting. There being no further discussion, the December 18, 1991 meeting was adjourned at 2:08 P.M.

Respectfully submitted,



Sharon Weiss
Recording Secretary

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

January 21, 1992

TO: UMHC Board of Governors
FROM: Clifford P. Fearing
Senior Associate Director, UMHC
SUBJECT: Bad Debts - Second Quarter
Fiscal Year 1991-92



The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the second quarter of 1991-92 is \$555,108.29 represented by 1,881 accounts. Bad debt recoveries during the period amounted to \$2,163.82 (38 accounts) leaving a net charge-off of \$552,944.47.

The net bad debts of \$552,944.47 for the quarter were 0.60% of gross charges. This compares to a budgeted level of bad debts of 0.79% (\$732,200).

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.

Total fiscal year bad debts have amounted to \$1,175,901.51 represented by 4,041 accounts. Recoveries during the fiscal year amounted to \$12,814.48 (82 accounts), leaving a net charge-off of \$1,163,087.03.

The net bad debts of \$1,163,087.03 for the fiscal year were 0.64% of gross charges. This compares to a budgeted level of bad debts of 0.79% (\$1,504,758.00).

Along with the quarter attachments, we have also included a fiscal year statistical summary and a breakdown of bad debts by residence and admitting clinical services.

CPF:slw

Attachments

UMHC Hospital Billing Department

Bad Debt Statistics: October 91 thru December 91
In five ranges of account size

	Less Than \$10	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	\$2,187.08	40	\$29,270.70	63	\$27,881.65	19	67,055.86	17	\$12,323.66	1	\$138,718.95	140
Bad Debt (702) Charity Care	\$444.09	8	\$4,972.73	17	\$10,555.50	8	\$53,765.20	11	\$13,080.90	1	\$82,818.42	45
Total	\$2,631.17	48	\$34,243.43	80	\$38,437.15	27	\$120,821.06	28	\$25,404.56	2	\$221,537.37	185
Recoveries	(\$112.40)	2	(\$271.55)	1							(\$383.95)	3
Net Total	\$2,518.77	48 *	\$33,971.88	80 *	\$38,437.15	27 *	\$120,821.06	28 *	\$25,404.56	2 *	\$221,153.42	185 *

Outpatient												
Bad Debt (701) Write-Offs	\$38,221.43	954	\$132,957.64	534	\$30,552.38	23	\$72,653.87	14	\$11,267.79	1	\$285,653.11	1526
Bad Debt (702) Write-Offs	\$3,362.95	81	\$23,739.04	81	\$3,920.31	3	\$16,895.51	5			\$47,917.81	170
Total	\$41,584.38	1035	\$156,696.68	615	\$34,472.69	26	\$89,549.38	19	\$11,267.79	1	\$333,570.92	1696
Recoveries	(\$610.29)	28	(\$1,169.58)	7							(\$1,779.87)	35
Net Total	\$40,974.09	1035 *	\$155,527.10	615 *	\$34,472.69	26 *	\$89,549.38	19 *	\$11,267.79	1 *	\$331,791.05	1696 *

Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$40,408.51	994	\$162,228.34	597	\$58,434.03	42	\$139,709.73	31	\$23,591.45	2	\$424,372.06	1666
Bad Debt (702) Charity Care	\$3,807.04	89	\$28,711.77	98	\$14,475.81	11	\$70,660.71	16	\$13,080.90	1	\$130,736.23	215
Total	\$44,215.55	1083	\$190,940.11	695	\$72,909.84	53	\$210,370.44	47	\$36,672.35	3	\$555,108.29	1881
Recoveries	(\$722.69)	30	(\$1,441.13)	8	\$0.00	0	\$0.00	0	\$0.00	0	(\$2,163.82)	38
Total Net Bad Debt	\$43,492.86	1083 *	\$189,498.98	695 *	\$72,909.84	53 *	\$210,370.44	47 *	\$36,672.35	3 *	\$552,944.47	1881 *
Dollars Budgeted											\$732,200.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: October 91 thru December 91
In five ranges of account size

	Less Than \$100	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Medicare Bad Debt (710)	\$205.28	4	\$17,377.66	33			\$4,736.00	1			\$22,318.94	38
Recoveries											\$0.00	0
Net Total	\$205.28	4 *	\$17,377.66	33 *	\$0.00	0 *	\$4,736.00	1 *	\$0.00	0 *	\$22,318.94	38 *
Outpatient												
Medicare Bad Debt (710)	\$6,335.88	194	\$28,764.04	88	\$2,950.34	2					\$38,050.26	284
Recoveries			(\$1,038.05)	2							(\$1,038.05)	2
Net Total	\$6,335.88	194 *	\$27,725.99	88 *	\$2,950.34	2 *	\$0.00	0 *	\$0.00	0 *	\$37,012.21	284 *
Total IP and OP Bad Debt												
Medicare Bad Debt (710)	\$6,541.16	198	\$46,141.70	121	\$2,950.34	2	\$4,736.00	1	\$0.00	0	\$60,369.20	322
Recoveries	\$0.00	0	(\$1,038.05)	2	\$0.00	0	\$0.00	0	\$0.00	0	(\$1,038.05)	2
Total Net Bad Debt	\$6,541.16	198 *	\$45,103.65	121 *	\$2,950.34	2 *	\$4,736.00	1 *	\$0.00	0 *	\$59,331.15	322 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: October 91 thru December 91
 in two ranges of account size

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Bad Debt (701) Write-Offs	\$59,339.43	122	\$79,379.52	18	\$138,718.95	140
Bad Debt (702) Charity Care	\$15,972.32	33	\$66,846.10	12	\$82,818.42	45
Total	\$75,311.75	155	\$146,225.62	30	\$221,537.37	185
Recoveries	(\$383.95)	3	\$0.00	0	(\$383.95)	3
Net Total	\$74,927.80	155 *	\$146,225.62	30 *	\$221,153.42	185 *
Outpatient						
Bad Debt (701) Write-Offs	\$201,731.45	1511	\$83,921.66	15	\$285,653.11	1526
Bad Debt (702) Write-Offs	\$31,022.30	165	\$16,895.51	5	\$47,917.81	170
Total	\$232,753.75	1676	\$100,817.17	20	\$333,570.92	1696
Recoveries	(\$1,779.87)	35	\$0.00	0	(\$1,779.87)	35
Net Total	\$230,973.88	1676 *	\$100,817.17	20 *	\$331,791.05	1696 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	\$261,070.88	1633	\$163,301.18	33	\$424,372.06	1666
Bad Debt (702) Charity Care	\$46,994.62	198	\$83,741.61	17	\$130,736.23	215
Total	\$308,065.50	1831	\$247,042.79	50	\$555,108.29	1881
Recoveries	(\$2,163.82)	38	\$0.00	0	(\$2,163.82)	38
Total Net Bad Debt	\$305,901.68	1831 *	\$247,042.79	50 *	\$552,944.47	1881 *
Dollars Budgeted					\$752,200.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: **October 91 thru December 91**
 in two ranges of account size

	# of Under \$2000 Accounts	# of Over \$2000 Accounts	Total Amount	# of Accounts
Inpatient				
Medicare Bad Debt (710)	\$17,582.94	\$4,736.00	\$22,318.94	38
Recoveries	\$0.00	\$0.00	\$0.00	0
Net Total	\$17,582.94	\$4,736.00	\$22,318.94	38 *
Outpatient				
Medicare Bad Debt (710)	\$38,050.26	\$0.00	\$38,050.26	284
Recoveries	(\$1,038.05)	\$0.00	(\$1,038.05)	2
Net Total	\$37,012.21	\$0.00	\$37,012.21	284 *
Total IP and OP Bad Debt				
Medicare Bad Debt (710)	\$55,633.20	\$4,736.00	\$60,369.20	322
Recoveries	(\$1,038.05)	\$0.00	(\$1,038.05)	2
Total Net Bad Debt	\$54,595.15	\$4,736.00	\$59,331.15	322 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: July 91 thru December 91
In five ranges of account size

	Less Than \$100	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	\$3,202.65	68	\$58,418.07	130	\$43,493.23	30	196,386.38	49	\$22,870.21	2	\$324,370.54	279
Bad Debt (702) Charity Care	\$564.77	11	\$12,289.15	32	\$13,338.22	10	\$87,458.01	21	\$58,189.08	4	\$171,839.23	78
Total	\$3,767.42	79	\$70,707.22	162	\$56,831.45	40	\$283,844.39	70	\$81,059.29	6	\$496,209.77	357
Recoveries	(\$118.28)	3	(\$1,183.35)	2			(\$7,062.96)	1			(\$8,364.59)	6
Net Total	\$3,649.14	79 *	\$69,523.87	162 *	\$56,831.45	40 *	\$276,781.43	70 *	\$81,059.29	6 *	\$487,845.18	357 *

Outpatient												
Bad Debt (701) Write-Offs	\$81,282.70	2087	\$288,160.57	1140	\$69,598.06	50	\$104,542.53	24	\$11,267.79	1	\$554,851.65	3302
Bad Debt (702) Write-Offs	\$6,918.17	164	\$58,360.82	188	\$26,278.59	19	\$33,282.51	11			\$124,840.09	382
Total	\$88,200.87	2251	\$346,521.39	1328	\$95,876.65	69	\$137,825.04	35	\$11,267.79	1	\$679,691.74	3684
Recoveries	(\$1,691.34)	65	(\$2,758.55)	11							(\$4,449.89)	76
Net Total	\$86,509.53	2251 *	\$343,762.84	1328 *	\$95,876.65	69 *	\$137,825.04	35 *	\$11,267.79	1 *	\$675,241.85	3684 *

Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$84,485.35	2155	\$346,578.64	1270	\$113,091.29	80	\$300,928.91	73	\$34,138.00	3	\$879,222.19	3581
Bad Debt (702) Charity Care	\$7,482.94	175	\$70,649.97	220	\$39,616.81	29	\$120,740.52	32	\$58,189.08	4	\$296,679.32	460
Total	\$91,968.29	2330	\$417,228.61	1490	\$152,708.10	109	\$421,669.43	105	\$92,327.08	7	\$1,175,901.51	4041
Recoveries	(\$1,809.62)	68	(\$3,941.90)	13	\$0.00	0	(\$7,062.96)	1	\$0.00	0	(\$12,814.48)	82
Total Net Bad Debt	\$90,158.67	2330 *	\$413,286.71	1490 *	\$152,708.10	109 *	\$414,606.47	105 *	\$92,327.08	7 *	\$1,163,087.03	4041 *
Dollars Budgeted											\$1,504,758.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: July 91 thru December 91
In five ranges of account size

	Less Than \$10	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Total Amount	# of Accounts
Inpatient												
Medicare Bad Debt (710)	\$205.28	4	\$17,377.66	33			\$4,736.00	1			\$22,318.94	38
Recoveries											\$0.00	0
Net Total	\$205.28	4 *	\$17,377.66	33 *	\$0.00	0 *	\$4,736.00	1 *	\$0.00	0 *	\$22,318.94	38 *
Outpatient												
Medicare Bad Debt (710)	\$6,557.33	208	\$29,495.99	91	\$2,950.34	2					\$39,003.66	301
Recoveries			(\$1,038.05)	2							(\$1,038.05)	2
Net Total	\$6,557.33	208 *	\$28,457.94	91 *	\$2,950.34	2 *	\$0.00	0 *	\$0.00	0 *	\$37,965.61	301 *
Total IP and OP Bad Debt												
Medicare Bad Debt (710)	\$6,762.61	212	\$46,873.65	124	\$2,950.34	2	\$4,736.00	1	\$0.00	0	\$61,322.60	339
Recoveries	\$0.00	0	(\$1,038.05)	2	\$0.00	0	\$0.00	0	\$0.00	0	(\$1,038.05)	2
Total Net Bad Debt	\$6,762.61	212 *	\$45,835.60	124 *	\$2,950.34	2 *	\$4,736.00	1 *	\$0.00	0 *	\$60,284.55	339 *

* Net total of accounts does not include recoveries:

UMHC Hospital Billing Department

Bad Debt Statistics July 91 thru December 91

In two ranges of account size

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Amount	Total # of Accounts
Inpatient						
Bad Debt (701) Write-Offs	\$105,113.95	228	\$219,256.59	51	\$324,370.54	279
Bad Debt (702) Charity Care	\$26,192.14	53	\$145,647.09	25	\$171,839.23	78
Total	\$131,306.09	281	\$364,903.68	76	\$496,209.77	357
Recoveries	(\$1,301.63)	5	(\$7,062.96)	1	(\$8,364.59)	6
Net Total	\$130,004.46	281 *	\$357,840.72	76 *	\$487,845.18	357 *
Outpatient						
Bad Debt (701) Write-Offs	\$439,041.33	3277	\$115,810.32	25	\$554,851.65	3302
Bad Debt (702) Write-Offs	\$91,557.58	371	\$33,282.51	11	\$124,840.09	382
Total	\$530,598.91	3648	\$149,092.83	36	\$679,691.74	3684
Recoveries	(\$4,449.89)	76	\$0.00	0	(\$4,449.89)	76
Net Total	\$526,149.02	3648 *	\$149,092.83	36 *	\$675,241.85	3684 *
Total IP and OP Bad Debt						
Bad Debt (701) Write-offs	\$544,155.28	3505	\$335,066.91	76	\$879,222.19	3581
Bad Debt (702) Charity Care	\$117,749.72	424	\$178,929.60	36	\$296,679.32	460
Total	\$661,905.00	3929	\$513,996.51	112	\$1,175,901.51	4041
Recoveries	(\$5,751.52)	81	(\$7,062.96)	1	(\$12,814.48)	82
Total Net Bad Debt	\$656,153.48	3929 *	\$506,933.55	112 *	\$1,163,087.03	4041 *
Dollars Budgeted					\$1,504,758.00	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: July 91 thru December 91

In two ranges of account size

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Total Amount	# of Accounts
Inpatient						
Medicare Bad Debt (710)	\$17,582.94	37	\$4,736.00	1	\$22,318.94	38
Recoveries	\$0.00	0	\$0.00	0	\$0.00	0
Net Total	\$17,582.94	37 *	\$4,736.00	1 *	\$22,318.94	38 *
Outpatient						
Medicare Bad Debt (710)	\$39,003.66	301	\$0.00	0	\$39,003.66	301
Recoveries	(\$1,038.05)	2	\$0.00	0	(\$1,038.05)	2
Net Total	\$37,965.61	301 *	\$0.00	0 *	\$37,965.61	301 *
Total IP and OP Bad Debt						
Medicare Bad Debt (710)	\$56,586.60	338	\$4,736.00	1	\$61,322.60	339
Recoveries	(\$1,038.05)	2	\$0.00	0	(\$1,038.05)	2
Total Net Bad Debt	\$55,548.55	338 *	\$4,736.00	1 *	\$60,284.55	339 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department**Bad Debt Statistics: Second Quarter and Year--to--Date, Fiscal Year 1992
By State**

State	Second	# of	Y-T-D	Total
	Quarter		Total	# of
	Amount	Accounts	Amount	Accounts
Alabama	144.95	3	144.95	3
Alaska			11.27	1
Arizona	422.92	7	5,179.89	14
Arkansas	535.14	4	535.14	4
California	14,297.86	21	15,342.17	24
Colorado	628.82	14	758.73	17
Connecticut	1,626.22	4	2,703.99	5
Delaware			0.00	0
Dist. of Columbia			3,843.02	3
Florida	682.42	3	5,657.68	23
Georgia	63.90	1	63.90	1
Hawaii			0.00	0
Idaho			0.00	0
Illinois	6,482.27	34	9,504.98	47
Indiana			0.00	0
Iowa	932.50	16	2,557.21	26
Kansas			340.30	1
Kentucky	921.10	4	946.10	5
Louisiana	1,396.59	4	1,396.59	4
Maine			0.00	0
Maryland	24.58	1	106.78	2
Massachusetts			110.39	1
Michigan	3,943.45	17	6,537.18	54
Minnesota	431,698.34	1,796	859,701.95	3,563
Mississippi	998.93	4	998.93	4
Missouri	100.03	2	387.50	3
Montana	779.96	4	3,772.54	10
Nebraska	422.36	4	878.86	7
Nevada	779.38	5	951.38	7
New Hampshire			0.00	0
New Jersey			2,640.27	2
New Mexico	46.42	2	46.42	2
New York	834.58	10	4,727.05	25
North Carolina	222.49	2	392.89	4
North Dakota	14,157.95	29	33,288.01	42
Ohio			43.00	1
Oklahoma	1,348.30	14	1,993.85	16
Oregon	150.00	1	150.00	1
Pennsylvania			2,882.83	5
Puerto Rico			0.00	0
Rhode Island			0.00	0

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1992
By State

State	Second	# of	Y-T-D	Total
	Quarter		Total	# of
	Amount	Accounts	Amount	Accounts
South Carolina	1,016.36	3	2,012.36	4
South Dakota	27,016.94	63	82,931.42	133
Tennessee	402.72	5	402.72	5
Texas	1,166.56	9	2,337.10	15
Utah			3,323.12	1
Vermont			0.00	0
Virginia			2,076.40	8
Washington	9,704.66	23	13,950.57	28
West Virginia			137.19	1
Wisconsin	43,086.76	82	96,935.98	216
Wyoming			327.56	5
Out-of-Country	2,247.88	5	7,562.20	24
Total	568,283.34	2,196	1,180,592.37	4,367
Medicare Bad Debt*	(59,331.15)	322	(60,284.55)	305
Legal Settlements	18,641.58	3	27,583.94	6
Bad Debt Agcy Und \$50			46.88	1
Bad Debt - Med NC Chgs	28,552.57	3	29,000.92	5
Grand Total	556,146.34	2,524	1,176,939.56	4,684
Recoveries	(3,201.87)	40	(13,852.53)	84
Net Total	552,944.47	2,524	1,163,087.03	4,684

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

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year--to--Date, Fiscal Year 1992
By Service

Admitting Service	Second	# of	Y-T-D	Total
	Quarter		Total	# of
	Amount	Accounts	Amount	Accounts
Anesthesiology			0.00	0
Clinical Research			2,076.06	2
Dentistry			28.93	1
Dermatology	8,659.08	2	8,659.08	2
Family Practice			0.00	0
OB			0.00	0
NB			0.00	0
General Med	37.95	1	37.95	1
GYN	896.78	1	1,847.33	3
GYN-Oncology	11,208.96	8	21,792.70	16
Lab Medicine & Pathology			0.00	0
Medicine-Blue	2,701.26	5	16,807.37	10
Green	1,114.58	3	4,830.99	4
Masonic (Onc)	5,725.92	10	16,545.35	22
Purple			0.00	0
Red A	150.87	2	1,144.04	5
Red B			0.00	0
Rose A	1,142.00	3	26,402.99	9
Rose B	680.00	1	680.00	1
White A	14,683.83	5	18,572.56	10
White B	6,348.21	10	15,255.55	19
White C	3,080.21	2	3,549.53	4
Yellow A	20,038.53	11	28,579.68	16
Yellow B	894.32	2	8,241.09	7
Neurology	13,906.47	7	18,470.48	9
Neuro-epilepsy	11,803.48	2	11,803.48	2
Neurosurgery	5,784.85	8	21,523.00	11
New Born-General	2,043.28	3	3,047.66	7
Obstetrics-General	8,992.51	6	17,309.80	17
-Midwife			0.00	0
Ophthalmology	12,899.36	10	20,960.16	15
Orthopaedic Surgery	9,997.61	17	27,502.62	31
Otolaryngology	3,218.28	5	7,431.88	11
Pediatrics-General	6,907.16	9	51,342.07	31
Dentistry			0.00	0
Dermatology			0.00	0
Cardiology	869.92	1	869.92	1
Gastro-Intestinal			356.64	1
Hematology Oncology	1468.99	2	2,495.49	3
Neonatology	1,180.03	2	25,181.30	5
Neurology	8,721.50	6	8,721.50	6
Neurosurgery			6,266.35	2

UMHC Hospital Billing Department

Bad Debt Statistics: Second Quarter and Year-to-Date, Fiscal Year 1992
By Service

Admitting Service	Second	# of	Y-T-D	Total
	Quarter		Total	# of
	Amount	Accounts	Amount	Accounts
Ophthalmology	12,011.90	3	14,843.40	5
Orthopaedics	8190.56	2	8,190.56	2
Otolaryngology	40.00	1	364.50	2
Pulmonary			1,049.43	1
Surgery Green			0.00	0
Surgery Orange	3,007.56	1	3,007.56	1
Surg. Transplant	82.70	1	116.10	2
Urology	3,047.38	1	5,098.97	2
Physical Med. & Rehab.	69.90	2	69.90	2
Psychiatry-Child			0.00	0
- Adult	19,656.02	13	32,412.77	25
Radiology	30.00	1	30.00	1
Surgery-Blue	9,346.99	25	11,895.51	30
Oral	6106.94	3	6,106.94	3
Orange	4,717.46	6	6,080.66	7
Purple	1,407.53	4	8,979.14	8
Red	7,197.12	6	15,059.67	7
White	1,017.23	4	2,860.90	5
Therapeutic Radiology			0.00	0
Urology	2,771.08	6	4,029.15	8
Unknown			0.00	0
Outpatient	324,427.03	1,974	662,063.66	3,973
Total	568,283.34	2197	1,180,592.37	4368
Medicare Bad Debt*	(59,331.15)	322	(60,284.55)	305
Legal Settlements	18,641.58	3	27,583.94	6
Bad Debt Agcy Und \$50			46.88	1
Bad Debt - Med NC Chgs	28,552.57	3	29,000.92	5
Grand Total	556,146.34	2,525	1,176,939.56	4,685
Recoveries	(3,201.87)	40	(13,852.53)	84
Net Total	552,944.47	2,525	1,163,087.03	4,685

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

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT:

Orthopaedic Clinic Remodeling

PURCHASE PRICE:

\$143,100

DESCRIPTION:

UMHC has seen a great deal of growth in outpatient activity since the Phillips-Wangensteen Building was opened in 1978-79. This growth was anticipated when the building was planned, however, recent demands in some of the clinic modules are exceeding capacity. One that is acutely in need of additional space is the Orthopaedic Clinic. The Orthopaedic activity has grown from 5,365 patient visits in 1979 to 12,191 visits in 1991. The Department continues to expand the number of faculty who see patients.

In addition, the types of demands placed on the clinic have changed over the years. For example, with greater emphasis on outpatient activity, medical education is shifting to the clinic setting. This creates a need for space where the resident-faculty interchange can occur. Also, since patients are not admitted until the day of their surgery, more education and preparation work is done in the clinic.

The objectives of this remodeling project are:

1. Create more examination rooms to accommodate the increased medical staff and resulting volume of patients;
2. Create an area for physical therapists to provide immediate, one-time treatment that is convenient for patients;
3. Create space for faculty and residents to confer outside of the busy corridors and out of earshot of the patients; and
4. Create a more efficient arrangement of examination and support rooms;

The following changes in the clinic are planned:

1. Five adjacent social work offices will be moved so the rooms can be incorporated into the clinic. The layout of the examination rooms will be changed from 6 rooms extending down a long corridor to 2 modular areas or "pods" with four exam rooms each.

Submitted By: Mary Ellen Wells
Title: Associate Director

Approved By: 
Title: Senior Associate Director

2. Four rooms will accomodate physical therapy, consulting, and patient education.
3. An area in the rear of the clinic will be converted for staff support (e.g. charting, telephone calls).

Careful planning will take place to minimize the effect on the current operations while the remodeling occurs. Staging, shifting patients temporarily to other locations, and night construction are all being considered.

This project accomplishes the stated objectives, will enable the staff to enhance patient service and will accomodate anticipated growth.

The project is estimated at \$143,100, with funds being provided from the current capital budget.



UNIVERSITY OF MINNESOTA
TWIN CITIES

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

January 15, 1992

TO: Members of the Board of Governors

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

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

The Medical Staff-Hospital Council on January 14 has endorsed the attached Credentials Committee Report and Recommendations.

I am forwarding these recommendations to you for your review and approval on January 22. If you should have any questions, please feel free to call on me.

REM/cf
Attachment

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

January 8, 1992

TO: Medical Staff-Hospital Council
FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee
SUBJECT: Credentials Committee Report and Recommendations

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

<u>Department of Hospital Dentistry</u>	<u>Category</u>
Charles F. Bungum	Clinical Staff
<u>Department of Laboratory Medicine and Pathology</u>	
Waclaw B. Jaszcz	Attending Staff
<u>Department of Medicine</u>	<u>Category</u>
Alan J. Bank	Attending Staff
John F. Eggert	Attending Staff
Mark R. Freiberg	Attending Staff-ER
Randolph W. Hurley	Attending Staff-ER
<u>Department of Neurology</u>	
Donald M. Olson	Clinical Staff
<u>Department of Pediatrics</u>	
Sami M. Awadallah	Clinical Staff
Emmanuel Katsanis	Attending Staff
Nathaniel R. Payne	Clinical Staff

Provisional status and clinical privileges continued:

<u>Department of Radiology</u>	<u>Category</u>
Richard E. Latchaw	Attending Staff
<u>Department of Urology</u>	
Richard Evans	Clinical Staff

The following medical staff member has submitted an application and supporting documentation requesting the addition of clinical privileges. The Committee has reviewed and considered this request and hereby recommends approval.

<u>Department of Surgery</u>	<u>Category</u>
Robert L. Goodale Add: laparoscopic inguinal hernia	Attending Staff

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

<u>Department of Hospital Dentistry</u>	<u>Category</u>	<u>Date Eligible</u>
Chris A. Blixrud	Attending Staff	November 22, 1991
Daniel H. Glenn	Clinical Staff	November 22, 1991
Abdollah Rahimi	Attending Staff	November 22, 1991
<u>Department of Medicine</u>		
Jeffrey H. Albrecht	Attending Staff-ER	June 19, 1991
Philip C. Halverson	Attending Staff	June 19, 1991
Timothy D. Henry	Attending Staff	August 27, 1991
Paul R. Pentel	Clinical Staff	August 27, 1991
Brad L. Pohlman	Attending Staff	August 27, 1991
Paul N. Yakshe	Attending Staff	August 27, 1991
<u>Department of Orthopaedic Surgery</u>		
Edward Y.D. Cheng	Attending Staff	November 22, 1991
Scott R. McGarvey	Clinical Staff	November 22, 1991
J. Patrick Smith	Clinical Staff	August 27, 1991

Regular appointments continued:

<u>Department of Neurosurgery</u>	<u>Category</u>	<u>Date Eligible</u>
Daniel B. Ahlberg	Clinical Staff	November 22, 1991
Gregg N. Dyste	Clinical Staff	November 22, 1991
Walter A. Hall	Attending Staff	November 22, 1991
<u>Department of Otolaryngology</u>		
Marcos V. Goycoolea	Clinical Staff	December 26, 1991
<u>Department of Psychiatry</u>		
Joyce Y. Chung	Attending Staff	November 22, 1991

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

<u>Department of Dermatology</u>	<u>Category</u>
William Gentry	Attending Staff
<u>Department of Medicine</u>	
Steven J. Bailin	Attending Staff
Randall Williams	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

January 14, 1992

To: Members of the Board of Governors
From: Robert M. Dickler, General Director
RE: Expansion of the Critical Care Clinical Information Management System

Two years ago the Board of Governors approved a pilot bedside computer project for patient care unit 4D, the surgical intensive care unit. Actual implementation of the Critical Care Clinical Information Management System called EMTEK occurred in November of 1990. This information system installation has been unique in the following ways:

- The project continues to have broad multidisciplinary support from Medicine, Nursing, Cardiopulmonary Services, Patient Monitoring, Pharmacy, and Laboratories.
- UMHC staff is involved in the development of software applications with the vendor. We have influenced the development of the product.
- It is a first step toward the realization of a computer based patient record and has already demonstrated early benefits in efficiencies and effectiveness in patient care.

We are now requesting an expansion of the project to the medical and pediatric intensive care units, based on the achievement of established criteria in the initial pilot as well as the opportunity for additional, greater benefits. This project will be presented to you for information on January 22nd; we would anticipate requesting your approval at the February meeting.

The enclosed materials provide a summary of the project and the financial expenditures associated with the implementation of this system on the two additional patient care units. The capital expenditure associated with this project is \$950,000 over five years with \$108,000 for installation.

We will be available at the meeting to respond to any questions.

Overview of the Clinical Information System Project

The bedside clinical information system (EMTEK) is proposed for expansion from its present location on the Surgical Intensive Care Unit to the Medical and Pediatric Intensive Care Units.

What is EMTEK? EMTEK is a clinical information management system which not only automates the patient record keeping functions, but creates the data base required to more effectively and efficiently manage patient care in the critical care setting. The clinical information system includes flowsheets, progress notes, results reporting, plan of care, and other charting functions and will include physician order entry. The system communicates to bedside monitoring to automatically acquire physiologic data from instruments such as ventilators and infusion pumps. The system connects to the hospital's laboratory system and integrates result reporting with other clinical data. EMTEK is developed for use in the critical care setting and is a building block for a hospital-wide patient care information system.

EMTEK Health Care Systems Inc. is a subsidiary of Motorola. Motorola provides EMTEK with financial stability and a long term business perspective. EMTEK has brought talented engineers and clinicians together and is committed to quality and customer satisfaction. The working relationship that has been established between EMTEK and staff at Minnesota provides confidence for continuing success in future endeavors.

What are the EMTEK expansion plans for the Medical and Pediatric Intensive Care Units? These two patient care units include 15 adult and 14 pediatric intensive care beds. The hardware and software provides workstations at each bedside, centrally at the unit desks, and in residents' and Medical Directors' offices. The costs include the database and system tools for quality improvement and research. The network hardware and software, computer and instrument interfaces, and training resources are included. The implementation will be incremental over three years and provides for tailoring the software (e.g. flowsheets, plan of care) for the clinical practice requirements of each ICU and specific patient population.

Why should we expand beyond the original pilot patient care unit?

- The initial benefits, proposed at the time the pilot was approved, have been demonstrated. This evaluation demonstrated evidence of initial benefits, satisfaction of clinical staff with the system, the clinical functions provided by the system fit our environment, system reliability, vendor performance, and system support for the UMHC mission .
- The EMTEK system provides effective tools for improved staff productivity, cost reductions and cost effective decision making in the clinical setting. The requirements of today's environment emphasize the importance of these tools. An automated charting system with access to real time and historical patient data is consistent with the direction of regulatory, and professional organizations.
- Clinical staff involved with the system on the surgical intensive care unit believe it helps them do their jobs and supports continuous quality improvement in patient care.
- The ability to impact medical practice and care delivery will be significantly enhanced if all three of the contiguous intensive care units are on the same system. Patients and staff do cross units. This system supports our hospital in being a leader in critical care.

Why now? The technology, staff and relationships are ready. The current health care environment demands that health care costs be managed to improve patient outcomes and reduce spending. The Medical Directors of the intensive care units believe that their ability to manage patient care with less resources requires a clinical information system such as EMTEK to provide the data to support cost effective decision making at the bedside. In addition, this clinical information system is a tool which supports the work of the entire team; medical, nursing, cardiorespiratory, pharmacy and other disciplines.

Cost Benefit Summary Medical & Pediatric ICU

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Total
Costs:									
Hardware and Software	(950,000)	0	0	0	0	0	0	0	(950,000)
Installation	(108,000)	0	0	0	0	0	0	0	(108,000)
FTE Support	(81,000)	(81,000)	(126,000)	(126,000)	(126,000)	(126,000)	(126,000)	(126,000)	(918,000)
Maintenance	0	0	(125,000)	(125,000)	(125,000)	(125,000)	(125,000)	(125,000)	(750,000)
Total Costs	(1,139,000)	(81,000)	(251,000)	(251,000)	(251,000)	(251,000)	(251,000)	(251,000)	(2,726,000)
Benefits:									
FTE Reductions	0	40,000	140,000	140,000	160,000	160,000	160,000	160,000	960,000
Oper Cost Reduction	0	244,000	244,000	244,000	244,000	244,000	244,000	244,000	1,708,000
Total Benefits	0	284,000	384,000	384,000	404,000	404,000	404,000	404,000	2,668,000
Net Benefit	(1,139,000)	203,000	133,000	133,000	153,000	153,000	153,000	153,000	(58,000)

**PROPOSAL FOR REPLACEMENT OF 1.0 TESLA MAGNETIC RESONANCE IMAGER
THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC**

BACKGROUND

UMHC is currently operating two MRI units: a 1.0 Tesla machine which UMHC began leasing and operating in January 1985, and a 1.5 Tesla machine acquired in 1989.

The architecture of the 1.0 machine is no longer state-of-the-art. Due to the significantly improved image quality, throughput, and increased versatility obtained, 1.5 Tesla has replaced 1.0 Tesla as the dominant size for high field strength magnets in the marketplace. Consequently, the majority of the vendor's development resources are focused on 1.5 Tesla machines. No upgrades or enhancements for this 1.0 machine are available without incurring significant additional expense. Timely, reliable service is also more difficult to obtain because of a shortage of technicians with training and experience in the repair of this older architecture machine.

The limitations of the 1.0 Tesla machine mean that it is currently being used for only about 30% of the procedure load, and that percentage continues to decrease steadily. Newer, more sophisticated procedures, such as internal auditory canals, orbits, sella, and shoulders, cannot be performed on it. Consequently, those must all be done on the newer, 1.5 Tesla unit. Because of the significant improvement in image quality, some physicians routinely request or demand that procedures for their patients be done on the newer machine. Due to the inferior image quality obtained from the 1.0 Tesla machine and lengthy waiting times for the 1.5 Tesla machine, UMHC physicians are sending more than 20 patients per month to an external imaging center. The conclusion has been reached that the 1.0 Tesla machine is no longer worth the \$28,650 monthly (\$343,800 annual) lease cost.

UMHC's current 1.5 Tesla unit has a projected capability of supporting 3400 procedures annually when operated 16 hours per weekday and on an on-demand basis on weekends and holidays. UMHC's actual 1990-91 volume of 3661 exceeded that projected capability by 261 or 7.7%. The 1991-92 budgeted volume of 4022 exceeds it by 622 or 18.3%.

A survey of clinical chiefs and selected medical staff from Neurosurgery, Orthopaedics, Otolaryngology and Obstetrics/Gynecology indicates that if timely, 1.5 Tesla imaging service was available on-site for all procedures, the following additional volumes would materialize within the first year from new business and elimination of external referrals:

PROCEDURE	NO.
Brain	520-780
Extremities	52
Abdomen	156-208
Head	76
TOTAL	804-1116

These additions would increase the total annual procedure volume to a range of 4826-5138 or 41.9%-51.1% above the projected capability of UMHC's existing 1.5 Tesla unit.

The following alternatives for meeting this demand have been considered:

A. Operate the existing 1.5 Tesla machine 24 hours per day on weekdays.

This option would increase the projected capability of the machine to 4533 procedures. That would be sufficient capacity to handle the current volume but not the increases projected above. Wait times for exams would not be shortened and would likely increase.

This option would provide no on-site backup. When the machine needed repair or had to be shut down for software or hardware upgrading, CT would be the only on-site backup. While ambulatory patients could temporarily be routed to an off-site location, that is not a viable backup for inpatients.

Under this option a very high percentage of the machine's capacity would be required for direct patient care procedures. This would severely limit the amount of time available for pursuit of one of the radiologists' and hospital's missions--research, development, or adaptation of new MRI imaging or spectroscopy procedures for clinical usage.

Technologist and nurse staffing for night shift operation could probably be recruited with payment of premium salaries. However, it is unlikely that necessary staff radiologist and physicist coverage could be obtained.

B. Contract with another hospital or imaging center for off-site service until UMHC's volume increases to a specific percentage of one machine's capacity (such as 167% or 5680 procedures).

A survey of available capacity at other local 1.5 Tesla MRI installations has not been conducted. However, it is unlikely that a single site could be found which could take on 600 additional procedures immediately and up to 1700 additional procedures within a year, at least not without a long-term commitment from UMHC.

An off-site location would be usable only for ambulatory cases. To minimize the inconvenience factor for patients, transportation service between UMHC and the off-site location would have to be provided.

This option would provide no on-site backup. When UMHC's machine needed repair or needed to be shut down for software or hardware upgrading, CT would be the only on-site backup for inpatient cases and for ambulatory cases which could not be scheduled at the off-site location.

Under this option a very high percentage of the machine's capacity during day and evening shift hours would be required for direct patient care procedures. Consequently, the only time available for research, development, or adaptation of new MRI imaging or spectroscopy procedures for clinical usage would be during night shift hours. As the radiologists and physicists engaged in research and development must also be present during many of the hours when patient care procedures are being performed, their ability to conduct research and development during the night shift would be very limited. Therefore, pursuit of one of the faculty's and hospitals' missions would be severely restricted.

If the off-site entity would not agree to having UMHC radiologists oversee performance of and provide the interpretation for procedures completed there, this option would also deprive UMHC's radiologist staff of the professional revenue for those cases.

C. Purchase on-site, mobile service from an imaging service company until UMHC's volume reaches a specific percentage of one machine's capacity.

Due to environmental constraints, 1.0 Tesla is the largest machine available on a mobile basis. There are a few installations where a 1.5 Tesla machine has been placed in a trailer. However, these are fixed installations where a trailer was used because it was a significantly less expensive enclosure than a constructed building. Because this option would not provide access to a 1.5 Tesla machine, it is not viable.

D. Replace the existing 1.0 Tesla machine with a 1.5 Tesla unit on-site.

This option enables provision of all service to patients on-site, provides on-site 1.5 Tesla MRI backup, provides time and equipment for research and development with minimal impact on patient service, and retains all hospital and professional fee revenue at UMHC.

Based on examination of the pros and cons of each of these alternatives, the following action is proposed.

PROPOSAL

Replace the 1.0 Tesla MRI machine with a new, state-of-the-art machine with a magnet strength of 1.5 Tesla or greater.

PROJECTED COST

Equipment	\$2,400,000
Installation	600,000

FINANCIAL ANALYSIS

The 1991-92 MRI revenue and expense budget is displayed in Section I of Attachment A. 4022 procedures resulting in gross charges of \$4,032,918 are projected. Based on a present overall reimbursement level of 89.8%, \$3,622,589 in net revenue is projected. \$2,090,531 in expenses are projected to produce this revenue.

As displayed in Section II of Attachment A, the projected annual incremental cost resulting from installation of a replacement machine is \$262,178. Based on the current 89.8% reimbursement rate, \$291,958 in additional gross charges would be required to cover this additional cost. That translates to the need for an additional 292 procedures assuming the ratio of procedures with and without the administration of contrast media remains constant.

The first year increases projected with the availability of two 1.5 Tesla machines as detailed above would yield the following additional net revenue:

PROCEDURE	NO.	NET REVENUE
-----	-----	-----
Brain		
Without Contrast	285-427	\$247,177 - 370,332
With Contrast	235-353	222,109 - 333,636
Extremities		
Without Contrast	2	1,735
With Contrast	50	47,257
Abdomen		
Without Contrast	15-19	13,009 - 16,478
With Contrast	141-189	133,265 - 178,632
Head		
Without Contrast	33	28,621
With Contrast	43	40,641
TOTAL	804-1116	\$733,814 - 1,017,332

The projected total range is 175-282% above the 292 additional procedures and \$441,856 to \$725,374 above the \$291,958 in additional gross charges required to cover the incremental cost.

This acquisition is included in UMHC's capital plan for the 1991-92 fiscal year.

**FINANCIAL ANALYSIS
REPLACEMENT OF MRI-I UNIT**

ATTACHMENT A

I. CURRENT ANNUAL MRI OPERATING BUDGET (1991-92)

PROCEDURE VOLUME PROJECTIONS

PROCEDURE	WITHOUT CONTRAST	WITH CONTRAST	TOTAL
Brain	1013	1224	2237
Spinal Cord	750	427	1177
Extremities	278	9	287
Myocardium	5	0	5
Pelvis/Hips	121	0	121
Abdomen	68	7	75
Head	50	39	89
Chest	25	6	31
TOTALS	2310	1712	4022

REVENUE PROJECTIONS

PAYER	% OF TOTAL	GROSS CHARGES	% REIMB.	NET REVENUE
Agency	9.6%	\$387,196	86.9%	\$336,000
BC/AWARE	11.7%	\$471,847	88.8%	\$419,000
HMO	3.2%	\$129,052	85.0%	\$109,694
Commercial	12.5%	\$504,110	100.0%	\$504,110
Medicare	18.2%	\$733,984	75.2%	\$551,956
MA/GAMC	8.6%	\$346,828	75.1%	\$260,468
Self-pay	27.5%	\$1,109,041	98.7%	\$1,094,623
Other	8.7%	\$350,860	98.7%	\$346,299
TOTALS	100.0%	\$4,032,918	89.8%	\$3,622,589

EXPENSE PROJECTIONS

Salaries & Fringe Benefits	\$313,891
Maintenance	\$455,000
Depreciation/Lease Payments	
MRI-I (Lease @ \$28,650/mo.)	\$343,800
MRI-II (Equipment & Facility)	\$557,617
Interest Expense	
MRI-II (Equipment & Facility)	\$211,590
Consumable Supplies	\$208,633
TOTAL	\$2,090,531

II. MARGINAL ANNUAL COST OF MRI-I REPLACEMENT

Salaries & Fringe Benefits	\$83,099
Depreciation	
Equip. & Facil. less current lease	\$24,906
Interest Expense (Equipment & Facility)	\$131,395
Consumable Supplies	\$22,778
TOTAL	\$262,178

III. ANNUAL VOLUME INCREASE REQUIRED TO RECOVER MARGINAL COST

Gross Charge Increase Required	
(\$262,178/.898)	\$291,958
Volume Increase Required	
Procedures Without Contrast (57.4% @ \$965.80)	174
Procedures With Contrast (42.6% @ \$1052.50)	118
Total	292

**Board of Governors
Nominating Committee**

Motion

January 22, 1992

Board of Governors
Nominating Committee
January 22, 1992

In accordance with the Board of Governors Bylaws - Article III. Section 1, the Nominating Committee hereby recommends that the term of office for the Chair and Vice Chair of the Board of Governors commence January 1, 1992 through December 31, 1992.

The Nominating Committee recommends that Ms. B. Kristine Johnson be elected to the position of Chair and Mr. David Lentz be elected to the position of Vice Chair for the January 1, 1992 through December 31, 1992 term.

Board of Governors Nominating Committee
Vice President Cherie Perlmutter, Chair
Mr. Michael Dougherty
Ms. Nellie Johnson

**THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS RESOLUTION**

WHEREAS, the Board of Regents has approved that The University of Minnesota Hospital and Clinic proceed with the due diligence process and the acquisition of the Interstate Medical Center in Red Wing, MN on January 10, 1992 and;

NOW, THEREFORE, be it resolved that the Board of Governors appoint the following individuals as members of Interstate Medical Center's Board of Directors:

Robert M. Dickler	One Year
S. Albert D. Hanser	Two Years
Clifford P. Fearing	Three Years

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO DECEMBER 31, 1991

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	\$189,517,000	\$182,906,000	(\$6,611,000)	-3.5%
Deductions From Revenue	46,738,000	50,169,000	3,431,000	7.3%
Net Patient Service Revenue	142,779,000	132,737,000	(10,042,000)	-7.0%
Other Operating Revenue				
Appropriation & Support	6,690,000	6,580,000	(110,000)	-1.6%
Other Revenue	5,979,000	5,859,000	(120,000)	-2.0%
Total Other Revenue	12,669,000	12,439,000	(230,000)	-1.8%
Total Revenue From Operations	155,448,000	145,176,000	(10,272,000)	-6.6%
Operating Expenses:				
Salaries	63,971,000	62,682,000	(1,289,000)	-2.0%
Fringe Benefits	15,510,000	15,153,000	(357,000)	-2.3%
Contract Compensation	9,989,000	10,000,000	11,000	0.1%
Supplies And Services	35,633,000	33,760,000	(1,873,000)	-5.3%
Utilities And Maintenance	5,882,000	6,083,000	201,000	3.4%
General Supplies & Expense	9,540,000	7,976,000	(1,564,000)	-16.4%
Insurance	928,000	925,000	(3,000)	-0.3%
Depreciation & Amortization	9,499,000	8,934,000	(565,000)	9%
Interest	5,773,000	5,936,000	163,000	3%
Provision For Uncollectibles	1,505,000	1,570,000	65,000	4.3%
Total Operating Expenses	158,230,000	153,019,000	(5,211,000)	-3.3%
Net Revenue From Operations	(2,782,000)	(7,843,000)	(5,061,000)	
Nonoperating Gains: Investment Income	6,054,000	5,091,000	(963,000)	-15.9%
Revenue And Gains In Excess Of Expense	<u>\$3,272,000</u>	<u>(\$2,752,000)</u>	<u>(\$6,024,000)</u>	

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	9,278	8,942	(336)	-3.6%
Patient Days	75,150	70,359	(4,791)	-6.4%
Average Length Of Stay	8.1	7.9	(0.2)	-2.5%
Average Daily Census	408.4	382.4	(26.0)	-6.4%
Percentage Occupancy	70.9	67.2	(3.7)	-5.2%
Outpatient Encounters	172,974	168,486	(4,488)	-2.6%

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

FEBRUARY 26, 1992

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
FEBRUARY 26, 1992
1:00 P.M.
RADISSON METRODOME HOTEL

AGENDA

		<u>Page</u>
I.	<u>Approval of the January 22, 1992 Minutes</u>	Approval 1
II.	<u>Chairman's Report</u> -Ms. Kristine Johnson	Information
III.	<u>Hospital Director's Report</u> -Mr. Robert Dickler	Information
IV.	<u>Committee Reports</u>	
A.	<u>Consent Items</u>	
	<u>Joint Conference Committee</u>	
1.	Medical Staff-Hospital Council Report Credentials Committee Recommendations	Approval 5
2.	End Stage Renal Disease Program (Separate Attachment)	Approval
	<u>Planning and Development Committee</u>	
1.	Quarterly Capital Expenditure Report	Information 10
	<u>Finance Committee</u>	
1.	January 22, 1992 Minutes	Information 11
B.	<u>Joint Conference Committee</u> - Ms. Margaret Matalamaki	
	No items requiring Board deliberation.	

C. Planning and Development Committee

- Mr. David Lentz

1. EMTEK Approval 14

D. Finance Committee

- Ms. Nellie Johnson

1. January 31, 1991 Financial Statements Information 21

2. Interstate Medical Center
(To be distributed) Approval

V. Other Business

VI. Adjournment

MINUTES

**BOARD OF GOVERNORS
The University of Minnesota Hospital and Clinic**

January 22, 1992

Call To Order

Ms. Kristine Johnson called the January 22, 1992 meeting of the Board of Governors to order at 2:40 p.m. in 555 Diehl Hall.

Attendance

Present: David Brown, M.D.
Robert Dickler
Phyllis Ellis
Maria Gomez
Albert Hanser
Terence Hill
Kris Johnson
Arthur Kydd
David Lentz
Margaret Matalamaki
Robert Maxwell, M.D.
John Morrison
Cherie Perlmutter
Roby Thompson, M.D.
Kristine Zualkernan

Not Present: Leonard Bienias
Michael Dougherty
Bob Erickson
Nellie Johnson

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the December 18, 1991 meeting as submitted.

Chairman's Report

Ms. Kris Johnson introduced and welcomed the newly appointed Board of Governors members; Maria Gomez, Albert Hanser, Terence Hill, Arthur Kydd, John Morrison and Kristine Zualkernan.

Ms. Johnson also welcomed Ruth Bettendorf, a representative of ASFME.

Ms. Johnson announced that the Board of Governors committee assignments would be finalized in the near future and mailed out to members.

Special Presentation: Gordon Ginder, M.D.

Mr. Robert Dickler introduced Dr. Gordon Ginder, Professor and Head of Oncology. Dr. Ginder presented an overview of the Oncology Division of the Department of Medicine.

Directors Report

Mr. Dickler introduced Dr. Jean Harris, Senior Associate Director and Director of Medical Affairs, to the Board.

Mr. Dickler reported that the Board of Regents approved the acquisition of the Interstate Medical Center in January. A resolution was distributed appointing the following individuals as members of Interstate Medical Center's Board of Directors: Robert M. Dickler (one year), S. Albert D. Hanser (two years) and Clifford P. Fearing (three years). The Board of Governors seconded and passed a motion to approve these appointments.

Mr. Dickler announced that the strategic planning process would be discussed at the February 26, 1992 Board of Governors retreat.

Consent Agenda

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

- a. Second Quarter, 1991-92, Bad Debts
- b. Orthopedic Clinic Remodeling

Finance Committee

Mr. David Lentz, representing the Finance Committee, called on Ms. Helen Pitt to present the EMTEK System.

The bedside clinical information system (EMTEK) is proposed for expansion from its present location on the Surgical Intensive Care Unit to the Medical and Pediatric Intensive Care Units. EMTEK is a clinical information management system which not only automates the patient record keeping functions, but creates the data base required to more effectively and efficiently manage patient care in the critical care setting. The capital expenditure associated with this project is \$950,000 over five years with \$108,000 for installation. This item is for information and will be presented for endorsement at the February Board of Governors meeting.

Mr. Lentz called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospitals's Statement of Operations for the period July 1, 1991 through December 31, 1991 shows expenses over revenues by \$2,752,000, an unfavorable variance of \$6,024,000. Patient care charges through December totaled \$182,906,000, which was 3.5% under budget.

Mr. Fearing reported inpatient admissions for December totaled 1,486 which was 86 above budgeted admissions of 1,400. Overall average length of stay for the month was 7.8 days. Outpatient clinic visits for the month of December totaled 26,964 which was 914, or 3.5% more than budgeted visits of 26,050.

Mr. Al Dees requested that the Board of Governors approve the purchase of a 1.0 Tesla Magnetic Resonance Imager which was presented in December. The Board of Governors seconded and passed a motion to approve the purchase of a 1.0 Tesla Magnetic Resonance Imager.

Joint Conference Committee

Ms. Johnson reported that the Joint Conference Committee did not meet in January, however, the Board of Governors was asked to approve the Credentials Committee Recommendations. Ms. Johnson called on Dr. Robert Maxwell to present the recommendations of the Credentials Committee which were endorsed by the Medical Staff Hospital Council on January 14, 1992. A motion to approve the recommendations of the Credentials Committee was passed unanimously.

Nominating Committee

Ms. Cherie Perlmutter, Chair of the Nominating Committee, requested that the Board of Governors approve the recommendation that Ms. Kristine Johnson be elected to the position of Chair and Mr. David Lentz be elected to the position of Vice Chair for the term January 1, 1992 through December 31, 1992. A motion was seconded and passed to approve the Nominating Committee recommendations.

Adjournment

There being no further business, the January 22, 1992 business meeting of the Board of Governors was adjourned at 4:20 p.m.

Respectfully submitted,

Gail A. Strandemo

Gail A. Strandemo
Board of Governors Office



UNIVERSITY OF MINNESOTA
TWIN CITIES

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

February 18, 1992

TO: Members of the Board of Governors
FROM: Robert E. Maxwell, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council
SUBJECT: Credentials Committee/Medical Staff-Hospital Council
Report and Recommendations.

The Medical Staff-Hospital Council on February 11 endorsed the attached Credentials Committee Report and Recommendations and forwarded this report to the Joint Conference Committee for their consideration on February 25.

I am forwarding these recommendations to you for your review and approval on February 26. I will report the outcome of the Joint Conference Committee's action at that time. If you should have any questions, please feel free to call on me.

REM/cf
Attachment

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

February 3, 1992

TO: Medical Staff-Hospital Council
FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee
SUBJECT: Credentials Committee Report and Recommendations

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

<u>Department of Laboratory Medicine and Pathology</u>	<u>Category</u>
Susan A. Fuhrman	Attending Staff
Patrick C. Sadler	Clinical Staff
<u>Department of Medicine</u>	
David M. Kendall	Attending Staff
Keith G. Lurie	Attending Staff
<u>Department of Obstetrics and Gynecology</u>	
Hardin E. Olson	Attending Staff
<u>Department of Ophthalmology</u>	
Mark W. Balles	Attending Staff
Steven R. Bennett	Clinical Staff
<u>Department of Radiology</u>	
Carol C. Coleman	Clinical Staff
Charles Krenzel	Clinical Staff

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

<u>Department of Medicine</u>	<u>Category</u>
M. Colin Jordan Delete: gastric lavage and cytology	Attending Staff
B. J. Kennedy Delete: gastric lavage and cytology	Attending Staff
Nancy L. Meryhew Delete: gastric lavage and cytology	Attending Staff
Wesley J. Miller Delete: gastric lavage and cytology	Attending Staff
Joseph M. Tombers Delete: gastric lavage and cytology, esophagoscopy, biopsy and cytology	Clinical Staff

Department of Pediatrics

William Krivit Delete: bone marrow exam and peripheral blood morphology exam	Attending Staff
Theodore R. Thompson Delete: bone marrow examination and peripheral blood morphology exam	Attending Staff

The following medical staff member has submitted an application and supporting documentation requesting change in his staff category. The Committee has reviewed and considered this request and hereby recommends approval.

<u>Department of Radiology</u>	<u>Present Category</u>	<u>Requested Category</u>
Joseph W. Yedlicka	Attending Staff	Clinical Staff

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

<u>Department of Family Practice and Community Health</u>	<u>Category</u>	<u>Date Eligible</u>
Charles E. Boulton	Attending Staff	November 22, 1991
Craig Christianson	Clinical Staff	November 22, 1991

Recommendation for provisional status continued:

Department of Neurology

Jacqueline T. Bernard	Attending Staff	November 22, 1991
Costantino Iadecola	Attending Staff	November 22, 1991
M. Elizabeth Ross	Attending Staff	November 22, 1991

Department of Pediatrics

David A. Ferenci	Clinical Staff	November 22, 1991
Dawn L. Martin	Attending Staff	November 22, 1991
Roy C. Maynard	Attending Staff	November 22, 1991
Christopher L. Moertel	Clinical Staff	November 22, 1991
Albert P. Rocchini	Attending Staff	November 22, 1991
John G. Wahlstrom	Clinical Staff	November 22, 1991

Department of Radiology

David A. Larson	Clinical Staff	November 22, 1991
Kent B. Remley	Clinical Staff	November 22, 1991
Brian T. Larkin	Clinical Staff	November 22, 1991

Department of Urology

Walter P. Gleich	Clinical Staff	November 22, 1991
Deepak A. Kapoor	Clinical Staff	November 22, 1991

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

Department of Anesthesiology

Category

James F. Cumming	Attending Staff
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Department of Medicine

Kevin E. Rist	Attending Staff
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Department of Urology

Abraham Ami Sidi	Attending Staff
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Department of Therapeutic Radiology

David J. Monyak	Attending Staff
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The Committee recommends acceptance of the resignation of Specified Professional Personnel-Psychology Staff from the following psychologist.

<u>Department of Psychiatry</u>	<u>Category</u>
Lloyd Sines	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

**CAPITAL EXPENDITURES
7-1-91 THRU 12-31-91**

	BUDGET	ROLLFORWARD FROM 6-30-91	TOTAL	6-MONTH BUDGET	6-MONTH ROLLFORWARD	TOTAL	91-92 ACTUAL	90-91 ROLLFORWARD	TOTAL
RECURRING EQUIP & REMOD									
EQUIPMENT PURCHASES									
91-92 BUDGET	\$6,818,850		\$6,818,850	\$3,400,000		\$3,400,000	\$2,817,782	\$0	\$2,817,782
ROLLFORWARD		\$4,871,763	\$4,871,763		\$2,435,000	\$2,435,000	\$0	\$644,203	\$644,203
	\$6,818,850	\$4,871,763	\$11,690,613	\$3,400,000	\$2,435,000	\$5,835,000	\$2,817,782	\$644,203	\$3,461,985
REMODELING PROJECTS									
91-92 BUDGET	\$1,692,150		\$1,692,150	\$850,000		\$850,000	\$137,654		\$137,654
ROLLFORWARD		\$1,446,000	\$1,446,000		\$723,000	\$723,000		\$365,440	\$365,440
	\$1,692,150	\$1,446,000	\$3,138,150	\$850,000	\$723,000	\$1,573,000	\$137,654	\$365,440	\$503,094
	\$8,511,000	\$6,317,763	\$14,828,763	\$4,250,000	\$3,158,000	\$7,408,000	\$2,955,436	\$1,009,643	\$3,965,079
PRINCIPLE PAYMENTS									
LAB CHEMICAL ANALYZERS	\$126,841		\$126,841	\$62,024		\$62,024	\$54,542		\$54,542
CT SCANNER	\$71,575		\$71,575	\$71,575		\$71,575	\$71,575		\$71,575
COMPUTER EQUIP	\$139,517		\$139,517	\$92,188		\$92,188	\$92,188		\$92,188
MRI 2	\$462,648		\$462,648	\$227,035		\$227,035	\$227,036		\$227,036
	\$800,581		\$800,581	\$452,822		\$452,822	\$445,341		\$445,341
TOTAL:	\$9,311,581		\$15,629,344	\$4,702,822		\$7,860,822	\$3,400,777		\$4,410,420

BOND PAYMENTS: \$2,490,000 (PAYMENTS DUE FEB. 1, 1992)

CAPITAL PROJECTS:	UMHC FUNDS FROM RESERVES	ADDITIONAL FUNDS FROM OTHER SOURCES	TOTAL BUDGET	1st QUARTER EXPEND. 1991-92	2nd QUARTER EXPEND. 1991-92	CURRENT & PRIOR YEAR(S) EXPENDITURES
(1) ARCHITECT FEES PH II				\$104,166	\$274,038	\$1,451,469
(1) OFFSITE RELOC.						\$10,516
(1) AUTOPSY	\$415,000		\$415,000	\$86,365	\$32,933	\$302,413
(1) OB INPT. (TEMP)	\$370,000		\$370,000	\$119,782	\$43,721	\$316,732
BMT/ICU 4F	\$100,000		\$100,000	\$1,874	\$1,689	\$89,300
BONE MARROW TRAN. EXP.	\$220,000		\$220,000	\$8,900	\$116,071	\$128,437
NEURO-ANGIOGRAPHY SYST	\$1,900,000		\$1,900,000	\$1,345,114	\$73,928	\$1,449,042
CUHCC	\$1,800,000	\$550,000	\$2,350,000	\$15,036	(\$15,306)	\$2,222,764
COMPUTER UPGRADE	\$4,348,000		\$4,348,000	\$28,338	\$209,219	\$977,995
AF15 SOFTWARE LICENSE	\$783,000		\$783,000	\$782,157		\$782,157
HEART CATH ROOM	\$3,100,000		\$3,100,000		\$1,515,073	\$1,528,182
TOTAL	\$13,036,000	\$550,000	\$13,586,000	\$2,491,733	\$2,251,367	\$9,259,007

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

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
January 22, 1992

MINUTES

ATTENDANCE:

Present: Edward Ciriacy, M.D.
Robert Dickler
Cliff Fearing
Leo Furcht, M.D.
Terence Hill
David Lentz
Margaret Matalamaki
John Morrison
Vic Vikmanis

Not Present: Michael Dougherty
Roger Paschke

Staff: Giles Caver
Greg Hart
Nels Larson
Shannon Lorbiecki
Joanne Disch
Sharon Weiss

Guests: Dr. Peter Bitterman
Dr. Frank Cerra
Al Dees
Dr. Tom Green
Helen Pitt
Mary Ellen Wells

CALL TO ORDER:

The Finance Committee was called to order by Mr. David Lentz, Interim Chairperson, on January 22, 1992 at 12:30 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the December 18, 1991 meeting as written.

JULY 1, 1991 THROUGH DECEMBER 31, 1991 FINANCIALS:

Mr. Cliff Fearing reported to the Finance Committee the month of December inpatient admissions totaled 1,486 which was 86 above budget; average length of stay was 7.8 days; patient days totaled 11,288 which were 553 days below budget. The December average daily census was 364, which was below the budgeted level of 382. Clinic visits for the month of December were reported to be 3.5% above budget.

The Hospital's year-to-date Statement of Operations showed expenses being greater than revenues by \$2,752,000, an unfavorable variance of \$6,024,000. Gross patient revenue was 3.5% below budget and operating expenditures through December were reported to be 3.3% below budget.

As of December 31, the balance of accounts receivable totaled \$102,685,000 and represented 98.3 days of revenue outstanding.

The Hospital's overall operating position shows a loss for the month and year-to-date.

SECOND QUARTER, 1991-92 BAD DEBTS:

Mr. Fearing reported the bad debts for the second quarter totaled \$555,108.29 represented by 1,881 accounts. Receivables amounted to \$2,163.82, leaving a net charge-off of \$552,944.47. This amount represents 0.60% of gross charges and compares to a budgeted level of 0.79%.

The Finance Committee seconded and passed a motion to endorse the Second Quarter, 1991-92 Bad Debt report as submitted.

SPECIAL CAPITAL PROJECT:

Magnetic Resonance Imager (MRI)

Mr. Al Dees introduced Dr. Arthur Stillman, Head of MRI Section of Radiology Department at UMHC, as a guest at today's Board of Governors Finance Committee meeting.

Mr. Dees presented to the Committee, for endorsement, a proposal to acquire an additional 1.5 Tesla Magnetic Resonance Imager to replace the leased 1.0 Tesla Magnetic Resonance Imager in the MRI section of the Department of Radiology at a cost of \$2,400,000 for equipment and \$600,000 for installation. This acquisition is included in UMHC's capital plan for the 1991-92 fiscal year and had been presented to the Committee for information at the December 18, 1991 meeting.

The Finance Committee seconded and passed a motion to endorse the proposal to acquire a new, state-of-the-art 1.5 Tesla Magnetic Resonance Imager at a projected cost of \$3,000,000 to replace the leased 1.0 Tesla Magnetic Resonance Imager.

MAJOR CAPITAL EXPENDITURE:

EMTEK System Upgrade

Helen Pitt introduced Dr. Frank Cerra, Medical Director of Surgical ICU, Dr. Tom Green, Medical Director Pediatric ICU, and Dr. Peter Bitterman, Medical Director of Medical ICU, as guests at today's Board of Governors Finance Committee meeting.

Ms. Pitt reported to the Committee, for information, a proposal to expand the Critical Care Clinical Information Management System called EMTEK to include the medical and pediatric intensive care units at a capital cost of \$950,000 with an additional \$108,000 for installation.

Ms. Pitt stated that EMTEK, bedside clinical information system for patient care on unit 4D (the surgical intensive care unit) was implemented in November of 1990 and has proven beneficial in staff productivity, cost reductions and improved efficiency and effectiveness in patient care. Currently, there are 24 beds equipped with the EMTEK system and an additional 29 would be up and running by the summer of 1992 under this proposal. The ability to impact medical practice and care delivery will be significantly enhanced if all three of the contiguous intensive care units are on the same system. Dr. Cerra described the benefits of the system from the physician's perspective.

This system expansion is part of the Long Range Capital Plan and has been included in the fiscal year 1991-92 capital budget. This proposal will be brought back to the Committee for endorsement next month.

Orthopaedic Clinic Remodeling

Ms. Mary Ellen Wells reported to the Committee, for information, a proposal to remodel the Orthopaedic Clinic in the Phillips-Wangensteen Building (PWB) at a cost of \$143,100.

Ms. Wells stated that the Orthopaedic Clinic has more than doubled in patient visits since 1979 when it was first opened in PWB. Under this remodeling project, five adjacent social work offices would be utilized in creating two additional exam rooms, four rooms to accommodate physical therapy, consulting and patient education, and an area for staff support activities. The displaced social work staff would be transferred to offices in the Mayo Building.

This remodeling is part of the fiscal year 1991-92 budget.

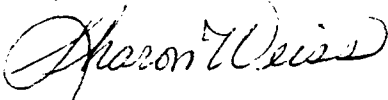
HOSPITAL PERSONNEL AUTONOMY - COMPENSATION:

Mr. Greg Hart reported to the Committee, for information, a proposal to extend the delegation of authority of the Hospital Board of Governors to include compensation policies for all employees of The University Hospital and Clinic; including student employees.

Upon approval of this action, new classifications and classification numbers would be created with incumbent employees being transferred to the new classification without loss of seniority or other benefits. Classifications in Bargaining Unit's 3 and 6 would continue to be administered according to the contracts as negotiated by the University.

There being no further discussion, the January 22, 1992 meeting was adjourned at 2:10 P.M.

Respectfully submitted,



Sharon Weiss
Recording Secretary

February 18, 1992

To: Members of the Board of Governors
From: Robert M. Dickler, General Director
RE: Expansion of the Critical Care Clinical Information Management System

Two years ago the Board of Governors approved a pilot bedside computer project for patient care unit 4D, the surgical intensive care unit. Actual implementation of the Critical Care Clinical Information Management System called EMTEK occurred in November of 1990. This information system installation has been unique in the following ways:

- The project continues to have broad multidisciplinary support from Medicine, Nursing, Cardiopulmonary Services, Patient Monitoring, Pharmacy, and Laboratories.
- UMHC staff is involved in the development of software applications with the vendor. We have influenced the development of the product.
- It is a first step toward the realization of a computer based patient record and has already demonstrated early benefits in efficiencies and effectiveness in patient care.

We are now requesting an expansion of the project to the medical and pediatric intensive care units, based on the achievement of established criteria in the initial pilot as well as the opportunity for additional, greater benefits. This project will be on the February 26th agenda, at which time we will be requesting your approval.

The enclosed materials provide a summary of the project and the financial expenditures associated with the implementation of this system on the two additional patient care units. The capital expenditure associated with this project is \$950,000 over five years with \$108,000 for installation.

We will be available at the meeting to respond to any questions.

Overview of the Clinical Information System Project

The bedside clinical information system (EMTEK) is proposed for expansion from its present location on the Surgical Intensive Care Unit to the Medical and Pediatric Intensive Care Units.

What is EMTEK? EMTEK is a clinical information management system which not only automates the patient record keeping functions, but creates the data base required to more effectively and efficiently manage patient care in the critical care setting. The clinical information system includes flowsheets, progress notes, results reporting, plan of care, and other charting functions and will include physician order entry. The system communicates to bedside monitoring to automatically acquire physiologic data from instruments such as ventilators and infusion pumps. The system connects to the hospital's laboratory system and integrates result reporting with other clinical data. EMTEK is developed for use in the critical care setting and is a building block for a hospital-wide patient care information system.

EMTEK Health Care Systems Inc. is a subsidiary of Motorola. Motorola provides EMTEK with financial stability and a long term business perspective. EMTEK has brought talented engineers and clinicians together and is committed to quality and customer satisfaction. The working relationship that has been established between EMTEK and staff at Minnesota provides confidence for continuing success in future endeavors.

What are the EMTEK expansion plans for the Medical and Pediatric Intensive Care Units? These two patient care units include 15 adult and 14 pediatric intensive care beds. The hardware and software provides workstations at each bedside, centrally at the unit desks, and in residents' and Medical Directors' offices. The costs include the database and system tools for quality improvement and research. The network hardware and software, computer and instrument interfaces, and training resources are included. The implementation will be incremental over three years and provides for tailoring the software (e.g. flowsheets, plan of care) for the clinical practice requirements of each ICU and specific patient populations.

Why should we expand beyond the original pilot patient care unit?

- The initial benefits, proposed at the time the pilot was approved, have been demonstrated. This evaluation demonstrated evidence of initial benefits, satisfaction of clinical staff with the system, the clinical functions provided by the system fit our environment, system reliability, vendor performance, and system support for the UMHC mission.
- The EMTEK system provides effective tools for improved staff productivity, cost reductions and cost effective decision making in the clinical setting. The requirements of today's environment emphasize the importance of these tools. An automated charting system with access to real time and historical patient data is consistent with the direction of regulatory, and professional organizations.
- Clinical staff involved with the system on the surgical intensive care unit believe it helps them do their jobs and supports continuous quality improvement in patient care.
- The ability to impact medical practice and care delivery will be significantly enhanced if all three of the contiguous intensive care units are on the same system. Patients and staff do cross units. This system supports our hospital in being a leader in critical care.

Why now? The technology, staff and relationships are ready. The current health care environment demands that health care costs be managed to improve patient outcomes and reduce spending. The Medical Directors of the intensive care units believe that their ability to manage patient care with less resources requires a clinical information system such as EMTEK to provide the data to support cost effective decision making at the bedside. In addition, this clinical information system is a tool which supports the work of the entire team; medical, nursing, cardiorespiratory, pharmacy and other disciplines.

Cost Benefit Summary Medical & Pediatric ICU

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Total
Costs:									
Hardware and Software	(950,000)	0	0	0	0	0	0	0	(950,000)
Installation	(108,000)	0	0	0	0	0	0	0	(108,000)
FTE Support	(81,000)	(81,000)	(126,000)	(126,000)	(126,000)	(126,000)	(126,000)	(126,000)	(918,000)
Maintenance	0	0	(125,000)	(125,000)	(125,000)	(125,000)	(125,000)	(125,000)	(750,000)
Total Costs	(1,139,000)	(81,000)	(251,000)	(251,000)	(251,000)	(251,000)	(251,000)	(251,000)	(2,726,000)
Benefits:									
FTE Reductions	0	40,000	140,000	140,000	160,000	160,000	160,000	160,000	960,000
Oper Cost Reduction	0	274,000	274,000	274,000	274,000	274,000	274,000	274,000	1,918,000
Total Benefits	0	314,000	414,000	414,000	434,000	434,000	434,000	434,000	2,878,000
Net Benefit	(1,139,000)	233,000	163,000	163,000	183,000	183,000	183,000	183,000	152,000
Cumulative Internal Rate of Return		-79.54%	-50.58%	-29.95%	-15.67%	-6.73%	-0.80%	3.30%	

**BACKGROUND OF COST BENEFIT ANALYSIS OF
EXPANSION OF EMTEK TO 4C AND 4E**

Cost

The hardware costs of \$388,000 and software costs of \$562,000 make up the \$950,000 in line one. The installation cost of \$108,000 consists of \$60,000 for site prep, \$45,000 for the network and \$3,000 for access for the medical directors of each unit.

In the line titled "FTE" support the dollars are for a systems administrator and a .8 implementation coordinator during the first two years. A decision support system data manager is added in subsequent years. The decision support system data manager will provide service to both of the new units and the unit brought up a year ago.

The service contract begins in the third year, and is paid on a monthly basis. The contract's cost is 13% of the cost of the hardware and software.

Benefits

The benefits are displayed in two categories. The first is in FTE savings projected from staff efficiencies gained in using the system. These are anticipated to increase over the years as new features are added increasing the utility of the system. These savings are based on our experience with the system installation already in operation on the first unit.

The detail for the annual operating cost reductions of \$274,000 are displayed on the following two pages. In discussions with the medical directors they were able to identify areas where the EMTEK system could support medical decision making in such a way that the utilization of lab tests, ventilator days, oximetry days, drugs and radiology procedures would be reduced between 10% and 15%. The detail then displays the anticipated reduction in charges as well as direct costs. For this analysis we used only direct costs, i.e., actual labor time, reagents, drugs, etc. We continue to track the volume of tests and procedures, adjusted by patient volume, to measure the impact of the system on ordering practices. Our goal is to add an intensive care patient acuity/intensity measure to this analysis so we can incorporate the analysis of patient care outcomes.

Summary

A positive cost benefit analysis of an information systems acquisition is heavily dependent on the anticipation of changes in other systems. In considering the expansion of this clinical information management system there are two significant factors.

- . We have already demonstrated initial benefits in FTE savings; increased accuracy in documentation and calculations; and positive change in ordering practices on the first unit.
- . Our medical directors set the projected changes in ordering practice and have taken the first steps to using the technology to incorporate cost effectiveness in the achievement of improved patient outcomes.

2/18/92(13)

Examples of operating cost reductions

The medical staff has identified a number of projects with potential for improvement in both medical outcome and resource utilization outcome. The following list presents four such projects and a targeted percentage of improvement:

<u>DESCRIPTION</u>	<u>MEDICAL OUTCOME</u>	<u>RESOURCE OUTCOME</u>	<u>TARGET % IMPROVEMENT</u>
1. Risk Stratification to identify short-term ICU stays	<ul style="list-style-type: none"> a. decreased injury from monitoring b. decreased injury from transfusion 	<ul style="list-style-type: none"> a. decreased use of all chemistries b. decreased use of x-ray resources 	15
2. Automated Ventilator Weaning	<ul style="list-style-type: none"> a. decreased ventilator days b. no increase in 24 hr reintubation rate 	<ul style="list-style-type: none"> a. decreased use of blood gases b. decreased ventilator use-days 	10
3. More effective use of oximetry	<ul style="list-style-type: none"> a. decreased low-flow artifact b. decreased anemia artifact 	<ul style="list-style-type: none"> a. decreased number oximetry use-days 	15
4. More effective use of laboratory tests	<ul style="list-style-type: none"> a. decrease in unnecessary medication b. decreased adverse effects of medication 	<ul style="list-style-type: none"> a. decreased use of measurements of coagulation parameters, calcium, liver function tests 	20

**Projected Reductions in Charges and Direct Costs from Changes in Medical Practice
Supported by the Implementation of the EMTEK System in the
Medical and Pediatric Intensive Care Units
February 1992**

Laboratory for Medical ICU

	Charges	Reduction	Annual Reduction in Charges	Cost/charge ratio	Annual Reduction in Cost
Chemistry	\$1,322,760	15%	\$198,414	.28	\$55,556
Coags	\$234,476	20%	\$46,895	.27	\$12,662
Total			\$245,309		\$68,218

Laboratory for Pediatric ICU

	Charges	Reduction	Annual Reduction in Charges	Cost/charge ratio	Annual Reduction in Cost
Chemistry	\$887,972	15%	\$133,196	.20	\$26,639
Coags	\$477,420	20%	\$95,484	.28	\$26,736
Total			\$228,680		\$53,375

Ventilator Days

ICU Ventilator Days	Volume last 12 months	Minimum Daily CRS Charge	Dollars	Target Reduction	Annual Reduction in Charges	Cost per day	Annual Reduction in Cost
Ventilator Days (adults)	1767 days	\$175	\$309,225	10%	\$30,922	\$67.80	\$11,980
Ventilator Days (peds)	1618 days	\$175	\$283,150	10%	\$28,315	\$67.80	\$10,970
TOTAL			\$592,375		\$59,237		\$22,950

Oximetry Days

ICU Oximetry Use Days	Volume last 12 months	Daily Charge	Dollars	Target Reduction	Annual Reduction in Charges	Cost per day	Annual Reduction in Cost
Adult Oximetry Days	2021	\$73	\$147,533	15%	\$22,130	\$12.52	\$2,529
Peds Oximetry Days	2310	\$73	\$168,630	15%	\$25,295	\$12.52	\$2,892
TOTAL					\$47,425		\$5,421

Pharmacy

ICU	Average Pharmacy charge per pt Day	Average Drug Cost per pt Day	Average Annual Drug Cost	10% reduction in Annual Drug Cost
Medical ICU	\$371	\$166	\$643,828	\$64,382
Pediatric ICU	\$452	\$ 99	\$300,491	\$30,049
TOTAL				\$94,431

Radiology

Chest xrays	Annualized total volume	15% reduction in charges	15% reduction in cost
Medical ICU chest xrays	3,487	\$35,897	\$18,307
Pediatric ICU chest xrays	2,225	\$22,905	\$11,682
TOTAL			\$29,989

Summary	Annual Reduction in Costs
Laboratory	\$121,593
Ventilator	\$22,950
Oximetry	\$5,421
Pharmacy	\$94,431
Radiology	\$29,989
TOTAL	\$274,384

PCU 4D
 JULY-DEC 1991 VS JAN-JUNE 1990 CHARGES

	JAN-JUNE 1990	CHG. PER STAY	CHG. PER DAY	JULY-DEC 1991	CHG. PER STAY	CHG. PER DAY	DIFF. PER STAY	DIFF. PER DAY
NO. PAT.	878			758				
NO. DAYS ON 4D	3259			2959				
R&B	\$1,763,492	\$2,009	\$541	\$1,516,700	\$2,001	\$513	(\$8)	(\$29)
ICU	\$3,524,850	\$4,015	\$1,082	\$2,935,123	\$3,872	\$992	(\$142)	(\$90)
PHARM	\$1,900,466	\$2,165	\$583	\$1,637,282	\$2,160	\$553	(\$5)	(\$30)
M/S/C SUPPLY	\$1,746,061	\$1,989	\$536	\$1,469,497	\$1,939	\$497	(\$50)	(\$39)
LAB	\$3,270,646	\$3,725	\$1,004	\$2,606,052	\$3,438	\$881	(\$287)	(\$123)
DIAG RAD	\$865,390	\$986	\$266	\$903,746	\$1,192	\$305	\$207	\$40
THER RAD	\$4,322	\$5	\$1	\$1,047	\$1	\$0	(\$4)	(\$1)
ER/TR/CLN	\$66,387	\$76	\$20	\$55,053	\$73	\$19	(\$3)	(\$2)
OR	\$3,375,210	\$3,844	\$1,036	\$2,645,235	\$3,490	\$894	(\$354)	(\$142)
DIALYSIS	\$739,279	\$842	\$227	\$966,440	\$1,275	\$327	\$433	\$100
BLOOD ADMIN	\$793,161	\$903	\$243	\$681,679	\$899	\$230	(\$4)	(\$13)
CARD	\$125,663	\$143	\$39	\$112,250	\$148	\$38	\$5	(\$1)
PT/OT/ST	\$13,113	\$15	\$4	\$14,942	\$20	\$5	\$5	\$1
CARDIO/RESP	\$3,178,825	\$3,621	\$975	\$2,477,860	\$3,269	\$837	(\$352)	(\$138)
OTHER THER	\$976	\$1	\$0	\$82	\$0	\$0	(\$1)	(\$0)
OTHER SERV	\$54,032	\$62	\$17	\$29,358	\$39	\$10	(\$23)	(\$7)
BLD BY-PROD	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PHARM TAKE HM	\$223	\$0	\$0	\$754	\$1	\$0	\$1	\$0
SUPP TAKE HM	\$373	\$0	\$0	\$276	\$0	\$0	(\$0)	(\$0)
OTHER PROFEE	\$263,914	\$301	\$81	\$170,561	\$225	\$58	(\$76)	(\$23)
DIAG RAD-PF	\$374,176	\$426	\$115	\$409,027	\$540	\$138	\$113	\$23
THER RAD-PF	\$3,414	\$4	\$1	\$1,100	\$1	\$0	(\$2)	(\$1)
CARD.-PF	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
LAB/PATH-PF	\$146,915	\$167	\$45	\$93,440	\$123	\$32	(\$44)	(\$14)
TOTAL	\$22,210,888	\$25,297	\$6,815	\$18,727,504	\$24,706	\$6,329	(\$591)	(\$486)
TOTAL EXCL. PF & TAK	\$21,421,871	\$24,398	\$6,573	\$18,052,346	\$23,816	\$6,101	(\$583)	(\$472)

Note: 1990 charges have been inflated to 1991-92 level

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

February 26, 1992

TO: Board of Governors
FROM: Clifford P. Fearing
SUBJECT: Report of Operations for the Period
July 1, 1991 through January 31, 1992

The Hospital's operations for the month of January reflect inpatient admissions, patient days and outpatient clinic visits all below budgeted levels.

INPATIENT CENSUS: For the month of January, inpatient admissions totaled 1,553 which was 42 below budgeted admissions of 1,595. Our overall average length of stay for the month was 7.8 days. Patient days for January totaled 11,864 and were 864 days below budget. The areas in which admissions were most significantly under budget were Gynecology and Pediatrics. Areas in which admissions were significantly over budget were Family Practice and Orthopedics.

OUTPATIENT CENSUS: Outpatient encounters (including CUHCC and Home Health) for the month of January totaled 29,737 which was 552, or 1.9%, more than budgeted visits of 29,185. CUHCC was 579 or 13.7% over budget and Home Health was 263 or 29.6% over budget. Other areas in which visits were significantly over budget include the Adult Psych, Sports Medicine, and the Heart Cath Lab (not budgeted for). Areas which were significantly under budget were Child Psych, Medicine, OB/GYN, and Radiation Therapy.

To recap our census:

Monthly Data					YTD Data				
90/91	91/92	91/92		%	90/91	91/92	91/92		%
<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>
1,617	1,595	1,553	(42)	(2.6)	Admissions	10,739	10,873	(134)	(1.2)
12,604	12,728	11,864	(864)	(6.8)	Patient Days	86,325	87,878	(1,553)	(1.8)
8.5	8.0	7.8	(0.2)	(2.5)	Avg Length of Stay	8.1	8.1	0.0	(0.0)
406.6	410.5	382.7	(27.8)	(6.8)	Avg Daily Census	401.5	408.7	(7.2)	(1.8)
70.3	71.3	67.4	(3.9)	(5.5)	Percent Occupancy	69.7	71.0	(1.3)	(1.8)
29,528	29,185	29,737	552	1.9	Outpt Encounters	196,605	202,159	(5,554)	(2.8)

REPORT OF OPERATIONS

January 1992

PAGE 2

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses being greater than revenues by \$3,107,000, an unfavorable variance of \$(6,752,000).

Patient care charges through January totaled \$214,836,000, which was 3.2% under budget. Routine revenue was \$4,118,000 (6.4%) below budget and ancillary revenue was \$2,897,000 (1.8%) below budget and reflects both our unfavorable inpatient and outpatient census variance. Inpatient revenue averaged \$16,181 per admission compared to the budgeted average of \$16,335. Outpatient revenue per outpatient encounter averaged \$227 per visit compared to the budgeted average of \$219.

Deductions from charges totaled \$58,406,000, which was \$3,694,000 (6.8%) over budgeted deductions of \$54,712,000. The variance is largely due to the Medicare and Medical Assistance programs where the average charges per case are higher than projected, thus resulting in higher than anticipated adjustments. Other factors contributing to the variance include increased prompt payor discounts, and increased write-offs associated with the increase in our transplant activity this year.

Operating expenditures through January totaled \$179,919,000 and were \$5,407,000 (2.9%) below budgeted levels of \$185,326,000. The overall favorable variance was primarily due to lower patient related costs (personnel, medical supplies and services, drugs and blood) and anticipated expenses not yet incurred.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of January 31, 1992, totaled \$106,021,000 and represented 102.2 days of revenue outstanding. The overall increase in patient receivables in January of 3.9 days was reflected by an increase in Medicare, and Special Contracts - Transplant.

CONCLUSION: The Hospital's overall operating position shows a monthly loss and a year-to-date loss. Actions with regard to our expenditure base are being developed. It is our intention to be in a breakeven financial position for the fourth quarter of the 1991/92 fiscal year.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO JANUARY 31, 1992

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	\$221,851,000	\$214,836,000	(\$7,015,000)	-3.2%
Deductions From Revenue	54,712,000	58,406,000	3,694,000	6.8%
Net Patient Service Revenue	167,139,000	156,430,000	(10,709,000)	-6.4%
Other Operating Revenue				
Appropriation & Support	7,805,000	7,676,000	(129,000)	-1.7%
Other Revenue	7,004,000	6,832,000	(172,000)	-2.5%
Total Other Revenue	14,809,000	14,508,000	(301,000)	-2.0%
Total Revenue From Operations	181,948,000	170,938,000	(11,010,000)	-6.1%
Operating Expenses:				
Salaries	75,015,000	73,548,000	(1,467,000)	-2.0%
Fringe Benefits	18,144,000	17,725,000	(419,000)	-2.3%
Contract Compensation	11,663,000	11,710,000	47,000	0.4%
Supplies And Services	41,715,000	39,936,000	(1,779,000)	-4.3%
Utilities And Maintenance	6,891,000	7,167,000	276,000	4.0%
General Supplies & Expense	11,147,000	9,530,000	(1,617,000)	-14.5%
Insurance	1,086,000	1,076,000	(10,000)	-0.9%
Depreciation & Amortization	11,165,000	10,452,000	(713,000)	-6.4%
Interest	6,739,000	6,929,000	190,000	2.8%
Provision For Uncollectibles	1,761,000	1,846,000	85,000	4.8%
Total Operating Expenses	185,326,000	179,919,000	(5,407,000)	-2.9%
Net Revenue From Operations	(3,378,000)	(8,981,000)	(5,603,000)	
Nonoperating Gains: Investment Income	7,023,000	5,874,000	(1,149,000)	-16.4%
Revenue And Gains In Excess Of Expense	<u>\$3,645,000</u>	<u>(\$3,107,000)</u>	<u>(\$6,752,000)</u>	

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	10,873	10,495	(378)	-3.5%
Patient Days	87,878	82,223	(5,655)	-6.4%
Average Length Of Stay	8.1	7.8	(0.3)	-3.7%
Average Daily Census	408.7	382.4	(26.3)	-6.4%
Percentage Occupancy	71.0	67.2	(3.8)	-5.4%
Outpatient Encounters	202,159	198,223	(3,936)	-1.9%

MEMORANDUM

DATE: FEBRUARY 14, 1992

TO: MEMBERS, BOARD OF GOVERNORS

FROM: JOANNE DISCH, PH.D., RN *JD*
SENIOR ASSOCIATE DIRECTOR
DIRECTOR OF NURSING

RE: DIALYSIS SERVICES POLICIES AND PROCEDURES

Approval is requested for the following changes in the Organizational Summary and policies/procedures as required by the End Stage Renal Disease ESRD federal program guidelines.

1. Chart of Organization

. Joanne Disch, Ph.D., RN, is the appointed CEO with Jeanne Jacobson, MA, RN, as the Alternate CEO.

2. Policy Deletions-The following policies were deleted due to duplication with hospital-wide policies, incorporation into other dialysis policies or due to changes in practice within Dialysis Services.

a. Dialysis Leadership Team

. Policy #II.3, Interaction of Transplantation and Renal Services. Included with Scope of Care and Organizational Summary.

. Policy #II.4, Interdisciplinary Primary Care. Combined to form Pol. #III.8

. Policy #II.5, Completion and Updating Interdisciplinary Patient of the Care Plan. Combined to form Pol. #III.8.

. Policy #II.6, Care Plan/Long Term Progress. Combined to form Pol. #III.8.

. Policy #III.2, Consultation Process. Combined to form Pol. #III.8.

. Policy #III.5, Medical Records. Combined to form Pol. #III.8.

. Policy #III.6, Standing Orders Policy. Incorporated into Policy III.8.

. Policy #III.8, Following Shift Set-Up. Aspects of this policy are incorporated in the Principal Lab Technician job description.

. Policy #III.9, Long Term Program. Incorporated into Policy #III.8.

. Policy #III.11, Patient Team Rounds and Care Conferences Incorporated into Pol. #III.8.

. Policy #IV.5, Policy for Shunt Service Physicians, Deleted to reflect changes in Unit Practice.

. Policy #IV.12, Permanent Shifts in the Dialysis Unit. Delete due to nursing philosophy changes with Dialysis Services.

. Policy #IV.13, Vacation Policy-Dialysis. Deleted due to redundancy with Hospital Vacation Policy.

b. Infection Control

. Policy #VI.1 General Guidelines for Universal Blood and Body Substance Technique for the Kidney Dialysis Services. Deleted due to information found in Hospital UBBST Guidelines. Policy #VI.1 Hepatitis B Control in Dialysis. New policy developed to outline our specific infection control concerns.

. Policy #VI.2 and VI.3, Deleted and combined to form Policy #VI.1, Hepatitis B Control in Dialysis.

. Policy #VI.4 Non A-Non B Hepatitis Policy. Renumbered as Pol. #VI.3.

c. Emergency Procedures

. VII.2, Notifying the Physician of Patient Problems and Emergencies. (Deleted due to this being a Standard of Nursing Practice.)

. VII.3, Drugs and Equipment for Emergency Procedure. (Deleted due to this being a Standard of Nursing Practice.)

. IX.1, Safety: Dialysis Services. Deleted because the policy is outdated and does not reflect current hospital policy relative to patient safety.

3. Policy Revisions

II.1 Scope of Care and Organizational Summary

.Revised to indicate closure of pediatric dialysis unit and organizational structure.
.Integration of Unit Quality Assurance/Improvement Plan.

II.2 Philosophy, Responsibilities and Objectives - Dialysis Unit

.Edited to reflect current operations in Dialysis Services.

III.1 Chronic Maintenance Dialysis Adult and Pediatric

.Sentence removed defining specific intervals for hemodialysis.

III.2 Patient Selection Criteria

.Previously #III.13, Number changed to Pol. #III.2.

III.3 Admission Policy-Dialysis Services

.Changes made to reflect current practice and Assistan Nurse Manager duties with transient patients.
.Reflects transient patient management.

III.4 Transfer-Discharge Policy-Dialysis Services

.Policy clarified to reflect current practice

III.6 Dialysis Services Medical Advisory Committee/Medical Direction

.Connie Manske identified as Directory of Adult Peritoneal Dialysis.
.Previously #III.12, Number changed to Pol. #III.6.

III.7 Patient Rights and Responsibility

.Revised to reflect current position relative to Patient Rights and Responsibilities.

III.8 Patient Documentation

.New Procedure and Policy. This policy incorporates Pol. #II.4, Pol. #II.5, Pol. #II.6, Pol. #III.2, Pol. #III.5, Pol. #III.6, Pol. #III.9, Pol. #III.11.

III.10 Mobile Pediatric Dialysis

.Updated to reflect current Unit Procedure. Renumbered III.5

III.12 Dialysis Services Medical Advisory Committee/Medical Direction

.Updated to Reflect current Unit Activities. Renumbered III.6

IV.3 Role of Fellows and Residents for the Renal Unit

.Wording changed to say Dialysis Services.

IV.6 Nursing and Technician Coverage-Dialysis Services

.Changes in wording made to reflect current on-call status. Renumbered IV.5

IV.6 Training and assimilation of new employees

.Renumbered, was Pol. #IV.7

IV.7 Specifications for Performing Procedures

.Renumbered was Pol. #IV.8

IV.8 Guidelines for Technicians

.Renumbered, was Pol. #IV.9

IV.9 Charting by Kidney Dialysis Technicians

.Renumbered, was Pol. #IV.10

IV.10 On-Call Guidelines

.Change in Hospital Policy 33.16, Renumbered was IV.11

IV.14 Preparation and Connection of Equipment for Continuous Arteriovenous Hemofiltration (CAVH)

.Integrated with 4D Guidelines, Renumbered IV.11

VI.3 Hepatitis B Control in Dialysis

.Policy #VI.2 and VI.3, were integrated here. Renumbered VI.1

VII.2 Emergency Preparedness

.Renumbered was Pol. #VII.4.

SCOPE OF CARE AND ORGANIZATIONAL SUMMARY
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
DIALYSIS SERVICES

I. INTRODUCTION

The goals and objectives of the unit are aimed toward excellence in clinical practice, research, and patient education. The leadership and staff of Dialysis Services (DS) support the Hospital's mission and the Nursing Services' philosophy, policies, and procedures. The professional staff believes that each patient is a significant individual who is to be given holistic, individualized, comprehensive care as identified in the Standards of Care. Dialysis Services provides hemodialysis for the acute and chronic renal failure in neonatal, pediatric, and adult patients. Dialysis Services also provides training for home peritoneal dialysis.

II. PHYSICAL

Dialysis Services is located in two separate areas. The Hemodialysis Unit is located in the Mayo Building. This area is composed of seven cubicles and four rooms, with one room having an anteroom to be used for patient isolation. Each cubicle/room has wall connections to Reverse Osmosis water, television, and blood pressure equipment. Suctioning and oxygen are available and equipment can be set up in any cubicle or room as needed. There are two portable cardiac monitors available in the unit. A Standardized Hospital Arrest Cart with emergency drugs and equipment is available in the area. A disposable resuscitation device (DRD) is kept on the cart. A Hewlett Packard defibrillator is located next to the arrest cart.

Unstable ICU patients are dialyzed on their own unit in rooms with wall connection to dialysis quality water or utilizing batch tanks.

The Peritoneal Dialysis Training Area is located in the Mayo Building. This area is composed of two training rooms. The Peritoneal Dialysis room contains a training mannequin, cycling machines for CCPD, and a disposable resuscitation device is kept in the training area. The type of Peritoneal Dialysis used is tailored to patient needs and their home environment.

III. PATIENT POPULATION

The patients who are treated by Dialysis Services staff are composed of two types of patients - those in chronic renal failure (CRF) and those in acute renal failure (ARF). The critically ill adult and pediatric patients include but are not limited to, a diagnosis of:

1. Sepsis
2. Drug Overdose
3. Hyperammoniaemia
4. Hemolytic Uremic Syndrome (HUS)
5. Multisystem Failure

and recipients of:

1. Bone Marrow Transplant
2. Heart/Lung Transplant
3. Kidney/Liver Transplant
4. Kidney Transplant
5. Open Heart Surgery.

The Chronic Renal Failure population includes adults, pediatric patients with ESRD secondary to, but not limited to, the following diseases:

1. Diabetes
2. Glomerulonephritis
3. Hypertension
4. Polycystic Kidney Disease
5. Hydronephrosis
6. Congenital Bladder/Kidney Dysfunction
7. Drug-Induced Kidney Failure
8. IGA Nephropathy
9. Nephrotic Syndrome
10. Alport's
11. Post Strep-Glomerulonephritis
12. Focal Segmental Sclerosis
13. Wegner's Disease
14. Fabry's disease.

IV. SCOPE OF SERVICES

The scope of Dialysis Services at The University of Minnesota Hospital and Clinic include, but are not necessarily limited to, the provision of:

1. Dialysis treatment to patients with End Stage Renal Disease (ESRD).
2. Dialysis treatment to patients with Acute Renal Failure (ARF).
3. Dialysis treatment to transplant patients requiring supportive dialysis following a Renal Transplant.
4. Other extracorporeal perfusion techniques to patients requiring such (e.g., overdoses, exchange transfusions, etc.).
5. Training for Self Care Peritoneal Dialysis to any patients with ESRD.
6. Ongoing education and management of those patients on Self Care Peritoneal Dialysis.
7. Education and consultative support services to patient care areas at The University of Minnesota which house Peritoneal Dialysis.
8. Patient/family education.
9. Psychosocial support of family system.
10. Initial and ongoing nursing assessment of effects of dialysis treatment.
11. Pre and post assessment of treatment.
12. Nutritional support.

V. PATIENT CARE DELIVERY SYSTEM

The goals of this system include:

1. That every CRF patient has a nurse accountable for the provision of patient care.
2. That every CRF patient has an Interdisciplinary Team composed of a Primary Nurse, Social Worker, Dietician, and Physician who plan, implement, and evaluate the patient's care plan and long term program.
3. Direct Nurse to Physician, Social Worker and Dietician communication, and Nurse to Nurse communication for coordinated patient care.

The patient care delivery system for inpatients with renal failure follows the plan of care prescribed by dialysis physicians in conjunction with the patient's primary physician, and all health team members.

- A. The adult and pediatric renal fellows care for the hospitalized dialysis patients and chronic outpatients under the direct supervision of the attending physicians of the dialysis services. Physician coverage is provided 24 hours each day. This includes renal fellows and attending staff.
- B. The nursing staff includes a Nurse Manager, Assistant Nurse Manager, Senior Dialysis Technician, Charge Nurse, GSN, PLT, NST, NA, and a Staff Development Instructor who provides consultation to the Assistant Nurse Manager and assists with the coordination of orientation and continuing education of the staff. (See Nursing Services Narrative for role description.)

- C. Support services include Dietary Services which provides patient education on nutrition and special diets, and Social Services which provides assistance with nursing home placement, transportation, home health care/counselling, and financial concerns.

VI. ORGANIZATION

- A. Written policies and procedures specific to DS provide criteria for practice on the unit.
- B. The Medical Advisory Committee, composed of the Medical Directors, the Associate Director of Nursing, the Nurse Manager of DS, and the Chief Executive Officer, approve all policies and procedures for DS.
- C. The Medical Advisory Committee develops/approves guidelines for therapeutic interventions specific to DS.
- D. The DS Quality Assurance Council participates in department-wide monitors as well as unit-specific monitors based upon Important Aspects of Care.

VII. EDUCATION

All staff on DS are prepared for their responsibilities through Orientation, Inservices, and Continuing Education.

- A. All staff will receive Basic Orientation through Central Orientation.
- B. Unit Orientation is provided by the Assistant Nurse Manager, Staff Development Instructor, and DS Staff Mentors. Orientation includes completion of the following:
- 1) Technical Dialysis
 - 2) Basic Hemodialysis Nursing
 - 3) Acute Hemodialysis Nursing
 - 4) Pediatric Chronic and Acute Hemodialysis Nursing
 - 5) Peritoneal Dialysis Nurse Orientation to teaching Self Care Peritoneal Dialysis
 - 6) Competency exams covering theory and related to technical aspects of Dialysis, Hemodialysis Nursing (acute and chronic) of Adult and Pediatric patients.
- C. Special unit specific education will be provided by the Assistant Nurse Manager, Staff Development Instructor, and DS Staff Mentors. Annual retraining occurs in:
- 1) Electrical Safety
 - 2) Emergency Preparedness
 - 3) Basic Cardiac Life Support (BCLS)
 - 4) Infection Control (UBBST).
- D. Inservice education appropriate for unit needs is identified from QA Monitor results and observations. It is also identified by staff and leadership.

- E. Staff members, in addition, may elect to attend education modules of the Minnesota Association of Public Teaching Hospitals Education Program (MAPTH). Each staff member is also responsible for continued growth and development in dialysis nursing through self study and attendance at seminars and inservices both within and outside the hospital.

VIII. DIALYSIS UNIT QUALITY ASSURANCE/IMPROVEMENT PLAN

Statement of Purpose:

The Dialysis Services Unit (DSU) of the University of Minnesota Hospital and Clinic is dedicated to the principle of providing the highest quality of care through an interdisciplinary management approach. The DSU Quality Assurance/Improvement activities are designed to improve patient care and assure optimal treatment of the patient with acute and chronic renal failure. The purpose of this plan is to define the Quality Assurance/Improvement activities for the unit.

Authority and Responsibility:

The interdisciplinary group includes the following:

- * The Physician Director
- * The Associate Director of Nursing
- * The Nurse Manager
- * The Assistant Nurse Manager
- * The Nurse Coordinator for CAPD
- * The Senior Dialysis Technician
- * The Unit QI Council Chair
- * The Unit Social Worker
- * The Unit Dietician
- * The assigned QA/UR Specialist

Scope of Care:

The DSU provides hemodialysis to patients with acute renal failure and end stage renal disease (ESRD). Continuous ambulatory peritoneal dialysis (CAPD) is provided for a limited number of ESRD patients. Continuous arteriovenous hemofiltration (CAVH) is provided on consultative basis to acute patients on the intensive care units. All age groups are served. This plan is for adult population only. A separate plan exists for pediatric (under 18 years) population.

Delivery of the services is provided in a main hemodialysis unit (C-223 Mayo) for ESRD patients. Acute patients are dialyzed on the intensive care units and CAPD patients receive training while outpatients and receive post discharge follow-up from offices in C-252 Mayo.

Treatment of patients is provided by an interdisciplinary team of health care professionals including board certified nephrologist, dialysis nurses (RNs), social work, nutrition, and principal lab technicians.

The scope of services provided in the DSU includes but is not limited to patients with the following types of diagnoses/conditions:

- * Diabetic nephropathy resulting in ESRD
- * Acute and chronic glomerulonephritis
- * Polycystic disease
- * Nephrotic syndrome
- * Hypertensive nephropathy
- * Hemolytic uremia syndrome
- * Renal insufficiency secondary to intraoperative/postoperative ischemia
- * Pre kidney transplant patients
- * S/P renal transplant ATN
- * And others

Important Aspects of Care:

The important aspects of care for the DSU include but are not limited to the following:

Important Aspect of Care

Indicators

Maintaining the efficiency of hemodialysis

- Measurement of following/quarterly:
- * Time Averaged Concentration of Urea (TAC).
 - * Residual Clearance measured -
 - a) All new starts
 - b) All chronics annually.
 - * Fistula recirculation.

Maintaining the efficiency of CAPD

- * Monitor BUN/CR quarterly.

Treating anemia through EPO administration and P.O. iron

- * Comparison of pre-treatment Hgb and ferritin levels with post-treatment Hgb and ferritin - O/O change within ESRD definitions of stable (every 6 months) or unstable (every month).

Managing complications of hemodialysis

- Measurement of the following/ monthly:
- * Frequency of death, chest pain, arrhythmia, arrests, and MI during or immediately after dialysis.
 - * Frequency of CNS deficit during or immediately after dialysis.
 - * Frequency of septicemia, access infections.
 - * Frequency of other access complications.
 - * Frequency of pathological fractures.

Important Aspect of Care

Indicators

Managing complications of peritoneal dialysis

Measurement of the following/ monthly:

- * Frequency of peritonitis.
- * Frequency of failed catheters, failure to drain.

Every six months monitoring of water supply

Maintaining water quality

Monthly monitoring for bacteria.

Maintaining fluids and electrolytes

In conjunction with nursing quality improvement.

Minimizing or preventing complications of diabetes

In conjunction with nursing quality improvement.

Thresholds for Evaluation:

Thresholds will be established by the Medical Advisory Committee (MAC) of the DSU based on clinical literature and past experience.

Collecting and Organizing Data:

The data sources that will be used to identify problems and to monitor and evaluate the quality and appropriateness of services provided include but are not limited to the following:

1. Dialysis run record
2. Unit specific data collection forms
3. Concurrent medical record review
4. Medical records database (Corporate)
5. Incident reports
6. Lab data
7. Water quality data
8. CAPD records.

Findings to be Integrated into the Monitoring and Evaluation Process,

1992:

1. Infection Control findings
2. Pharmacy and Therapeutics Committee findings
3. Transfusion and Therapeutics Committee findings
4. Patient complaints
5. Findings from other monitoring and evaluation programs (e.g., MICU Advisory Committee).

A summary of selected clinical indicators for the unit will be completed monthly and forwarded to the intracollaborative group for review. Individual cases requiring review will also be reported on a monthly basis. All monitoring is ongoing and includes all patients treated in the DSU.

Evaluating Care:

A case-by-case analysis will be performed monthly. An analysis of the patterns or trends in the care suggested by the cumulative data will be performed at least quarterly. If a clinical indicator exceeds the established threshold, the care provided will be evaluated to determine whether a problem or opportunity to improve care exists.

Actions to Solve Identified Problems:

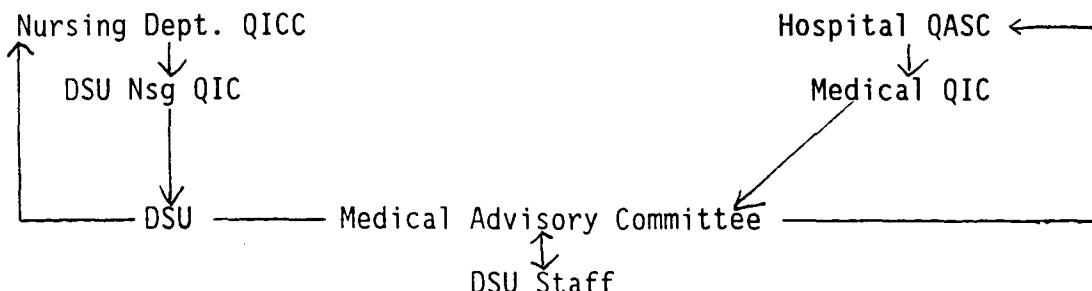
As problems or opportunities for improvement are identified, corrective action measures will be taken as appropriate. A summary of the findings, conclusions, recommendations, actions, and planned follow-up will be recorded on the Monitoring/Evaluation Report Form. (See Monitoring/Evaluation Form.)

Assessment and Documentation of the Effectiveness of Corrective Action Measures:

Assessment of the effectiveness of corrective measures will be carried out through additional monitoring. If, after additional monitoring, the quality or appropriateness of care in the specified area does not improve, then the problem, its cause, and the actions taken to solve it will be reassessed by the intracollaborative group. Additional action will be taken or recommended and the effectiveness of these new actions will be assessed. Follow-up findings and actions will be reported on the Monitoring/Evaluation Form.

Communication and Integration of Quality Assurance Information:

The findings, conclusions, and recommendations, actions and results of the DSU's quality assurance activities will be reported as follows:



As part of QASC's annual review, the effectiveness of the monitoring and evaluation activities of the DSU will be revised as necessary.

Confidentiality:

All data and information acquired and prepared for Quality Assurance activities are strictly confidential and are not considered discoverable or admissible in a court of law (protected under Minnesota State Statute 145.64). This data will be used, disseminated, or published on a need-to-know basis only to the extent required to effectively carry out Quality Assurance activities.

No person shall disclose to any individual, organization, or association, any Quality Assurance information that was discussed at any meeting or other review proceeding, except to the extent required to effectively perform those evaluation activities as set forth in Minnesota State Statute 145.61, Subdivision 5. Obviously, information, documents, or records otherwise available from original sources do not become confidential merely because they were utilized in connection with a Quality Assurance activity. (See Hospital Policy 15.16: Confidentiality Policy for Quality Assurance Information.)

Lucie Mankovsky
Medical Director, Adult Hemodialysis

Michael Mauer
Medical Director, Ped. Hemodialysis

Selma Beyer
Medical Director, Adult Peritoneal

Thomas Neuring MD
Medical Director, Ped. Peritoneal

Jeanne Dieck
Chief Executive Officer, ESRD

Jeanne Jacobson
Associate Director of Nursing

Date 2/6/92

Keith Hampton
Nurse Manager, Dialysis Services

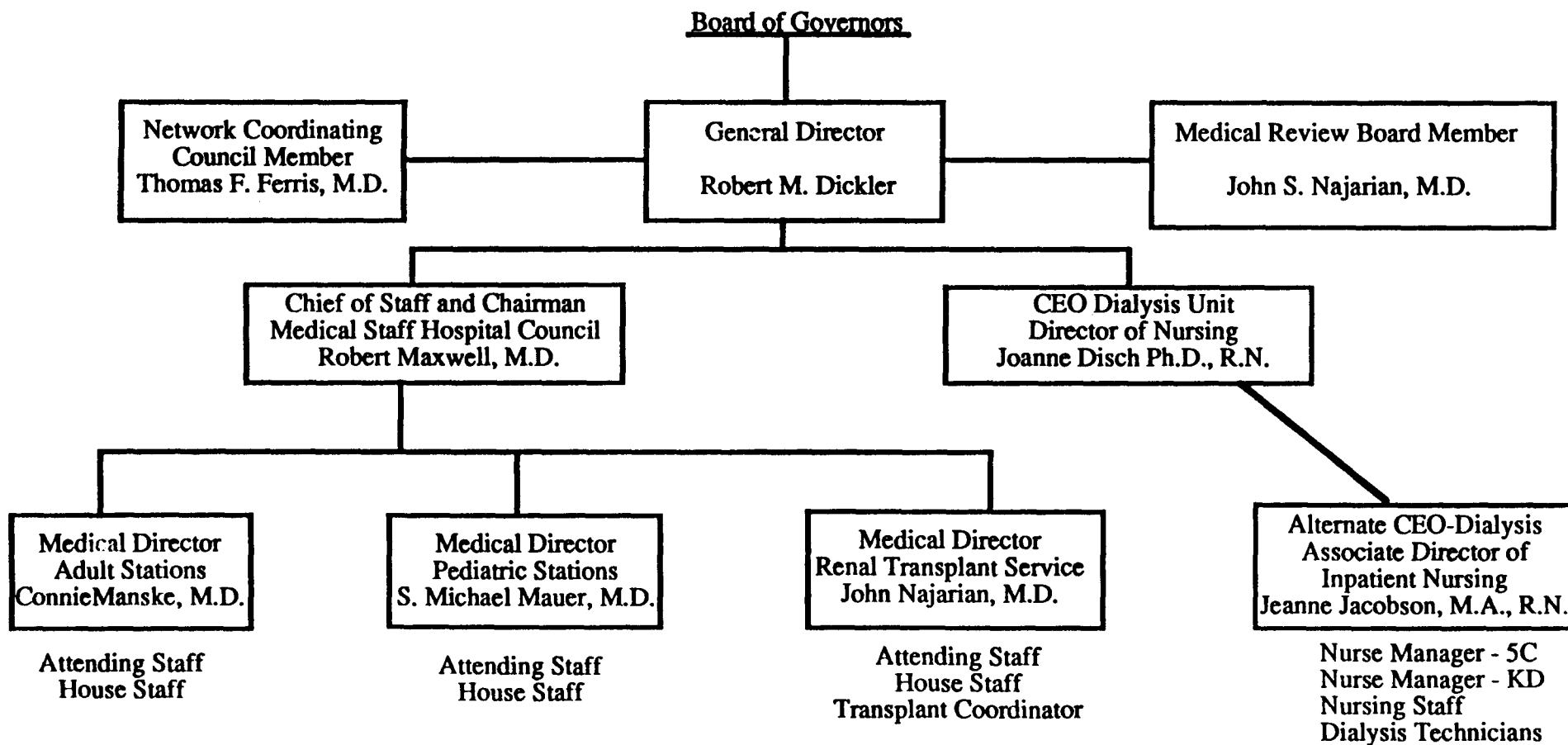
Revised 01/19/88
Revised 02/89
Revised 11/21/90
Revised 12/03/91
Revised 01/07/92
Revised 02/06/92

University of Minnesota Hospital and Clinic

Organizational Chart

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 6
VOL.:	POLICY NUMBER: II.2
EFFECTIVE:	6/83
REVISION:	6/83, 1/86, 12/87, 12/9
REVIEWED:	1/84, 1/85, 1/86, 12/87 1/89, 1/90, 1/91, 12/91

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.
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

kd1231877nm

APPROVED: <i>SM M... 1/23/92</i> (M...) TITLE: <i>Assoc Director</i>	DATE: <i>1/23/92</i> <i>Assoc Director of NSG</i>
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Real

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

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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. Inservice 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 Nurse Manager, Assistant Nurse Manager, Staff Development Instructor, Senior Dialysis Technician, Principal Lab Technician, General Staff Nurse, Secretary, Nursing Assistant, Nursing Station Technician

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 the Mayo Building. There are eleven operating stations certified for chronic hemodialysis. Capabilities for acute hemodialysis exist in the hospital as well as mobile hemodialysis units and peritoneal dialysis.

The patient care staff consists of a Nurse Manager, one Assistant Nurse Manager, Registered Nurses, one Senior Dialysis Technician, Technicians, Nursing Assistants, a Nursing Station Technician, and a Senior Secretary.

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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 Services is closed.

Chronic dialysis patients are evaluated every Dialysis by nurses and physicians. 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 being 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.

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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. Medical Staff (Staff Physicians and/or 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 (Unit Mentors). New personnel progress 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 substitutes.

Continuing Education for Nurses and Technicians is facilitated through the Education Council with support from the Staff Development Instructor and the Assistant Nurse Manager. Inservice Education is developed based upon a unit needs assessment. Physician continuing 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 associates. The actual performance of these procedures is done following a patient specific prescription.

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.

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SUBJECT: PHILOSOPHY, RESPONSIBILITIES, AND OBJECTIVE DIALYSIS	

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.

kd1231877nm

POLICY AND PROCEDURES MANUAL



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REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/90, 1/91, 12/91	

SUBJECT: CHRONIC MAINTENANCE DIALYSIS ADULT AND PEDIATRIC
SOURCE: Dialysis Leadership Team

POLICY

Chronic Maintenance Dialysis, both inpatient and outpatient, will be performed at the University of Minnesota Hospital and Clinic. The Dialysis Schedule will be arranged in order to accommodate employed patients, and those patients with transportation difficulties and/or school commitments.

In the event the patient load increases to the point that staffing becomes inadequate or space is not reasonably available, Chronic, Stable Dialysis patients may be asked to transfer to other renal units in the area who will coordinate.

A Continuous Ambulatory Peritoneal Dialysis (CAPD) Training Program is available in this facility for those patients who desire this modality. Patients will be referred elsewhere for Home Hemodialysis Training.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Patients Undergoing Transplant Work-ups	<ol style="list-style-type: none"> 1. Receive Dialysis at University of Minnesota Dialysis Services until work-up is complete or until they are transplanted. 2. Discharged to Dialysis unit close to their home if a long waiting period before transplantation occurs.
Nurse Manager or Assistant Nurse Manager in Cooperation with the Attending Physician(s)	<ol style="list-style-type: none"> 1. Arrange the transfer of Chronic, Stable Dialysis patients to other Dialysis units in the area, if staffing becomes inadequate or space is not reasonably available to handle the patient load.

KDU01/91.16nm

APPROVED: <i>[Signature]</i>	<i>[Signature]</i> , RN, MSN.	DATE:
TITLE: Medical Directors	Associate Director, Nursing	12-30-91

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VOL.:	POLICY NUMBER: III. 2	
EFFECTIVE:	3/84	
REVISION:	2/90	
REVIEWED:	2/86, 1/91, 12/91	

SUBJECT:	PATIENT SELECTION CRITERIA
SOURCE:	Dialysis Services Leadership Management Committee

POLICY

- I. The philosophy of the Dialysis Services is to accept anyone who is in need of treatment for Acute or Chronic Renal Failure. The interdisciplinary team is made up of social worker, dietician, hemodialysis nurses and/or peritoneal nurses, nephrologist, staff physicians, fellows, and residents. The interdisciplinary team works with each individual patient and family to assess the medical suitability, social and economic factors, psychological and emotional factors, and the rehabilitative potential of the patient.
- II. The available treatments for Acute and Chronic Renal Failure are inpatient and outpatient hemodialysis, inpatient peritoneal dialysis, and self care training for home peritoneal dialysis.
- III.
 - A. In accordance with Medicare regulations, no residents of a nursing home can be admitted to or be maintained by the UMHC peritoneal dialysis program. If a patient is admitted to the nursing home after he/she has been dialyzing at home, the team will consult with the patient and/or family to provide other dialysis options and care until such time as the patient is able to return home.
 - B. Patients unable to be adequately dialyzed at home, or who appear to need acute dialysis will be admitted to the hospital until the medical director has deemed them stable for home care.

KDU022290nm

APPROVED:	<i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i> <i>[Signature]</i>	DATE:	2-22-90
TITLE:	CEO MEDICAL DIRECTORS Associate Director, Nursing		

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EFFECTIVE: 1/79	
REVISION: 6/83, 1/86, 1/87, 1/91, 12/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91	

SUBJECT: ADMISSIONS POLICY - DIALYSIS SERVICES
SOURCE: Dialysis Leadership Team

POLICY

The philosophy of the Adult and Pediatric Dialysis programs is to consider everyone with Renal Failure for dialysis. Patients of any age, from newborn to the elderly, will be eligible for dialysis unless hemodialysis is medically contraindicated. Patients with End Stage Renal Disease and Acute Renal Failure are accepted in the Unit for treatment. The Medical Team will determine if the patient meets appropriate admission selection criteria.

Patients are referred to the Unit for dialysis by the Transplant Office, UMHC physicians, outside referring physicians or institutions, and other dialysis units.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Transplant Office	1. Refers patients for dialysis who are hospitalized for surgery, transplant work-up, and/or during evaluation for acceptance for transplantation.
University of Minnesota Hospital and Clinic Physicians - Medicine, Surgery, and Pediatrics	1. Refer patients for dialysis.
Other Dialysis Units (in and out of state)	1. Refer patients for dialysis.
Outside Referring Physicians or Institutions	1. Refer patients for dialysis.

KDU01/91.14nm

APPROVED: <i>[Signatures]</i>	DATE: 12-30-91
TITLE: Medical Directors Associate Director, Nursing	

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: III.
SUBJECT: ADMISSIONS POLICY - DIALYSIS SERVICES	

<u>Responsible Individual</u>	<u>Action</u>
Physician in Charge of Adult or Pediatric Dialysis	<ol style="list-style-type: none"> 1. Notifies Nurse Manager, Assistant Nurse Manager, or Charge Nurse of impending treatment. 2. Reviews patient's condition and plans the dialysis. 3. Writes patient's Initial Dialysis Orders.
Assistant Nurse Manager <i>* TRANSIENT PATIENTS</i>	<ol style="list-style-type: none"> 1. Takes referral call from Dialysis facility or individual. 2. Collects data. (See Attachment #1.) 3. Coordinates patient arrival with schedule availability and Medical ... 4. Confirms date by mailing confirmation letter. (See Attachment #2.)
KDU01/91.14nm	

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EFFECTIVE: 6/83	
REVISION: 6/83, 1/86, 5/87, 1/91, 12/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91	

SUBJECT: TRANSFER/DISCHARGE POLICY - DIALYSIS SERVICES
SOURCE: Dialysis Leadership Team

POLICY

When dialysis patients are transferred/discharged to other renal units, the dialysis team will facilitate the transfer of information to provide a smooth transition between units for the patient. Copies of pertinent information and correct dialysis data will be mailed/faxed to the new renal unit before transfer, or forwarded with the patient at the time of transfer.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Renal Fellow, Pediatric Renal Fellow, or Attending Physician	<ol style="list-style-type: none"> 1. Approaches the patient regarding the possibility of transfer. 2. Contacts the physician of the unit to which the patient is being transferred. 3. Writes and sends a discharge letter to the new facility.
Primary Nurse, Nurse Manager, or Assistant Nurse Manager	<ol style="list-style-type: none"> 1. Contacts the Nurse Manager of the unit to which the patient is being transferred. 2. Completes a Dialysis Interfacility Transfer Data form, copies the most recent dialysis records (up to three), the Dialysis Flow Sheet and Laboratory Sheet, and any other pertinent information. 3. Sends above information to new dialysis facility, or forwards information with the patient.

KDU01/91.13nm

APPROVED:	<i>Cecilia Thompson, RN, MSN</i>	DATE:
TITLE:	Medical Directors Associate Director, Nursing	12-30-91

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VOL.: POLICY NUMBER: III.5

EFFECTIVE: 8/85

REVISION: 5/87, 1/90, 1/91

REVIEWED: 1/86, 1/87, 1/88, 1/89,
1/91, 12/91

SUBJECT:

MOBILE PEDIATRIC DIALYSIS

SOURCE: Dialysis Leadership Team

POLICY

University of Minnesota Hospital and Clinic has contracted with St. Paul Children's Hospital (SPCH) and Minneapolis Children's Medical Center (MCMC) to provide off-site pediatric dialysis services on an as needed basis. Services shall include hemoperfusion, hemodialysis, and hemodialysis related care. Hemodialysis related care is defined as all activities necessary to the safe and efficacious delivery of dialytic therapy, such as, but not limited to, blood pressure regulation, body weight regulation, blood access maintenance, the monitoring of equipment and vital signs, and adjustments in dialysis medications.

Staffing

A Registered Nurse, Dialysis Technician, and Pediatric Nephrologist from the University of Minnesota Hospital and Clinic will provide dialysis care for each treatment. During normal hours of Dialysis Unit operation, a Nurse and Technician will be pulled from that shift to go to St. Paul Children's Hospital and/or Minneapolis Children's Medical Center. During On-Call hours, the On-Call Nurse and Technician will respond to requests for services.

Transportation

Employees providing care at off-site facilities will use their own vehicles for transportation. Mileage will be reimbursed between UMHC and the off-site facility and back at the rate of 21 cents per mile. Reimbursement will be made within two to four weeks.

Parking

A SPCH Courtesy Card has been issued to the Dialysis Unit which allows for free parking in the ramp on Smith Avenue. Maps describing the fastest routes to SPCH and the location of the ramp will be available. MCMC parking stickers will be provided for free parking on a daily basis by Pediatric ICU. Maps will also be provided describing fastest routes and ramp location by MCMC.

APPROVED:

Connie Maunula M.D.

Carol Auguste R.N., M.S.N.

DATE:

2/1/90

TITLE:

CEO

J.M. Quam
Medical Directors

Associate Director, Nursing

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VOL.:	POLICY NUMBER: III.5
SUBJECT: MOBILE PEDIATRIC DIALYSIS	

Supplies and Equipment

Supplies for treatment will be carried by the nurse and technician responsible for care. There will be one supply case equipped with all necessary supplies except the following:

- appropriate dialyzer
- appropriate blood lines
- appropriate bath and additives (i.e., CaCl, KCl, Bicarb, PO₄)
- emergency access
- arteriosonde (if appropriate)

An AK10 dialysis machine will be left at the mobile sites while need for dialysis treatments exists.

Forms

The Hemodialysis Record will look identical to the University of Minnesota Hospital and Clinic's record except that it will be labeled with SPCH or MCMC logo.

The Kidney Dialysis Charges/Credits slip will be completed at the remote site by the nurse, and a copy will be left with the remote facility.

Legal Aspects

As agents of the University of Minnesota Hospital and Clinic, the University of Minnesota Hospital and Clinic assumes full responsibility for the performance of all personnel involved in the delivery of remote care.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Nurse and Technician	<ol style="list-style-type: none"> 1. Complete dialysis treatment unless a significant portion (i.e., one hour or greater) of the treatment falls into the next shift or the 16-hour rule intervenes. 2. Request reimbursement for mileage by completing Mobile Pediatric Hemodialysis Program Mileage Reimbursement Record form, and forward it to Assistant Administrator for Kidney Dialysis. Sign form sent by AA and return to AA when completed.

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SUBJECT: MOBILE PEDIATRIC DIALYSIS	

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Nurse and Technician (continued)	<ol style="list-style-type: none"> 3. Follow UMHC Nursing Department Dress Code when performing off-site dialysis. 4. Bring two of the prescribed dialyzers and two sets of blood lines. Check with attending physician regarding access and bath. 5. Take the key to SPCH locked storage area. Key is kept in mobile equipment boxes. 6. Restock supply cases upon return to UMHC. 7. Bring arteriosonde with trans. cuff, and paste if deemed appropriate. 8. Complete <u>Hemodialysis Run Record</u>, and leave the original (white) in the patient's chart and bring the carbon (yellow) copy back. 9. Complete <u>Kidney Dialysis Charges/ Credit slip</u>, leaving white sheet at remote facility and bringing yellow and pink copies back. Staple yellow copy to <u>Hemodialysis Record</u>, and send pink copy to Medicare Supervisor, Patient Accounting, Box 602 Mayo. 10. Adhere to UMHC policies, procedures, and standards of care that govern the remote facility and the ICU.
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VOL.:	POLICY NUMBER: III.5
SUBJECT: MOBILE PEDIATRIC DIALYSIS	

<u>Responsible Individual</u>	<u>Action</u>
Pediatric Nephrologist from UMHC	<ol style="list-style-type: none"> 1. Orders appropriate dialyzer, blood lines, bath and access for patient at SPCH. 2. Is present for all off-site mobile dialysis treatments. If physician feels patient is stable, he/she may elect to leave with the nurse's agreement and will be available by long range beeper.
St. Paul Children's Hospital Staff	<ol style="list-style-type: none"> 1. Maintain water treatment equipment. Obtain cultures on a bimonthly basis. 2. Disinfect water treatment equipment on a bimonthly basis.
Minneapolis Children's Medical Center Staff	<ol style="list-style-type: none"> 1. Maintain water treatment equipment on a bimonthly basis.
University of Minnesota Hospital and Clinic	<ol style="list-style-type: none"> 1. Assumes full responsibility for the performance of all personnel involved in the delivery of remote care.
KD011990nm	

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VOL.:	POLICY NUMBER: III.6
EFFECTIVE: 11/87	
REVISION: 1/88, 1/90, 12/91	
REVIEWED: 1/89, 1/91, 12/91	

SUBJECT:

DIALYSIS SERVICES MEDICAL ADVISORY
COMMITTEE/MEDICAL DIRECTION

SOURCE: Dialysis Services Management

POLICY

I.

Medical Direction for Dialysis Services is provided by three Co-Directors each representing and responsible for a specialty area of medical practice.

Director - Adult Hemodialysis - Dr. Connie Manske
Director - Pediatric Hemodialysis - Dr. Michael Mauer
Director - Adult Peritoneal Dialysis - Sylvia Azar
Director - Pediatric Peritoneal Dialysis - Dr. Thomas Nevins

II. MANAGEMENT COMMITTEE

The Medical Directors and Unit Nursing Leadership Staff shall meet as often as necessary but not less than quarterly, to review activity, patient care services, policy, procedures, patient care standards, quality assurance issues, and discuss items that will enhance unit efficiency/quality of care. Minutes of these meetings shall be maintained.

The meetings are open to nursing and house staff members as well as attending physicians and other unit related professionals.

KDU0219903nm

APPROVED:

SM Man
TITLE:

Medical Directors

Connie Manske

Connie Manske, RN, MSN

Associate Director, Nursing

DATE:

12-30-91

SECTION:		Page 2 of 2
VOL.:	POLICY NUMBER: III.6	
SUBJECT:	DIALYSIS SERVICES MEDICAL ADVISORY COMMITTEE/ MEDICAL DIRECTION	

III. MEDICAL DIRECTORS' ROLE DESCRIPTION

1. The Medical Directors facilitate the overall direction and management of Dialysis Services.
2. The Medical Directors assure quality patient care on the patient care units.

The Directors assure that the quality, safety, and appropriateness of patient care services provided within the unit are reviewed and evaluated on a regular basis and that appropriate action is taken based on the findings of the review and evaluation activities.
3. The Medical Directors are involved in the development, approval, implementation, and evaluation of policies and procedures relating to patient care management of the unit.
4. The Medical Directors will arbitrate and act as final authority regarding interpretation of policies and procedures governing medical practice on the unit.
5. The Medical Directors are responsible for coordinating and implementing hospital and medical staff policies and procedures in the unit.
6. The Medical Directors review and approve, in consultation with nursing staff, clinical research protocols in the unit.
7. The Medical Directors consult with Nursing Leadership, and nursing staff, regarding unit operational matters.
8. The Medical Directors are responsible for providing education to house staff and nursing staff on the unit.
9. In the absence of the Medical Directors, a designee shall be appointed.
10. When necessary, the Medical Directors make decisions in consultation with the Renal Fellow and responsible physician, for the disposition of patients when patient load exceeds optimal operational capacity.

IV.

All policy changes are submitted annually to the program CEO and Board of Governors, University of Minnesota Hospital and Clinic, for approval.

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VOL.: POLICY NUMBER: III.7

EFFECTIVE: 1/79

REVISION: 6/83, 1/86, 4/87, 12/87, 2/89, 12/91

REVIEWED: 1/84, 1/85, 1/86, 1/87, 4/87, 12/87, 2/89, 1/90, 1/91

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:

1. The Dialysis Nurse gives the patient The University of Minnesota Hospital and Clinic Patient Rights and Responsibilities booklet and a packet of information from Network 11 (Renal Patient Bill of Rights and Responsibilities, Consumer Committee information, and Grievance form and procedure).
2. The Dialysis Nurse reads the Rights and Responsibilities to the patient if patient is visually impaired, or provides translator if language barrier exists.
3. The Dialysis Nurse answers questions patients and families may have regarding Rights and Responsibilities.
4. The patient will receive an appointment letter informing them of our scheduling procedure. This letter will be signed by patient and nurse. (See attached.)
5. The patient (or guardian, if patient is unable) signs his or her name to a statement indicating that he or she has received and understands the Rights and Responsibilities information and packet of information from Network 11.

KDU122691.1nm

APPROVED:

Kim Mauer

Conroy Heath

Jeanne Jacobson Interim

DATE:

TITLE:

Medical Director

Associate Director

12-30-91

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

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VOL.:	POLICY NUMBER: III.8
EFFECTIVE: 12/91	
REVISION:	
REVIEWED:	

SUBJECT: DIALYSIS SERVICES PATIENT DOCUMENTATION
SOURCE: Dialysis Leadership Team

POLICY

Documentation Standards for Use of Nursing Diagnosis-based Standards will be followed. Nursing Documentation Standards will be followed. (See Nursing Services Nursing Practice Manual.)

GOALS

1. To establish and implement with input from the patient, a plan of care that meets his/her physical, psychosocial, and dietary needs.
2. To establish and maintain a working rapport with the patient, in order to accurately assess his/her physical, psychosocial, and dietary status.
3. To establish and maintain channels of communication.
4. To become aware of and communicate specific patient needs to the appropriate service of the Health Care Team, e.g., Physician, Nursing Staff (both unit and hospital-wide), Dietician, and Social Worker.
5. To develop and implement a Patient Education Program specific to the patient.
6. To assist the patient in the establishment and attainment of realistic goals.
7. To promote active participation in health care by the patient.

KDU122691.2nm

APPROVED: <i>SM Maurer</i> <i>Amellich</i>	<i>Jeanne Jacobson Intieri</i>	DATE:
TITLE: Medical Director	Associate Director	12-30-91

SECTION: Page 2 of 4	
VOL.:	POLICY NUMBER: III.
SUBJECT: DIALYSIS SERVICES PATIENT DOCUMENTATION	

PROCEDURE

Initial Documentation

The Initiating Nurse will:

1. On first outpatient hemodialysis treatment give Patient Data Base to patient/family to complete. Instruct patient to bring back on next run.
2. At next treatment, review and complete with patient. Also review patient rights, patient schedule, emergency disconnect procedure.
 - Each patient or parent is to receive a University of Minnesota Patient's Rights Booklet and Renal Network Bill of Rights. Insure that the booklet is read by patient or parent (or nurse must read it to him/her). Have patient or guardian sign on the line provided at the bottom of the page to indicate that the information was received.

The nurse will:

1. Identify collaborative problems and nursing diagnoses. Initiate nursing diagnosis standards form(s) as appropriate. Obtain the chart form specific to that diagnosis. If a specific form is not available, a blank form should be used.
 - Based on interviews with patient, share the Care Plan with the patient and/or family. Seek input from patient and/or family in generating the Care Plan. Review patient's medication record.

Ongoing Documentation

1. Follow documentation standards for use of Nursing Diagnosis-based Standards.

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SECTION: Page 3 of 4	
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SUBJECT: DIALYSIS SERVICES PATIENT DOCUMENTATION	

PATIENT TEAM ROUNDS

Purpose:

Multidisciplinary Patient Team Rounds are held to evaluate, review, and update patient care plan.

Policy:

Interdisciplinary Team will consist of Physicians, Social Worker, Dietician, Dialysis Nurses. Additional information resources are included.

Procedure:

Stable hemodialysis outpatients will have their Care Plan reviewed in detail every six months during Patient Team Rounds. Unstable outpatients whose medical condition requires hospitalization for greater than 48 hours will have Care Plan reviewed at least monthly by Team Members.

All team members will:

- Review and update the Care Plan every six months or more frequently if there is a problem with the patient's status, during patient team rounds.
- Update dialysis orders, review lab findings, review current medications.

LONG-TERM PROGRAM

Purpose:

A major objective of the long-term program is to help the patient and his/her family achieve and maintain a meaningful life-style within the limitations of his/her illness and treatment. To assure that it represents the selection of the most suitable treatment modality (dialysis or transplantation) the long-term program should be based upon a medical, nutritional, and social evaluation of the patient.

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SECTION: Page 4 of 4	
VOL.:	POLICY NUMBER: III
SUBJECT: DIALYSIS SERVICES PATIENT DOCUMENTATION	

LONG-TERM PROGRAM (continued)

Standards of Performance:

1. A Long-Term Program will be formally completed and/or reviewed and revised in writing once a year or as often as indicated by the patient's response to treatment. The yearly review will include input from a variety of disciplines (listed below), including the patient, parent, or legal guardian.
2. When signed by all staff and the patient involved or his guardian, the Long-Term Program will be incorporated into the patient's medical record.
3. The following team members participate: Renal Fellow, Dialysis Attending M.D., Dietician, Social Worker, Nurse Manager, Assistant Nurse Manager, Staff Nurses, and the appropriate patient and/or his/her guardian or family. Additional information resources are included as necessary (representatives from nursing homes, rehabilitation therapy, consult services, etc.).

Considerations: (Nursing Staff and Health Team Members)

1. Will plan and lead patient care conferences with the interdisciplinary health team members, the patient, and his/her family (if available).
2. Informs the patient and/or family of the date of his/her care plan review. Extends an invitation for them to attend.
3. Give to the patient/patient's family a long-term program review document.
4. Will inform patient's family of outcome of program review. Patient/patient's family will sign review document if not present at conference.
5. Implement decisions after discussions with patient/patient's family if patient/family did not attend conference.
6. All team members will complete and sign review.

KDU122691.2nm

POLICY AND PROCEDURES MANUAL



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SECTION: Personnel Policies	
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EFFECTIVE: 3/79	
REVISION:	6/83, 1/84, 1/86, 1/87, 1/90, 12/91
REVIEWED:	1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91

SUBJECT: ROLE OF FELLOWS AND RESIDENTS FOR DIALYSIS SERVICES
SOURCE: Medical Directors - Adult and Pediatric Dialysis

POLICY

Pediatric and Adult Renal Fellows will, from time to time, have patient care responsibilities under the direction of the Medical Director and/or Attending Physician for that Dialysis Area. A current schedule of Physician Rotation and on-call rotation will be posted in each Dialysis Area.

PROCEDURE

I. Areas of Responsibility

<u>Responsible Individual</u>	<u>Action</u>
Connie L. Manske, M.D. S. Michael Mauer, M.D.	Medical Director, Adult Stations Medical Director, Pediatric Stations
Thomas H. Hostetter, M.D. Thomas F. Ferris, M.D. Mark S. Pallor, M.D. Karl Nath, M.D. Connie L. Manske, M.D.	Attending Physicians, Adult Stations
S. Michael Mauer, M.D. Thomas Nevins, M.D. - CAPD/CCPD Blanche Chavers, M.D. Clifford Kashtan, M.D.	Attending Physicians, Pediatric Stations
Silvia Azar, M.D. - CAPD/CCPD Barbara S. Daniels, M.D. Anthony C. Woolley, M.D. Mark E. Rosenberg, M.D.	Attending Physicians, Adult Stations

KD120591.2nm

APPROVED:	<i>S. Mauer</i>	<i>Cecilia Hargrave, RN, MSN</i>	DATE:
TITLE:	Medical Directors	Associate Director, Nursing	12-30-91

SECTION: Page 2 of 4	
VOL.:	POLICY NUMBER: IV.3
SUBJECT: ROLE OF FELLOWS AND RESIDENTS FOR DIALYSIS SERVICES	

II. Pediatric Renal Fellow Responsibilities

<u>Responsible Individual</u>	<u>Action</u>
Medical Director	Assigns the rotations of coverage which are approximately six months per year.
Pediatric Renal Fellow	<ul style="list-style-type: none"> - Attends daily rounds conducted by the Attending Physician every weekday at 9:00 a.m. and 4:00 p.m. - Attends the Friday Patient Review Conference at 12:00 noon. - Carries a hospital pager while on duty and a long-range pager when on call. - Manages patient care of the pediatric dialysis patient with the direct assistance of the Attending Physician for the first three weeks. - After the first three weeks, manages patient care of the pediatric dialysis patient independently. Daily rounds will continue. - With input and corroboration of the Nurse Manager and/or Assistant Nurse Manager, makes arrangements concerning patient schedules, written orders, notifies unit of patient problems, and informs staff of admissions. - During rounds, examines patients, sets finishing weights, sets ideal hematocrits, orders laboratory tests and blood products, resolves dialysis related care problems, and writes necessary orders on the order sheet.

KD120591.2nm

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SUBJECT: ROLE OF FELLOWS AND RESIDENTS FOR DIALYSIS SERVICES	

<u>Responsible Individual</u>	<u>Action</u>
Pediatric Renal Fellow (continued)	<ul style="list-style-type: none"> - Makes monthly notes regarding the patient's condition. - During dialysis, is available to solve problems not left up to nursing judgment, rearranges schedule with Nurse Manager and/or Assistant Nurse Manager, is present when acutely ill patients arrive, and is available by pager for needed changes. - Reports off to the Resident on call at the end of the day.
III. Green (Renal) Medicine Resident Responsibilities	
<u>Responsible Individual</u>	<u>Action</u>
Green (Renal) Medicine Resident	<ul style="list-style-type: none"> - Cares for renal patients on the ^{Green} (Renal) Medicine Service under the guidance of the Green Medicine Attending Physician. - Coordinates and completes transplant work-ups. - Correlates the management of the renal dialysis patient with the Dialysis Attending Physician. - Discharges patients with chronic renal failure and/or dialysis patients and arranges their follow-up. - Sends a discharge summary and registers the patient with the Transplant Office on patients who are discharged after a Transplant Work-up. - Presents potential transplant recipients at the Friday Patient Review Conference.

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SUBJECT: ROLE OF FELLOWS AND RESIDENTS FOR DIALYSIS SERVICES	

IV. Renal Fellow - Consultation Responsibilities

Renal Fellow on Consultation

- Attends the following conferences:
 - * Nephrology Conference every Tuesday - 4:30 to 5:30 p.m.
 - * Renal Clinics and Clinic Conference every Tuesday - 1:00 to 5:00 p.m.
 - * Journal Club every Wednesday at 4:30 p.m.
- Alternates call with other fellows to cover the Dialysis Unit and CAPD from 5:00 p.m. to 8:00 a.m. on weekdays and 5:00 p.m. Fridays to 8:00 a.m. on weekends.
- Answers all requested Renal Consults for adult services.

V. Renal Fellows - Dialysis Responsibilities

<u>Responsible Individual</u>	<u>Action</u>
Renal Fellow in Dialysis	<ul style="list-style-type: none"> - Attends conferences as outlined above for Renal Fellow on Consultation. - Alternates call as described above. - Coordinates the management of patients requiring dialysis with the Dialysis Attending Physician. - Participates in the therapy plan for patients with acute or chronic renal failure.

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies	
VOL.:	POLICY NUMBER: IV.6
EFFECTIVE: 6/83	
REVISION: 1/86, 8/87, 1/88, 1/89, 1/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/90, 1/91, 12/91	

SUBJECT: TRAINING AND ASSIMILATION OF NEW EMPLOYEES
SOURCE: Dialysis Leadership Team

POLICY

Orientation for the new Registered Nurse trainee will be approximately two to three months. During this time the trainee will learn to operate dialysis and dialysis related equipment, nursing care of the chronic adult and pediatric dialysis patient, and nursing care of the acutely ill adult and pediatric dialysis patient.

Following didactic sessions and skills lab orientation with the Staff Development Instructor, the new employee's clinical experience will start with the dialysis of chronic, stable adult patients. Gradually, as dictated by the new employee's progress, care of more acutely ill adult and pediatric patients will be introduced. The Assistant Nurse Manager and employee's mentor will evaluate the new employee's progress on an ongoing basis. The new employee will proceed at a pace consistent with her/his increasing expertise.

During the orientation process, the Assistant Nurse Manager will communicate with the Nurse Manager on the new employee's progress.

When orientation is complete, the new RN staff member will be assigned a normal rotation of hours (a.m., p.m., and weekends).

Independent assignment will be made based on the individual's level of expertise and ability by the Nurse Manager, Assistant Nurse Manager, or Charge Nurse. Gradually, assignments will be increased to include a higher level of acuity and a more varied cross-section of patients.

When the new employee has worked in the Dialysis Unit for six months, Nursing Leadership will determine if the new employee is clinically ready to be placed on the call rotation. New RNs will not be teamed with new technicians on call.

Orientation for the technician trainee will be approximately two to three months. During this time the trainee will learn to operate, prepare, and maintain dialysis and dialysis related equipment.

APPROVED: <i>Louise Mamba MD</i>	<i>Carol Stangor, RN, MSN</i>	DATE: 2/4/90
TITLE: <i>LM</i>		
Medical Director	Medical Director	Associate Director, Nursing

SECTION: Page 2 of 3	
VOL.:	POLICY NUMBER: IV.
SUBJECT: TRAINING & ASSIMILATION OF NEW EMPLOYEES	

Clinical experience for the new technician will start with the set-up of equipment for chronic, stable adult patients, under the guidance of a trained technician. Gradually, as dictated by the trainee's progress, set-up of equipment for more acutely ill adult and pediatric patients will be introduced. The trainee's progress will be evaluated on an ongoing basis and the trainee will proceed at a pace consistent with his/her increasing expertise.

When orientation is complete, the new technician staff member will be assigned a normal rotation of hours (a.m., p.m., and weekends).

Independent assignment will be made based on the individual's level of expertise and ability. Gradually, assignments will be increased to include more stations and more difficult set-ups and break reliefs.

When the new employee has worked in the Dialysis Unit for six months, the Nurse Manager and/or Assistant Nurse Manager will meet with the Senior Dialysis Technician to determine if the new employee is clinically ready to be placed on the call rotation. New technicians will not be teamed with new RNs on call.

In the training of new employees, experienced Dialysis Staff will be utilized as Mentors, and all clinical experiences will be closely observed and supervised until the trainee exhibits competency.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
New RN and Technician Trainees	<ol style="list-style-type: none"> 1. Participate in Dialysis orientation program until competency is displayed. 2. Assume a normal rotation of hours (a.m., p.m., and weekends) when orientation is complete. 3. Take call after six months in Dialysis.
Dialysis RNs and Technicians	<ol style="list-style-type: none"> 1. Serve as mentors to train new employees as requested.

KDU01/91.11nm

SECTION: Page 3 of 3	
VOL.:	POLICY NUMBER: IV.6
SUBJECT: TRAINING & ASSIMILATION OF NEW EMPLOYEES	

Responsible Individual

Action

Senior Dialysis Technician

1. Assists in coordination of technician trainee's orientation.
2. Provides input regarding independent assignments for new technicians.
3. Provides input regarding new technician's readiness for taking call.

Assistant Nurse Manager

1. Coordinates and assists in orientation of new dialysis RNs and Technicians.
2. Evaluates new employee's progress on an ongoing basis.
3. Communicates with Nurse Manager on progress of new employees.
4. Determines new employee's readiness to be placed on the call rotation.

Nurse Manager

1. Communicates with Assistant Nurse Manager throughout new employee's orientation regarding progress.
2. Determines employee's readiness to be placed on the call rotation, with the Assistant Nurse Manager.

KDU01/91.11nm

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies Page 1 of 2	
VOL.:	POLICY NUMBER: IV.7
EFFECTIVE: 3/79	
REVISION: 12/79, 6/83, 1/86, 4/87, 1/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91	

SUBJECT:

**SPECIFICATIONS FOR PERFORMING
PROCEDURES (NURSES AND TECHNICIANS)**

SOURCE: Dialysis Leadership Team

POLICY

Dialysis nurses and technicians may independently perform certain procedures specific to the Dialysis Unit. Competency in performance of these procedures must first be demonstrated by completion of the dialysis nurse and/or technician orientation programs.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Nurse	<ol style="list-style-type: none"> 1. Withdraws blood for laboratory tests from dialysis lines and access devices. 2. Performs clotting times. 3. Performs venipuncture. 4. Connects and disconnects the patient for treatment. 5. Performs chronic, acute, and pediatric dialysis according to written Standing Orders and Procedures. 6. Administers IV fluids/medications according to the Standing Orders and Hospital Policy. 7. Recirculates or discontinues dialysis when it appears unsafe for the patient.

KDU01/91.10nm

APPROVED: <i>Connie Hauke MD</i>	<i>Carol Engstrom</i>	DATE: 2/4/91
TITLE: <i>SM</i>		
Medical Director	Medical Director	Associate Director, Nursing

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: IV.10
SUBJECT: SPECIFICATIONS FOR PERFORMING PROCEDURES (NURSES AND TECHNICIANS)	

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Technician	<ol style="list-style-type: none"> 1. Withdraws blood for laboratory testing from dialysis lines. 2. Performs clotting times. 3. Performs venipuncture after he/she has been taught and observed for competence and understanding. 4. Dialyzes stable adult patients when finished with nursing orientation, as assigned by the Assistant Nurse Manager. 5. Connects and disconnects stable patients as assigned by the Charge Nurse. 6. Infuses normal saline, 5% albumin on assigned patients or patients on whom they are relieving under the direction of a Registered Nurse. 7. Infuses normal saline/heparin solution provided it has been prepared and hung by the nurse. 8. Infuses back blood and blood products providing they have been checked and hung by the nurse. 9. Infuses 25% serum albumin under the direction of a Registered Nurse. 10. Assists the nurse with stable, acute and pediatric dialysis after orientation.

KDU01/91.10nm

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies Page 1 of 2	
VOL.:	POLICY NUMBER: IV.8
EFFECTIVE: 9/83	
REVISION: 1/86, 9/87, 1/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91	

SUBJECT: GUIDELINES FOR TECHNICIANS DIALYZING PATIENTS
SOURCE: Dialysis Leadership Team

POLICY

Except in extreme situations or emergencies, the following guidelines will be followed by the Charge Nurse when assigning technicians to perform dialysis. Extreme situations or emergencies are defined as, but not limited to, the following: addition of patients to the schedule for unplanned emergency or acute dialysis, high number of sick calls.

PROCEDURE

Responsible Individual

Technicians, under the supervision of an RN

Action

1. May be assigned to dialyze stable, chronic, adult dialysis patients who are either inpatients or outpatients.
2. Dialyzes stable, chronic, pediatric dialysis patients who weigh over 20 kg.
3. Relieves an RN for coffee breaks and lunch breaks, on stable, chronic adult dialysis patients, uncomplicated post surgical patients, or stable, acute renal failure patients.
4. Relieves an RN on stable, chronic pediatric dialysis patients over 15 kg.

KDU01/91.9nm

APPROVED: <i>Cornie Mander MD</i>	<i>Cassidy Anguine RN, MSN</i>	DATE: 2/4/91
TITLE: <i>MD</i>	<i>MD</i>	
Medical Director	Medical Director	Associate Director, Nursing

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: IV. 8
SUBJECT: GUIDELINES FOR TECHNICIANS DIALYZING PATIENTS	

Responsible Individual

Action

Technicians, under the supervision
of an RN (continued)

5. Relieves an RN on stable, chronic pediatric patients who are under 15 kg, but at least 10 kg, only when a nurse is dialyzing a patient in the adjoining cubicle.
6. May be assigned one stable adult in addition to dialyzing a pediatric patient.
7. Will not dialyze patients in the following situations:
 - a) When a vasoactive drip is being administered.
 - b) When the patient's condition requires continual nursing assessment.
 - c) When a patient requires continual medications.
8. Inserts fistula needles into the fistula of a patient.

KDU01/91.9nm

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies Page 1 of 1	
VOL.:	POLICY NUMBER: IV.9
EFFECTIVE: 9/76	
REVISION: 6/83, 1/85, 1/86, 6/87, 12/87, 1/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 1/88, 1/89, 1/90, 1/91, 12/91	

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 UDOC system after orientation to data collection and the policies. A DAIR 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 DAIR note, and sign his/her name to indicate awareness of the technician's charting.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Dialysis Technician	<ol style="list-style-type: none"> 1. Collects data on assigned patients. 2. Writes DAIR note pre-dialysis, describing patient's condition, complaints, and plan of care for the dialysis treatment.
Charge Nurse	<ol style="list-style-type: none"> 1. Reads and reviews charting completed by Dialysis Technician. 2. Signs name to DAIR note.

KDU01/91.8nm

APPROVED: <i>Connie Mander MD</i>	<i>Carol Engstrom</i>	DATE: 2/4/91
TITLE: <i>MD</i>	<i>MD</i>	
Medical Director	Medical Director	Associate Director, Nursing

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies Page 1 of 3	
VOL.:	POLICY NUMBER: IV.10
EFFECTIVE: 6/83	
REVISION: 1/84, 8/84, 1/86, 1/87, 12/87, 1/91, 12/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87, 12/87, 1/89, 1/90, 1/91, 12/91	

SUBJECT: ON-CALL GUIDELINES
SOURCE: Dialysis Leadership Team

POLICY

New employees are assimilated into the Call Schedule 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.

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.

kd1231879nm

APPROVED: <i>S. M. Mauer</i> <i>C. Mauer</i> <i>Cecilia Augusto, PhD, MSN</i>	DATE:
TITLE: Medical Directors Associate Director, Nursing	12-30-91

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Nurse and Technician On-Call	<ol style="list-style-type: none"> 1. Carries a long range beeper when away from home. 2. Reports to the Unit within one hour when called in.
Nurse On-Call	<ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. Staff anticipate exceeding 16 consecutive hours of work. b. The number of patients to be dialyzed exceeds: <ol style="list-style-type: none"> 1. One acute patient 2. One pediatric patient 3. Three stable chronic pts.

kd1231879nm

SECTION: Page 3 of 3	
VOL.:	POLICY NUMBER: IV.10
SUBJECT: On-Call Guidelines	

<u>Responsible Individual</u>	<u>Action</u>
The Resource Nurse	<ol style="list-style-type: none"> 1. Contacts other dialysis staff to come in to assist. 2. Contacts the Nurse Manager, and then the Assistant Nurse Manager if the Nurse Manager is not available.
Dialysis Physician On-Call	<ol style="list-style-type: none"> 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	

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Personnel Policies	
VOL.:	POLICY NUMBER: IV.11
EFFECTIVE: 9/9/87	
REVISION: 12/87, 1/91, 12/91	
REVIEWED: 12/87, 1/88, 1/89, 1/91, 12/91	

SUBJECT: PREPARATION AND CONNECTION OF EQUIPMENT FOR CONTINUOUS ARTERIO-VEINUS 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

<u>Responsible Individual</u>	<u>Action</u>
Nephrologist or Renal Fellow	<ol style="list-style-type: none"> 1. Contacts the Charge Nurse in the 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 ICU Nurse during the patient-blood pathway connection.
Charge Nurse - Dialysis (if during regular working hours)	<ol style="list-style-type: none"> 1. See Attachment #1. 2. Completes CAVH Initial Connect Flowsheet (Attachment #2).

kd1230871nm

APPROVED: <i>S. Mauer</i> (Mauer) <i>Carol Engquist, RN, MSN</i>	DATE:
TITLE: Medical Directors Associate Director, Nursing	12-30-91

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: IV. 11
SUBJECT: PREPARATION & CONNECTION OF EQUIPMENT FOR CAVH	

Responsible Individual

Action

Charge Nurse - ICU (if during
Dialysis Unit on-call hours)

1. Transcribes the doctor's orders.
2. Reviews orders with the Dialysis RN/Technician.

Dialysis Technician

1. Sets up and prepares the necessary equipment for CAVH.

The Individual RN Who Terminates
the CAVH Treatment

1. Completes CAVH Daily Charge Assessment (Attachment #3).

kd1230871nm

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Infection Control	
VOL.:	POLICY NUMBER: VI. I
EFFECTIVE: 5/82	
REVISION: 6/83, 12/91	
REVIEWED: 1/84, 1/85, 1/86, 1/87 1/88, 1/89, 1/90, 1/91 12/91	

SUBJECT:

HEPATITIS B CONTROL IN DIALYSIS

SOURCE: Dialysis Leadership Team

POLICY

The Dialysis Unit will follow the Hospital Policy and Procedures Manual, Procedure Number 33.6, with regard to Hepatitis B surveillance. All patients who permanently dialyze in this facility will be offered the Hepatitis B vaccine, but are not required to be immunized.

PROCEDURE

Responsible Individual

Action

New patients on dialysis
(chronic or acute)

- Screened for Hepatitis B (HBsAg and anti-HBs) at their first dialysis and then once per month during their period of treatment in this facility.

Patients presenting for dialysis
who have dialyzed elsewhere

- Present Hepatitis B status prior to their first dialysis in this facility when possible. If patient has not been screened for Hepatitis B within the past month, blood will be obtained for screening at the first treatment here and then once per month during their period of treatment in this facility.

KD120591.lnm

APPROVED:

B. Mauer (Maur)

C. H. ...

DATE:

TITLE:

Medical Directors

Associate Director, Nursing

12-30-91

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: VI. 1
SUBJECT: HEPATITIS B CONTROL IN DIALYSIS	

Dialysis patients who have been vaccinated with Heptavax B virus

- Screened for HBsAg and anti-HBs every month during the administration of the vaccine, and every six months thereafter.

Patients who refuse the Hepatitis B vaccine

- Screened for HBsAg and anti-HBs every month.

POLICY

The Dialysis Unit will provide surveillance in regard to Hepatitis B for Dialysis Services personnel. All staff will be offered the Hepatitis B vaccine, but are not required to be immunized (Policy 33.6).

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Nurse Manager, Assistant Nurse Manager	<ol style="list-style-type: none"> 1. Instruct new staff members to have base line Hepatitis testing done in their first week of employment. 2. Offer Hepatitis B vaccine to new employees.
Nurse Manager	<ol style="list-style-type: none"> 1. Posts list every six months of employees who need repeat testing.
Employee	<ol style="list-style-type: none"> 1. Reports every six months to Employee Health for Hepatitis screening (e.g., January/July). See Table 13 attached.

KD120591.1nm

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Emergency Preparedness	
VOL.:	POLICY NUMBER: VII.2
EFFECTIVE: 8/88	
REVISION: 1/91	
REVIEWED: 1/90, 12/91	

SUBJECT: EMERGENCY PREPAREDNESS - DIALYSIS SERVICES
SOURCE: Nurse Manager - Dialysis Fire and Safety Committee

POLICY

Insure that proper precautions, care, and safety are taken for kidney dialysis patients and personnel during an emergency within the hospital system.

PROCEDURE

<u>Responsible Individual</u>	<u>Action</u>
Fire Warden/Charge Nurse	<ol style="list-style-type: none"> 1. Instructs staff to rinse back and move the patient nearest the alarming smoke detector out of the immediate area. 2. Instructs staff to clamp and disconnect patient lines if fire or smoke is present. 3. Evacuates staff and patients to adjoining zone if fire or smoke is present.
Dialysis Services Staff	<ol style="list-style-type: none"> 1. Rinse back and move patient in area where alarm is sounding but no smoke or fire is noted. 2. Clamp and disconnect dialysis lines to each patient. 3. Remove patients from fire hazard zone. 4. Monitor patients' vital signs.

KDU01/91.6nm

APPROVED: <i>Carol Hagman, RN, MSN</i>	<i>George Mauer, MD</i>	DATE: 2/4/91
TITLE: Associate Director, Nursing	Medical Directors	

SECTION: Page 2 of 2	
VOL.:	POLICY NUMBER: VII.2
SUBJECT: EMERGENCY PREPAREDNESS - DIALYSIS SERVICES	

Responsible Individual

Action

Fire Warden/Charge Nurse

1. Instructs staff to return patients to dialysis area.
2. Inspects dialysis equipment for damage.

Renal Fellow and Charge Nurse

1. Evaluate each patient.
2. Decide for each patient if:
 - a) treatment must be restarted;
 - b) blood products need to be given.

KDU01/91.6nm

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

February 26, 1992

TO: Board of Governors
FROM: Robert Dickler
General Director
SUBJECT: Interstate Medical Center

As part of the closing process for the acquisition of Interstate Medical Center, the Board of Governors is required to approve the annual budget (inclusive of the compensation plan) for the New Interstate Medical Center.

The attached documents are the proposed 1992 operating budget balance sheet and cashflow statement of Interstate Medical Center, and a summary of the 1992 compensation plan.

The Board of Directors of the New Interstate Medical Center approved this budget and the compensation plan on February 21, 1992, and the University of Minnesota members of that board, Mr. Al Hanser, Clifford Fearing and myself are recommending them to you for your approval.

The remaining steps to closing the acquisition of the clinic are targeted for completion by March 2, 1992.

RD/sw

**INTERSTATE MEDICAL CENTER, P.A.
SUMMARY OF PHYSICIAN COMPENSATION FORMULA
EFFECTIVE WITH 8/15/91 PAYROLL**

The new pay system is production based, with all full-time physicians participating at the same percentage of bookings. The physicians are separated into two groups, primary-care providers (includes Family Practice, Internal Medicine, and Pediatrics) and specialty departments (includes General Surgery, Orthopedics, Ophthalmology, Urology, and OB/Gyn).

In this production system Fee For Service (FFS) bookings net of discounts and allowances and gross HMO bookings are used as the production base (no credit is given for lab and x-ray bookings). A percentage is applied to actual FFS (currently 50.2%) and actual HMO (currently 28%) bookings based on fiscal year-end (year-ended 5/31/91) production figures. These computed salary figures are used as the annual gross base pay for the coming "salary-year" (8/1/91 to 7/31/92). The actual percentages used in the pay-formula may vary from year to year depending on actual overhead changes or significant production changes. These percentages will be reviewed and set by the compensation committee and board of directors each year.

While the computation above establishes the salary for the specialty departments, the primary-care departments calculated salaries go into a primary-care salary pool. This salary pool is divided among the providers with 80% of the pool dollars being shared equally and the remaining 20% being allocated based on total production. The total production used for this allocation gives equal weight to HMO bookings and FFS (net) bookings.

All provisions in the current compensation system are subject to modifications as directed by the board of directors of Interstate Medical Center; and, the total compensation for all physicians cannot exceed 125% of the weighted average of the median salary of the annual physician productivity and salary survey prepared by McGladery & Pullen.

Salary increases for non-physicians averaged 5.6% for the 1992 calendar year.

**INTERSTATE MEDICAL CENTER (NewCo)
COMPARATIVE SUMMARY INCOME STATEMENT**

	-----NewCo-----		-----The Interstate Medical Center, P.A.-----		
	10 Months PROJECTED 12/31/92	12 Months PROJECTED 12/31/92	Budget Fiscal Year 5/31/92	Audited Fiscal Year 5/31/91	Audited Fiscal Year 5/31/90
REVENUE:					
Net FFS	\$ 7,876,500	\$ 9,434,000	\$ 9,757,000	\$ 9,116,487	\$ 8,889,741
Net HMO	2,514,607	3,018,200	3,026,600	3,052,109	2,428,558
Other Income	337,636	382,400	275,800	266,769	216,395
TOTAL INCOME	\$10,728,743	\$12,834,600	\$ 13,059,400	\$ 12,435,365	\$ 11,534,694
EXPENSES:					
Human Resource	\$ 7,608,343	\$ 9,197,400	\$ 9,401,400	\$ 9,268,852	\$ 8,135,673
Physical Resource	1,492,483	1,790,150	1,799,573	1,817,707	1,828,662
Purchased Service	622,216	749,600	753,800	705,751	596,721
General & Administrative	563,818	674,200	763,500	666,553	643,112
TOTAL EXPENSES	\$10,286,860	\$12,411,350	\$ 12,718,273	\$ 12,458,863	\$ 11,204,168
NET INCOME/(LOSS)	\$ 441,883	\$ 423,250	\$ 341,127	\$ (23,498)	\$ 330,526
Non-Physician Expenses	\$ 6,020,193	\$ 7,217,950	\$ 7,301,873	\$ 7,334,878	\$ 6,626,125
Physician Salary	\$ 3,360,000	\$ 4,050,000	\$ 4,255,000	\$ 4,175,387	\$ 3,713,926
Physician Benefits	\$ 906,667	\$ 1,143,400	\$ 1,161,400	\$ 1,148,598	\$ 864,117
Net Income/(Loss)	\$ 441,883	\$ 423,250	\$ 341,127	\$ (23,498)	\$ 330,526

INTERSTATE MEDICAL CENTER (NewCo)
 PROJECTED BALANCE SHEET
 March 1, 1992 and December 31, 1992

MJL
 2/19/92

ASSETS	Beginning BALANCE 3/1/92	PROJECTED BALANCE 12/31/92
-----	-----	-----
CASH	\$ 2,550	\$ 230,896
ACCOUNTS RECEIVABLE (net of allowance)	\$ 0	\$1,700,000
PROPERTY & EQUIPMENT (net of deprec.):		
Real Estate	\$ 2,600,000	\$3,500,000
Equipment & Furniture	1,284,286	1,664,286
Leasehold Improvements	85,000	85,000
Vehicle	4,000	4,000
Less: Accumulated Depreciation	0	(229,583)
OTHER ASSETS:		
Prepaid Expenses	\$ 130,000	\$ 195,000
MMIC Stock & Surplus	110,000	110,000
Notes Receivable	38,000	38,000
Supplies Inventory	138,450	138,450
Intangible Assets	260,000	260,000
	-----	-----
TOTAL ASSETS	\$ 4,652,286	\$7,696,049
	=====	=====
LIABILITIES & SOLE MEMBER'S EQUITY		

CURRENT LIABILITIES:		
Property Taxes Payable	\$ 0	\$ 118,283
Accounts Payable	0	100,000
Accrued Income Taxes (Assumed to be Exempt)	0	0
Accrued Wages	145,000	125,000
Accrued Referral & Network Liability	320,000	320,000
Payroll Taxes Payable	0	70,000
Accrued Retirement Plan Contributions	0	479,167
DEBT OBLIGATIONS:		
Mortgage Note Payable	\$ 2,600,000	\$2,500,587
Equipment Notes Payable	988,286	1,117,129
Capital Leases (Assumed from IMC)	385,000	260,000
Working Capital Loan	0	950,000
Building Project	0	1,000,000
SOLE MEMBER'S EQUITY	\$ 214,000	\$ 655,883
	-----	-----
TOTAL LIABILITIES & SOLE MEMBER'S EQUITY	\$ 4,652,286	\$7,696,049
	=====	=====

ERSTATE MEDICAL CENTER (NewCo)
 STATEMENT OF CASH FLOWS
 Ten Months Ending 12/31/92

MJL 2/19/92

	NEWCO 10 Months ENDING 12/31/92
CASH SOURCES:	

Net Income	\$ 441,883
Non-Cash Expenses:	
Depreciation	\$ 229,583
Cash From Financing:	
Working Capital Loan	\$ 1,750,000
FYE 92 Capital Budget Financing	\$ 230,000
Building Project Financing	\$ 1,000,000
Increase in Current Liabilities	\$ 750,000
Equity Contributions:	
3/1/92 - Initial Physician Payments	\$ 418,000
TOTAL CASH SOURCES	\$ 4,819,466

CASH USES:	

Capital Expenditures:	
FYE 92 Capital Equipment Budget	\$ 255,000
Building Project	\$ 1,025,000
Payment of Debt Principal:	
Mortgage Note Payable	\$ 99,413
Equipment Notes Payable	\$ 101,157
Capital Leases (Assumed from IMC)	\$ 125,000
Working Capital Loan	\$ 800,000
Building Project	\$ 0
Increase in Receivables	\$ 1,700,000
Increase in Prepaid Expenses	\$ 65,000
Other Distributions:	
3/1/92 - Initial Physician Payments	\$ 418,000
TOTAL USES OF CASH	\$ 4,588,570

NET CASH FLOW	\$ 230,896
BEGINNING CASH BALANCE	\$ 0

ENDING CASH BALANCE	\$ 230,896
	=====

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

APRIL 22, 1992

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
 BOARD OF GOVERNORS
 APRIL 22, 1992
 2:30 P.M.
 RADISSON METRODOME HOTEL
 REGENTS ROOM

AGENDA

			<u>Page</u>
I.	<u>Approval of the February 26, 1992 Minutes</u>	Approval	1
II.	<u>Chairman's Report</u>	Information	
III.	<u>Hospital Director's Report</u>	Information	
IV.	<u>Special Presentation: Kamil Ugurbil, Ph.D.</u>	Information	5
	-Director of Center for Magnetic Resonance Research		
V.	<u>Committee Reports</u>		
A.	<u>Consent Items</u>		
	<u>Planning and Development Committee</u>		
	1. March 25, 1992 Minutes	Information	15
	2. Quarterly Purchasing Report	Approval	19
	3. Major Capital Expenditure Reports:	Information	
	-Surgical Laser		26
	-MRI Upgrade Diagnostic Radiology		27
	<u>Finance</u>		
	1. March 25, 1992 and February 26, 1992 Minutes	Information	28
	2. Third Quarter, 1991-92 Bad Debts	Approval	34
	<u>Joint Conference Committee</u>		
	1. February 25, 1992 Minutes	Information	64
	1. Medical Staff-Hospital Council Report	Approval	67
	Credentials Committee Recommendations		
	2. Annual Review of Home Health Care Services	Approval	71
	3. Quality Assurance Steering Committee Report and Recommendations	Approval	80
B.	<u>Planning and Development Committee</u>		
	-Mr. David Lentz		
	1. BMT Program - stem cell project	Information	86
	2. Strategic Planning Update	Information	

C. Joint Conference Committee

-Ms. Margaret Matalamaki

1. No items requiring Board deliberation

D. Finance Committee

-Ms. Nellie Johnson

- | | | | |
|----|--|-------------|-----|
| 1. | March 31, 1992 and February 29, 1992
Financial Statements | Information | 101 |
| 2. | 1992/93 Budget | Information | |
| 3. | Renewal Project | Information | 114 |

VII. Other Business

VIII. Adjournment

MINUTES

BOARD OF GOVERNORS The University of Minnesota Hospital and Clinic

February 26, 1992

Call To Order

Ms. Kristine Johnson called the February 26, 1992 meeting of the Board of Governors to order at 1:00 p.m. at the Radisson Hotel Metrodome.

Attendance

Present: Robert Anderson, M.D.
Leonard Bienias
David Brown, M.D.
Robert Dickler
Phyllis Ellis
Robert Erickson
Maria Gomez
S. Albert Hanser
Terence Hill
B. Kristine Johnson
Nellie Johnson
Arthur Kydd
Margaret Matalamaki
Robert Maxwell, M.D.
John Morrison
Kristine Zualkernan

Not Present: Michael Dougherty
David Lentz
Roby Thompson, M.D.

Approval of Minutes

The Board of Governors seconded and passed a motion to approve the minutes of the January 22, 1992 meeting as submitted.

Chairman's Report

Ms. Kris Johnson introduced and welcomed Dr. Robert Anderson, Vice President for Health Sciences.

Ms. Johnson presented Ms. Cherie Perlmutter, Interim Health Sciences Vice President, with a gift and plaque recognizing his participation as a member of the Board of Governors.

Director's Report

Mr. Robert Dickler encouraged the Board of Governors to attend the University of Minnesota Alumni Association Annual Meeting on April 29, 1992 with Garrison Keillor as guest speaker.

Mr. Dickler reported on the status of the proposal to separate the University's Health Insurance from the State which was presented to the Board of Regents at their March meeting.

Mr. Dickler reported that discussions are continuing with Riverside Medical Center regarding development of joint obstetrical and neonatal services.

Mr. Dickler reminded the members of the Board of Governors to turn in their self-evaluation surveys.

Mr. Dickler presented an update on the University Hospital Renewal Project. Due to the Hospital's negative financial results for the first 7 months of 1991/92, plans for the Renewal Project Phase II will be modified.

Consent Agenda

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

- a. Medical Staff-Hospital Council Report
Credentials Committee Recommendations
- b. End Stage Renal Disease Program
- c. Quarterly Capital Expenditure Report
- d. January 22, 1992 Finance Committee Minutes

Planning and Development Committee

Mr. Dickler, representing the Planning and Development Committee, called on Ms. Helen Pitt to present the EMTEK system.

The bedside clinical information system (EMTEK) is proposed for expansion to the Medical and Pediatric Intensive Care Units. The system has been operating in the Surgical Intensive Care Unit since late 1990 and has resulted in reduced operating expenses. The capital expenditure associated with this project is \$950,000 over five years with \$108,000 for installation. The Board of Governors seconded and passed a motion to approve the proposed expansion of the EMTEK System.

Finance Committee

Ms. Nellie Johnson called on Mr. Cliff Fearing to give the monthly financial report. Mr. Fearing reported that the Hospital's Statement of Operations for the period July 1, 1991 through January 31, 1992 shows expenses being greater than revenues by \$3,107,000, an unfavorable variance of \$6,752,000.

Mr. Fearing reported inpatient admissions for January totaled 1,553 which was 42 below budgeted admissions of 1,595. Overall average length of stay for the month was 7.8 days. Outpatient clinic visits for the month of January totaled 29,737 which was 579, or 1.9% more than budgeted visits of 29,185.

Ms. Nellie Johnson presented to the Board, for approval, the proposed 1992 budget and compensation plan for the new Interstate Medical Center (IMC).

The Interstate Medical Center Board of Directors, Robert Dickler, Cliff Fearing, Al Hanser, Dr. Tom Witt, Dr. Robert Schulenberg, and Ellen Dunn, approved this budget and compensation plan at their first board meeting on February 21, 1992. Ms. Johnson stated that the acquisition of IMC provides a significant opportunity for the University and UMHC to provide greater opportunities for education, research, and service to the Greater Minnesota community and the Red Wing region. The Board of Governors seconded and passed a motion to approve the proposed budget and compensation plan for Interstate Medical Center.

Adjournment

There being no further business, the February 26, 1992 business meeting of the Board of Governors was adjourned at 1:50 p.m.

Respectfully submitted,



Gail A. Strandemo
Board of Governors Office

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 17, 1992

TO: Members of the Board of Governors

FROM: Shannon Lorbiecki
Secretary to the Board of Governors

We are pleased to welcome Dr. Kamil Ugurbil as our enrichment speaker this month. Kamil is Director of the Center for Magnetic Resonance Research.

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

/gs

KAMIL UGURBIL • CURRICULUM VITAE • 03/92

Center for Magnetic Resonance Research
 University of Minnesota Medical School
 385 East River Road • Minneapolis, MN 55392
 612-626-7007 (Phone) • 612-626-7005 (FAX)

Personal Data

Birthdate: July 11, 1949

Education

1971 A.B. Columbia College, Columbia University (Physics)
 1974 M.A. Columbia University (Chemistry)
 1976 M. Phil. Columbia University (Chemistry)
 1977 Ph.D. Columbia University (Chemistry)

Academic Appointments

1977 - 1979 Postdoctoral Fellow Bell Laboratories
 1979 - 1982 Assistant Professor Biochemistry Department, Columbia University
 1982 - 1986 Associate Professor Dept. of Biochemistry, and Gray Freshwater Biological Institute, U of MN
 1986 - 1991 Full Professor Departments of Biochemistry, Radiology, and Medicine and
 Gray Freshwater Biological Institute, University of Minnesota
 1991 - Director Center for Magnetic Resonance Research, U of MN Medical School

Appointments on Advisory and Editorial Boards

1988 - National Magnet Lab, Massachusetts Institute of Technology
 1987 - 1989 Center for Nuclear Imaging Research (CNIR), University of Alabama
 1987 - NMR in Biomedicine, Journal Editorial Board
 1988 - Trustee of the Society of Magnetic Resonance in Medicine
 1989 - Biochemical Journal, Journal Editorial Board

Honors and Awards

1973 - 1974 Columbia University, Graduate Faculties Alumni Scholar
 1976 - Recipient of Hammett Award for original and distinguished research
 1980 - 1982 Irma T. Hirschl Career Scientist Award
 1983 - 1988 NIH Research Career Development Award

Area of Research

Application of high resolution nuclear magnetic resonance (NMR) spectroscopy to intact biological systems.

Professional Societies

Biophysical Society
Biochemical Society
The Society of Magnetic Resonance in Medicine

Grants and Awards

NIH (R01 HL26089; P.I., K. Ugurbil)	07/01/80 - 06/30/83	\$ 118,524
NIH (1K04 HL4201; P.I., K. Ugurbil) (Career Development Award)	12/01/83 - 11/30/88	\$ 226,000
NIH (R01 HL33600; P.I., K. Ugurbil)	12/01/84 - 11/30/89	\$ 473,294
NIH (R01 HL33600; P.I., K. Ugurbil)	12/01/89 - 11/30/94	\$ 57,934
NIH (S10 RR02751; P.I., K. Ugurbil) (Instrumentation Grant)	01/01/86	\$ 300,000
NIH (S10 RR03358-01; P.I., K. Ugurbil) (Instrumentation Grant)	05/87	\$ 300,000
NSF (DMB 8614031) (Instrumentation Grant)	1988	\$ 200,000
NIH (1S10 RR04762-01; P.I., K. Ugurbil) (Instrumentation Grant)	1989	\$ 225,000
NIH (1P01 HL32427) (within this PPG, the budget for the project headed by K. Ugurbil is \$1,010,244)	12/86 - 11/91	\$ 3,847,534
NIH (1P01 HL32427) (within this PPG, the budget for the project headed by K. Ugurbil is \$1,508,976)	09/91 - 09/96	\$ 5,196,632
NIH (R01 HL21872) (P.I. R.J. Bache, K. Ugurbil 20% Effort)	03/91 - 11/93 (renewed)	
NIH (1F32 HL07438) (NRSA for Dr. Zimmer under sponsorship of K. Ugurbil)	06/86 - 05/88	\$ 54,000
NIH (R29 HL42168; P.I. Peter Kingsley-Hickman)	12/88 - 11/93	\$ 342,889
NIH (1F32 HL07618) (NRSA for Dr. Lew under sponsorship of K. Ugurbil)	06/86 - 06/88	\$ 29,004
NIH (R01 HL26640; P.I., J. Foker)	12/01/86 - 11/31/91	\$ 837,890
Association for Brain Tumor Research; P.I. Brian Ross	06/87 - 06/90	\$ 60,000
American Cancer Society; P.I. Brian Ross	06/89 - 06/90	\$ 8,700
American Heart Association	09/86 - 08/88	\$ 24,000
University of Minnesota Support for 4 Tesla project; P.I., K. Ugurbil	1989	\$ 4,500,000
Keck Foundation	1992	\$ 875,000
NIH (1S10RR0706-01) (Instrumentation Grant)	1992	\$ 400,000

MINUTES
Planning and Development Committee
Board of Governors
March 26, 1992

Attendance:	Present:	Leonard Bienias Robert Dickler S. Albert Hanser Greg Hart Clint Hewitt Terrance Hill John LaBree, M.D. David Lentz Peter Lynch, M.D. Ted Thompson, M.D.
	Absent:	William Jacott, M.D.
	Staff:	Fred Bertschinger Giles Caver Mark Koenig
	Guests:	Mary Sumpmann Lou Vietti

CALL TO ORDER

Mr. David Lentz called the meeting to order at 11:10 a.m.

APPROVAL OF MEETING MINUTES

The minutes of the joint meeting of the Finance Committee and Planning and Development Committee on February 26, 1992 were approved as submitted.

STRATEGIC PLANNING UPDATE

Mr. Robert Dickler provided an update regarding the Hospital's joint strategic planning process with the Medical School. Mr. Dickler said the external consulting team was completing the first of three phases. The first phase entailed several weeks of intense data collection and processing and included extensive interviews with UMHC administrators and medical staff, as well as interviews with other hospital administrators, physician group practice leaders, and health insurers.

Mr. Dickler said the consulting team will organize a retreat on Saturday, March 28 for the Executive Coordinating Committee and other select Hospital administrators and medical staff members. The retreat will focus on the Hospital and Medical School's strategic challenges and alternatives. The process itself should be completed by August 1992.

Mr. Dickler said he will provide another update regarding the strategic planning process at the April 1992 meeting.

QUARTERLY PURCHASING REPORT AND VALUE ANALYSIS

Mr. Mark Koenig presented the quarterly purchasing report for October-December 1991. Total purchase order activity was \$17,766,129. This amount represents a decline from July-September 1991 and reflects the general decline in patient volume.

Mr. Koenig also introduced Mr. Lou Vietti who presented a description and the results of the Value Analysis Program. Mr. Vietti said the program helps identify potential savings in non-salary expenses by assessing the cost, performance, patient need, and value to the Hospital of various purchase items. During the first year of the program, over \$1.6 million in savings was identified.

ONCOLOGY MARKETING CAMPAIGN

Mr. Robert Dickler introduced Ms. Mary Sumpmann, director of the Hospital's Cancer Center. Ms. Sumpmann presented the Cancer Center's marketing campaign as a vehicle to increase market share in oncology. The marketing campaign includes direct mailing, educational programs, and a telephone information hot-line, as well as television, radio, and print media advertisement.

RIVERSIDE MEDICAL CENTER

Mr. Greg Hart presented an update regarding the Hospital's proposed transfer of neonatal intensive care services to Riverside Medical Center. Riverside has more obstetrical deliveries than any other local hospital, but it lacks a Level 3 NICU. The Hospital has a Level 3 NICU but does not have many obstetrical deliveries. Mr. Hart said physicians and administrators at the Hospital and Riverside are meeting and discussing issues regarding financing, operations, medical affairs, and human resources.

Mr. Hart also said he hopes to present a proposal to the Committee this summer.

RENEWAL PROJECT UPDATE

Mr. Robert Dickler presented an update regarding the Renewal Project. Mr. Dickler said the plans for the Renewal Project are being down-sized by about \$12 million. He also said the Hospital was proceeding with plans to upgrade facilities for psychiatry and urologic surgery.

Mr. Dickler said he hopes to present a revised time schedule and budget for the Renewal Project at the next Committee meeting.

DEVELOPMENT OFFICE UPDATE

Mr. Fred Bertschinger presented an update regarding Development Office activity. Mr. Bertschinger said the Development Office has sponsored several fund-raising activities during the past several months and intends to sponsor several more during 1992.

Mr. Bertschinger also presented an financial update for the Development Office. With a fund-raising goal of \$1.2 million for Fiscal Year 1991-92, the Development Office generated donations of \$552,522 during July-December 1991.

UMCA UPDATE

Dr. Peter Lynch provided an update regarding UMCA's contracting activities. Dr. Lynch said UMCA is pursuing new contractual agreements with Preferred One and Ethix, and is close to finalizing an agreement with Medica to provide primary care services to any and all state employees.

Dr. Lynch also said UMCA is crafting a bid with other providers and insurers to provide tertiary care services to the Business Health Care Action Group, a coalition of 14 of the largest employers in Minnesota.

OTHER BUSINESS

Mr. Robert Dickler provided an update regarding other business items. Mr. Dickler said he, Mr. Cliff Fearing, and Mr. Al Hanser had had several board meetings at Interstate Medical Center in Red Wing. These meeting have focused on issues related to budgeting, strategic planning, and facilities planning.

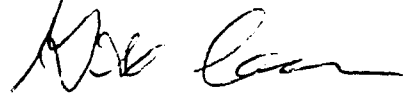
Mr. Dickler also said the Minnesota health care access bill is quickly passing through House and Senate committees and will probably become law next month. Mr. Dickler said the bill might affect current Hospital projects, and he is preparing documentation to support current activities.

Finally, Mr. Dickler said Dr. Phil McGlave will begin working on a new bone marrow stem cell project and will require Hospital funding. Mr. Dickler reported that due to some timing and space imperatives, facility remodeling for the project has already been initiated. A full proposal for the project will be brought forward in one or two months.

ADJOURNMENT

There being no further business, the Planning and Development Committee meeting was adjourned at 12:46 p.m.

Respectfully submitted,



Giles Caver
Administrative Fellow

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 17, 1992

TO: Members, Board of Governors
FROM: Greg Hart
RE: Quarterly Purchasing Report

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

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

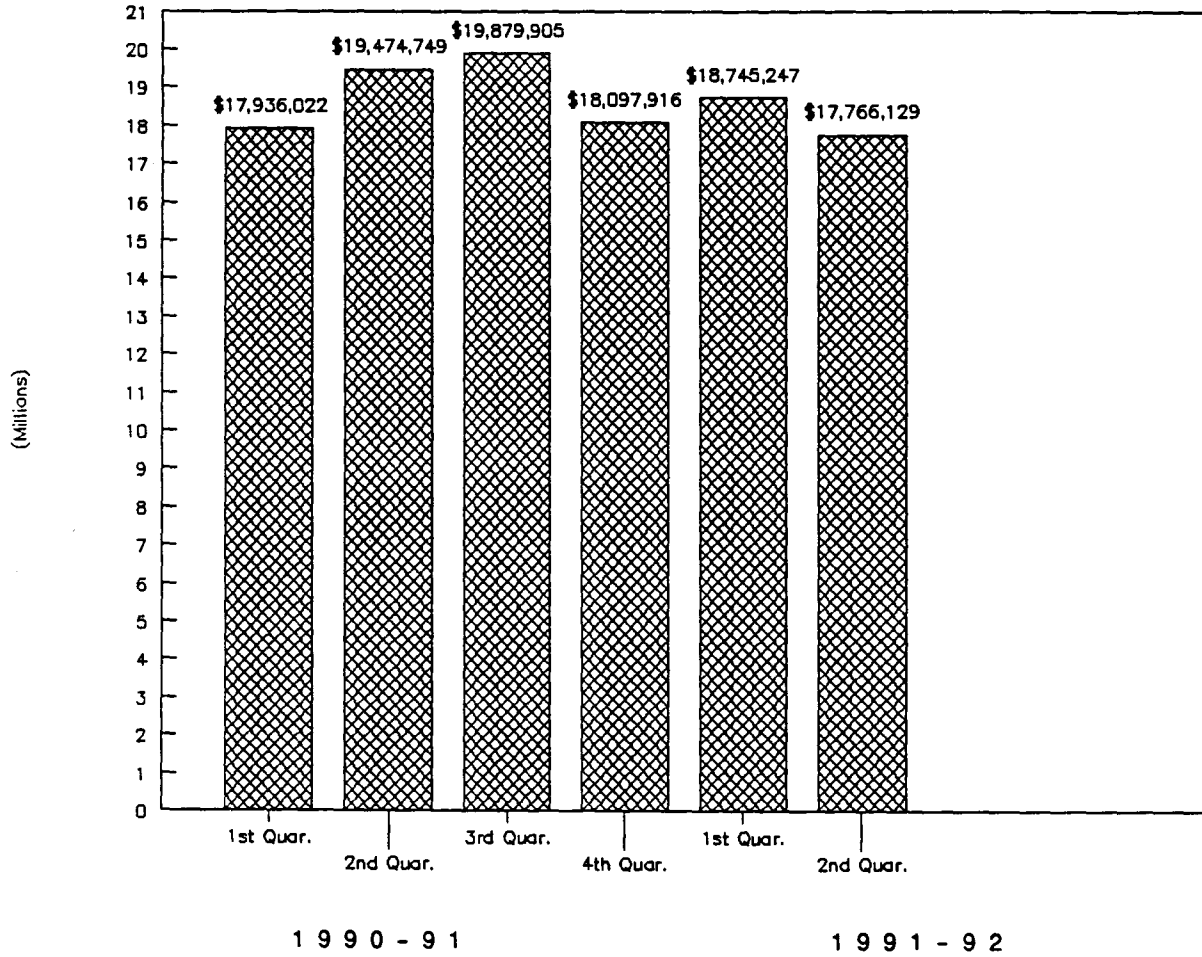
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Attachments

**UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY
PERIOD OF OCTOBER - DECEMBER 1991**

- I. PURCHASE ORDER ACTIVITY
- II. AWARDS TO OTHER THAN APPARENT LOW BIDDER
- III. SOLE SOURCE ACTIVITY
- IV. VENDOR APPEALS

PURCHASE ORDER ACTIVITY



SECOND QUARTER, FISCAL YEAR 1991-92, ACTIVITY:

	<u>NUMBER</u>	<u>VALUE</u>
PURCHASE ORDERS	7672	\$15,427,623.64
OTHER PAYMENTS	323	\$1,580,449.64
CONFIRMING ORDERS	<u>338</u>	<u>\$758,055.63</u>
TOTAL THIS QUARTER	<u><u>8,333</u></u>	<u><u>\$17,766,128.91</u></u>

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

<u>ITEM</u>	<u>UNSUCCESSFUL VENDOR/AMOUNT</u>	<u>SUCCESSFUL VENDOR/AMOUNT</u>	<u>DEPARTMENT</u>
1. Introducers	Medline \$ 15,158.40	Medix/3M \$ 16,144.00	Materials
	The product does not adhere to the degree necessary to provide maximum wound closure.		
2. Dressing, Kerlex 4" x 4"	Sherwood \$ 38,844.00	Kendall \$ 45,360.00	Materials
	The product has a loose weave which results in less stretch, and therefore poor wrapping potential. Also the fraying ends of the dressing could contaminate the wound and lead to infection.		

III. SOLE SOURCE-\$5,000 and Over

<u>VENDOR</u>	<u>CONTRACT/PO P.O. #</u>	<u>VALUE</u>	<u>DEPT.</u>	<u>PRODUCT</u>
Danek	91-603	Open	O.R.	Spinal Implants
Target Therapeutics	H121889	\$8,355.00	Radiology	Guidewires & Trachs
Balt Extrusion	H121888	\$14,428.00	Radiology	Guidewires & Trachs
U.S. West	H119359	\$46,332.00	Pl. & Mktg.	Advertising
Bentley Labs	91-573	\$12,030.00	Labs	Anti Coag & Aspiration Assays
Vitek Systems	91-585	\$48,762.60	Labs	Kits
Sanofi Diagnostics	91-590	\$10,869.80	Labs	Kits
MN Department of Health	H121673	\$13,000.00	Labs	Neonatal Screening Forms
Northern X-Ray	H444748	\$19,200.00	Radiology	Reassemble CGR
Micro Vena	H444758	\$6,650.00	Radiology	Catheters
Peripheral	H444759	\$14,160.00	Radiology	Atherocath
North Central Instruments	H121651	\$6,809.00	Labs	Rotary Microtome
Philips Medical	H121663	\$16,568.00	Radiology	Monitor Suspension Upgrade
SW Biomedical Electronic Inc	H119339	\$13,500.00	Cardio-Resp	Bedside Monitors
Interventional Therapeutics	H446630	\$15,209.00	Radiology	Catheters
Smith & Nephew	92-73	Open	Pharmacy	Pharmaceuticals
Synthes Max	91-623	Open	O.R.	Implantable Maxillofacial Products
Advanced Tech Labs	H122627	\$6,900.00	Radiology	Ultra Mark 9 System Upgrade
* Keomed	H122630	\$252,760.00	Cardio-Resp	Anesthesia Gas Machines
Cobe Gambro Hospal	H122646	\$41,500.00	Labs	Apheresis System
Vittek System	H122665	\$37,000.00	Labs	Immunodiagnostic Assay System
Medical Alliance	H122672	\$47,000.00	Cardio-Resp	Ventilator
Dictaphone	H122669	\$49,340.00	Med Records	Dictating Equipment Upgrade
* Quantum Industries	H123117	\$75,000.00	Bio Med	Upgrade to PTS
Data Stream Systems	H123120	\$6,485.00	Mnt & Op	Software Maintenance Management System
Johnson & Johnson	H600030	\$11,120.00	Radiology	Stent
Iolab	H600079	\$16,680.00	Radiology	Stent
* Lexi Comp	H123277	\$67,925.00	Labs	Computerized Lab Handbooks

Microvena
Biomet

H600040
92-90

\$16,165.00
Open

Radiology
O.R.

Catheters
Implantable Ortho
Products

TOTAL

\$873,748.40

* Over \$50,000

IV. VENDOR APPEALS

1. VENDOR NAME/DOLLAR AMOUNT: Surgilase/\$49,500.00
NATURE OF PURCHASE: CO2 Laser
INTENDED VENDOR/DOLLAR AMOUNT: Preferred Surgical/\$50,675.00

REASON FOR APPEAL:

Although vendor appeared low bid it was necessary to add components at additional costs to make a comparison to other bids submitted. Vendor contended we did not consider an extra component included in their bid. Upon re-calculation with exact component parts compared and all extra accessories removed, Surgilase was higher at \$48,350.00 versus Preferred Surgical at \$47,975.00.

STATUS: Award made to Preferred Surgical

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: 100 Watt ND. YAG/20 WATT 532 GREEN COMBINATION SURGICAL LASER

PURCHASE PRICE: \$114,000

DESCRIPTION:

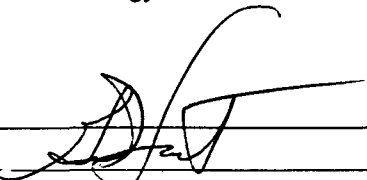
The equipment requested consists of a 100 watt Nd: YAG/532 wavelength green combination laser with appropriate controlling, calibrating mechanisms and accessories.

Laser technology as a surgical tool was introduced in the operating room during the late 1960's. Since that time, laser surgery has become the accepted method of choice for performing numerous surgical procedures due to its ability to cut, coagulate and vaporize tissue simultaneously, thus limiting local tissue destruction. Specifically the 532 wavelength green laser (also known as the KTP laser) represents the most recent of surgical laser technology developments. The primary benefits of this technology over earlier technologies such as the CO₂ laser is the high degree of both aim accuracy and surgical precision. While these features enhance the application of laser technology in several surgical specialties, they are of particular significance in the areas of Neurosurgery and Otolaryngology. Both of these services continue to show a strong growth pattern and their patient populations are most suitable to benefit from this newer technology. It is anticipated this device will be utilized in approximately 550 surgical procedures annually.

Additionally, the combination feature of this device would enable the O.R. to provide needed back-up for the older Nd: YAG laser currently being used for procedures within the main O.R. and Ambulatory Surgery. Further, case delays will be minimized as two cases can begin and precede concurrently.

Finally, acquisition of this laser technology is important from a competitive position in order to provide patients and referring physicians current surgical technology.

Submitted By: R. Carter McComb
Title: Associate Director

Approved By: 
Title: Sr. Associate Director

Planning & Dev. Committee Review:	April 22, 1992
Finance Committee Review:	April 22, 1992
Board of Governors Review:	April 22, 1992

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: SP4000 Upgrade, Diagnostic Radiology; MRI Section

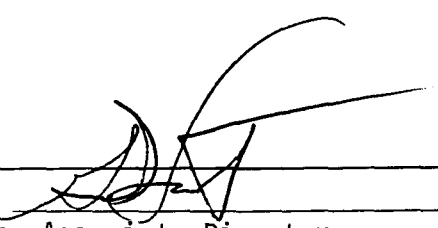
PURCHASE PRICE: \$115,000

DESCRIPTION: The MRI Section of Diagnostic Radiology seeks to upgrade the current 1.5 Tesla System purchased in 1990 with a VAX 4000 Model 300 coast processor, disc drive, expansion board and optical disc storage unit. This upgrade will improve patient through put and image acquisition capabilities of this system which will allow the Department to increase scheduled patients by at least one per day, as well as allow the Department to perform more complex, time consuming MRI scans. This is particularly important given the expansion of coils needed to do state-of-the-art imaging.

Principally, this upgrade will allow patients to spend less time in the tunnel while being imaged. This, in turn, will increase our through put by 1+ patients per day. At \$966 per exam, this represents a potential billable revenue of \$251,160 in the first 12 months of ownership. Secondly, the availability of this upgrade will allow us to expedite some of our more difficult neurovascular imaging cases which are currently taking an additional 30 to 60 minutes to complete. Given that our MRI neurovascular exams are up 8% since Dr. Latchaw's arrival, this upgrade enhancement can help to manage the additional case work time required by each additional exam. The decrease in per patient image acquisition/manipulation time can also reduce the number of aborted exams.

The cost of this acquisition is included in this year's budget.

Submitted By: Helen Pitt
Title: Associate Director

Approved By: 
Title: Sr. Associate Director

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
March 25, 1992

MINUTES

ATTENDANCE:

Edward Ciriacy, M.D.
Robert Dickler
Clifford Fearing
Leo Furcht, M.D.
Nellie Johnson
Arthur Kydd
John Morrison
Roger Paschke
Vic Vikmanis

Staff: Giles Caver
Greg Hart
Nels Larson
Joanne Disch
Sharon Weiss
Roger Paschke

CALL TO ORDER:

The meeting of the Board of Governors Finance Committee was called to order by Nellie Johnson, Finance Committee Chairperson, on March 25, 1992 at 1:30 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the Finance Committee minutes of the February 26, 1992 meeting as written.

JULY 1, 1991 THROUGH FEBRUARY 29, 1992 FINANCIALS:

Mr. Cliff Fearing reported to the Finance Committee the month of February inpatient admissions totaled 1,455 which was 56 over budget; average length of stay was 7.5 days or 0.6 days below budget; patient days totaled 11,010 which were 349 days below budget. The February average daily census was 380, which was below the budgeted level of 392. Clinic visits for the month of February were reported to be 7.5% above budget.

The Hospital's year-to-date Statement of Operations showed expenses being greater than revenues by \$2,435,000, an unfavorable variance of \$5,772,000. Gross patient revenue was 2.3% below budget and operating expenditures through February were reported to be 2.8% below budget.

As of February 29, the balance of accounts receivable totaled \$110,267,000 and represented 104.8 days of revenue outstanding.

1992-93 BUDGET:

Mr. Fearing presented to the Committee, for information, preliminary 1992-93 budget forecasts. Four possible 1992-93 budget scenarios were outlined for discussion. A final budget forecast will be presented for information to the Committee and the full Board of Governors in April along with the projected effects of various selected rate increases. UMHC's maximum level rate increase must be submitted to the state's rate review agency by May, 1992.

Mr. Fearing reported the 1992-93 projections include an admissions decline of 3.6% with an outpatient visits increase of 2.0%. It is projected that Medicare payment increases should average 4.0% and non-Medicare and non-Medical Assistance payment increases should average 5.5%.

At this time, there are many unresolved State of Minnesota legislative issues that will have a significant impact on this budget forecast. If the Minnesota Healthcare Access Bill is passed, the 1992-93 impact will be a \$1.8M Hospital tax. Also, Medical Assistance payments could decrease by \$1.5M depending on surcharge legislation currently being considered by both Houses.

Final approval of the 1992-93 Budget will be sought from the Board of Governors in May and the Board of Regents in June.

UMHC LONG TERM DEBT RESTRUCTURING:

Mr. Fearing presented to the Committee, for information, three options for reducing the long term debt costs. The recent decline in interest rates has created an opportunity for UMHC to restructure a portion of its Long Term Debt.

As of the end of February, the debt structure includes \$102,160,000 in long term fixed rate debt with an average interest rate of 7.611%, while current rates are in the 6.7% to 6.8% range; and, our long term variable rate debt of \$62,971,365 has an average interest rate of 4.73%, while current rates are in the 3% range. Depending on how the debt was restructured, UMHC could have a present value savings from approximately \$3M to upwards of \$18M.

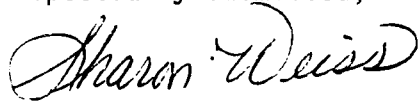
Mr. Fearing stated that since we have already refinanced UMHC's debt twice, which is the limit under existing Federal regulations, we are limited to three options for reducing the debt costs. 1) Perform a cash defeasance, which is essentially depositing cash in a Trustee held escrow account to cover the cost of the bonds until they are callable in 1996 and issuing new debt at lower current interest rates for capital needs; or, 2) tender an offer to purchase the bonds from their existing owners for a price higher than par and reissuing new debt at lower rates; or, 3) Perform a restructuring within the University by either an internal defeasance or unbundling UMHC's variable rate debt to move toward more commercial paper and less 5 year fixed rate debt; or, 4) a combination of the above.

Roger Paschke, Director of University Asset Management, presented some additional information on Hospital internal financing alternatives and the advantages of this type of debt restructuring.

Transaction details will be outlined for the BOG at the April Finance Committee and the Full Board meeting. If the internal restructuring is the chosen option, the Board of Regents approval would not be needed, thus expediting the process.

There being no further discussion, the March 25, 1992 meeting was adjourned at 3:25 P.M.

Respectfully submitted,

A handwritten signature in cursive script that reads "Sharon Weiss".

Sharon Weiss
Recording Secretary

**THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE and
PLANNING & DEVELOPMENT COMMITTEE
February 26, 1992**

MINUTES

ATTENDANCE:

Finance:	Robert Dickler Clifford Fearing Leo Furcht, M.D. Maria Gomez Nellie Johnson Arthur Kydd Margaret Matalamaki John Morrison Vic Vikmanis	P&D:	Leonard Bienias S. Albert Hanser Greg Hart Clint Hewitt Terrance Hill Dr. William Jacott Dr. Ted Thompson Dr. Peter Lynch
Staff:	Giles Caver Nels Larson Shannon Lorbiecki Joanne Disch Sharon Weiss	Guests:	Dr. Frank Cerra Al Dees Dr. Tom Green Helen Pitt Dr. Ted Thompson

CALL TO ORDER:

The joint meeting of the Finance Committee and Planning & Development Committee was called to order by Nellie Johnson, Finance Committee Chairperson, on February 26, 1992 at 10:30 A.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the Finance Committee minutes of the January 22, 1992 meeting as written.

JULY 1, 1991 THROUGH JANUARY 31, 1992 FINANCIALS:

Mr. Cliff Fearing reported to the Finance Committee the month of January inpatient admissions totaled 1,553 which was 42 below budget; average length of stay was 7.8 days or 0.2 days below budget; patient days totaled 11,864 which were 864 days below budget. The January average daily census was 383, which was below the budgeted level of 411. Clinic visits for the month of January were reported to be 1.9% above budget.

The Hospital's year-to-date Statement of Operations showed expenses being greater than revenues by \$3,107,000, an unfavorable variance of \$6,752,000. Gross patient revenue was 3.2 below budget and operating expenditures through January were reported to be 2.9% below budget.

As of January 31, the balance of accounts receivable totaled \$106,021,000 and represented 102.2 days of revenue outstanding.

The Hospital's overall operating position shows a loss for the month and year-to-date. The over all loss for fiscal year 1991-92 is currently at \$3,100,000. We are on target in bringing about a balanced budget for the fourth quarter of 1991-92.

MAJOR CAPITAL EXPENDITURE:

EMTEK System Upgrade

Helen Pitt introduced Dr. Frank Cerra, Medical Director of Surgical ICU, and Dr. Tom Green, Medical Director Pediatric ICU, as guests at today's joint meeting of the Board of Governors Finance and Planning & Development Committees.

Ms. Pitt reported to the Committee, for endorsement, a proposal to expand the Critical Care Clinical Information Management System called EMTEK to include the medical and pediatric intensive care units at a capital cost of \$1,058,000.

Dr. Cerra and Ms. Pitt presented a worksheet of projected reductions in charges and direct costs from changes in medical practice supported by the implementation of the EMTEK System in the Medical and Pediatric Intensive Care Units. Ms. Pitt also presented a cost benefit analysis and summary for the proposed expansion. Some of the benefits highlighted were: reduction in FTEs due to increase in staff efficiencies; increased accuracy in documentation and calculations; projected annual operating cost reductions of \$275,000; and reduction in utilization of lab tests, ventilator days, oximetry days, drugs and radiology procedures by 10% to 15% thus reducing charges as well as direct costs.

The Finance Committee seconded and passed a motion to endorse the proposal to expand the EMTEK System to include the medical and pediatric intensive care units at a capital cost of \$950,000 over five years with an additional \$108,000 for installation.

QUARTERLY CAPITAL EXPENDITURES REPORT:

Greg Hart presented to the Committee, for information only, the Second Quarterly Capital Expenditure Report for fiscal year 1991-92.

Mr. Hart reported that the actual capital expenditure for the year-to-date, including items that were rolled forward from 1990-91, was \$3,965,079. Comparing that amount to the seasonalized budget, the Hospital has underspent the capital budget by \$3,442,921.

INTERSTATE MEDICAL CENTER:

Robert Dickler presented to the Committee, for endorsement, the proposed 1992 budget and compensation plan for the new Interstate Medical Center (IMC). The new non-profit corporation is incorporation under the name of Interstate Medical Center.

The Interstate Medical Center Board of Directors, Robert Dickler, Cliff Fearing, Al Hanser, Dr. Tom Witt, Dr. Robert Schulenberg, and Ellen Dunn, approved this budget and compensation plan at their first board meeting on February 21, 1992. Mr. Dickler stated that the acquisition of IMC provides a significant opportunity for the University and UMHC provide greater opportunities for education, research, and service to the Greater Minnesota community and the Red Wing region. Mr. Dickler also presented to the Committee for its consideration a Comparative Summary Income Statement, a Projected Balance Sheet, and a Statement of Cash Flows for IMC.

Mr. Dickler commended Mr. Fearing, Mr. Dunder and Dr. Ted Thompson for their efforts leading to this acquisition.

The Finance Committee seconded and passed a motion to endorse the proposed 1992 budget and compensation plan, and financial statements, for the new Interstate Medical Center.

RENEWAL PROJECT UPDATE:

Mr. Dickler presented to the Committee, for information only, an update on the University Hospital Renewal Project.

Due to a decline in UMHC's inpatient activity over the past three years, a less expensive plan for facility modification is being developed and should cost considerably less than the approved \$37.5 million. The new plan would involve renovation of existing units in both the main hospital and the Mayo building for the Psychiatry programs. Urology would be accommodated in the existing ambulatory surgery center by expanding the main operating rooms to support both inpatient and ambulatory surgery in accord with the existing plan. Proposed department changes and upgrades for Physical Medicine & Rehabilitation and Obstetrics would be done within existing space or considered for outside joint ventures.

A modified plan of the Renewal Project will be presented to the Committee by April.

There being no further discussion, the February 26, 1992 meeting was adjourned at 2:05 P.M.

Respectfully submitted,


Sharon Weiss
Recording Secretary

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 21, 1992

TO: UMHC Board of Governors
FROM: Clifford P. Fearing
Senior Associate Director, UMHC
SUBJECT: Bad Debts - Third Quarter
Fiscal Year 1991-92

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the third quarter of 1991-92 is \$530,135.27 represented by 1,749 accounts. Bad debt recoveries during the period amounted to \$1,782.14 (30 accounts) leaving a net charge-off of \$528,353.13.

The net bad debts of \$528,353.13 for the quarter were 0.56% of gross charges. This compares to a budgeted level of bad debts of 0.79% (\$733,637).

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 third quarter.

Total fiscal year bad debts have amounted to \$1,706,036.78 represented by 5,790 accounts. Recoveries during the fiscal year amounted to \$14,596.62 (112 accounts), leaving a net charge-off of \$1,691,440.16.

The net bad debts of \$1,691,440.16 for the fiscal year were 0.61% of gross charges. This compares to a budgeted level of bad debts of 0.79% (\$2,238,395).

Along with the quarter attachments, we have also included a fiscal year statistical summary and a breakdown of bad debts by residence and admitting clinical services.

CPF:slw

Attachments

UMHC Hospital Billing Department

Bad Debt Statistics: July 91 thru March 92

In five ranges of account size

	Less Than \$10	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	\$5,029.97	110	\$81,999.25	182	\$61,501.17	43	266,200.29	66	\$57,629.77	4	\$472,360.45	405
Bad Debt (702) Charity Care	\$1,121.14	22	\$20,863.80	52	\$20,359.48	15	\$90,197.57	22	\$69,212.08	5	\$201,754.07	116
Total	\$6,151.11	132	\$102,863.05	234	\$81,860.65	58	\$356,397.86	88	\$126,841.85	9	\$674,114.52	521
Recoveries	(\$167.77)	4	(\$1,649.39)	5			(\$7,062.96)	1			(\$8,880.12)	10
Net Total	\$5,983.34	132 *	\$101,213.66	234 *	\$81,860.65	58 *	\$349,334.90	88 *	\$126,841.85	9 *	\$665,234.40	521 *

Outpatient												
Bad Debt (701) Write-Offs	\$113,440.24	2977	\$408,989.81	1607	\$90,587.54	64	\$142,032.03	36	\$93,684.85	3	\$848,734.47	4687
Bad Debt (702) Write-Offs	\$11,612.68	268	\$86,097.57	276	\$33,632.75	24	\$41,303.11	13	\$10,541.68	1	\$183,187.79	582
Total	\$125,052.92	3245	\$495,087.38	1883	\$124,220.29	88	\$183,335.14	49	\$104,226.53	4	\$1,031,922.26	5269
Recoveries	(\$2,171.88)	87	(\$3,544.62)	15							(\$5,716.50)	102
Net Total	\$122,881.04	3245 *	\$491,542.76	1883 *	\$124,220.29	88 *	\$183,335.14	49 *	\$104,226.53	4 *	\$1,026,205.76	5269 *

Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$118,470.21	3087	\$490,989.06	1789	\$152,088.71	107	\$408,232.32	102	\$151,314.62	7	\$1,321,094.92	5092
Bad Debt (702) Charity Care	\$12,733.82	290	\$106,961.37	328	\$53,992.23	39	\$131,500.68	35	\$79,753.76	6	\$384,941.86	698
Total	\$131,204.03	3377	\$597,950.43	2117	\$206,080.94	146	\$539,733.00	137	\$231,068.38	13	\$1,706,036.78	5790
Recoveries	(\$2,339.65)	91	(\$5,194.01)	20	\$0.00	0	(\$7,062.96)	1	\$0.00	0	(\$14,596.62)	112
Total Net Bad Debt	\$128,864.38	3377 *	\$592,756.42	2117 *	\$206,080.94	146 *	\$532,670.04	137 *	\$231,068.38	13 *	\$1,691,440.16	5790 *
Dollars Budgeted												

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: July 91 thru March 92
 In five ranges of account size

Less Than \$100	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
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Inpatient												
Medicare Bad Debt (710)	\$422.42	8	\$36,759.50	72	\$0.00	0	\$4,736.00	1	24205.91	1	\$66,123.83	82
Recoveries											\$0.00	0
Net Total	\$422.42	8 *	\$36,759.50	72 *	\$0.00	0 *	\$4,736.00	1 *	\$24,205.91	1 *	\$66,123.83	82 *

Outpatient												
Medicare Bad Debt (710)	\$15,075.89	489	\$41,537.13	158	\$2,950.34	2					\$59,563.36	649
Recoveries	(\$93.13)	1	(\$1,038.05)	2							(\$1,131.18)	3
Net Total	\$14,982.76	489 *	\$40,499.08	158 *	\$2,950.34	2 *	\$0.00	0 *	\$0.00	0 *	\$58,432.18	649 *

Total IP and OP Bad Debt												
Medicare Bad Debt (710)	\$15,498.31	497	\$78,296.63	230	\$2,950.34	2	\$4,736.00	1	\$24,205.91	1	\$125,687.19	731
Recoveries	(\$93.13)	1	(\$1,038.05)	2	\$0.00	0	\$0.00	0	\$0.00	0	(\$1,131.18)	3
Total Net Bad Debt	\$15,405.18	497 *	\$77,258.58	230 *	\$2,950.34	2 *	\$4,736.00	1 *	\$24,205.91	1 *	\$124,556.01	731 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statement July 91 thru March 92

In two ranges of account size

	# of Under \$2000 Accounts	# of Over \$2000 Accounts	Total Total # of AmountAccounts
Inpatient			
Bad Debt (701) Write-Offs	\$148,530.39 335	\$323,830.06 70	\$472,360.45 405
Bad Debt (702) Charity Care	\$42,344.42 89	\$159,409.65 27	\$201,754.07 116
Total	\$190,874.81 424	\$483,239.71 97	\$674,114.52 521
Recoveries	(\$1,817.16) 9	(\$7,062.96) 1	(\$8,880.12) 10
Net Total	\$189,057.65 424 *	\$476,176.75 97 *	\$665,234.40 521 *

Outpatient			
Bad Debt (701) Write-Offs	\$613,017.59 4648	\$235,716.88 39	\$848,734.47 4687
Bad Debt (702) Write-Offs	\$131,343.00 568	\$51,844.79 14	\$183,187.79 582
Total	\$744,360.59 5216	\$287,561.67 53	\$1,031,922.26 5269
Recoveries	(\$5,716.50) 102	\$0.00 0	(\$5,716.50) 102
Net Total	\$738,644.09 5216 *	\$287,561.67 53 *	\$1,026,205.76 5269 *

Total IP and OP Bad Debt			
Bad Debt (701) Write-offs	\$761,547.98 4983	\$559,546.94 109	\$1,321,094.92 5092
Bad Debt (702) Charity Care	\$173,687.42 657	\$211,254.44 41	\$384,941.86 698
Total	\$935,235.40 5640	\$770,801.38 150	\$1,706,036.78 5790
Recoveries	(\$7,533.66) 111	(\$7,062.96) 1	(\$14,596.62) 112
Total Net Bad Debt	\$927,701.74 5640 *	\$763,738.42 150 *	\$1,691,440.16 5790 *
Dollars Budgeted			\$1,750,000.00

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics July 91 thru March 92

In two ranges of account size

	# of Under \$2000 Accounts	# of Over \$2000 Accounts	Total Total # of AmountAccounts
Inpatient			
Medicare Bad Debt (710)	\$37,181.92 80	\$28,941.91 2	\$66,123.83 82
Recoveries	<u>\$0.00 0</u>	<u>\$0.00 0</u>	<u>\$0.00 0</u>
Net Total	\$37,181.92 80 *	\$28,941.91 2 *	\$66,123.83 82 *
Outpatient			
Medicare Bad Debt (710)	\$59,563.36 649	\$0.00 0	\$59,563.36 649
Recoveries	<u>(\$1,131.18) 3</u>	<u>\$0.00 0</u>	<u>(\$1,131.18) 3</u>
Net Total	\$58,432.18 649 *	\$0.00 0 *	\$58,432.18 649 *
Total IP and OP Bad Debt			
Medicare Bad Debt (710)	\$96,745.28 729	\$28,941.91 2	\$125,687.19 731
Recoveries	<u>(\$1,131.18) 3</u>	<u>\$0.00 0</u>	<u>(\$1,131.18) 3</u>
Total Net Bad Debt	\$95,614.10 729 *	\$28,941.91 2 *	\$124,559.01 731 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: JANUARY 92 thru MARCH 92
In five ranges of account size

	Less Than \$100	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Bad Debt (701) Write-Offs	\$1,827.32	42	\$23,581.18	52	\$18,007.94	13	69,813.91	17	\$34,759.56	2	\$147,989.91	126
Bad Debt (702) Charity Care	\$556.37	11	\$8,574.65	20	\$7,021.26	5	\$2,739.56	1	\$11,023.00	1	\$29,914.84	38
Total	\$2,383.69	53	\$32,155.83	72	\$25,029.20	18	\$72,553.47	18	\$45,782.56	3	\$177,904.75	164
Recoveries	(\$49.49)	1	(\$466.04)	3							(\$515.53)	4
Net Total	\$2,334.20	53 *	\$31,689.79	72 *	\$25,029.20	18 *	\$72,553.47	18 *	\$45,782.56	3 *	\$177,389.22	164 *

Outpatient												
Bad Debt (701) Write-Offs	\$32,157.54	890	\$120,829.24	467	\$20,989.48	14	\$37,489.50	12	\$82,417.06	2	\$293,882.82	1385
Bad Debt (702) Write-Offs	\$4,694.51	104	\$27,736.75	88	\$7,354.16	5	\$8,020.60	2	\$10,541.68	1	\$58,347.70	200
Total	\$36,852.05	994	\$148,565.99	555	\$28,343.64	19	\$45,510.10	14	\$92,958.74	3	\$352,230.52	1585
Recoveries	(\$480.54)	22	(\$786.07)	4							(\$1,266.61)	26
Net Total	\$36,371.51	994 *	\$147,779.92	555 *	\$28,343.64	19 *	\$45,510.10	14 *	\$92,958.74	3 *	\$350,963.91	1585 *

Total IP and OP Bad Debt												
Bad Debt (701) Write-offs	\$33,984.86	932	\$144,410.42	519	\$38,997.42	27	\$107,303.41	29	\$117,176.62	4	\$441,872.73	1511
Bad Debt (702) Charity Care	\$5,250.88	115	\$36,311.40	108	\$14,375.42	10	\$10,760.16	3	\$21,564.68	2	\$88,262.54	238
Total	\$39,235.74	1047	\$180,721.82	627	\$53,372.84	37	\$118,063.57	32	\$138,741.30	6	\$530,135.27	1749
Recoveries	(\$530.03)	23	(\$1,252.11)	7	\$0.00	0	\$0.00	0	\$0.00	0	(\$1,782.14)	30
Total Net Bad Debt	\$38,705.71	1047 *	\$179,469.71	627 *	\$53,372.84	37 *	\$118,063.57	32 *	\$138,741.30	6 *	\$528,353.13	1749 *
Dollars Budgeted											\$737,837.90	

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: **JANUARY 92 thru MARCH 92**
 in two ranges of account size

	Under \$2000	# of Accounts	Over \$2000	# of Accounts	Total Total # of AmountAccounts
Inpatient					
Bad Debt (701) Write-Offs	\$43,416.44	107	\$104,573.47	19	\$147,989.91 126
Bad Debt (702) Charity Care	\$16,152.28	36	\$13,762.56	2	\$29,914.84 38
Total	\$59,568.72	143	\$118,336.03	21	\$177,904.75 164
Recoveries	(\$515.53)	4	\$0.00	0	(\$515.53) 4
Net Total	\$59,053.19	143 *	\$118,336.03	21 *	\$177,389.22 164 *

Outpatient					
Bad Debt (701) Write-Offs	\$173,976.26	1371	\$119,906.56	14	\$293,882.82 1385
Bad Debt (702) Write-Offs	\$39,785.42	197	\$18,562.28	3	\$58,347.70 200
Total	\$213,761.68	1568	\$138,468.84	17	\$352,230.52 1585
Recoveries	(\$1,266.61)	26	\$0.00	0	(\$1,266.61) 26
Net Total	\$212,495.07	1568 *	\$138,468.84	17 *	\$350,963.91 1585 *

Total IP and OP Bad Debt					
Bad Debt (701) Write-offs	\$217,392.70	1478	\$224,480.03	33	\$441,872.73 1511
Bad Debt (702) Charity Care	\$55,937.70	233	\$32,324.84	5	\$88,262.54 238
Total	\$273,330.40	1711	\$256,804.87	38	\$530,135.27 1749
Recoveries	(\$1,782.14)	30	\$0.00	0	(\$1,782.14) 30
Total Net Bad Debt	\$271,548.26	1711 *	\$256,804.87	38 *	\$528,353.13 1749 *
Dollars Budgeted					\$235,437.00

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
Bad Debt Statistics: JANUARY 92 thru MARCH 92
In five ranges of account size

	Less Than \$10	# of Accounts	\$100 - \$999	# of Accounts	\$1000 - \$1999	# of Accounts	\$2000 - \$9,999	# of Accounts	\$10,000 +	# of Accounts	Total Amount	Total # of Accounts
Inpatient												
Medicare Bad Debt (710)	\$217.14	4	\$19,381.84	39	\$0.00	0	\$0.00	0	24205.91	1	\$43,804.89	44
Recoveries											\$0.00	0
Net Total	\$217.14	4 *	\$19,381.84	39 *	\$0.00	0 *	\$0.00	0 *	\$24,205.91	1 *	\$43,804.89	44 *
Outpatient												
Medicare Bad Debt (710)	\$8,518.56	281	\$12,041.14	67							\$20,559.70	348
Recoveries	(\$93.13)	1									(\$93.13)	1
Net Total	\$8,425.43	281 *	\$12,041.14	67 *	\$0.00	0 *	\$0.00	0 *	\$0.00	0 *	\$20,466.57	348 *
Total IP and OP Bad Debt												
Medicare Bad Debt (710)	\$8,735.70	285	\$31,422.98	106	\$0.00	0	\$0.00	0	\$24,205.91	1	\$64,364.59	392
Recoveries	(\$93.13)	1	\$0.00	0	\$0.00	0	\$0.00	0	\$0.00	0	(\$93.13)	1
Total Net Bad Debt	\$8,642.57	285 *	\$31,422.98	106 *	\$0.00	0 *	\$0.00	0 *	\$24,205.91	1 *	\$64,271.46	392 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department
 Bad Debt Statement: JANUARY 92 thru MARCH 92
 in two ranges of account size

	# of Under \$2000 Accounts	# of Over \$2000 Accounts	Total Total # of AmountAccounts
Inpatient			
Medicare Bad Debt (710)	\$19,598.98 43	\$24,205.91 1	\$43,804.89 44
Recoveries	<u> \$0.00 0</u>	<u> \$0.00 0</u>	<u> \$0.00 0</u>
Net Total	\$19,598.98 43 *	\$24,205.91 1 *	\$43,804.89 44 *
Outpatient			
Medicare Bad Debt (710)	\$20,559.70 348	\$0.00 0	\$20,559.70 348
Recoveries	<u> (\$93.13) 1</u>	<u> \$0.00 0</u>	<u> (\$93.13) 1</u>
Net Total	\$20,466.57 348 *	\$0.00 0 *	\$20,466.57 348 *
Total IP and OP Bad Debt			
Medicare Bad Debt (710)	\$40,158.68 391	\$24,205.91 1	\$64,364.59 392
Recoveries	<u> (\$93.13) 1</u>	<u> \$0.00 0</u>	<u> (\$93.13) 1</u>
Total Net Bad Debt	\$40,065.55 391 *	\$24,205.91 1 *	\$64,271.46 392 *

* Net total of accounts does not include recoveries.

UMHC Hospital Billing Department

Bad Debt Statistics: Third Quarter and Year-to-Date, Fiscal Year 1992
By State

State	Third Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Alabama			144.95	3
Alaska			11.27	1
Arizona	89.47	2	5,269.36	16
Arkansas	2,701.70	2	3,236.84	6
California	1,635.31	9	16,977.48	33
Colorado	254.10	2	1,012.83	19
Connecticut	279.60	1	2,983.59	8
Delaware			0.00	0
Dist. of Colombia			3,843.02	3
Florida	1,870.68	14	7,528.36	37
Georgia	544.70	1	608.60	2
Hawaii			0.00	0
Idaho			0.00	0
Illinois	3,041.08	6	12,546.06	53
Indiana	209.45	4	209.45	4
Iowa	1,719.61	8	4,276.82	34
Kansas	886.33	3	1,226.63	4
Kentucky			946.10	5
Louisiana			1,396.59	4
Maine			0.00	0
Maryland	248.65	3	355.43	5
Massachusetts	34.00	1	144.39	2
Michigan	13,904.10	14	20,441.28	68
Minnesota	358,403.10	1,817	1,218,105.05	5380
Mississippi	46.64	1	1,045.57	5
Missouri	96.18	3	483.68	6
Montana	132.60	1	3,905.14	11
Nebraska	376.95	1	1,255.81	8
Nevada			951.38	7
New Hampshire			0.00	0
New Jersey	27,826.47	6	30,466.74	8
New Mexico	157.00	2	203.42	4
New York	994.16	3	5,721.21	28
North Carolina			392.89	4
North Dakota	5,080.66	31	38,368.67	73
Ohio	2,003.73	15	2,046.73	16
Oklahoma	1,893.07	4	3,886.92	20
Oregon			150.00	1
Pennsylvania	8.98	1	2,891.81	6
Puerto Rico			0.00	0
Rhode Island	58.06	1	58.06	1

UMHC Hospital Billing Department

Bad Debt Statistics: Third Quarter and Year-to-Date, Fiscal Year 1992
By State

State	Third Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
South Carolina			2,012.36	4
South Dakota	21,794.61	61	104,726.03	194
Tennessee	7,258.46	7	7,661.18	12
Texas	1,636.28	3	3,973.38	18
Utah			3,323.12	1
Vermont			0.00	0
Virginia			2,076.40	8
Washington	11.40	1	13,961.97	29
West Virginia			137.19	1
Wisconsin	18,145.45	99	115,081.43	315
Wyoming			327.56	5
Out-of-Country	23,466.27	7	31,028.47	30
Total	496,808.85	2,134	1,677,401.22	6,502
Medicare Bad Debt*	(64,271.46)	392	(124,556.01)	731
Legal Settlements	12,158.26	3	39,742.20	9
Bad Debt Agcy Und \$50	6.50	1	53.38	2
Bad Debt - Med NC Chgs	85,526.25	3	114,527.17	8
Grand Total	530,228.40	2,533	1,707,167.96	7,252
Recoveries	(1,875.27)	31	(15,727.80)	115
Net Total	528,353.13	2,533	1,691,440.16	7,252

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

UMHC Hospital Billing Department

Bad Debt Statistics: Third Quarter and Year-to-Date, Fiscal Year 1992
By Service

Admitting Service	Third Quarter Amount	# of Accounts	Y-T-D Total Amount	Total # of Accounts
Anesthesiology			0.00	0
Clinical Research	1,247.55	4	3,323.61	6
Dentistry			28.93	1
Dermatology			8,659.08	2
Family Practice	540.00	1	540.00	1
OB			0.00	0
NB			0.00	0
General Med	1105.77	4	1,143.72	5
GYN	1,435.83	2	3,283.16	5
GYN-Oncology	1,238.64	2	23,031.34	18
Lab Medicine & Pathology			0.00	0
Medicine-Blue	2,542.67	9	19,350.04	19
Green	2,442.39	8	7,273.38	12
Masonic (Onc)	4,902.32	10	21,447.67	32
Purple	2,129.29	2	2,129.29	2
Red A	3,278.55	15	4,422.59	20
Red B			0.00	0
Rose A	1,752.17	3	28,155.16	12
Rose B	39.12	1	719.12	2
White A	13,851.89	5	32,424.45	15
White B	5,372.63	13	20,628.18	32
White C	5,401.72	5	8,951.25	9
Yellow A	1,819.46	3	30,399.14	19
Yellow B			8,241.09	7
Neurology	6,881.97	4	25,352.45	13
Neuro-epilepsy			11,803.48	2
Neurosurgery	2,645.35	4	24,168.35	15
New Born-General	3,957.95	6	7,005.61	13
Obstetrics-General	14,040.44	9	31,350.24	26
-Midwife			0.00	0
Ophthalmology	5,638.78	8	26,598.94	23
Orthopaedic Surgery	6,934.06	11	34,436.68	42
Otolaryngology			7,431.88	11
Pediatrics-General	8,304.50	5	59,646.57	36
Dentistry			0.00	0
Dermatology			0.00	0
Cardiology	440.64	1	1,310.56	2
Gastro-Intestinal			356.64	1
Hematology Oncology			2,495.49	3
Neonatology			25,181.30	5
Neurology			8,721.50	6
Neurosurgery			6,266.35	2

UMHC Hospital Billing Department

Bad Debt Statistics: Third Quarter and Year-to-Date, Fiscal Year 1992
By Service

Admitting Service	Third		Y-T-D	
	Quarter Amount	# of Accounts	Total Amount	Total # of Accounts
Ophthalmology	2,924.51	2	17,767.91	7
Orthopaedics			8,190.56	2
Otolaryngology			364.50	2
Pulmonary			1,049.43	1
Renal	1474	1	1,474.00	1
Surgery Green	1,270.84	1	1,270.84	1
Surgery Orange			3,007.56	1
Surg. Transplant			116.10	2
Urology	325.15	2	5,424.12	4
Physical Med. & Rehab.	867.60	2	937.50	4
Psychiatry-Child	761.80	2	761.80	2
-Adult	28,146.72	13	60,559.49	38
Radiology			30.00	1
Surgery-Blue	44,158.11	16	56,053.62	46
Oral			6,106.94	3
Orange	22,985.83	1	29,066.49	8
Purple	6,592.12	9	15,571.26	17
Red	1,352.07	4	16,411.74	11
White	6,764.40	12	9,625.30	17
Therapeutic Radiology			0.00	0
Urology	6,142.80	8	10,171.95	16
Unknown	275,099.21	1,926	275,099.21	1,926
Outpatient			662,063.66	3,973
Total	496,808.85	2134	1,677,401.22	6502
Medicare Bad Debt*	(64,271.46)	392	(124,556.01)	731
Legal Settlements	12,158.26	3	39,742.20	9
Bad Debt Agcy Und \$50	6.50	1	53.38	2
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Grand Total	530,228.40	2,533	1,707,167.96	7,252
Recoveries	(1,875.27)	31	(15,727.80)	115
Net Total	528,353.13	2,533	1,691,440.16	7,252

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

MINUTES
Joint Conference Committee
Board of Governors
February 25, 1992

Attendance:	Present:	Robert Dickler Phyllis Ellis Maria Gomez Margaret Matalamaki Robert Maxwell, M.D. Richard Price, M.D. Kristine Zaulkernan
	Absent:	Debbie Day, M.D. Amos Deinard, M.D.
	Staff:	Giles Caver Joanne Disch, Ph.D. Jean Harris, M.D. Greg Hart Shannon Lorbiecki

CALL TO ORDER

Ms. Margaret Matalamaki called the meeting to order at 4:33 p.m.

APPROVAL OF MEETING MINUTES

The minutes of the October 9, 1991 meeting were approved as submitted.

END STAGE RENAL DISEASE PROGRAM

Dr. Joanne Disch and Mr. Keith Hampton presented proposed changes to the organizational summary and policies and procedures as required by End Stage Renal Disease federal program guidelines. Dr. Disch and Mr. Hampton said the proposed changes will not only meet federal guidelines, but they also will be more responsive to the needs of patients, practitioners, and the Hospital. They noted the changes require Board approval.

Dr. Disch and Mr. Hampton also noted changes to the text. In section 3.III.6. on page 37, the Director of Adult Peritoneal Dialysis is Sylvia Azar, not Connie Manske.

The Joint Conference Committee endorsed the recommended changes to the organizational summary and policies and procedures.

REVIEW OF QUALITY ASSURANCE WORK PLAN

Dr. Jean Harris presented the Quality Assurance Steering Committee Task Force Report of August 1991. Dr. Harris said the report reflects the trend from quality assurance to continuous quality improvement. She also said the report and its contents comply with the recommendations of the Joint Commission on the Accreditation of Healthcare Organizations, as well as the Hospital's goals and objectives.

OVERVIEW OF THE CREDENTIALLING PROCESS

Dr. Robert Maxwell provided an overview of the Medical Staff's credentialling process. Dr. Maxwell said Medical Staff members must have a faculty appointment from the Medical School and must be licensed to practice medicine in the State of Minnesota. He said a clinical chief must recommend the physician and the Credentials Committee must approve the recommendation. The Medical Staff Office supports the credentialling process by ensuring physician information is accurate and by investigating past performance.

MEDICAL STAFF - HOSPITAL COUNCIL REPORT: CREDENTIALS COMMITTEE RECOMMENDATIONS

Dr. Maxwell also presented Credentials Committee recommendations. The recommendations were for approval of provisional status and clinical privileges, deletion of clinical privileges, change in staff category, approval of regular appointments, and acceptance of resignations.

Dr. Maxwell also noted changes to the text. At the beginning of page 7, the names listed under the departments of Neurology, Pediatrics, Radiology, and Urology were recommended for regular appointments, not for continued provisional status.

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

1992 COMMITTEE WORK PLAN

Ms. Matalamaki presented the 1991 Committee Work Plan for consideration and discussion. Mr. Robert Dickler said the Hospital bylaws mandate the Committee oversee "routine items," including the approval of Medical Staff appointments, Medical Staff committee chairs, End Stage Renal Disease policies, and home health care policies, as well as receive Clinical Chief reports and Medical Staff - Hospital Council reports. Mr. Dickler also recommended the Committee continue monitoring JCAHO follow-up, patient survey results, faculty recruitment and retention, technology transfer, and resource utilization, as well as develop the role of the clinical chiefs. Finally, he said the Committee should monitor the progress of implementing the Quality Assurance Steering Committee Task Force Report of August 1991.

CLINICAL CHIEFS REPORT

Dr. Richard Price provided a brief overview of the Council of Clinical Chiefs and its activities. Dr. Price said the Council consists of the Clinical Chiefs, as well as the Dean of the Medical School and the General Director of the Hospital. He also said the Council advises the General Director on a variety of Hospital issues.

ADJOURNMENT

There being no further business, the Joint Conference Committee meeting was adjourned at 5:55 p.m.

Respectfully submitted,



Giles Caver
Administrative Fellow

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Office of the Chief of Staff

*Box 707
Harvard Street at East River Parkway
Minneapolis, MN 55455
612-626-1945*

April 15, 1992

TO: Members of the Board of Governors

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

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

The Medical Staff-Hospital Council on April 14 endorsed the attached Credentials Committee Report and Recommendations and forwarded this report to the Joint Conference Committee for their consideration on April 21.

I am forwarding these recommendations to you for your review and approval on April 22. I will report the outcome of the Joint Conference Committee's action at that time. If you should have any questions, please feel free to call on me.

REM/cf
Attachment

cred/BOG

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Medical Staff Office

Box 707
Harvard Street at East River Road
Minneapolis, MN 55455
612-626-1945

April 8, 1992

TO: Medical Staff-Hospital Council
FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee
SUBJECT: Credentials Committee Report and Recommendations

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

Department of Anesthesiology

Category

Barbara S. Gold

Attending Staff

Department of Hospital Dentistry

Paul H. Kwon

Clinical Staff

Terry G. Orr

Clinical Staff

Department of Family Practice
and Community Health

Richard J. Feist

Attending Staff-Boynton Health Services

Bernerd L. O'Neil

Attending Staff

Angela M. Vargas

Attending Staff

Department of Medicine

Terese M. Collins

Attending Staff

Department of Neurology

Benard H. Maister

Clinical Staff

Department of Obstetrics
and Gynecology

Lowell J. Byers

Attending Staff

Jay M. Carlson

Attending Staff

Steven A. Elg

Attending Staff

Mark M. Moradi

Attending Staff

Provisional status and clinical privileges continued:

<u>Department of Orthopedics</u>	<u>Category</u>
David W. Polly	Attending Staff
<u>Department of Pediatrics</u>	
Richard D. Andersen	Clinical Staff
Stephen C. Kurachek	Clinical Staff
John J. McNamara	Clinical Staff
William B. Wheeler	Clinical Staff
<u>Department of Radiology</u>	
Andrew H. Cragg	Clinical Staff
<u>Department of Surgery</u>	
Rainer W.G. Gruessner	Attending Staff

The following Medical Staff have submitted applications and supporting documentation requesting addition of clinical privileges and change in staff category. The Committee has reviewed and considered their requests and hereby recommends approval.

<u>Department of Laboratory Medicine and Pathology</u>	<u>Category</u>	
Alejo Erice	Attending Staff	
Add: Joint appointment in Department of Medicine with Department of Medicine clinical privileges		
<u>Department of Physical Medicine and Rehabilitation</u>	<u>Present Category</u>	<u>Requested Category</u>
Karen S. Ryan	Attending Staff	Clinical Staff

The following member of the Medical Staff has requested a leave of absence from the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed this request and hereby recommends approval.

<u>Department of Neurology</u>	<u>Category</u>
Myoung C. Lee	Attending Staff
LOA: September 15, 1991 through September 15, 1992 with option to extend another year	

The following member of the Medical Staff has returned from a leave of absence and is applying for reappraisal and reappointment to the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed this application and recommends reappointment for the following staff member.

<u>Department of Psychiatry</u>	<u>Category</u>
George M. Realmuto	Attending Staff

The following Psychologist has applied for appointment to the Specified Professional Personnel-Psychology Staff and has requested clinical privileges. The Committee hereby recommends approval of this applicant and request for privileges.

<u>Department of Obstetrics and Gynecology</u>	<u>Category</u>
Linda Hammer Burns	Attending Staff

The following Specified Professional Personnel-Psychology Staff member has submitted an application and supporting documentation requesting addition of clinical privileges. The Committee has reviewed and considered this request and hereby recommends approval.

<u>Department of Neurology</u>	<u>Category</u>
Lynn A. Blackburn	Attending Staff

Add: Performance of Neuropsychological Assessment portion of the WADA angiogram procedure with children

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

<u>Department of Laboratory Medicine and Pathology</u>	<u>Category</u>
Raouf E. Nakhleh	Attending Staff

<u>Department of Obstetrics and Gynecology</u>	
William R. Phipps	Attending Staff

<u>Department of Radiology</u>	
Samuel B. Feinberg	Attending Staff Retiring effective 6/30/92


UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

April 14, 1992

TO: Members, Board of Governors

FROM: Mary Ellen Wells 
Associate Director, UMHC

RE: Annual Review of Home Health Care Services

In April, 1989, The Hospital established an annual review process of the Home Health Care Services Department by the Board of Governors as required by Medicare and JCAHO. In accordance with this, the following is a summary of the Department's major activities and significant policy changes that have occurred during the past year. This report is for your endorsement.

UMHC Home Health Care Services continues to provide a full range of in-home services to UMHC patients who live within a 30 minute, one-way drive from UMHC.

The fiscal year '91-'92 has been one of significant growth and accomplishments. We have experienced a 19% increase in overall home visits - year to date - above what we reported last year for the same time period. Increases in home visits were made in every service we provide, with the exception of speech therapy (a rarely ordered service). Attached, for your information, is a summary of home visit activity and other statistical data through March, 1992. Of particular note are the major increases in the areas of Occupational Therapy, Social Work and Physical Therapy. These increases are all due to increased availability of staff, either through Hospital departments or contracts. This fiscal year we have also experienced significant increases in new cases (up 18%) and the average number of patients serviced per month (up 12%).

During the first nine months of this fiscal year, we implemented the recommendations made by JCAHO, and accreditation was finalized. We also contracted to provide services to the University Group Health patients, and currently provide home health services to Preferred One and Medica Transplant patients.

Over the past year, a few policies were developed or substantially revised which have been approved by the Home Health Care Services Advisory Committee. The new and revised policies put us in compliance with State and Federal regulations and JCAHO standards, and/or provide written clarification of other general Home Health

policies. One policy was newly developed and five were revised. The policies and procedures for your endorsement include:

- * Auto Usage for Home Visits
- * Do Not Resuscitate
- * HH Referral-Procedure for a Health Professional to Make a Referral to UMHC HHCS
- * Safety in the Patient's Home
- * Staffing - HHCS
- * Transportation of HHCS Patients

As part of our annual report to the Board, we would also like to present the following HHCS Goals and Objectives for fiscal year '92-'93:

1. Increase new referrals from our current average of 38 permonth to 43 per month.
2. Develop and implement a cost effective management information system which would provide on-going data regarding: staff productivity, cost per visit, average number of visits per patient, referral sources, etc.
3. Increase productivity, measured by the number of visits/FTE by 5%.
4. Explore the expansion of HH services beyond the current 30 minute, one-way boundary and UMHC only referral base.
5. Produce a mutually acceptable agreement with Managed Care Initiatives (MCI), identifying roles and services as they relate to MCI and HHCS.
6. Perform a financial analysis of the impact of early hospital discharge with the use of Home Health Services.

Beverly Dorsey, Director - HHCS and Deborah Spindler, Nurse Manager - HHCS will be available at the Board of Governors meeting at on April 22, 1992 to answer any of your questions.

BOG:JCC.92

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINICS
HOME HEALTH CARE SERVICES
STATUS REPORT TO THE BOARD OF GOVERNORS - 4/92

	FISCAL YEAR '91 - '92	FISCAL YEAR '90 - '91	% INCREASE/ DECREASE
TOTAL HOME VISITS (HV's)	9651	8118	19%
PHN/RN HOME VISITS	4843	4212	15%
RESPIRATORY THERAPISTS	2240	2212	1%
HOME HEALTH AIDE VISITS	1565	1274	23%
PHYSICAL THERAPY HOME VISITS	646	339	91%
OCCUPATIONAL THERAPY HV'S	249	54	361%
SOCIAL WORK HOME VISITS	100	0	100%
SPEECH THERAPY HOME VISITS	8	19	58%
WEEKEND/EVENING HOME VISITS	1938	1666	16%
NEW CASES YEAR TO DATE	347	295	18%
AVERAGE # OF PATIENTS SERVED PER MONTH	140	125	12%
MEDICARE	31%	29%	NA
MEDICAL ASSISTANCE	41%	36%	NA
PRIVATE INSURANCE/HMO'S	25%	33%	NA
PRIVATE PAY	3%	2%	NA

■ - REIMBURSEMENT BREAKOUT

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:

Page 1 of 1

VOL.:

POLICY NUMBER: 3.

EFFECTIVE: 3/76

REVISION:

10/87;10/91

REVIEWED:

3/76...10/88;10/89;10/91

SUBJECT:

AUTO USAGE FOR HOME VISITS

SOURCE:

Home Health Care Services

 = Delete

{ } = New/Add

POLICY

It is the responsibility of personnel making home visits for/through UMHC Home Health Care Services to provide their own transportation ~~to and from the home visits.~~ {proper auto insurance with which to make home visits.}

PROCEDURE

Personnel making home visits will be required to have the following:

- I. A valid State of Minnesota driver's license - or -
- II. A license acceptable to the Minnesota Department of Public Safety.
- III. A current automobile insurance policy that corresponds to auto usage, i.e., driving is not just to and from work, but includes driving to and from home visits. {Evidence of current auto insurance coverage will be requested of all full time staff on an annual basis.}

APPROVED:

DATE:

TITLE: Assoc. Director, Home Health Care Services

10/31/91

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Page 1 of 1	
VOL.:	POLICY NUMBER: 100
EFFECTIVE: 6/1/90	
REVISION: 11/90;10/91	
REVIEWED: 11/90;10/91	

SUBJECT: DO NOT RESUSITATE (DNR/DNI)
SOURCE: Home Health Care Services

{ } = New/Add
POLICY

CPR will be initiated in the home, unless a signed order indicating "DNR" is in the HHCS chart.

PROCEDURE


Upon the arrest of a patient in the home, HHCS personnel will call "911" (or, direct family/caregiver, if available, to call 911) and initiate CPR.

A signed DNR/DNI order may be obtained on the Home Health referral or by a verbal order.

If obtained through a verbal order, the patient/family and physician must be aware and in agreement with the plan. It is the physician's responsibility to discuss the DNR/DNI order with the patient (family), if possible, and document discussion in patient's chart.

The PHN is to document discussions with the patient/family regarding "DNR/DNI". These discussions regarding the patient's desires may result from the patient's direction or the PHN initiating the discussion. DNR discussions initiated by the PHN will be done when the disease prognosis is poor and patient is terminal.

{In order to prevent resuscitation, by paramedics, on a patient that is DNR/DNI, the DNR/DNI form must be filled out and signed by the patient and their physician and embossed. Family members should be made aware of the location of the home copy of the DNR/DNI form.}

APPROVED: 	DATE:
TITLE: Assoc. Director, Home Health Care Services	11/20/90

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	
Page 1 of 2	
VOL.:	POLICY NUMBER: 39
EFFECTIVE: 8/6/79	
REVISION: 12/80;8/87...9/89;10/91	
REVIEWED: 12/81...10/88;10/89;10/91	

SUBJECT:
HOME HEALTH REFERRAL - PROCEDURE FOR A HEALTH PROFESSIONAL TO MAKE A REFERRAL TO UMHC HHCS
SOURCE:
Home Health Care Services

_____ = Delete
{ } = New/Add

POLICY

Completion of a Home Health Referral is necessary for care to be provided by UMHC Home Health Care Services.

PROCEDURE

- I. The referral is to be initiated by a health professional or the patient/family with a phone call to HHCS as soon as the discharge is anticipated or needs are identified.
- II. The HHCS Liaison Nurse will+ {collect appropriate information regarding the referral. (In the Liaison Nurse's absence, the ANM or NM will take referrals.) The Liaison Nurse will then:}
 - A. Meet and discuss the plan of care with the patient/family and referral source.
 - B. Determine reimbursement options and discuss cost and options with the patient/family.
 - C. Determine if the patient meets HHCS admission criteria. Notify referral source if patient does not meet these criteria.
 - D. Give the patient the HHCS office and after hours telephone number.
 - E. Make copies of pertinent information from the patient's medical record as necessary.
 - {F. Notify the ANM of the referral to work out staffing.}

APPROVED: <i>Doreen R. Doreen</i>	DATE:
TITLE: /Assoc. Director, Home Health Care Services	10/31/91

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: Page 1 of 1	
VOL.:	POLICY NUMBER: 31
EFFECTIVE: 9/76	
REVISION: 9/87;10/91	
REVIEWED: 6/78...10/88;10/89;10/91	

SUBJECT: SAFETY IN THE PATIENT'S HOME
SOURCE: Home Health Care Services

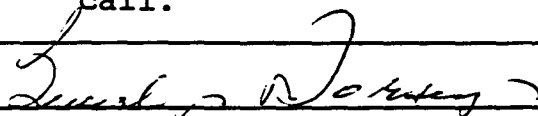
— = Delete
{ } = New/Add

POLICY

During the initial home visit, the PHN will assess the physical and emotional milieu of the patient's home and evaluate its contribution to the patient's needs. ~~These observations will be recorded on the HHCS initial evaluations forms.~~

PROCEDURE

- I. The PHN will make recommendations to provide for a safe home environment, i.e., grab bar for the tub, side rails for the bed, removal of scatter rugs.
- II. Once the patient is at home, the PHN will also develop a plan (or plans) that can include, but not be limited to the following:
 - A. Safe use and maintenance of equipment.
 - B. Proper use and storage of medicine.
 - C. Correct use and disposal of medical supplies, such as needles, syringes and dressings.
 - D. Correct and safe body mechanics in transferring, ambulation, etc.
 - E. Prevention and correction of fire hazards.
- {III. Safety issues will be documented on the "Safety/Vulnerability Form.
- IV. Safety issues will be monitored on an ongoing basis. Deviations should be charted on the flowsheet or narrative section.}
- {V} ~~III.~~ Patients will also be instructed on the use of "911" and given the HHCS emergency number to contact the HHCS nurse on call.

APPROVED: 	DATE:
TITLE: Assoc. Director, Home Health Care Services	10/31/91

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	
Page 1 of 1	
VOL.:	POLICY NUMBER: 22
EFFECTIVE:	
REVISION:	
9/87;...3/89;10/89;10/91	
REVIEWED:	
10/81...10/88;10/89;10/91	

SUBJECT:
STAFFING - HOME HEALTH CARE SERVICES
SOURCE:
Home Health Care Services

{ } = New/Add

I. Home Health Care Services' staff consists of:

- A. Nurse Manager.
- {B. Assistant Nurse Manager}
- {C. Liaison Nurse}
- {D}. Public Health Nurses.
- {E}. Associate Administrator.
- {F}. [Senior] Accounts Specialist.
- {G}. [Student] {Senior} Secretary.
- {H}. Home Health Aides.
- {I. Physical Therapist
- J. Social Worker}
- {H}. Several PHN vacation/weekend/evening staff.

II. Each PHN will carry a patient caseload that will be determined by:

- A. PHN appointment.
- B. Patient acuity level.
- C. Knowledge, expertise and experience with the type of patient referred to the HHCS program.
- D. Geographic location of the patient.
- E. Present workload, and availability to take a new patient.
- F. Productivity standard is 4.25 home visits/day.

{III. Subject to the review of Joint Conference Committee, the positions in this policy, can be modified by the Director of the program consistent with the intent of this policy and in compliance with Medicare regulation.}

APPROVED:	DATE:
TITLE: Assoc. Director, Home Health Care Services	10/31/91

POLICY AND PROCEDURES MANUAL



UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	
Page 1 of 1	
VOL.:	POLICY NUMBER: 111
EFFECTIVE:	10/91
REVISION:	
REVIEWED:	

SUBJECT: TRANSPORTATION OF HHCS PATIENTS
SOURCE: Home Health Care Services

Policy

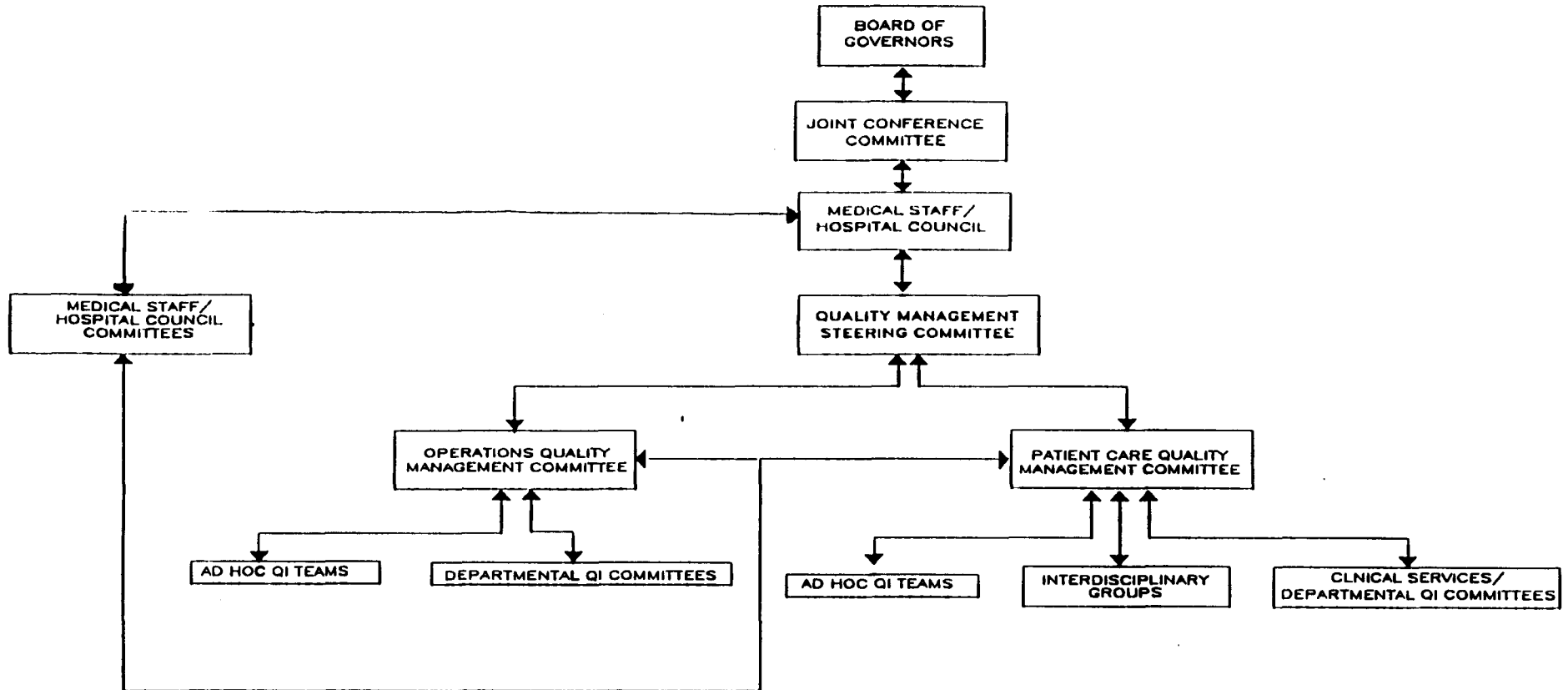
Home Health Care Services employees are not (for any reason) allowed to transport patients or their family members.

Procedure

- I. Whenever possible, transportation should be prearranged through the patient, their family, a friend or a social worker.
- II. Cab slips are available for use as necessary.
- III. If there is an emergency, an ambulance or "9-1-1" should be called to assist.

APPROVED: <i>[Signature]</i>	DATE:
TITLE: / Assoc. Director, Home Health Care Services	10/31/91

University of Minnesota Hospital & Clinic Quality Management Structure



HOSPITAL-WIDE QUALITY MANAGEMENT STRUCTURE:

The Quality Assurance Steering Committee (QASC) Task Force Recommendations (Executive Summary, Attachment 1) and the 1994 Joint Commission Standards for quality management (Attachment 2) specify a reexamination of the role of the hospital leaders and a reorganization of the committee structure that supports QA/QI activities at UMHC. In planning the role and organizational changes necessary to carry forward the QASC's and JCAHO's recommendations, greater emphasis will be placed on:

- o The participation and leadership of hospital administration, including the chief executive officer and other senior managers, in planning and implementing programmatic activities that are clinically relevant and present opportunities for continuously improving patient care.
- o Interdisciplinary, collaborative discussion, evaluation, and action to improve direct patient care and services.
- o Evaluation and improvement of all hospital processes and systems (e.g., management, governance, and support services), not just clinical services.
- o Integration of a continuous quality improvement philosophy that is uniquely appropriate to UMHC, into all clinical and management functions.

The attached Quality Management Reporting Structure outlines the reporting relationships and accountability for all hospital quality improvement activities from the clinical/departmental level up to the senior management and the Board of Governors. This structure utilizes and integrates discipline specific QA/QI activities with interdisciplinary group activities and ad hoc quality improvement teams to address both patient care issues and operations issues. Decision making and problem identification and resolution at the lowest possible level is expected.

OUTLINE OF COMMITTEE MEMBERSHIP AND FOCUS:

Quality Management Steering Committee:

Membership

- o General Director
- o Senior Associate Director of Nursing
- o Senior Associate Director of Operations
- o Senior Associate Director of Medical Affairs
- o Senior Associate Director of Finance
- o Chief of Staff
- o Representatives from the Clinical Chiefs
- o Hospital QA/QI Staff
- o Others ?

Focus:

- o Establish expectations, develop plans, coordinates the implementation of activities to assess and improve the quality of the organization's governance, management, clinical and support systems.

Meeting and Reporting Frequency:

Meets quarterly. Reports to Medical Staff Hospital Council quarterly.

Patient Care Quality Management Committee

Membership Interdisciplinary

Representation could include member(s) from the medical staff, managers from clinical departments such as Nursing, Rehabilitation Therapies, Labs, Social Work, Patient Relations, Outpatient Clinics, Pharmacy, Hospital QA/QI Staff, Nursing QI Staff.

Focus:

Decision-making and problem solving as it relates to broad patient care management functions such as admission and discharge planning, diagnostic imagery, medication and laboratory utilization, nutrition care, rehabilitation and nursing care, pertinent risk management, and other issues.

This group would deal with issues that cross disciplines and departments that cannot be resolved at a lower level.

Meeting Frequency:

Monthly

Lines of communication would be established between this committee and other Medical Staff Hospital Council Committees including the Tissue and Procedure Review Committee, the Infection Control Committee, Transfusion and Therapeutics Committee, Pharmacy and Therapeutics Committee, the Medical Records Committee, the Outpatient Committee and others.

Operations Quality Management Committee

Membership: Interdisciplinary

Representation could include member(s) of the the medical staff, managers from Nursing, Hospital Administration, Human Resources, Facilities, Information Systems, Outpatient Clinics, Admissions, Patient Billing, Environmental Services, Material Services, Medical Records, and the Hospital QI Department.

Focus:

The focus of this group would be organizational functions such as safety and utilities management, information management, education and training, (occupational risks and exposures), emergency preparedness, equipment management, pertinent risk management issues, and other operational issues.

This group would deal with issues that cross departments that cannot be resolved at a lower level.

Meeting Frequency:

Monthly

Lines of communication would be established between this committee and other Medical Staff Hospital Council Committees including the Safety Committee, the Medical Records Committee, and the Credentials Committee.

EXECUTIVE SUMMARY

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

- 1) UMHC should make its quality assurance programs more clinically relevant by better integrating the clinical research activities of the medical staff with the Hospital's quality assurance programs and by promoting publication of findings in a manner that will influence clinical practice.
- 2) In order to truly impact the many aspects of patient care, UMHC's quality assurance activities should become more interdisciplinary, both at the physician-to-physician level and between physicians and other hospital departments.
- 3) The Quality Assurance Steering Committee should direct departmental and programmatic quality assurance activities toward clinical relevance and opportunities for patient care improvement, and should actively assess the effectiveness of actions taken.
- 4) UMHC should appoint a physician to its administrative staff (Senior Associate Director of Medical Affairs) to work with Medical Staff leadership, Hospital Administration, the Health Sciences, and Medical School in guiding future quality assurance activities.
- 5) UMHC should continue to "fine-tune" certain aspects of the quality assurance program to assure ongoing compliance with JCAHO standards.

- 6) The Quality Assurance Steering Committee should be restructured to support implementation of the recommendations in this document.
- 7) UMHC should enhance its level of expertise and participation in outcome assessment studies on a selected basis, and seek to upgrade the level of research quality in such studies. UMHC should promote participation in cost-effectiveness evaluations.
- 8) UMHC should utilize outcomes data more effectively in marketing and contract negotiation, and should incorporate outcomes and other "customer-focused" data desired by third party payors into the quality assurance program.
- 9) UMHC should develop a continuous quality improvement program uniquely appropriate to the University of Minnesota health care environment.
- 10) Consistent with the philosophy of continuous quality improvement, UMHC should develop quality assurance indicators which reflect the priorities of both internal and external customers, and utilize a quality management process which focuses on improving quality from that perspective.

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

JOINT COMMISSION UPDATE

REVISION OF THE ACCREDITATION MANUAL FOR HOSPITALS (AMH)

By 1994, the Joint Commission plans to complete a total reorganization of its hospital accreditation manual. The revised manual will differ from its predecessor by increasing its emphasis on:

- the role of hospital leaders (i.e., executive management, including the chief executive officer, other senior managers and nurse executives; medical staff leaders; and trustees) in promoting and coordinating quality assessment and improvement resources and activities hospital-wide;
- key patient-oriented functions and the inter-disciplinary assessment and improvement of care and services, instead of the Joint Commission's historical focus on department-level review;
- improving the quality of all hospital processes and systems (e.g., management governance and support services), not just clinical services;
- the assessment and ongoing improvement of hospital systems, as well as the practice of individual caregivers; and finally,
- quality assessment and improvement as a positive, non-punitive process into all clinical and management functions.

By 1994, the AMH will look substantially different. Most noticeably, it will be shorter, with its chapters organized around "key functions" instead of hospital departments. While the final categories have yet to be determined, proposed functions include:

- organizational functions, such as safety and utilities management, information management, organizational leadership (governance, management/administrative services and medical staff), competency assessment, and education and training. The quality assessment and improvement and utilization management standards will also be included as organization-wide functions;
- patient care functions, such as admitting and discharge services, diagnostic imaging, medication use, laboratory services, nutritional care, rehabilitation and direct nursing services. Patient satisfaction will likely be included in the assessment of patient care functions.

Reorganization of the accreditation manual is taking place incrementally, with a number of changes included in the 1992 edition released in late August. The following is a summary of the major changes for 1992, as well as their implications for hospitals. Also included as Appendix I is a listing of all chapters of the accreditation manual, summarizing those which have and those which have not undergone significant revision for 1992.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 16, 1992

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: Bone Marrow Transplant Program - Stem Cell Project

Enclosed please find a narrative proposal for enhancement of our Bone Marrow Transplant (BMT) program through development and clinical application of stem cell technology. The BMT program is one of our most highly regarded and largest revenue producing programs. The stem cell project has the promise of moving the BMT project forward to another level of regional and national prominence.

The stem cell project is complex from a number of perspectives. Because of its complexity, we will be dividing the Board presentation into two segments over the next two months. This month we will present the basic outline of the proposal, focusing on what this technology is and why it will be important to the future of the BMT program. Dr. McGlave will make a presentation toward this end at the full Board meeting, with additional introductory information being presented at the Finance and Planning and Development Committee meetings. Next month we will focus more on the business and financial aspects of the proposal, and will request Board approval of the project.

It is probable that we will view this project as both an enhancement of a major patient care program and an investment in development of a proprietary technology. The latter context is relatively new for UMHC and should be an element of the Board discussion. Because we envision a number of technology development opportunities of this nature, we would recommend that the Finance Committee and the Planning and Development Committee appoint a special subcommittee to provide guidance to the potential commercialization of technology in which UMHC is making an early stage investment. We would recommend that this subcommittee include Board representation, Medical School representation, staff from the University Technology Transfer Office, and potentially others both internal and external to UMHC.

We look forward to discussion of this project with you next week.

GH/kj

enclosure

Stem Cell Project Executive Summary

The stem cell project began as a basic laboratory research effort to identify a technique for isolating stem cells (which constitute approximately one in one million cells) from bone marrow and for cultivating them for marrow transplantation. The project is currently at the stage of transition from basic research, which has been funded by research grants, to clinical research, which requires support beyond the scope of available research grants. With appropriate laboratory space, equipment and staff, it appears likely that the stem cell selection and cultivation techniques can be further refined and adapted for clinical use at University Hospital.

This project has several potential benefits. (1) As the first or one of the first bone marrow transplant programs to apply this therapy to patients, we expect this technology to boost our competitive position regionally and nationally. (2) Stem cell transplantation is expected to result in shorter length of stay and reduced costs, an achievement which is especially important in light of the increasing volume of marrow transplantation referrals which are under fixed cost contracts. (3) The Bone Marrow Transplantation Program's reputation has been built on innovative research and being among the first to offer new therapies, a reputation which has led to reliable referral relationships and designation as a "center of excellence" by several major insurers. This project will allow the Program to enhance its stature as a research and clinical program. (4) The stem cell technology may have important proprietary value, offering a benefit beyond the patient care program at UMHC from the Hospital's investment.

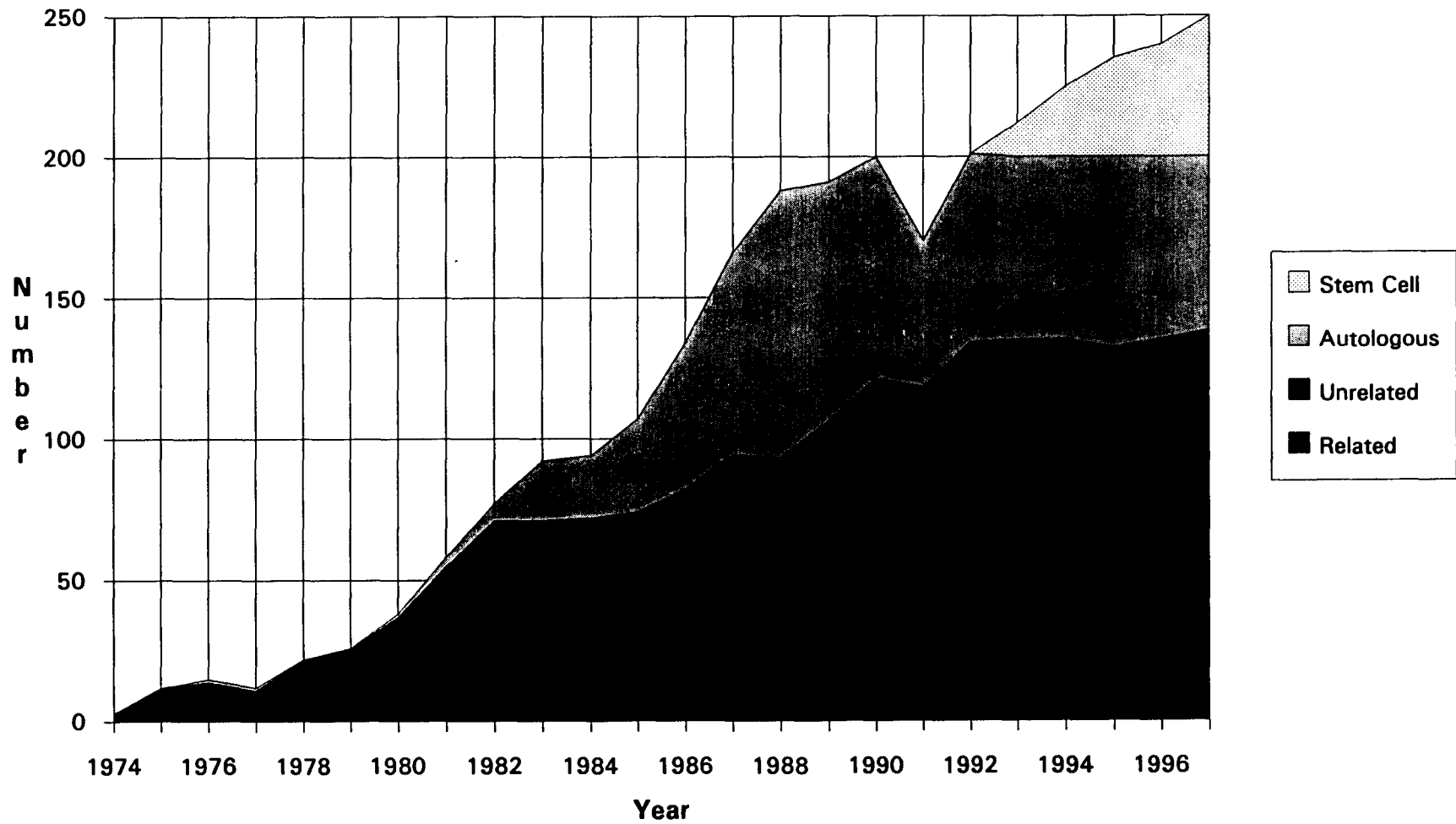
The capital cost of the project includes \$350,000 for remodeling (of which 50% will be from non-hospital sources), \$527,000 for equipment acquisition, and \$400,000-\$450,000 per year for laboratory staff and supplies.

STEM CELL PROPOSAL – PROJECT COST SUMMARY

Remodeling	\$350,000*
Capital Equipment	\$527,000
Annual Staff and Supplies	\$400,000 – \$450,000 per year

*Approximately 50% to be funded from non-hospital sources

Projected Bone Marrow Transplants by Donor Type



HUMAN BONE MARROW STEM CELL PROJECT

Philip McGlave, M.D.

INTRODUCTION

The human bone marrow stem cell has the capability to produce red blood cells which carry oxygen throughout the body, white blood cells which defend the body against infection and platelets which facilitate blood clotting. The stem cell also has the unique capacity to replicate itself, thereby providing a long lasting reservoir of stem cells to sustain blood production throughout the human life span. The stem cell represents only approximately one in one million cells in the human bone marrow. We have recently developed laboratory methods to select human bone marrow stem cells. After further development of this technology, stem cell selection can be applied to the treatment of human diseases under several different circumstances. General application of stem cell selection technology include:

Stem Cell Transplantation. In a variety of lethal human diseases including acute leukemias, chronic leukemias, lymphomas, metastatic breast cancer and other cancers, normal human stem cells co-exist with malignant cells in the bone marrow. Selection and storage of benign stem cells permits treatment of the patient with very high doses of chemotherapy and radiation. Subsequently the patient is "rescued" by reinfusion of the patient's own stem cell population in a procedure termed "stem cell transplantation." Stem cell transplantation has several advantages over currently available donor bone marrow transplant approaches: It is unnecessary to locate a donor, older patients can be transplanted, side effects, inpatient hospital stay and mortality are markedly diminished. These features of stem cell transplantation will dramatically increase the number of patients eligible for potentially life saving therapy and will reduce the cost of the procedure. The number of patients presenting with diseases potentially aided by stem cell transplantation therapy exceeds 100,000 per year in the United States.

Cultivation of stem cell products in the laboratory. Human stem cells have the capacity to differentiate into formed, mature blood cells. With the development of laboratory stem cell cultivation techniques, it can be envisioned that stem cells will be used not only for stem cell transplantation, but to serve as a "blood factory" in which relatively small numbers of stem cells properly stimulated, supported and cultivated in the laboratory will provide a never ending source of "stem cell products" such as red cells, white blood cells and platelets suitable for transfusion therapy. Cultivation of a small number of an individual's own stem cells in the laboratory for subsequent transfusion therapy will markedly reduce the expensive, inconvenient and sometimes futile effort to locate properly ABO-matched blood donors and will eliminate the risk of HIV (AIDS), hepatitis virus and other infections currently associated with transfusion therapy. Stem cell products will last longer in the body than blood products currently obtained from donors. Stem cell products will also have an indefinite shelf life since, unlike blood products currently obtained from donors, they can be frozen. The number of red blood cell and platelet transfusions administered in 1991 at the University of Minnesota hospital using current donor sources is 78,500. Ultimately, the stem cell selection and cultivation technique may obviate the need to locate donors as a source for many of these blood products.

Gene therapy. In a number of lethal diseases, strategies have been developed in which gene insertion into stem cells will either correct the underlying condition directly or will provide a survival advantage for stem cells which will indirectly facilitate therapy. Well known examples of such conditions include sickle cell anemia, thalassemia, the leukemias, the lymphomas, metastatic breast cancer and a variety of other metastatic malignancies. Further development of such treatment strategies is dependent on the ability to select human stem cells which can then be subjected to gene insertion technology.

Summary. We have already developed and published pioneering methods for the selection of human bone marrow stem cells. These studies have been performed in a basic research laboratory using small numbers of cells. In order to continue our lead in the development of stem cell selection techniques for clinical purposes, it is necessary to "scale-up" the stem cell selection methods. This "scale-up" effort is the object of this proposal and is intended to develop safe, efficient means for the selection of human stem cells in sufficient quantities to perform stem cell transplantation as innovative, curative therapy for leukemias, breast cancer and other conditions described above. The specific project as well as a budget and time table for the development of the large scale stem cell selection and initiation of clinical trials are described below.

PROPOSAL

Introduction. We have developed a laboratory method for the selection of stem cells from human bone marrow. We propose to modify these current techniques in order to provide a safe, efficient, reproducible, laboratory-based method for the selection of sufficient numbers of stem cells which can be used for human therapy.

Specific Project. Benign stem cells will be obtained from the bone marrow of patients with chronic myelogenous leukemia or breast cancer in sufficient quantities to allow stem cell transplantation therapy for these lethal diseases. The project will have three components which will be performed in parallel:

Project I: Scale-up of stem cell selection. A series of modifications of our current small scale, laboratory-based technique for selection of benign stem cells from the bone marrow of patients with CML or breast cancer will be performed to increase the yield of benign stem cells suitable for transplantation. As each modification is made, laboratory tests will be performed to ascertain that a viable benign stem cell population is being preserved.

Project II: Laboratory cultivation of mature blood cells from benign stem cells. Benign stem cells will be selected and cultivated in the laboratory to produce large numbers of blood cells suitable for infusion into the patient following stem cell transplantation. These cultivated stem cells will provide a large population of white blood cells needed to sustain the patient in the early course of the transplant. Modifications in our current methods for cultivation of such blood cells from the stem cell population will be made in order to scale-up the procedure. As each modification is made, the resultant stem cell products will be tested for their viability and benign nature.

Project III: Production of monoclonal antibodies to recognize human stem cells. Mouse antihuman monoclonal antibodies which recognize human stem cells will be manufactured. The characterization of one or more such monoclonal antibodies will greatly increase the efficiency of future stem cell selection approaches and may have great proprietary value.

Time course: We anticipate that the first human transplants using stem cell selection will be performed within 6–12 months after funding of the project, occupation of the stem cell laboratory and procurement of all necessary equipment. Should initial stem cell transplants be performed successfully, we anticipate pilot studies testing the efficacy of stem cell transplantation in the therapy of CML and, subsequently, breast cancer will be well underway within 24 to 36 months after initiation of the project.

Additional use of stem cell selection techniques. We anticipate that the stem cell selection and cultivation approaches described above will be applicable not only to therapy of chronic myelogenous leukemia and breast cancer with stem cell transplantation as described in Project I above, but to therapy of a variety of other cancers as well. Preliminary discussions are underway to initiate a similar study in the treatment of malignancies such as small cell cancer of the lung. These stem cell selection techniques will also be useful for clinical studies testing the efficacy of gene insertion currently in the early planning stages within the University of Minnesota Bone

Marrow Transplantation group. We anticipate that the stem cell cultivation techniques also to be developed in the project described above (Project II) will be applicable in a variety of transfusion therapy settings to be tested on our inpatient bone marrow transplantation unit and on the hematology/oncology inpatient treatment units.

IMPACT ON THE UNIVERSITY OF MINNESOTA MEDICAL CENTER

As described above, stem cell selection techniques may lend themselves to innovative therapy for a variety of diseases. Three examples in which stem cell selection might have a major impact on the visibility of the University of Minnesota Medical Center as well as a direct impact on patient accrual are presented below:

Stem cell transplantation therapy for CML. Approximately 46 patients received bone marrow transplantation therapy for CML at the University of Minnesota in 1991. The majority of these patients received related or unrelated donor transplantation. It has been estimated that only 50% of patients referred with CML are candidates for donor bone marrow transplantation because of restrictions in donor availability and applicability of donor transplantation to older recipients. Autologous bone marrow transplantation using stem cell selection techniques obviates the need for matched donors and considerably increases the recipient age limit. After adjustment for these factors, it is anticipated that within two to four years an additional 25–50 patients per year would be eligible for stem cell transplant relying solely on our current referral sources. Additional accrual might be expected if implementation of stem cell transplantation therapy and publication of results increased awareness of the University of Minnesota Bone Marrow Transplantation Program. After scale-up of the stem cell selection process, clinical trials of stem cell transplantation therapy for CML will be performed at the University of Minnesota.

Stem cell transplantation therapy for breast cancer. A second use for stem cell selection therapy would be in the case of stem cell transplantation for breast cancer. Here, selection of the benign

stem cell population coupled with high dose chemotherapy and radiation might prove to be highly effective therapy for this otherwise lethal condition. Approximately 40,000 women per year are diagnosed with stage IV breast cancer. Currently, no curative therapy exists for this condition. Implementation of clinical trials testing the efficacy of this novel and promising approach would be expected to increase visibility of the University of Minnesota Medical Center and Bone Marrow Transplantation Program markedly throughout the nation and to provide a virtually unlimited number of referrals for transplantation therapy as well spill over for other forms of therapy for breast cancer. Preliminary discussions are currently underway to initiate stage IV breast cancer stem cell transplant trials at the University of Minnesota.

Cultivation of stem cells in the laboratory for transfusion therapy. Development of methods for the cultivation of immature blood cells from a small stem cell population ("stem cell products") in the laboratory has important ramifications for transfusion support of patients undergoing high dose chemotherapy. Under such circumstances, a small population of stem cells could be selected from the bone marrow or peripheral blood of patients anticipating subsequent chemotherapy. Large numbers of cultivated stem cell products could be frozen and stored. Following high dose chemotherapy, the stem cell products could be thawed and reinfused to support patients during the period of anemia, low white count and low platelet counts. This would decrease dramatically the need for blood transfusions from donors. This benefit, in turn, would diminish the risk of infection from HIV (AIDS), hepatitis and other blood borne virus infections, would diminish dependency on the Red Cross blood donor network and might markedly diminish the length of hospital stay for patients receiving chemotherapy in the bone marrow transplant or anticancer setting. These stem cell products could be used by many of the approximately 1000 patients per year who receive marrow suppressive chemotherapy for a variety of malignancies at the University of Minnesota.

Proprietary interests. The funding and implementation of the proposed stem cell project for selection and cultivation of human hematopoietic stem cells will most probably result in the development of novel devices and biological substances with proprietary value. These devices may fall into at least two categories: 1) Devices for cultivation of stem cells in the laboratory may be invented. One novel device call the "Transwell system" has already been developed in our laboratory and will allow efficient cultivation of stem cells and stem cell products. Development of this device may lead to more efficient methods for the cultivation of blood products in the laboratory and for gene insertion. A patent application has been filed by our research group for this invention. 2) Our ability to isolate and cultivate human hematopoietic stem cells will allow us to apply conventional monoclonal antibody production techniques in order to create novel monoclonal antibodies which recognize receptors on the surface of human hematopoietic stem cells. We anticipate that one or more such novel monoclonal antibodies will be produced over the next 3 years if the proposed stem cell project is funded. Such monoclonal antibodies may allow us to develop a "one step" selection method for human hematopoietic stem cells to replace our current "four step" method. This would be a significant improvement in stem cell selection technology. Such novel monoclonal antibodies would be patented and would be expected to have a very high proprietary value.

COMPETITION FOR STEM CELL TRANSPLANTATION

Introduction

Several bone marrow transplantation centers in the United States are developing the capability to perform stem cell transplantation. A brief description of these programs is provided:

M.D. Anderson Cancer Center (Houston). The M.D. Anderson Cancer Center is now rapidly developing a stem cell transplantation program based on basic research observations made at the University of Minnesota. They have developed their own monoclonal antibodies to recognize human stem cells and have actually begun a pilot study testing efficacy of a partially purified stem

cell population in autologous bone marrow transplantation. A more complete stem cell selection process similar to the one which is envisioned at the University of Minnesota will not be put in place at M.D. Anderson for at least 12–18 months. We can anticipate that the bone marrow transplantation program at M.D. Anderson will provide vigorous competition for us in the area of stem cell transplantation. This effort has been aided by their ability to focus a great deal of support on the development of stem cell transplantation over the last 12 months. This bone marrow transplantation program is rapidly becoming a major competitor for the University of Minnesota.

Stanford University Bone Marrow Transplantation Program (Palo Alto). The Stanford group has been a leader in the development of stem cell selection in the mouse model. They have recently focused their efforts on selection of a human stem cell. With the advent of a viable bone marrow transplantation program at Stanford over the last three years, basic and clinical researchers at Stanford have united in a common attempt to perform human stem cell transplants. We can anticipate that Stanford will perform a small number of well publicized stem cell transplants within the next 12–18 months. Should these transplants be successful, Stanford will become a major competitor in the area of stem cell transplantation.

Memorial Sloan Kettering Cancer Center (New York). The Memorial Sloan Kettering group has been interested in stem cell selection for at least three years. They are currently developing a method for selection of human bone marrow stem cells for subsequent stem cell transplantation and will undoubtedly initiate clinical stem cell transplant pilot studies.

Fred Hutchinson Cancer Research Center (Seattle). The Seattle bone marrow transplantation program has been interested in basic stem cell research for over five years. They are quite capable of developing clinical stem cell transplantation approaches. They have already performed a small pilot study testing the efficacy of transplantation therapy using partially purified stem cells in the treatment of advanced breast cancer. It can be anticipated that the Seattle group will initiate stem

cell transplantation within the next three to five years, if not sooner. The Seattle transplantation program is our chief competitor in the area of related and unrelated donor bone marrow transplantation and is the only bone marrow transplant program in the world which is larger than our own.

WSJ TUE, DEC 17, 1991

Sandoz Makes Big Biotech Bet On SyStemix

By CHARLES MCCOY

Staff Reporter of THE WALL STREET JOURNAL

Swiss pharmaceutical giant Sandoz Ltd. agreed to acquire 60% of tiny SyStemix Inc. for a pricey \$392 million, extending a wave of acquisitions in the U.S. biotechnology business that's being driven by big-spending foreign investors.

SyStemix, which was founded in 1988 and only went public in August, has developed several avant-garde technologies in gene therapy and related fields that could lead to new treatments for immune disorders, cancers and genetic diseases. Its guiding light is Dr. Irving Weissman, a Stanford University professor who is one of the most highly regarded immunology specialists in the country.

Stock Price Jumps \$19.75

Under yesterday's agreement, Sandoz will pay \$70 a share for four million of SyStemix's shares outstanding and \$56 a share for about two million newly issued shares. The average price, about \$65 a share, represents a fat premium over SyStemix's recent trading range of around \$35 a share.

After the announcement, SyStemix shares soared \$19.75 to close at \$53 in national over-the-counter trading. In Zurich, Sandoz closed at 2,410 Swiss francs (\$1,718.81), down from Friday's close of 2,420 Swiss francs.

The agreement may signal a new phase of big-bucks acquisitions in the U.S. biotechnology industry. Ever since last year, powerhouse drug makers—often foreign concerns—have been paying fat premiums for smaller companies with promising, cutting-edge technologies. For example, Switzerland's Roche Holding Ltd. bought 60% of Genentech Inc. for \$2.1 billion in 1990, a premium of about 66% over Genentech's stock price at the time.

The cash infusions are vital in an industry notorious for volatile stock prices and heavy spending on exotic, high-risk research. Foreign money has found ready takers because Wall Street has run hot and cold on the industry, though U.S. investors in recent months have shown renewed faith in biotechnology.

Research on 'Stem Cells'

The prize for Sandoz in gaining control of SyStemix is the work that Dr. Weissman and his team have done in isolating purified bone marrow "stem cells," which are known as the grandfather of all human stem cells. Scientists say stem cells hold great promise in helping treat various diseases. They also believe that using the purified stem cells could reduce rejection rates in organ transplants.

SyStemix caused a big splash in November when it announced that it had received a patent covering stem cells. In addition to the potential for developing treatments, the patent thrust SyStemix into the middle of the bubbling debate over attempts to patent the basic building blocks of human life.

The company also is known for developing a research animal endowed with a human immune system, the SCID-hu mouse. But clearly, SyStemix's work in stem cells is what caught Sandoz's eye. "We feel they are redefining the state of the art of biotechnology with their stem cell work," said Dr. Craig Burrell, vice president of external affairs for Sandoz Corp., the company's U.S. unit. "They are the world leaders, and their expertise will expand our ability in several key areas." He said the high price was justified, partly as a way to ensure that Dr. Weissman and his scientists stay on board.

SyStemix, Palo Alto, Calif., went public at \$18 a share just four months ago. Dr. Weissman owns 5.3% of SyStemix, which gives his personal holdings a current value of about \$27.6 million, based on the \$65 average share price. But the biggest potential winner in the deal apparently is Eli Jacobs, the New York investor who owns the Baltimore Orioles baseball team. Mr. Jacobs owns about 38% of SyStemix, bought before the company went public; his shares now have a value of about \$195 million.

...reaction. WST
3/30/92

CellPro Inc. Planning To Start Clinical Tests On Bone Marrow Plan

BOTHELL, Wash.—CellPro Inc. plans to start clinical tests in the second quarter of bone marrow transplant in breast cancer patients, using its cell-separation system.

The biotechnology company makes devices that use monoclonal antibodies to isolate specific populations of blood cells for use in therapeutic, diagnostic and research applications.

Pending Food and Drug Administration approval of the test protocol, Richard Murdock, CellPro's president, said in an interview that about 80 patients would be treated at five U.S. medical centers with transplants of their own bone marrow.

Half of the test patients will be randomly assigned to receive bone marrow transplants with stem cells, which are primitive grandfather cells that give rise to all red and white cells of the bloodstream. The other half would receive their bone marrow without the stem-cell separation technique. The test seeks to compare the effectiveness of stem cells versus whole marrow transplants.

The CellPro cell separator isolates a mix of stem cells and other progenitor or early blood-cells which together constitute about 1% of all bone marrow cells. About 1% of this select group are comprised of true stem cells, which are "immortal" or self-replicating cells increasingly being sought by researchers doing cell-transplants and gene therapy.

Mr. Murdock said using the stem cell mixture instead of conventional bone marrow transplant may significantly reduce the time it takes to regenerate enough healthy white cells to protect patients against life-threatening infection. Currently, bone marrow transplant recipients must spend extended periods of time isolated in a germ-free environment.

Mr. Murdock said that after completion of clinical tests the company hopes to file for pre-market approval with the FDA in 1993 to use its cell-separation system in bone marrow transplants. He also said that the company hopes to be profitable by 1996.

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

April 22, 1992

TO: Board of Governors
FROM: Clifford P. Fearing
SUBJECT: Report of Operations for the Period
July 1, 1991 through March 31, 1992

The Hospital's operations for the month of March reflect inpatient census and outpatient clinic visits greater than budgeted levels.

INPATIENT CENSUS: For the month of March, inpatient admissions totaled 1,617 which was 93 over budgeted admissions of 1,524. Our overall average length of stay for the month was 8.1 days. Patient days for March totaled 12,680 and were 93 days over budget. The areas in which admissions were most significantly over budget were Medicine, Surgery, Orthopedics, and Family Practice. Gynecology was an area in which admissions were significantly less than budget.

OUTPATIENT CENSUS: Outpatient encounters (including CUHCC and Home Health) for the month of March totaled 30,972 which was 1,900, or 6.5%, more than budgeted visits of 29,072. CUHCC was 1,068 or 24.2% over budget and Home Health was 356 or 40.0% over budget. Other areas in which visits were significantly over budget include Adult Psych, A.C.T.U., Sports Medicine, and Heart Cath Lab (not budgeted for). Areas which were significantly under budget were Child Psych, Emergency Room, Medicine, and Radiation Therapy.

To recap our census:

Monthly Data					YTD Data					
90/91	91/92	91/92		%	90/91	91/92	91/92		%	
<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>	
1,497	1,524	1,617	93	6.1	Admissions	13,697	13,796	13,567	(229)	(1.7)
12,347	12,587	12,680	93	0.7	Patient Days	109,998	111,824	105,913	(5,911)	(5.3)
7.7	8.3	8.1	(0.2)	(2.4)	Avg Length of Stay	8.0	8.1	7.8	(0.3)	(3.7)
398.3	406.0	409.0	3.0	0.7	Avg Daily Census	401.5	406.6	385.1	(21.5)	(5.3)
68.9	70.5	72.9	2.4	3.4	Percent Occupancy	69.7	70.6	67.9	(2.7)	(3.8)
27,778	29,072	30,972	1,900	6.5	Outpt Encounters	250,995	257,769	257,946	177	0.1

REPORT OF OPERATIONS
March 1992
PAGE 2

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses being greater than revenues by \$1,396,000, an unfavorable variance of \$(5,160,000).

Patient care charges through March totaled \$277,383,000, which was 1.6% under budget. Ancillary revenue was \$178,000 (0.1%) above budget and routine revenue was \$4,710,000 (5.7%) below budget and reflects both our unfavorable inpatient and outpatient census variance. Inpatient revenue averaged \$16,167 per admission compared to the budgeted average of \$16,352. Outpatient revenue per outpatient encounter averaged \$225 per visit compared to the budgeted average of \$218.

Deductions from charges totaled \$74,225,000, which was \$4,700,000 (6.8%) over budgeted deductions of \$69,525,000. The variance is largely due to the Medicare and Medical Assistance programs where the average charges per case are higher than projected, thus resulting in higher than anticipated adjustments. Other factors contributing to the variance include increased activity with Laboratory Outreach programs, increased write-offs associated with an increase in transplant activity, and increased contract activity from the Veterans Administration Hospital.

Operating expenditures through March totaled \$230,537,000 and were \$5,977,000 (2.5%) below budgeted levels of \$236,514,000. The overall favorable variance was primarily due to lower patient related costs (personnel, drugs and blood) and anticipated expenses that will not be incurred.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of March 31, 1992, totaled \$109,873,000 and represented 101.4 days of revenue outstanding. The overall decrease in patient receivables in March of 3.4 days was reflected by a decreased balance in Discharged but not Final Billed totals. This decrease was mainly due to more efficient operations of the Outpatient Encounter Billing System.

CONCLUSION: The Hospital's overall operating position for the month of March was very positive. Both increased patient volumes and reduced expenditure levels contributed to our favorable month outcome. We will continue to take appropriate actions with regard to our expenditure base to ensure at least a break-even financial position for the fourth quarter of the 1991/92 fiscal year.

**UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO MARCH 31, 1992**

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	\$281,915,000	\$277,383,000	(\$4,532,000)	-1.6%
Deductions From Revenue	69,525,000	74,225,000	4,700,000	6.8%
Net Patient Service Revenue	212,390,000	203,158,000	(9,232,000)	-4.3%
Other Operating Revenue				
Appropriation & Support	10,035,000	9,869,000	(166,000)	-1.7%
Other Revenue	8,963,000	8,751,000	(212,000)	-2.4%
Total Other Revenue	18,998,000	18,620,000	(378,000)	-2.0%
Total Revenue From Operations	231,388,000	221,778,000	(9,610,000)	-4.2%
Operating Expenses:				
Salaries	95,565,000	93,263,000	(2,302,000)	-2.4%
Fringe Benefits	23,109,000	22,424,000	(685,000)	-3.0%
Contract Compensation	15,010,000	15,085,000	75,000	0.5%
Supplies And Services	53,008,000	51,605,000	(1,403,000)	-2.6%
Utilities And Maintenance	8,796,000	9,231,000	435,000	4.9%
General Supplies & Expense	14,254,000	12,622,000	(1,632,000)	-11.4%
Insurance	1,401,000	1,400,000	(1,000)	-0.07%
Depreciation & Amortization	14,496,000	13,644,000	(852,000)	-5.9%
Interest	8,637,000	8,877,000	240,000	2.8%
Provision For Uncollectibles	2,238,000	2,386,000	148,000	6.6%
Total Operating Expenses	236,514,000	230,537,000	(5,977,000)	-2.5%
Net Revenue From Operations	(5,126,000)	(8,759,000)	(3,633,000)	
Nonoperating Gains: Investment Income	8,890,000	7,363,000	(1,527,000)	-17.2%
Revenue And Gains In Excess Of Expense	<u>\$3,764,000</u>	<u>(\$1,396,000)</u>	<u>(\$5,160,000)</u>	
	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	13,796	13,567	(229)	-1.7%
Patient Days	111,824	105,913	(5,911)	-5.3%
Average Length Of Stay	8.1	7.8	(0.3)	-3.7%
Average Daily Census	406.6	385.1	(21.5)	-5.3%
Percentage Occupancy	70.6	67.9	(2.7)	-3.8%
Outpatient Encounters	257,769	257,946	177	0.1%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
BALANCE SHEETS

MARCH 31, 1992 AND JUNE 30, 1991

ASSETS	03/31/92	6/30/91	LIABILITIES AND FUND BALANCES	03/31/92	6/30/91
	-----	-----		-----	-----
CURRENT ASSETS			CURRENT LIABILITIES		
Operating Cash	\$12,128,000	\$13,611,000	Accounts Payable	\$12,959,000	\$11,539,000
Reserve Cash- Third Party Payable	24,350,000	21,246,000	Payable to Third Party Contr. Payors	21,535,000	18,431,000
Reserve Cash- Current Indebtedness	2,322,000	5,721,000	Salaries, Wages and Payroll Taxes	13,566,000	9,833,000
Accounts Receivable			Accrued Vacation	9,190,000	9,233,000
Patient Receivables	109,873,000	95,679,000	Accrued Professional Fees and Physician Compensation	2,217,000	2,171,000
Other Receivables	1,910,000	1,795,000	Contracts Payable	5,020,000	522,000
Third Party Receivable	1,427,000	2,145,000	Construction Retainages	139,000	307,000
Appropriation Receivable	2,338,000	1,325,000	Interest Payable	1,880,000	4,684,000
Promissory Notes Receivable	211,000	0	Current Portion of Long-Term Debt	3,110,000	3,157,000
	-----	-----			
	115,759,000	100,944,000			
Less Allowances for Losses in Collection	(8,367,000)	(7,805,000)			
Less Allowances for Discounts to Third Party Payors	(30,501,000)	(24,620,000)			
	-----	-----			
	76,891,000	68,519,000			
Inventories of Drugs & Supplies	4,639,000	4,723,000			
Prepaid Expenses	584,000	1,061,000			
	-----	-----			
TOTAL CURRENT ASSETS	\$120,914,000	\$114,881,000	TOTAL CURRENT LIABILITIES	\$69,616,000	\$59,877,000
ASSETS WHOSE USE IS LIMITED					
Board Designated Assets Available for Assignment					
Cash & Investments	\$44,956,000	\$44,819,000			
Accrued Interest	2,684,000	148,000			
	-----	-----			
	47,640,000	44,967,000			
Cash & Invest for Debt Service	13,000,000	13,000,000			
Cash & Invest for Working Capital	16,000,000	16,000,000			
	-----	-----			
TOTAL	\$76,640,000	\$73,967,000	LONG-TERM DEBT, LESS CURRENT PORTION	\$162,261,000	\$165,282,000
PROPERTY, PLANT, & EQUIPMENT					
Land, Buildings & Improvements	\$192,129,000	\$191,909,000			
Equipment	106,713,000	98,495,000			
	-----	-----			
	298,842,000	290,404,000			
Less Accumulated Depreciation	(146,980,000)	(133,650,000)			
	-----	-----			
	151,862,000	156,754,000			
Construction in Progress	8,576,000	5,581,000			
	-----	-----			
TOTAL PROPERTY, PLANT, & EQUIPMENT	160,438,000	162,335,000			
Assigned Cash & Investments for Construction/Equipment	41,364,000	45,136,000			
	-----	-----			
TOTAL	\$201,802,000	\$207,471,000			
INVESTMENTS HELD BY BOND TRUSTEE	\$17,255,000	\$19,108,000			
PROMISSORY NOTES RECEIVABLE	\$4,057,000	\$0			
OTHER ASSETS					
Deferred Third Party Reimbursement	\$5,905,000	\$6,404,000			
Deferred Debt Expense	946,000	1,009,000			
Deposits and Other	1,197,000	374,000			
	-----	-----			
TOTAL	\$8,048,000	\$7,787,000	UNRESTRICTED FUND BALANCE	\$196,839,000	\$198,055,000
TOTAL ASSETS	\$428,716,000	\$423,214,000	TOTAL LIABILITIES & FUND BALANCE	\$428,716,000	\$423,214,000
	=====	=====		=====	=====
RESTRICTED ASSETS			RESTRICTED FUND BALANCES		
			Endowment Funds	\$2,751,000	\$2,553,000
			Gift Funds	5,269,000	4,863,000
				-----	-----
Cash and Investments	\$8,020,000	\$7,416,000		\$8,020,000	\$7,416,000
	=====	=====		=====	=====

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

CASH FLOW

FOR THE PERIOD JULY 1, 1991 TO MARCH 31, 1992

OPERATING ACTIVITIES AND NONOPERATING REVENUES:

Excess of operating revenues over operating expenses:	(\$8,759,000)
Noncash revenues and expenses included in operating activity:	
Depreciation and amortization	\$14,244,000
Unreimbursed University G & A services	167,000
Provision for uncollectible accounts	2,386,000
Change in patient receivable and other receivables	(11,265,000)
Change in due from third party reimbursement program	717,000
Change in due to third party reimbursement programs	3,105,000
Change in accounts payable	1,420,000
Change in accrued expenses	5,261,000
Other, net	(263,000)

Net cash provided by operating activities \$7,013,000

Nonoperating revenues \$7,363,000

Net cash provided by operating activities and nonoperating revenues \$14,376,000

INVESTING ACTIVITIES:

Acquisition of property, plant and equipment	(\$11,683,000)
Funds transferred from other sources	13,000
Cash outflows for property & plant	(11,670,000)
Increase in promissory notes receivable	(4,268,000)
Decrease in assets whose use is limited	2,953,000
Net cash used in investing activities	(\$12,985,000)

FINANCING ACTIVITIES:

Repayment of long-term debt	(\$2,490,000)
Repayment of notes payable	(678,000)

(\$3,168,000)

Decrease in cash and equivalents (\$1,777,000)

Cash and cash equivalents at June 30, 1991 \$40,577,000

Cash and equivalents at March 31, 1992 \$38,800,000

University of Minnesota Hospital & Clinic
Statement of Changes in Fund Balance
For the Period July 1, 1991 through March 31, 1992

	OPERATING FUND	CURRENT DEBT SERVICE FUND	BOARD DESIGNATED FUND	PLANT FUND	TRUSTEE FUND	TOTAL UNRESTRICTE FUNDS
UNRESTRICTED FUNDS						
Beginning Balance	\$53,120,000	\$5,721,000	\$73,967,000	\$46,139,000	\$19,108,000	\$198,055,000
Net Income						
Excess of Revenue over Expense	4,077,000					
Interest Income on Reserves			6,153,000			
Depreciation Expense				(13,582,000)		
Gain on Disposal of Assets				1,000		
Interest Income on Trustee Held Fund					1,039,000	
Amortization of Deferred Bond Expense				(163,000)		
Amort of Deferred 3rd Party Reimb.				(500,000)		
Interest Income on Bond Proceeds			1,459,000		120,000	
Total Income						(1,396,000)
Less Expense						
University Support: G & A	167,000					167,000
Transfers Between Funds						
Major Building Projects- Hosp.	(2,134,000)			2,134,000		
Capital Expenditures	(5,931,000)			5,931,000		
Major Equipment Requisition	(678,000)			678,000		
Bond Interest Payment	11,409,000	(10,887,000)			(522,000)	
Bond Principal Payment				2,490,000	(2,490,000)	
Bond Interest Expense Funding	(8,084,000)	8,084,000				
Bond Principal Funding	596,000	(596,000)				
Practice Acquisition	4,946,000		(4,946,000)			
Dermatology Loan Payment	(7,000)		7,000			
Transfer from Gift Fund to Plant				13,000		13,000
Ending Balance	\$57,481,000	\$2,322,000	\$76,640,000	\$43,141,000	\$17,255,000	\$196,839,000

	GIFT	ENDOWMENT	TOTAL
RESTRICTED FUNDS			
Beginning Balance	\$4,863,000	\$2,553,000	\$7,416,000
Income	582,000	198,000	780,000
Disbursements	(163,000)		(163,000)
Transfer to Plant Fund for Capital Exp.	(13,000)		(13,000)
Ending Balance	\$5,269,000	\$2,751,000	\$8,020,000

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

Harvard Street at East River Parkway
Minneapolis, MN 55455

March 25, 1992

TO: Board of Governors Finance Committee
FROM: Clifford P. Fearing
SUBJECT: Report of Operations for the Period
July 1, 1991 through February 29, 1992

The Hospital's operations for the month of February reflect inpatient admissions and outpatient clinic visits greater than budgeted levels. Patient days were less than budgeted levels.

INPATIENT CENSUS: For the month of February, inpatient admissions totaled 1,455 which was 56 over budgeted admissions of 1,399. Our overall average length of stay for the month was 7.5 days. Patient days for February totaled 11,010 and were 349 days below budget. The areas in which admissions were most significantly over budget were Medicine and Urology. Gynecology was an area in which admissions were significantly less than budget.

OUTPATIENT CENSUS: Outpatient encounters (including CUHCC and Home Health) for the month of February totaled 28,518 which was 1,980, or 7.0%, more than budgeted visits of 26,538. CUHCC was 784 or 19.6% over budget and Home Health was 271 or 32.6% over budget. Other areas in which visits were significantly over budget include Adult Psych, Emergency Room, Sports Medicine, and Heart Cath Lab (not budgeted for). Areas which were significantly under budget were Child Psych, Medicine, Orthopedic, and Radiation Therapy.

To recap our census:

Monthly Data					YTD Data					
90/91	91/92	91/92		%	90/91	91/92	91/92		%	
<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>	<u>Actual</u>	<u>Budget</u>	<u>Actual</u>	<u>Variance</u>	<u>Var</u>	
1,461	1,399	1,455	56	4.0	Admissions	12,200	12,272	11,950	(322)	(2.6)
11,326	11,359	11,010	(349)	(3.1)	Patient Days	97,651	99,237	93,233	(6,004)	(6.1)
7.8	8.1	7.5	(0.6)	(7.4)	Avg Length of Stay	8.0	8.1	7.8	(0.3)	(3.7)
404.5	391.6	379.7	(11.9)	(3.0)	Avg Daily Census	401.9	406.7	382.1	(24.6)	(6.1)
70.0	68.0	67.4	(0.6)	(0.9)	Percent Occupancy	69.7	70.6	67.2	(3.4)	(4.8)
26,612	26,538	28,518	1,980	7.5	Outpt Encounters	223,217	228,697	226,741	(1,956)	(0.9)

REPORT OF OPERATIONS
February 1992
PAGE 2

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows expenses being greater than revenues by \$2,435,000, an unfavorable variance of \$(5,772,000).

Patient care charges through February totaled \$244,861,000, which was 2.3% under budget. Routine revenue was \$4,204,000 (5.8%) below budget and ancillary revenue was \$1,441,000 (0.8%) below budget and reflects both our unfavorable inpatient and outpatient census variance. Inpatient revenue averaged \$16,184 per admission compared to the budgeted average of \$16,335. Outpatient revenue per outpatient encounter averaged \$227 per visit compared to the budgeted average of \$219.

Deductions from charges totaled \$66,125,000, which was \$4,346,000 (7.0%) over budgeted deductions of \$61,779,000. The variance is largely due to the Medicare and Medical Assistance programs where the average charges per case are higher than projected, thus resulting in higher than anticipated adjustments. Other factors contributing to the variance include increased activity with Laboratory Outreach programs, increased write-offs associated with an increase in transplant activity, and increased contract activity from the Veterans Administration Hospital.

Operating expenditures through February totaled \$204,291,000 and were \$5,921,000 (2.8%) below budgeted levels of \$210,212,000. The overall favorable variance was primarily due to lower patient related costs (personnel, medical supplies and services, drugs and blood) and anticipated expenses not yet incurred.

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of February 29, 1992, totaled \$110,267,000 and represented 104.8 days of revenue outstanding. The overall increase in patient receivables in February of 2.6 days was reflected by an increase in Medicare and Commercial Insurance.

CONCLUSION: The Hospital's overall operating position shows a monthly gain and a year-to-date loss. Actions with regard to our expenditure base are being developed. It is our intention to be in a breakeven financial position for the fourth quarter of the 1991/92 fiscal year.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
SUMMARY STATEMENT OF OPERATIONS
FOR THE PERIOD JULY 1, 1991 TO FEBRUARY 29, 1992

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Gross Patient Revenue	\$250,507,000	\$244,861,000	(\$5,646,000)	-2.3%
Deductions From Revenue	61,779,000	66,125,000	4,346,000	7.0%
Net Patient Service Revenue	188,728,000	178,736,000	(9,992,000)	-5.3%
Other Operating Revenue				
Appropriation & Support	8,920,000	8,773,000	(147,000)	-1.6%
Other Revenue	7,964,000	7,735,000	(229,000)	-2.9%
Total Other Revenue	16,884,000	16,508,000	(376,000)	-2.2%
Total Revenue From Operations	205,612,000	195,244,000	(10,368,000)	-5.0%
Operating Expenses:				
Salaries	84,963,000	82,948,000	(2,015,000)	-2.4%
Fringe Benefits	20,544,000	19,963,000	(581,000)	-2.8%
Contract Compensation	13,336,000	13,392,000	56,000	0.4%
Supplies And Services	47,108,000	45,571,000	(1,537,000)	-3.3%
Utilities And Maintenance	7,836,000	8,213,000	377,000	4.8%
General Supplies & Expense	12,649,000	10,946,000	(1,703,000)	-13.5%
Insurance	1,243,000	1,227,000	(16,000)	-1.3%
Depreciation & Amortization	12,830,000	12,032,000	(798,000)	-6.2%
Interest	7,714,000	7,893,000	179,000	2.3%
Provision For Uncollectibles	1,989,000	2,106,000	117,000	5.9%
Total Operating Expenses	210,212,000	204,291,000	(5,921,000)	-2.8%
Net Revenue From Operations	(4,600,000)	(9,047,000)	(4,447,000)	
Nonoperating Gains: Investment Income	7,937,000	6,612,000	(1,325,000)	-16.7%
Revenue And Gains In Excess Of Expense	<u>\$3,337,000</u>	<u>(\$2,435,000)</u>	<u>(\$5,772,000)</u>	

	1991-92 Budgeted	1991-92 Actual	Variance Over/(Under) Budget	Variance %
Admissions	12,272	11,950	(322)	-2.6%
Patient Days	99,237	93,233	(6,004)	-6.1%
Average Length Of Stay	8.1	7.8	(0.3)	-3.7%
Average Daily Census	406.7	382.1	(24.6)	-6.1%
Percentage Occupancy	70.6	67.2	(3.4)	-4.8%
Outpatient Encounters	228,697	226,741	(1,956)	-0.9%

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
BALANCE SHEETS

FEBRUARY 29, 1992 AND JUNE 30, 1991

ASSETS	02/29/92	6/30/91	LIABILITIES AND FUND BALANCES	02/29/92	6/30/91
	-----	-----		-----	-----
CURRENT ASSETS			CURRENT LIABILITIES		
Operating Cash	\$10,215,000	\$13,611,000	Accounts Payable	\$13,410,000	\$11,539,000
Reserve Cash- Third Party Payable	25,068,000	21,246,000	Payable to Third Party Contr. Payors	22,253,000	18,431,000
Reserve Cash- Current Indebtedness	1,150,000	5,721,000	Salaries, Wages and Payroll Taxes	12,322,000	9,833,000
Accounts Receivable			Accrued Vacation	9,091,000	9,233,000
Patient Receivables	110,267,000	95,679,000	Accrued Professional Fees and Physician Compensation	2,051,000	2,171,000
Other Receivables	1,713,000	1,795,000	Contracts Payable	4,727,000	522,000
Third Party Receivable	1,427,000	2,145,000	Construction Retainages	139,000	307,000
Appropriation Receivable	1,242,000	1,325,000	Interest Payable	930,000	4,684,000
	-----	-----	Current Portion of Long-Term Debt	3,122,000	3,157,000
Less Allowances for Losses in Collection	(8,301,000)	(7,805,000)			
Less Allowances for Discounts to Third Party Payors	(31,209,000)	(24,620,000)			
	-----	-----			
	75,139,000	68,519,000			
Inventories of Drugs & Supplies	4,801,000	4,723,000			
Prepaid Expenses	633,000	1,061,000			
	-----	-----			
TOTAL CURRENT ASSETS	\$117,006,000	\$114,881,000	TOTAL CURRENT LIABILITIES	\$68,045,000	\$59,877,000
ASSETS WHOSE USE IS LIMITED					
Board Designated Assets Available for Assignment					
Cash & Investments	\$49,949,000	\$44,819,000			
Accrued Interest	1,923,000	148,000			
	-----	-----			
	51,872,000	44,967,000			
Cash & Invest for Debt Service	13,000,000	13,000,000			
Cash & Invest for Working Capital	16,000,000	16,000,000			
	-----	-----			
TOTAL	\$80,872,000	\$73,967,000	LONG-TERM DEBT, LESS CURRENT PORTION	\$162,339,000	\$165,282,000
PROPERTY, PLANT, & EQUIPMENT					
Land, Buildings & Improvements	\$192,129,000	\$191,909,000			
Equipment	104,679,000	98,495,000			
	-----	-----			
	296,808,000	290,404,000			
Less Accumulated Depreciation	(145,445,000)	(133,650,000)			
	-----	-----			
	151,363,000	156,754,000			
Construction in Progress	10,182,000	5,581,000			
	-----	-----			
TOTAL PROPERTY, PLANT, & EQUIPMENT	161,545,000	162,335,000			
Assigned Cash & Investments for Construction/Equipment	42,177,000	45,136,000			
	-----	-----			
TOTAL	\$203,722,000	\$207,471,000			
INVESTMENTS HELD BY BOND TRUSTEE	\$17,144,000	\$19,108,000			
OTHER ASSETS					
Deferred Third Party Reimbursement	\$5,960,000	\$6,404,000			
Deferred Debt Expense	953,000	1,009,000			
Deposits and Other	499,000	374,000			
	-----	-----			
TOTAL	\$7,412,000	\$7,787,000	UNRESTRICTED FUND BALANCE	\$195,772,000	\$198,055,000
TOTAL ASSETS	\$426,156,000	\$423,214,000	TOTAL LIABILITIES & FUND BALANCE	\$426,156,000	\$423,214,000
	=====	=====		=====	=====
RESTRICTED ASSETS			RESTRICTED FUND BALANCES		
Cash and Investments	\$7,979,000	\$7,416,000	Endowment Funds	\$2,621,000	\$2,553,000
	-----	-----	Gift Funds	5,358,000	4,863,000
	=====	=====		-----	-----
				\$7,979,000	\$7,416,000
	=====	=====		=====	=====

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

CASH FLOW

FOR THE PERIOD JULY 1, 1991 TO FEBRUARY 29, 1992

OPERATING ACTIVITIES AND NONOPERATING REVENUES:

Excess of operating revenues over operating expenses:	(\$9,047,000)
Noncash revenues and expenses included in operating activity:	
Depreciation and amortization	\$12,566,000
Unreimbursed University G & A services	140,000
Provision for uncollectible accounts	2,106,000
Change in patient receivable and other receivables	(9,442,000)
Change in due from third party reimbursement program	718,000
Change in due to third party reimbursement programs	3,822,000
Change in accounts payable	1,871,000
Change in accrued expenses	2,510,000
Other, net	224,000

Net cash provided by operating activities \$5,468,000

Nonoperating revenues \$6,612,000

Net cash provided by operating activities
and nonoperating revenues \$12,080,000

INVESTING ACTIVITIES:

Acquisition of property, plant and equipment (\$11,186,000)

Funds transferred from other sources 12,000

Cash outflows for Property & Plant (11,174,000)

Increase in assets whose use is limited 1,982,000

Net cash used in investing activities (\$13,156,000)

FINANCING ACTIVITIES:

Repayment of long-term debt (\$2,490,000)

Repayment of notes payable (578,000)

(\$3,068,000)

Increase in cash and equivalents (\$4,144,000)

Cash and cash equivalents at June 30, 1991 \$40,577,000

Cash and equivalents at February 29, 1992 \$36,433,000

University of Minnesota Hospital & Clinic
Statement of Changes in Fund Balance
For the Period July 1, 1991 through February 29, 1992

	OPERATING FUND	CURRENT DEBT SERVICE FUND	BOARD DESIGNATED FUND	PLANT FUND	TRUSTEE FUND	TOTAL UNRESTRICTED FUNDS
UNRESTRICTED FUNDS						
Beginning Balance	\$53,120,000	\$5,721,000	\$73,967,000	\$46,139,000	\$19,108,000	\$198,055,000
Net Income						
Excess of Revenue over Expense	2,229,000					
Interest Income on Reserves			5,553,000			
Depreciation Expense				(11,972,000)		
Loss on Disposal of Assets				(4,000)		
Interest Income on Trustee Held Fund					925,000	
Amortization of Deferred Bond Expense				(145,000)		
Amort of Deferred 3rd Party Reimb.				(445,000)		
Interest Income on Bond Proceeds			1,301,000		124,000	
Total Income						(2,435,000)
Less Expense						
University Support: G & A	140,000					140,000
Transfers Between Funds						
Major Building Projects- Hosp.	(2,263,000)		29,000	2,233,000		
Capital Expenditures	(6,149,000)			6,149,000		
Major Equipment Requisition	(578,000)			578,000		
Bond Interest Payment	11,410,000	(10,887,000)			(523,000)	
Bond Principal Payment				2,490,000	(2,490,000)	
Bond Interest Expense Funding	(7,133,000)	7,133,000				
Bond Principal Funding	817,000	(817,000)				
Dermatology Loan Payment	(22,000)		22,000			
Transfer from Gift Fund to Plant				12,000		12,000
Ending Balance	\$51,571,000	\$1,150,000	\$80,872,000	\$45,035,000	\$17,144,000	\$195,772,000

	GIFT	ENDOWMENT	TOTAL
RESTRICTED FUNDS			
Beginning Balance	\$4,863,000	\$2,553,000	\$7,416,000
Income	573,000	68,000	641,000
Disbursements	(66,000)		(66,000)
Transfer to Plant Fund for Capital Exp.	(12,000)		(12,000)
Ending Balance	\$5,358,000	\$2,621,000	\$7,979,000

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 ADMISSIONS & AVERAGE LENGTH OF STAY (ALOS) BY SERVICE
 1990/91 AND 1991/92 COMPARISON

CLINICAL SERVICE	ADMISSIONS							AVERAGE LENGTH OF STAY		
	1990/91	1991/92				CHANGE	% CHANGE	1990/91	1991/92	CHANGE
	FEB YTD ACTUAL	FEB YTD BUDGET	FEB YTD ACTUAL	VARIANCE	% VARIANCE	FROM PRIOR YR	FROM PRIOR YR	FEB YTD ALOS	FEB YTD ALOS	
ANESTHESIOLOGY	0	0	1	1		1		0.0	1.5	1.5
CLINICAL RESEARCH	261	269	185	(84)	-31.2%	(76)	-29.1%	3.5	3.1	(0.4)
DENTISTRY	5	5	3	(2)	-40.0%	(2)	-40.0%	0.6	2.3	1.7
ORAL SURGERY	30	33	55	22	66.7%	25	83.3%	1.8	1.6	(0.2)
DERMATOLOGY	9	10	11	1	10.0%	2	22.2%	3.9	5.2	1.3
FAMILY PRACTICE	14	16	66	50	312.5%	52	371.4%	3.8	3.5	(0.3)
GYNOCLOGY	917	961	741	(220)	-22.9%	(176)	-19.2%	4.8	4.8	0.0
MEDICINE	2,969	3,004	3,149	145	4.8%	180	6.1%	6.5	6.4	(0.1)
NEWBORN	230	242	222	(20)	-8.3%	(8)	-3.5%	2.5	1.9	(0.6)
NEUROLOGY	214	218	234	16	7.3%	20	9.3%	6.4	6.8	0.4
NEUROSURGERY	657	655	776	121	18.5%	119	18.1%	5.9	6.0	0.1
OBSTETRICS	370	375	347	(28)	-7.5%	(23)	-6.2%	3.1	3.0	(0.1)
OPHTHALMOLOGY	327	314	263	(51)	-16.2%	(64)	-19.6%	2.8	2.6	(0.2)
ORTHOPEDECS	761	737	771	34	4.6%	10	1.3%	5.6	5.6	0.0
OTOLARYNGOLOGY	267	274	247	(27)	-9.9%	(20)	-7.5%	4.3	3.9	(0.4)
PEDIATRICS	2,126	2,163	1,916	(247)	-11.4%	(210)	-9.9%	10.1	8.8	(1.3)
PHYSICAL MEDICINE & REHAB	141	141	128	(13)	-9.2%	(13)	-9.2%	18.0	19.7	1.7
PSYCHIATRY ADULT	555	526	501	(25)	-4.8%	(54)	-9.7%	13.6	15.1	1.5
PSYCHIATRY CHILD	48	41	51	10	24.4%	3	6.3%	22.0	27.4	5.4
RADIATION THERAPY	0	0	1	1		1		0.0	1.0	1.0
RADIOLOGY	18	16	11	(5)	-31.3%	(7)	-38.9%	1.3	1.1	(0.2)
SURGERY	1,920	1,935	1,893	(42)	-2.2%	(27)	-1.4%	9.4	9.5	0.1
UROLOGY	361	337	378	41	12.2%	17	4.7%	4.7	4.7	0.0
TOTAL	12,200	12,272	11,950	(322)	-2.6%	(250)	-2.0%	8.0	7.8	(0.2)

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 16, 1992

TO: Members, Board of Governors

FROM: Robert Dickler 
Hospital Director

SUBJECT: Renewal Project

At the February meeting of the Board of Governors we described the reconfiguration of the Renewal Project in general terms, noting in particular that we are proposing that we not proceed with the two floor addition to Unit J. We are providing the Board of Governors with more detail on the reconfiguration of the project this month.

Attached is information describing the components of the project, the previous and new budgets for each of the components, and a schedule for the project. As you can see, we are now budgeting a total of \$23.0 million for the project, compared to the previously approved \$37.6 million.

In addition to discussing the specific parameters of the project, the Board may wish to discuss what process it wishes to use for ongoing assessment and monitoring of the various elements of the project.

I look forward to our discussion next week.

/kj

attachments

RENEWAL PROJECT RECONFIGURATION

Psychiatry

New construction on top of Unit J will not occur. The Department of Psychiatry is in the preliminary stages of reconfiguring its programs based on an estimated bed capacity of 50 beds. One Unit J Med Surg Unit will be converted into a 18-24 bed high acuity Psych Unit. An existing Psych Unit on Mayo 6 will be renovated to accommodate 16-18 Chem Dep/Eating Disorder/Depression beds. A 12-14 bed Child Adolescent Unit will be accommodated in a yet undetermined location on the 5th or 6th floor of Mayo. Revised planning for Psych Day Hospital, Clinic and offices will soon be initiated. It is assumed these functions will be relocated to the 5th or 6th floor of Mayo at budget levels similar to previous commitments. The timetable for inpatient renovation is approximately 18-24 months. Approximately \$50,000 has been spent to date on interim upgrades. The aggregate budget for renovations is \$5.6 - 7 million.

Inpatient Rehab

A study is underway to determine if a segment of a Unit J Med Surg Unit can be renovated to accommodate approximately 10 inpatient Rehab beds. Relocation of Rehab beds to Unit J presents significant bed allocation and remodeling challenges which are currently being researched as part of this study. The previous budget of \$.5 million is used here but may need to be revised.

Rehab Therapies

Both Adult and Pediatric Rehab therapies will consolidate on renovated Mayo 4 in revised planning. A preliminary estimate of renovation cost is \$1 million. Some flexibility exists in contingency funds if a higher budget is justified.

The Adult Rehab satellite project planned for Unit J is currently underway. Peds Rehab Therapy satellite in Unit J is complete.

OB

Potential relocation of OB to Unit J is on hold pending the outcome of the discussion with Riverside Medical Center on merging OB programs.

OR Expansion/Urology Clinic/Cystoscopy/Ambulatory Surgery Same Day Admit Program

The expansion of 4 OR's in Unit J along with associated Post Anesthesia Care Unit renovation will move forward as planned. This expansion and renovation will accommodate the consolidation of

Ambulatory Surgery (currently in the PWB building) with the inpatient OR's and Post Anesthesia Care Unit at an approximate cost of \$2.25 million.

The vacated Ambulatory Surgery space (in PWB) will be remodeled to house Cystoscopy and Urology Clinic. The admitting, assessment and waiting functions associated with Ambulatory Surgery will be accommodated on the Short Stay Unit which will occupy renovated space on Masonic 1 and/or 2. Current cost estimate for Short Stay Unit relocation and Urology Clinic/Cystoscopy renovation is \$2.25 million.

Pharmacy

Pharmacy renovation planning is currently underway with an estimated cost of \$.75 million.

Autopsy

Autopsy renovation is completed.

Mayo Upgrade

A \$4 million budget for Mayo upgrading will remain intact to accommodate HVAC upgrade in Mayo and address life safety issues.

Faculty Office Renovation

The original commitment of space and \$1.5 million for faculty office renovation remains valid. Approximately \$50,000 has been spent to date on NICU offices.

REVISED RENEWAL PROJECT BUDGET

4/16/92

PROJECT ELEMENT	PREVIOUS LOCATION	PREVIOUS BUDGET	PROPOSED LOCATION	PROPOSED BUDGET	REMAINING EXPENSE
SHELL SPACE	UNIT J 9	\$5.62		\$0.00	\$0.00
PSYCH INPATIENT	UNIT J 10	\$16.40	UNIT J 7	\$1.50	\$1.50
PSYCH INPATIENT			MAYO 6 & 5	\$3.00	\$3.00
PSYCH CLINIC	MAYO 4/6	\$0.50	MAYO 6 & 5	\$0.50	\$0.50
PSYCH DAY HOSP	MAYO 3/6	\$0.57	MAYO 6 & 5	\$0.57	\$0.57
PSYCH OFFICES	MAYO 3/6	BELOW	MAYO 6 & 5	BELOW	BELOW
PSYCH TEMP FIX	MAYO 6	\$0.10	MAYO 6	\$0.10	\$0.05
REHAB INPATIENT	REHAB 4	\$0.50	UNIT J ?	\$0.50	\$0.50
REHAB THERAPY	MAYO 4	\$1.96	MAYO 4	\$1.00	\$1.00
REHAB THER SAT	UNIT J ?	\$0.24	UNIT J	\$0.24	\$0.18
OB INPT (TEMP)	MAYO 5/6	\$0.37	MAYO 5/6	\$0.37	DONE
OB INPT (FINAL)	UNIT J 5D	\$0.75		\$0.00	HOLD
OR EXPAN-AMB SURG	UNIT J 3	\$1.97	UNIT J	\$2.00	\$2.00
AMB SURG SUPPORT	UNIT J / MAS	\$0.25	UNIT J/MAS	PACU RENO	PACU RENO
SHORT STAY UNIT			MAS 1 & 2	\$1.50	\$1.50
UROLOGY CLINIC	PWB 1	\$0.10	PWB 1	\$0.25	\$0.25
UROLOGY CYSTO	PWB 1	\$0.45	PWB 1	\$0.50	\$0.50
UROLOGY TEMP FIX	MAYO 5	\$0.10	MAYO 5	\$0.10	\$0.10
UROLOGY OFFICE	MAYO 5	BELOW	MAYO 5	BELOW	BELOW
PACU RENOVATION			UNIT J 3	\$0.25	\$0.25
PHARMACY		\$0.60	KE 1	\$0.75	\$0.75
AUTOPSY	MAYO	\$0.40	MAYO	\$0.40	DONE
MAYO CODE/ ASBES	MAYO	\$2.00	MAYO	\$2.50	\$2.50
MAYO SYS UPGRADE	MAYO	\$2.00	MAYO	\$2.50	\$2.50
MAYO MISC RENO	MAYO	\$0.14	MAYO	\$0.70	\$0.70
RELOCATION COST	VARIOUS	\$1.10	VARIOUS	\$1.00	\$1.00
FACULTY OFFICE	VARIOUS	\$1.50	VARIOUS	\$1.50	\$1.45
PROJ CONTINGENCY				\$0.50	\$0.50
TOTAL		\$37.62		\$22.23	\$21.30

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

TO: Members, Board of Governors

FROM: Robert M. Dickler
General Director

DATE: April 17, 1992

As you know, we are scheduled to present the 1992-93 fiscal year budget at the Finance Committee and Board of Governors this month. Legislative decisions on Health Right and Medicaid reimbursement are important variables in our budget. We would like to include at least a preliminary analysis of final legislative decision-making in the material we present to the Board, thus we have not included the budget information in the enclosed packets. We will deliver a supplemental packet to the Board members with the budget materials, if possible, before the Board meeting.

We were also planning to discuss performance indicators at the April meeting. Because these so closely follow the budget, and because of the number of important items in the April agenda, we will plan on discussing the performance indicators at the May Board meeting.

Thank you.

RMD/gs

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 ADMISSIONS & AVERAGE LENGTH OF STAY (ALOS) BY SERVICE
 1990/91 AND 1991/92 COMPARISON

CLINICAL SERVICE	ADMISSIONS							AVERAGE LENGTH OF STAY		
	1990/91		1991/92		CHANGE % CHNAGE			1990/91	1991/92	CHANGE
	MAR YTD	MAR YTD	MAR YTD	MAR YTD	%	FROM	FROM	MAR YTD	MAR YTD	
ACTUAL	BUDGET	ACTUAL	VARIANCE	VARIANCE	PRIOR YR	PRIOR YR	ALOS	ALOS		
ANESTHESIOLOGY	0	0	1	1		1		0.0	1.5	1.5
CLINICAL RESEARCH	290	302	218	(84)	-27.8%	(72)	-24.8%	3.5	3.1	(0.4)
DENTISTRY	5	5	3	(2)	-40.0%	(2)	-40.0%	0.6	2.3	1.7
ORAL SURGERY	42	37	58	21	56.8%	16	38.1%	1.5	1.5	0.0
DERMATOLOGY	10	11	12	1	9.1%	2	20.0%	4.6	6.4	1.8
FAMILY PRACTICE	23	18	88	70	388.9%	65	282.6%	4.0	3.6	(0.4)
GYNECOLOGY	1,014	1,080	838	(242)	-22.4%	(176)	-17.4%	4.8	4.9	0.1
MEDICINE	3,374	3,377	3,567	190	5.6%	193	5.7%	6.4	6.4	0.0
NEWBORN	254	272	245	(27)	-9.9%	(9)	-3.5%	2.5	1.9	(0.6)
NEUROLOGY	246	245	263	18	7.3%	17	6.9%	6.3	6.7	0.4
NEUROSURGERY	742	736	876	140	19.0%	134	18.1%	5.9	5.9	0.0
OBSTETRICS	412	422	383	(39)	-9.2%	(29)	-7.0%	3.1	3.1	0.0
OPHTHALMOLOGY	368	353	295	(58)	-16.4%	(73)	-19.8%	2.9	2.6	(0.3)
ORTHOPEDICS	837	829	885	56	6.8%	48	5.7%	5.5	5.5	0.0
OTOLARYNGOLOGY	300	308	277	(31)	-10.1%	(23)	-7.7%	4.3	4.1	(0.2)
PEDIATRICS	2,377	2,432	2,183	(249)	-10.2%	(194)	-8.2%	10.0	8.9	(1.1)
PHYSICAL MEDICINE & REHAB	156	160	140	(20)	-12.5%	(16)	-10.3%	17.9	19.4	1.5
PSYCHIATRY ADULT	614	591	568	(23)	-3.9%	(46)	-7.5%	14.0	15.1	1.1
PSYCHIATRY CHILD	55	46	60	14	30.4%	5	9.1%	23.1	28.9	5.8
RADIATION THERAPY	0	0	1	1		1		0.0	1.0	1.0
RADIOLOGY	24	18	16	(2)	-11.1%	(8)	-33.3%	1.3	1.4	0.1
SURGERY	2,145	2,175	2,160	(15)	-0.7%	15	0.7%	9.4	9.5	0.1
UROLOGY	409	379	430	51	13.5%	21	5.1%	4.6	4.8	0.2
TOTAL	13,697	13,796	13,567	(229)	-1.7%	(130)	-0.9%	8.0	7.8	(0.2)

UNIVERSITY OF MINNESOTA

The University of Minnesota Hospital and Clinic

*Harvard Street at East River Parkway
Minneapolis, MN 55455*

April 21, 1992

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: 1992-93 Operating Budget for The University
of Minnesota Hospital and Clinic

Enclosed for your review are the operating budget schedules for the 1992-93 fiscal year. These budget projections are the results of a budget process which has involved all levels of management preparing a projection of activity, costs, revenue deductions, and reserve and capital needs required to operate The University of Minnesota Hospital and Clinic in fiscal year 1992-93 and in later years.

In our shaping of the 1992-93 budget, I wish to highlight several significant factors which we have incorporated. The first item, of course, is the HealthRight legislation. This will impose a 2.0% provider tax beginning January 1, 1993. While there are provisions for passing this tax through to payors, it is still unclear to us how much of the tax can and will be actually reimbursed. Therefore, this legislation has the potential of reducing our reimbursement approximately \$1,800,000 within the 1992-93 fiscal year (six months of tax). We do not believe we will see much, if any, increase in patient referrals or reimbursement as a result of this legislation. Because of this legislation's potential impact on UMHC we have included an additional 1.0% rate increase in our budget.

A second legislative item is a 3.5 percent reduction in University appropriations made by the state as part of its budget balancing actions. We anticipate that this reduction will be approximately \$540,000 for UMHC. The reduction in hospital appropriations, which are basically for education support, will necessitate an equal reduction in the amount of cost the Hospital can support for graduate medical education, other allied health programs, and academic support.

We have been working with University administration regarding payments the Hospital makes to the University for such things as fringe benefits, utilities, maintenance and construction, and other goods and services. It is our position, after having analyzed the various billing rates and charging mechanisms currently in place, that the Hospital is paying in aggregate a disproportionate share of these centralized costs. Because of the magnitude of these costs, we have

budgeted a \$2,000,000 reduction in the payments we will make to the University. We are also seeking changes in the rates charged the Hospital so that we are more fairly charged based on our actual experience or utilization. The actual viability of this change still needs to be explored with central administration.

As we look at the current market and the census projections for next fiscal year we are again faced with the need to reduce our staffing levels. During the current fiscal year our staffing has declined by 196 FTE's from an average of 3,836 last summer to our current average of approximately 3,640. We are targeting to be at 3,600 FTE's by June 30, 1992. The 1992-93 budget will require further reductions. We are targeting to be at a staffing level of approximately 3,500 FTE by October 1, 1992. It is our desire to achieve as much of this reduction as possible through attrition. In addition to the projected staffing reductions, we have budgeted non-volume related reductions to various supply and expense categories totaling \$750,000.

In developing the 1992-93 budget we have not specifically incorporated any of the preliminary findings and recommendations being developed by our strategic planning consultants. We have compared our volume projections for 1992-93 with the consultants and they are within approximately 1% of each other. While we anticipate that the outcome of the planning effort may have significant impact on the budget and financial performance later in the year, we believe it would be inappropriate to forecast or pre-empt this process. Depending on the magnitude of these changes it may be appropriate to restructure the budget later in the year.

We are budgeting for a 2% net gain for the Hospital. This is consistent with our long range capital plan. More important, we feel this level of planned performance is necessary to deal with the volatility in the hospital and health system and provide appropriate margins for change.

Over the last few years the Hospital, Medical School, and other academic units have experienced reductions in funding from a number of sources. Because so much of the Hospital's financial outcome is the result of our relationship with the medical staff and other faculty; and their role in patient care, education, and research; we believe it is appropriate and timely to consider an arrangement whereby the academic programs could share in the Hospital's success. We would therefore propose an arrangement where the Hospital would distribute twenty percent of any excess above it's budgeted net gain. The distribution would be made to those academic units that helped in meeting the Hospital's financial goals. We believe such a methodology is consistent with the partnership between the Hospital and academic units which has always existed and is incorporated into the strategic planning effort. The exact methodology for this potential distribution, and whether it should be an ongoing arrangement, are still under study.

We are also preparing, in relationship to reserves, that \$2,000,000 be set aside and designated for one time investments to increase productivity, provide transition funds for cost reduction strategies, and to provide some flexible resources to initiate activities emanating from the strategic plans. If approved by the Board, these changes will be reflected in the reserve schedule.

The projected financial statements have been compiled using a rate increase of eight (8.0) percent. The capital budget which we have incorporated in these financial projections is consistent with our long range capital plan. These financial projections include \$8,200,000 in annual equipment replacement and minor renovation costs, and \$3,336,000 in principal payments. In addition, we are dedicating \$6,431,000 of interest income on reserves for the capital plan.

At our April, 1992 meeting, we intend to present the remaining assumptions we have used in developing the budget and provide you with the impact this budget will have on Hospital and Clinic operations in 1992-93. We will seek your preliminary approval of an eight (8.0) percent rate increase at the April Board Meeting, and will seek your approval of rate increases and the operating budgets at the May, 1992 meeting. The capital budget will be presented to the Planning and Development Committee at their June, 1992 meeting.

The enclosed narrative and schedules outline our 1992-93 budget based on current assumptions. We look forward to our discussion with you on the budget.

RD/sw

Enclosure

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BUDGET LETTER
1992-93 BUDGET

The 1992-93 Budget has been developed with the following set of assumptions:

1991-92 Budget Base

In projecting the 1992-93 fiscal year budget elements, the current experience in each category was used as the starting point to determine expected 1992-93 results. As described below and shown in the attached schedules, forecast admissions, patient days, clinic visits, expenses, revenues, and revenue deductions have been 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 1992-93 budget were projected:

*** Demand Analysis:**

For the 1991-92 fiscal year we had developed a budget of 18,335 admissions and 147,862 patient days. Using our actual experience through March, 1992, we are projecting 17,894 admissions and 140,638 patient days. The decrease in admission levels occurred in more than half of the clinical service areas, with the most significant decreases occurring in Pediatrics, Gynecology, Clinical Research and Ophthalmology. Areas that experienced increases in admissions included Neurosurgery and Family Practice. The 4.9% decrease in patient days also reflects our decrease in the overall average length of stay from 8.1 days to 7.9.

The 1992-93 census projections reflect a slight overall decline in demand but with significant decreases in specific services, such as Medicine, Surgery, and Ophthalmology. These decreases reflect changes in clinical staff or programs, and changes in reimbursement from third party payors that continue to force a shift of inpatient activity to an outpatient venue. They are slightly offset by anticipated growth in Neurosurgery, Neurology, Orthopedics, and Otolaryngology. Inpatient census for 1992-93 has been budgeted at 17,079 admissions and 136,510 patient days.

For the 1991-92 fiscal year we had developed a budget of 348,437 outpatient encounters. Based on actual March, 1992, volumes, we are projecting 349,277 encounters for 1991-92 and 352,325 encounters for 1992-93. These increases reflect the anticipated growth in Neurology, Neurosurgery, and Orthopedics, as well as projected growth in CUHCC activity.

Schedules I, II, and III summarize the demand forecasts for 1991-92 and 1992-93.

*** Ancillary Service Utilization**

The 1992-93 budget for ancillary service revenue reflects the projected decline in inpatient admissions with slight changes anticipated for both program expansions and reductions. While we anticipate continued expansion of programs such as Bone Marrow Transplants, we have also budgeted for a decrease in revenue due to anticipated declines in one or more programs. In addition, expected growth in the Orthopedic and Oncology programs in the outpatient clinics is partially offset by these same anticipated declines.

*** Deductions from Charges**

Schedule IV is a summary of the expected deductions from revenue for fiscal years 1991-92 and 1992-93. The fiscal 1992-93 projection is based on current experience as well as pending legislative and regulatory changes relating to the Medicare and Medicaid Programs.

o **Medicare Prospective Payment System (PPS)**

Assumptions affecting UMHC payments include the following:

- 1) A 3.0% payment rate increase (comparable to ProPAC recommendation of 3.05% for all urban hospitals) on the DRG rate, effective October 1, 1992.
- 2) A reduction in the indirect medical education factor from 7.7% to 6.9%, effective October 1, 1992.
- 3) Capital cost reimbursement is incorporated into the DRG payment effective July 1, 1992. For fiscal year 1992-93, we anticipate no material change in the effective reimbursement for capital costs.

These assumptions are, of course, subject to change and will be monitored closely.

o **Medical Assistance (Medicaid) and General Assistance Medical Care (GAMC)**

Payments will continue to be based on the 39 diagnostic categories set up by the State Department of Human Services (DHS). We are assuming a continued distinction in payment rates between AFDC and non-AFDC patients, with a 5.0% increase in those rates effective July 1, 1992. We are assuming no increase in payment rates for GAMC patients. In addition, new state legislation would result in a provider surcharge of 1.4% of net patient revenues, excluding Medicare, which is offset by the foregoing rate changes.

We have also recognized the possibility of a \$1,800,000 reduction in reimbursement levels in relation to the 2.0 percent provider tax contained in the Minnesota HealthRight legislation.

o **HMO/PPO Discounts**

The major contracts with HMO's and PPO's include the Blue Cross and Blue Shield AWARE and Blue Plus contracts, Group Health, Med Centers, and MEDICA. For the budget year we are assuming that our payment to charge ratios will worsen slightly as the expected increases in our payment levels (4.0% January 1, 1993) fall behind our required overall rate increase of 8.0%.

* **Other Operating Revenue**

Schedule V is a summary of projected appropriations and other operating revenues from sources other than patient care. The decrease in other operating revenue projected for the 1991-92 fiscal year is expected in almost all categories of revenue. Lower than anticipated census levels account for some of the decrease. In addition, the income from bond proceeds is lower than budgeted due to a lower than expected interest rate being earned on the principal. Our appropriations were greater than budgeted due to a lower than anticipated reduction in the state specials for 1991-92. We expect to see an increase in other operating revenues in the budget year, primarily due to the restoration of the \$2,000,000 one-time assessment imposed on UMHC by the University in 1991-92. Offsetting this increase is an expected 3.5% reduction in appropriation levels in 1992-93.

* **Expenditure Summary**

Schedule VI is a comparative summary of expenditures projected for 1991-92 and budgeted for 1992-93. The expenditure levels have been determined using February, 1992, year-to-date actual experience as a basis for projection.

Salaries:

Although no pay plans for employees have been finalized, we have incorporated salary and wage increases that appear consistent with those in the community and the University pay plans. We are in the second year of existing union contract settlements, which have a base increase of 5%. Other employee classes are budgeted

with a 5% base increase. Also included in the salary projection are adjustments for step increases and marketplace range moves. Specific pay plans have not yet been determined; these will be presented to the Board in May or June.

Other Expenses:

Inflationary increases for supplies and expenses are expected to average almost 5.7% in the budget year. In addition to the anticipated inflationary increases, we are including increases for expansion and development of new and existing programs.

* **Non-Operating Revenue**

Schedule VIII is a summary of expected non-patient revenues for fiscal years 1991-92 and 1992-93. The decrease in non-operating revenue projected for the 1991-92 fiscal year is expected in all three categories of revenue. Although our principal balance in reserves is slightly higher than anticipated, we are earning a lower than expected rate of interest on that principal. The decrease in earnings on the investments held by the trustee is also due to a lower than anticipated yield on those investments. The decrease in other investment income is due largely to the delay in the Interstate Medical Center acquisition. In the budget year 1992-93 we are expecting an overall decrease of \$1,378,000. Although we're assuming an increase in investment income from our equity in Interstate Medical Center, we're budgeting reductions in the interest earned on our reserves and investments held by the trustee. In both cases, we anticipate a continued decline in the interest rate. In addition, we expect the average cash balance of our reserves to decline significantly in relation to our planned capital expenditures.

Fiscal Year 1992-93 Price and Revenue Increases

The price increase proposed for 1992-93 is 8.0% and results in an increase in patient charges of approximately \$20,663,000. It brings total patient charges to \$389,547,000. The Comparative Statement of Operations and Operating Cash Flow on Schedule IX summarizes our projected position for the 1992-93 fiscal year.

Capital Expenditures

Capital expenditures that will be provided from operating cash flows in 1992-93 for recurring equipment replacement and minor remodeling will be \$8,200,000. In addition, \$3,336,000 will be spent for debt service on equipment and the bonds, capital lease payments, and parking ramp amortization.

In addition to those capital expenditures provided from operating cash flow, we are projecting that we will spend \$34,916,700 from Hospital reserves. Within this total is \$8,568,400 related to the Renewal Project Phase II, \$3,722,900 for the completion of other projects that have received Board of Governors approval (MRI I replacement, Heart Cath expansion, linear accelerator replacement, the Cancer Center, Interstate Medical Center), \$12,089,500 for equipment/renovation projects that have yet to be brought to the Board for approval (computer upgrade, Heart Cath expansion, CT scanner replacement, Neuroradiology upgrade, parking ramp addition), \$3,036,000 for support of new technology/program development, and \$7,500,000 for the potential acquisition of outstate clinics.

Schedule X summarizes the Board-Designated Fund Activity for the current year 1991-92 and the budget year 1992-93 (Schedules XI, XII, and XIII show details). The specified activity includes the capital expenditures mentioned above, and transfers of income and other funds. As the schedules indicate, the balance at July 1, 1992, is projected to be \$81,470,000; we are projecting a balance of \$54,966,000 at June 30, 1993.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 COMPARATIVE DEMAND ANALYSIS
 INPATIENT ADMISSIONS

SCHEDULE I

	<u>1991/92 PLANNED ADMITS</u>	<u>1991/92 PROJECTED ADMITS</u>	<u>1992/93 BUDGET ADMITS</u>
Anesthesiology	0	2	4
Clinical Research	401	280	266
Dentistry	55	96	117
Dermatology	14	14	16
Family Practice	24	143	121
Gynecology	1,436	1,123	1,115
Medicine	4,487	4,587	4,172
Newborn	362	343	336
Neurology	326	347	360
Neurosurgery	978	1,181	1,181
Obstetrics	561	515	494
Ophthalmology	468	375	352
Orthopedics	1,103	1,166	1,196
Otolaryngology	408	358	408
Pediatrics	3,231	2,887	2,877
PM&R	212	183	182
Psychiatry -- Adult	787	749	717
Psychiatry -- Child	62	76	70
Radiation Therapy	0	1	2
Radiology	25	22	15
Surgery	2,891	2,877	2,482
Urology	<u>504</u>	<u>569</u>	<u>537</u>
Total Hospital	<u><u>18,335</u></u>	<u><u>17,894</u></u>	<u><u>17,079</u></u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 COMPARATIVE DEMAND ANALYSIS
 PATIENT DAYS

SCHEDULE II

	1991/92 PLANNED DAYS	1991/92 PROJECTED DAYS	1992/93 BUDGET DAYS
Anesthesiology	0	3	11
Clinical Research	1,447	897	862
Dentistry	101	136	153
Dermatology	55	90	81
Family Practice	96	484	349
Gynecology	6,893	5,451	5,626
Medicine	32,502	32,960	32,231
Newborn	921	676	653
Neurology	2,410	2,639	2,989
Neurosurgery	6,064	7,134	7,709
Obstetrics	1,712	1,627	1,566
Ophthalmology	1,289	977	969
Orthopedics	6,548	6,556	6,878
Otolaryngology	1,883	1,602	1,583
Pediatrics	35,724	28,024	28,492
PM&R	3,909	3,628	3,510
Psychiatry – Adult	10,911	11,397	11,125
Psychiatry – Child	1,418	2,629	2,777
Radiation Therapy	0	1	1
Radiology	35	30	14
Surgery	31,513	30,910	26,403
Urology	2,431	2,787	2,528
Total Hospital	<u>147,862</u>	<u>140,638</u>	<u>136,510</u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 COMPARATIVE DEMAND ANALYSIS
 OUTPATIENT ENCOUNTERS

SCHEDULE III

	<u>1991/92 PLANNED ENCOUNTERS</u>	<u>1991/92 PROJECTED ENCOUNTERS</u>	<u>1992/93 BUDGET ENCOUNTERS</u>
Clinic Visits	244,638	242,758	241,789
Emergency Room Visits	20,559	20,922	21,800
Radiation Therapy Visits	19,010	14,703	15,240
Ambulatory Surgery Visits	<u>3,008</u>	<u>3,799</u>	<u>3,746</u>
Subtotal	287,215	282,182	282,575
Community University Health Care Center & Health ETC	50,719	54,395	54,800
Home Health	10,503	12,700	12,700
Star Clinic	<u>0</u>	<u>0</u>	<u>2,250</u>
Total Encounters	<u><u>348,437</u></u>	<u><u>349,277</u></u>	<u><u>352,325</u></u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 DEDUCTIONS FROM CHARGES

SCHEDULE F

		<u>1991/92 PLANNED BUDGET</u>	<u>1991/92 PROJECTED</u>	<u>1992/93 BUDGET @ 8'</u>
Billing Adjustments	1	\$5,715,000	\$6,705,000	\$6,918,000
Contracts	2	\$6,817,000	\$8,501,000	\$9,136,000
HMO/PPO Discounts	3	29,547,000	29,124,000	30,537,000
Governmental Contractual Adjust	4	49,943,000	51,680,000	57,960,000
Charitable Care		<u>600,000</u>	<u>805,000</u>	<u>876,000</u>
Total		<u>\$92,622,000</u>	<u>\$96,815,000</u>	<u>\$105,427,000</u>

- 1 Includes Prompt Payment Discounts, Quality Control Procedures, and other Miscellaneous Billing Adjustments.
- 2 Includes Outreach Lab billings, Clinic Contracts, and VA Contracts.
- 3 Includes HMO's and BCBSM.
- 4 Includes Medicare, Medical Assistance, GAMC, and other government program write-offs.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 OTHER OPERATING REVENUE SUMMARY

SCHEDULE

	<u>1991/92 PLANNED BUDGET</u>	<u>1991/92 PROJECTED</u>	<u>1992/93 BUDGET @ 8%</u>
Appropriations & Support	\$13,380,000	\$13,611,000	\$14,973,000
Food Services	1,739,000	1,648,000	1,672,000
Parking Services	926,000	939,000	1,008,000
Department Non-Patient	285,000	392,000	362,000
Grant Income	1,920,000	1,842,000	1,838,000
Reference Lab Income	2,787,000	2,884,000	3,052,000
Pro Fees -- Net Revenue	2,029,000	1,891,000	2,012,000
Interest Income on Remaining Construction Fund Bond Proceeds	2,220,000	2,058,000	2,008,000
Other	<u>35,000</u>	<u>13,000</u>	<u>14,000</u>
Total	<u><u>\$25,321,000</u></u>	<u><u>\$25,278,000</u></u>	<u><u>\$26,935,000</u></u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 EXPENDITURE SUMMARY: 1991/92 PROJECTION VS 1992/93 BUDGET

SCHEDULE VI

	1991/92 PLANNED BUDGET	1991/92 PROJECTED	VARIANCE	PERCENT VARIANCE	1992/93 BUDGET	INCREASE/ DECREASE	PERCENT CHANGE
Salaries	\$126,698,000	\$123,907,000	(\$2,791,000)	-2.2%	\$123,154,000	(\$753,000)	-0.6%
Fringe Benefits	30,675,000	29,871,000	(804,000)	-2.6%	29,486,000	(385,000)	-1.3%
Academic Contracts	1,208,000	1,181,000	(27,000)	-2.2%	1,240,000	59,000	5.0%
Resident Contracts	9,688,000	9,539,000	(149,000)	-1.5%	9,449,000	(90,000)	-0.9%
Physician/Contract Compensation	9,134,000	9,530,000	396,000	4.3%	9,115,000	(415,000)	-4.4%
Total Salary, F.B., & Fees	177,403,000	174,028,000	(3,375,000)	-1.9%	172,444,000	(1,584,000)	-0.9%
Laundry & Linen	2,215,000	2,136,000	(79,000)	-3.6%	2,200,000	64,000	3.0%
Raw Food	1,897,000	1,760,000	(137,000)	-7.2%	1,855,000	95,000	5.4%
Drugs	25,561,000	24,554,000	(1,007,000)	-3.9%	27,987,000	3,433,000	14.0%
Blood & Blood Derivatives	12,544,000	11,549,000	(995,000)	-7.9%	12,392,000	843,000	7.3%
Medical Supplies & Services	28,478,000	28,586,000	108,000	0.4%	29,190,000	604,000	2.1%
Utilities	6,395,000	6,572,000	177,000	2.8%	6,843,000	271,000	4.1%
Insurance	1,874,000	1,870,000	(4,000)	-0.2%	2,104,000	234,000	12.5%
Rental	2,682,000	2,522,000	(160,000)	-6.0%	2,655,000	133,000	5.3%
Maintenance & Repair	5,205,000	5,207,000	2,000	0.0%	5,567,000	360,000	6.9%
Net Loss On Disposal Of Assets	64,000	18,000	(46,000)	-71.9%	18,000	0	0.0%
Campus Administration Expense	311,000	311,000	0	0.0%	327,000	16,000	5.1%
Depreciation	19,548,000	18,569,000	(979,000)	-5.0%	18,942,000	373,000	2.0%
Interest	11,476,000	11,814,000	338,000	2.9%	11,681,000	(133,000)	-1.1%
Provision For Uncollectables	2,982,000	3,179,000	197,000	6.6%	3,364,000	185,000	5.8%
General Supplies & Expense	15,971,000	14,660,000	(1,311,000)	-8.2%	15,259,000	599,000	4.1%
Total Expenditures	<u>\$314,606,000</u>	<u>\$307,335,000</u>	<u>(\$7,271,000)</u>	<u>-2.3%</u>	<u>\$312,828,000</u>	<u>\$5,493,000</u>	<u>1.8%</u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
EXPLANATION OF VARIANCES AND BUDGET INCREASES
FOR FISCAL YEARS 1991-92 AND 1992-93

SCHEDULE VII

1. **RESIDENT CONTRACTS**

The variance in the current year is due to: (a) a slight reduction in FTE's supported (-\$73,000), and a lower than anticipated increase in health insurance rates (-\$65,000). The decrease in the budget year is due to a reduction in contract expenses that corresponds to the 3.5% reduction in our appropriation levels, (-\$527,000). This is offset by inflationary increases in the various contract components (\$425,000).

2. **PHYSICIAN/CONTRACT COMPENSATION**

Variance in the current year is due to: (a) the contract agreement with Lab Medicine and Pathology being less than anticipated (-\$339,000) and (b) Hospital financial support of two clinical trials (\$769,000). The budget year decrease is due to: (a) the completion of clinical trials from the previous year (-\$560,000), (b) an increase in the base contract with Lab Medicine and Pathology (\$136,000), and (c) inflationary increases of (\$298,000).

3. **DRUGS**

Variance in the current year is due to: (a) expenses not being incurred for investigational drugs which have not been approved by the FDA (-\$705,000), (b) lower than anticipated volume (-\$886,000), and (c) higher than expected utilization of newer, more expensive drugs (\$594,000). The budget year increase is due to: (a) inflation increase of \$1,165,000, (b) \$1,599,000 for new drugs, and (c) an expected increase of \$700,000 due to anticipated growth in outpatient prescription volume, mainly due to the assumption of adding an Outpatient Discharge Pharmacy.

4. **BLOOD & BLOOD DERIVATIVES**

The favorable variance in the current year is due a project specifically aimed at holding down utilization of blood products. The budget year increase is due to: (a) inflation (\$1,136,000), and (b) offset by an anticipated decline in census (-\$387,000).

5. **MEDICAL SUPPLIES & SERVICES**

The unfavorable variance in the current year is due to: (a) greater than anticipated rate increases on transplant acquisition fees (\$683,000). This variance is offset by lower utilization of implants (-\$289,000) and lower than expected use of medical supplies due to lower census levels (-\$520,000). The increase in the budget year is due to: (a) inflation of \$1,643,000, and (b) to an anticipated decline in census levels (-\$964,000).

6. **UTILITIES**

The budgeted increase is primarily due to anticipated rate increases.

7. **INSURANCE**

The increase in the budget year reflects anticipated inflationary increases.

8. **RENTAL**

The favorable variance in rental in the current year is due: (a) lower utilization of patient related equipment due to lower census, and (b) fewer airplane trips to our Outreach Clinics. The increase in the budget year is due to inflation and also rental expense for the new off-site Sports Medicine Clinic.

9. **MAINTENANCE & REPAIRS**

The increase in the budget year is due to: (a) the change of our practice which increases the minimum for amounts to be capitalized from \$500 to \$5000, (\$160,000) and (b) inflation increases (\$268,000).

10. **DEPRECIATION**

Variance in the current year is due to the delayed receipt of the Heart Cath Lab equipment, not acquiring all of the capital equipment that was originally planned, (CT Scanner and a Lithotripter), and reduced spending of recurring capital. The budget year increase is due to depreciation on: (a) new acquisitions (\$697,000), (b) one full year of depreciation on equipment received late in the current year (\$419,000), and (c) a reduction in depreciation due to a higher level of retiring assets, for depreciation purposes, than new assets being added to our depreciation base (\$-800,000).

11. **INTEREST**

The variance in the current year is due to an unfavorable rate on the variable rate bonds. The decrease in the budget year is due to the principal payment made during the year.

12. **GENERAL SUPPLIES & EXPENSES**

The favorable variance in the current year is due to: (a) lower utilization of outside agency personnel services (-\$329,000), and (b) new programs budgeted for that didn't materialize (-\$1,110,000). Increase in the budget year is due to: (a) inflation (\$719,000), (b) decreased utilization of consulting services (-\$392,000), and (c) programmatic changes of \$240,000, which include Drug Testing for New Employees, and increased activity with the Workforce Diversity Council.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
 FOR FISCAL YEARS 1991/92 AND 1992/93
 NON-OPERATING REVENUE SUMMARY

SCHEDULE VII

	<u>1991/92 PLANNED BUDGET</u>	<u>1991/92 PROJECTED</u>	<u>1992/93 BUDGET @ 8%</u>
Interest Income On Reserves	\$8,909,000	\$7,911,000	\$6,431,000
Investment Income Held By Trustee	1,869,000	1,387,000	1,287,000
Other Investment Income	<u>779,000</u>	<u>233,000</u>	<u>435,000</u>
Total	<u>\$11,557,000</u>	<u>\$9,531,000</u>	<u>\$8,153,000</u>

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC
FOR FISCAL YEARS 1991/92 AND 1992/93

SCHEDULE

SUMMARY STATEMENT OF OPERATIONS AND OPERATING CASH FLOW

	1991/92 PLANNED BUDGET	1991/92 PROJECTED	1992/93 BUDGET @ 8
Gross Patient Charges	\$375,569,000	\$368,884,000	\$389,547,000
Deductions from Charges	92,622,000	96,815,000	105,427,000
Other Operating Revenue	<u>25,321,000</u>	<u>25,278,000</u>	<u>26,939,000</u>
Total Operating Revenue	\$308,268,000	\$297,347,000	\$311,059,000
Total Expenditures	<u>314,606,000</u>	<u>\$307,335,000</u>	<u>\$312,828,000</u>
Net Revenue from Operations	(\$6,338,000)	(\$9,988,000)	(\$1,769,000)
Total Non-Operating Revenue	<u>11,557,000</u>	<u>9,531,000</u>	<u>8,153,000</u>
Revenue Over/-Under Expenses	\$5,219,000	(\$457,000)	\$6,384,000
Add Non-Cash Outlays:			
Depreciation	19,548,000	18,569,000	18,942,000
University Support	211,000	211,000	227,000
Net Increase to Working Capital	<u>3,731,000</u>	<u>615,000</u>	<u>419,000</u>
Total Funds Provided	\$28,709,000	\$18,938,000	\$25,972,000
Funds Applied:			
Increase in Accounts Receivable	2,673,000	4,917,000	(444,000)
Capital Expenditures:			
Principal Payments on Debt and Equipment	3,555,000	3,367,000	3,336,000
Recurring Equipment and Renovation	8,511,000	8,511,000	8,200,000
Interest Income Committed to Capital Plan	<u>8,909,000</u>	<u>7,911,000</u>	<u>6,431,000</u>
Total Funds Applied	23,648,000	24,706,000	17,523,000
Total Cash Available from Operations	<u>\$5,061,000</u>	<u>(\$5,768,000)</u>	<u>\$8,449,000</u>

University of Minnesota Hospital and Clinic
Board Designated Fund Activity
7-01-91 through 6-30-93

Schedule X

	<u>Unassigned</u>	<u>Assigned</u>	<u>Total</u>
Beginning Balance at 7-01-91	\$44,967,100	\$45,136,600	\$90,103,700
Investment Income:	6,853,600	-0-	6,853,600
Other receipts:	51,400	-0-	51,400
Project Expenditures:	-0-	(5,192,900)	(5,192,900)
Transfer 90-91 unused Equipment Reserve to Operations:	-0-	(2,622,100)	(2,622,100)
Net 91-92 Equipment Rollforward Reserve:	-0-	4,855,900	4,855,900
Ending Balance at 2-29-92	<u>\$51,872,100</u>	<u>\$42,177,500</u>	<u>\$94,049,600</u>
Investment Income:	3,115,400	-0-	3,115,400
Funding for Projects:	(10,306,000)	10,306,000	-0-
Project Expenditures:	-0-	(11,895,300)	(11,895,300)
91-92 Equipment Rollforward Expenditures:	-0-	(3,800,000)	(3,800,000)
Projected Ending Balance at 6-30-92	<u>\$44,681,500</u>	<u>\$36,788,200</u>	<u>\$81,469,700</u>
Investment Income:	8,439,000	-0-	8,439,000
Funding for Projects:	(26,348,400)	26,348,400	-0-
Project Expenditures:	-0-	(34,916,800)	(34,916,800)
Transfer 91-92 unused Equipment Reserve to Operations:	-0-	(1,055,900)	(1,055,900)
Net 92-93 Equipment Rollforward Reserve:	-0-	1,029,900	1,029,900
Projected Ending Balance at 6-30-93	<u>\$26,772,100</u>	<u>\$28,193,800</u>	<u>\$54,965,900</u>

University of Minnesota Hospital and Clinic
Board Designated Funds Activity
7-01-91 through 2-29-92

Schedule XI

	Unassigned	Assigned	Total
Beginning Balance at 7-01-91	\$44,967,100	\$45,136,600	\$90,106,700
Investment Income on Reserves	5,552,700	-0-	5,552,700
Investment Income from Bond Proceeds	1,300,900	-0-	1,300,900
Loan Principal Payments:	21,900		21,900
Project Insurance Reimbursement:	29,500		29,500
Expenditures:			
Heart Cath Lab	-0-	(1,466,100)	(1,466,100)
Computer/Backbone	-0-	(700,100)	(700,100)
Neuroradiology	-0-	(1,449,000)	(1,449,000)
Bone Marrow	-0-	(12,700)	(12,700)
BMT/ICU 4F	-0-	(87,900)	(87,900)
CUHCC	-0-	(123,800)	(123,800)
Temporary Psych	-0-	(8,500)	(8,500)
Rehab Satellites	-0-	(3,600)	(3,600)
Autopsy - 1st Floor Mayo	-0-	(198,200)	(198,200)
Temporary OB	-0-	(269,900)	(269,900)
Urology Remodeling	-0-	(2,000)	(2,000)
Architect & Engineer Mgr.	-0-	(871,100)	(871,100)
Equipment Rollforward Reserve:			
Transfer to Operations of Unexpended 1989-1990 Reserves	-0-	(2,622,100)	(2,622,100)
Transfer from Operations for Unexpended 1990-1991 Capital Budget	-0-	6,233,600	6,233,600
Expenditures against 1990-1991 Reserve	-0-	(1,377,700)	(1,377,700)
Ending Balance at 2-29-92	\$51,872,100	\$42,177,500	\$94,049,600

* In addition to the 2-29-92 balance for Board Designated Funds, there is cash and investments of \$13,000,000 for Debt Service Reserves, and \$16,000,000 for Working Capital Reserves.

**University of Minnesota Hospital and Clinic
Board Designated Fund Activity
Projected 3-01-92 through 6-30-92**

Schedule XII

	<u>Unassigned</u>	<u>Assigned</u>	<u>Total</u>
Beginning Balance at 3-01-92	\$51,872,100	\$42,177,500	\$94,049,600
Investment Income on Reserves	2,358,300	-0-	2,358,300
Investment Income from Bond Proceeds	757,100	-0-	757,100
Funding for Plant Projects			
Computer Upgrade	(2,180,000)	2,180,000	-0-
Linear Accelerator	(450,000)	450,000	-0-
BMT/ICU	(510,000)	510,000	-0-
Practice Acquisition	(4,746,000)	4,746,000	-0-
MRI	(1,920,000)	1,920,000	-0-
New Program Development	(500,000)	500,000	-0-
Expenditures			
MRI	-0-	(1,920,000)	(1,920,000)
Practice Acquisition	-0-	(4,746,000)	(4,746,000)
CUHCC	-0-	(3,200)	(3,200)
Computer Upgrade	-0-	(1,489,900)	(1,489,900)
Neuroradiology	-0-	(420,900)	(420,900)
Heart Cath Lab	-0-	(620,800)	(620,800)
BMT/ICU	-0-	(523,000)	(523,000)
Linear Accelerator	-0-	(450,000)	(450,000)
New Program Development	-0-	(500,000)	(500,000)
Cancer Center	-0-	(142,800)	(142,800)
Phase II Renovation	-0-	(1,078,700)	(1,078,700)
Projected Equipment Rollforward Purchases	-0-	(3,800,000)	(3,800,000)
Ending Balance at 6-30-92	<u>\$44,681,500</u>	<u>\$36,788,200</u>	<u>\$81,469,700</u>

* In addition to the 6-30-92 projected balance for Board Designated Funds, there is cash and investments of \$13,000,000 for Debt Service Reserves, and \$16,000,000 for Working Capital Reserves.

**University of Minnesota Hospital and Clinic
Board Designated Fund Activity
Projected 7-01-92 through 6-30-93**

Schedule XIII

	Unassigned	Assigned	Total
Beginning Balance at 7-01-92	\$44,681,500	\$36,788,200	\$81,469,700
Investment Income from Reserves	6,431,000	-0-	6,431,000
Investment Income from Bond Proceeds	2,008,000	-0-	2,008,000
Funding for Plant Projects			
MRI - 1992	(1,080,000)	1,080,000	-0-
Neuroangiography Systems	(1,440,000)	1,440,000	-0-
Computer Upgrade	(2,760,000)	2,760,000	-0-
Heart Cath	(3,200,000)	3,200,000	-0-
Parking Ramp	(1,000,000)	1,000,000	-0-
MTS Replacement	(600,000)	600,000	-0-
Linear Accelerator	(1,420,000)	1,420,000	-0-
Laboratories / Mayo 2	(1,400,000)	1,400,000	-0-
Cancer Center	(142,900)	142,900	-0-
CT Scanners	(1,369,500)	1,369,500	-0-
New Program / Technology	(2,000,000)	2,000,000	-0-
Stem Cell Support	(1,036,000)	1,036,000	-0-
Practice Acquisition	(8,100,000)	8,100,000	-0-
Neurorad Gamma Camera	(800,000)	800,000	-0-
Expenditures:			
MRI - 1992	-0-	(1,080,000)	(1,080,000)
Neuroangiography Systems	-0-	(1,440,000)	(1,440,000)
Computer Upgrade	-0-	(2,760,000)	(2,760,000)
Heart Cath	-0-	(3,200,000)	(3,200,000)
Parking Ramp	-0-	(1,000,000)	(1,000,000)
MTS Replacement	-0-	(600,000)	(600,000)
Linear Accelerator	-0-	(1,420,000)	(1,420,000)
Laboratories / Mayo 2	-0-	(1,400,000)	(1,400,000)
Cancer Center	-0-	(142,900)	(142,900)
CT Scanners	-0-	(1,369,500)	(1,369,500)
New Program / Technology	-0-	(2,000,000)	(2,000,000)
Stem Cell Support	-0-	(1,036,000)	(1,036,000)
Practice Acquisition	-0-	(8,100,000)	(8,100,000)
Neurorad Gamma Camera	-0-	(800,000)	(800,000)
Phase II Renovation	-0-	(8,568,400)	(8,568,400)
Equipment Rollforward Reserve			
Transfer of Unexpended 1990-91 Reserves	-0-	(973,300)	(973,300)
Transfer for Unexpended 1991-92 Capital Budget	-0-	5,797,300	5,797,300
Expenditure Against 1991-92 Reserve	-0-	(4,850,000)	(4,850,000)
Ending Balance at 6-30-93	\$26,772,100	\$28,193,800	\$54,965,900

* In addition to the 6-30-92 projected balance for Board Designated Funds, there is cash and investments of \$13,000,000 for Debt Service Reserves, and \$16,000,000 for Working Capital Reserves.

University of Minnesota Strategic Planning Steering Group

**Discussion Session III
April 23, 1992**

April 23 Steering Committee Meeting

- **External Strategic Options**
 - Option I: University- led system
 - Option II: a) Opportunistic linkages
b) Utility approach
 - Option III: System alignment

- **Process to Select Options**
 - Define working groups, e.g.,
 - Rural/Metro network integration
 - System affiliation
 - Set goals, milestones, timeframes, etc.

Strategic Options

Options	Issues
<p>I. Build a vertically integrated managed care delivery system capable of delivering required patient volume</p>	<p>What additional patient base could be generated from outstate market? What approaches could be used to capture this base</p> <p>What opportunities exist to increase patient volume in the metro area? What groups should be targeted?</p> <p>How would increasing access of community physicians to University facilities help build the metro area system</p>
<p>II. Disperse Programs / Downsize UMHC</p> <p>a. Opportunistic linkages</p> <p>b. Maintain UMHC as a public utility</p>	<p>Is this option economically feasible and would it maintain the integrity of the missions?</p> <p>Would success require a "public utilities" approach?</p>
<p>III. Affiliate with existing system ("Aligned model")</p>	<p>What are the main affiliation options for the University</p> <p>How can win/win affiliations be structured?</p> <p>What impact could such affiliations have on on-site clinical activity?</p>

Option I:

Potential Impact of Building Own System: Out-State Strategy

<u>Program</u>	<u>Major Features</u>	<u>Incremental Discharges</u>	<u>Contribution Margin, 1997</u> \$ Millions
Buy Clinics	Target 4 high volume clinics to acquire and provide UM faculty support for specialty services not available	400	2.8
Managed Care Product	Develop UCare products to capture Medicaid, Medicare and uninsured/small company markets	300	0.3
Practice Management Support	Provide practice management support to independent primary care physicians who are UM graduates; target 20% of UM graduates in out-state area	130	1.1
Seed Primary Care Practices	Seed 5-10 FP physicians in identified underserved primary care physician communities (e.g. Pine, Sherburne, Wright Counties)	100	0.6
	TOTAL POTENTIAL OUT-STATE IMPACT	930	4.8

Option I:

Potential Impact of Building Own System: Metro Strategy

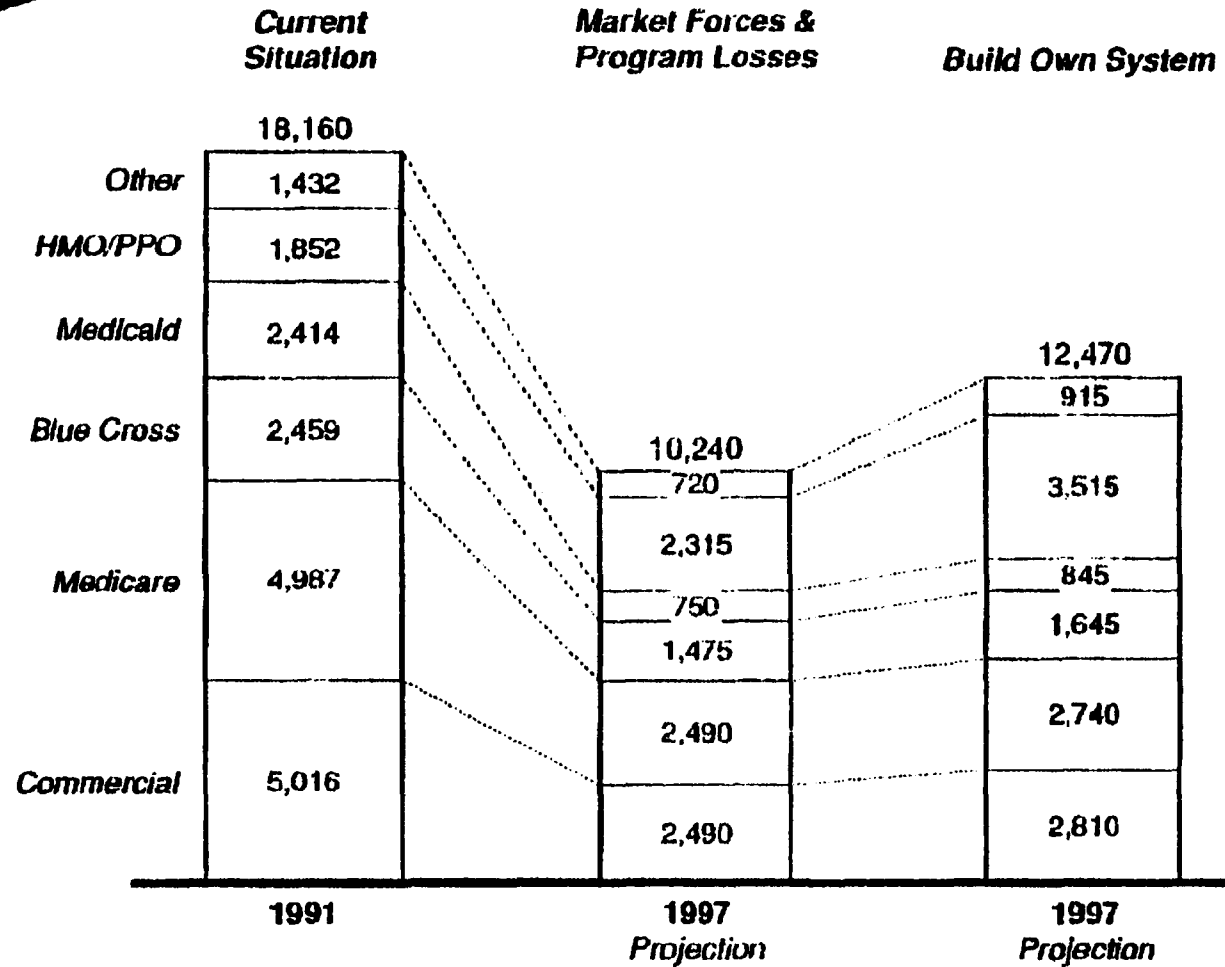
<u>Program</u>	<u>Major Features</u>	<u>Incremental Discharges</u>	<u>Contribution Margin, 1997</u> \$ Millions
Managed Care Product	Develop UCare products to capture Medicaid, Medicare, underinsured/ small company markets, and UM graduate students and employees	750	1.4
Seed Primary Care Practices	Seed 5 FP physicians in identified underserved areas (e.g., Anoka and Dakota Counties)	200	1.1
Buy Clinic(s)	Acquire clinic(s) with an established patient base and an interest in University ownership	300	1.3
Minimize "Referral Leaks"	Improved service quality to and referral relations between UMHC specialists and FP Clinic	50	0.5
	TOTAL POTENTIAL METRO IMPACT	1300	4.3
	TOTAL METRO AND OUT-STATE IMPACT	2230	9.1

Option I:

POTENTIAL IMPACT OF BUILDING OWN SYSTEM: METRO & NON-METRO STRATEGIES

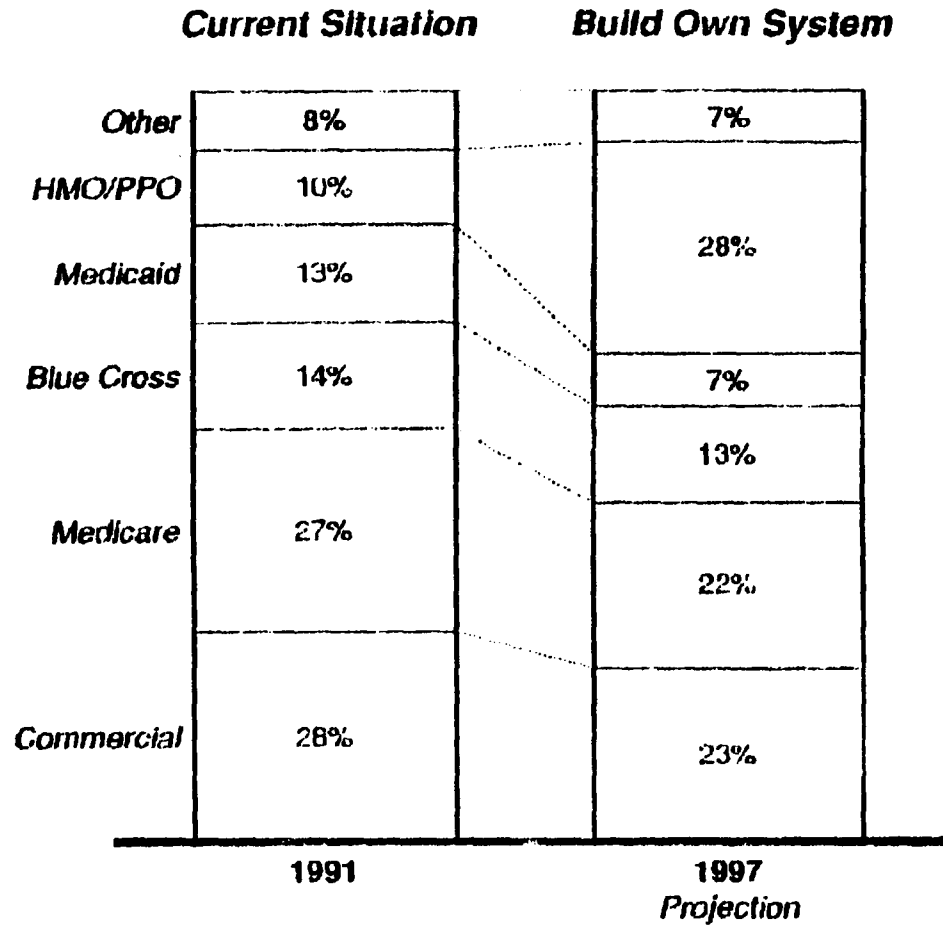
UMHC Discharges By Payor

ILLUSTRATIVE



Option I:

UMHC DISTRIBUTION OF DISCHARGES BY PAYOR



ILLUSTRATIVE

**Potential Benefit of Increasing
Access to Community MDs**

- Could provide incremental cases to sustain University Hospital
- Could provide incremental consults and demand for hospital based services
- Could strengthen referral relationships

Need to establish clinical faculty arrangements with 200+ specialty physicians to generate 2000 admissions

Option II:

Opportunistic Alliances by Department

Advantages

- Each department can pick best partners in city
- Politically viewed as least threatening by general provider community
- Some win-win potential, e.g., bring referrals back to UMHC

Disadvantages

- Limits bargaining power to create institutionally advantageous relationships
- Difficult to maintain balanced portfolio of services on campus
- Difficult to ensure that all departments strike advantageous arrangements
- Strengthens providers and systems, which view themselves as cross-the-board competitors
- Loss of financial contribution to the Hospital and hospital-based specialties

UMHC AS DOWNSIZED SECONDARY/TERTIARY FACILITY
Admissions by Clinical Service

Downsize To 2°/3° Services

ILLUSTRATIVE

	18,020
Other**	747
Psychiatry	900
Obstetrics/Newborn	917
Orthopedics	1,192
Neurosciences	1,539
BMT/Transplant	1,549
Pediatrics	2,038
Oncology	2,055
Medicine	3,120
Surgery*	3,963

1991

	5,980
Clinical Research	394
Orthopedics	417
Neurosciences	588
BMT/Transplant	1500
Pediatrics	445
Oncology	357
Medicine	889
Surgery	1410

1997 (P)

* Surgery includes: General Surgery, Ophthalmology, Otolaryngology, Urology.

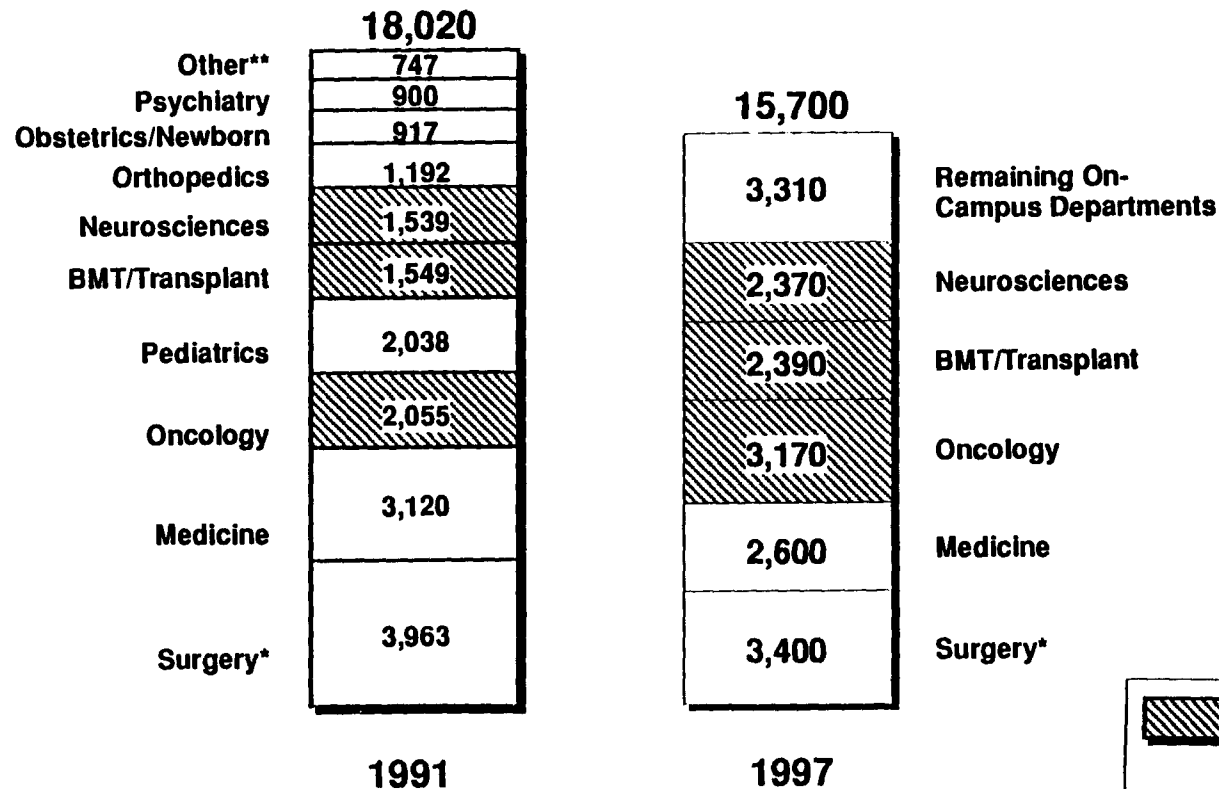
** Other includes: Dermatology, Clinical Research, Gyn (general), Dentistry, Physical Med & Rehab.

Source: UMHC Administration and Finance Offices; APM Analysis.

OPTION II:

**CENTERS OF EXCELLENCE PROGRAM
Admissions by Clinical Service**

ILLUSTRATIVE



* Surgery includes: General Surgery, Ophthalmology, Otolaryngology, Urology.

** Other includes: Dermatology, Clinical Research, Gyn (general), Dentistry, Physical Med & Rehab.

Source: UMHC Administration and Finance Offices; APM Analysis.

OPTION III:

The rationale for a major affiliation

Advantages to the University

- **Capturing specific program referrals from the network to consolidate areas of distinction**
- **Promise of financial support by becoming a system member**
- **Provides focused practice sites for off-campus clinical practice and teaching**

Advantages to the System

- **Limits need to make investments to obtain tertiary care capabilities**
- **Provides teaching support**
- **Leverages the University's excellent clinical reputation**

Option III:

JOINT BENEFITS

- Ability to maintain more patients within the system
- Better competitive position for growth
- Potential for cost reduction through service consolidations
- Reduced investment in duplicate services

Option III:

Potential Affiliate	Advantages	Disadvantages
St. Paul Ramsey	<p>Public / private primary care base, including very active ER</p> <p>Close ties with University faculty across most departments</p> <p>East-side coverage</p> <p>Organized group practice</p> <p>High interest level</p>	<p>High cost position</p> <p>Public hospital stigma</p> <p>Relatively small player</p>
Hennepin County Medical Center	<p>Large active ER</p> <p>Teaching affiliation with University in many departments</p>	<p>County hospital stigma</p> <p>Developing competitive tertiary services</p> <p>Low interest level</p> <p>Financial weakness</p> <p>Negligible private pay base</p> <p>Relatively small player</p>
Fairview System	<p>Large integrated system</p> <p>Strong relation with University in selected services</p> <p>Financially strong</p> <p>Vertically linked with Group Health</p> <p>Relatively limited tertiary care capability</p> <p>Low cost position</p> <p>High interest level</p> <p>Good west-side coverage</p>	<p>Competitive in some services</p>

Option III:

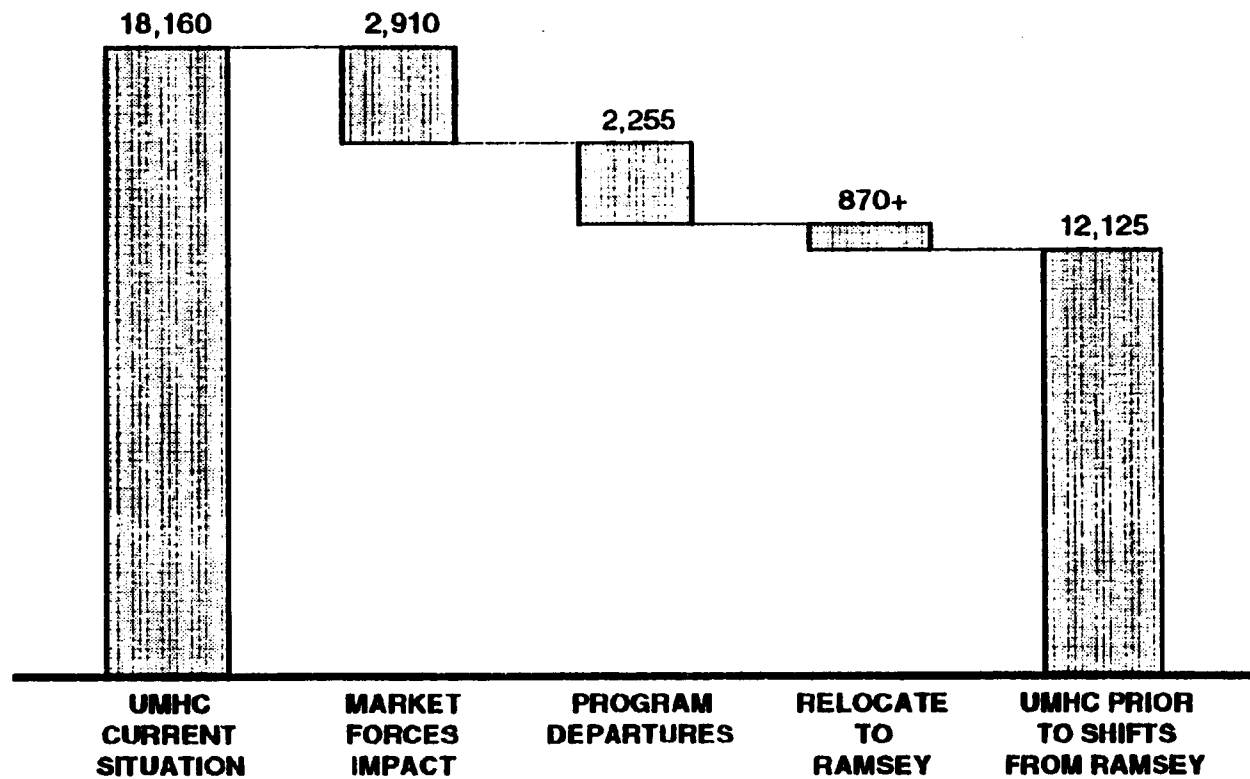
Potential Affiliate	Advantages	Disadvantages
Health East System	Medium sized system East-side coverage Low cost position Moderate interest level	Relatively weak financial position Independent medical staff Limited teaching relationships Growing tertiary care
Methodist	Strong vertically integrated system Financially strong Broad primary care base through Park Nicollet and MedCenters Clinics Low cost position	Tertiary care competitor Low(?) interest level Limited teaching relationships

Option III:

ILLUSTRATIVE

UMHC — ST. PAUL RAMSEY AFFILIATION

UMHC Admission Losses & Transfers

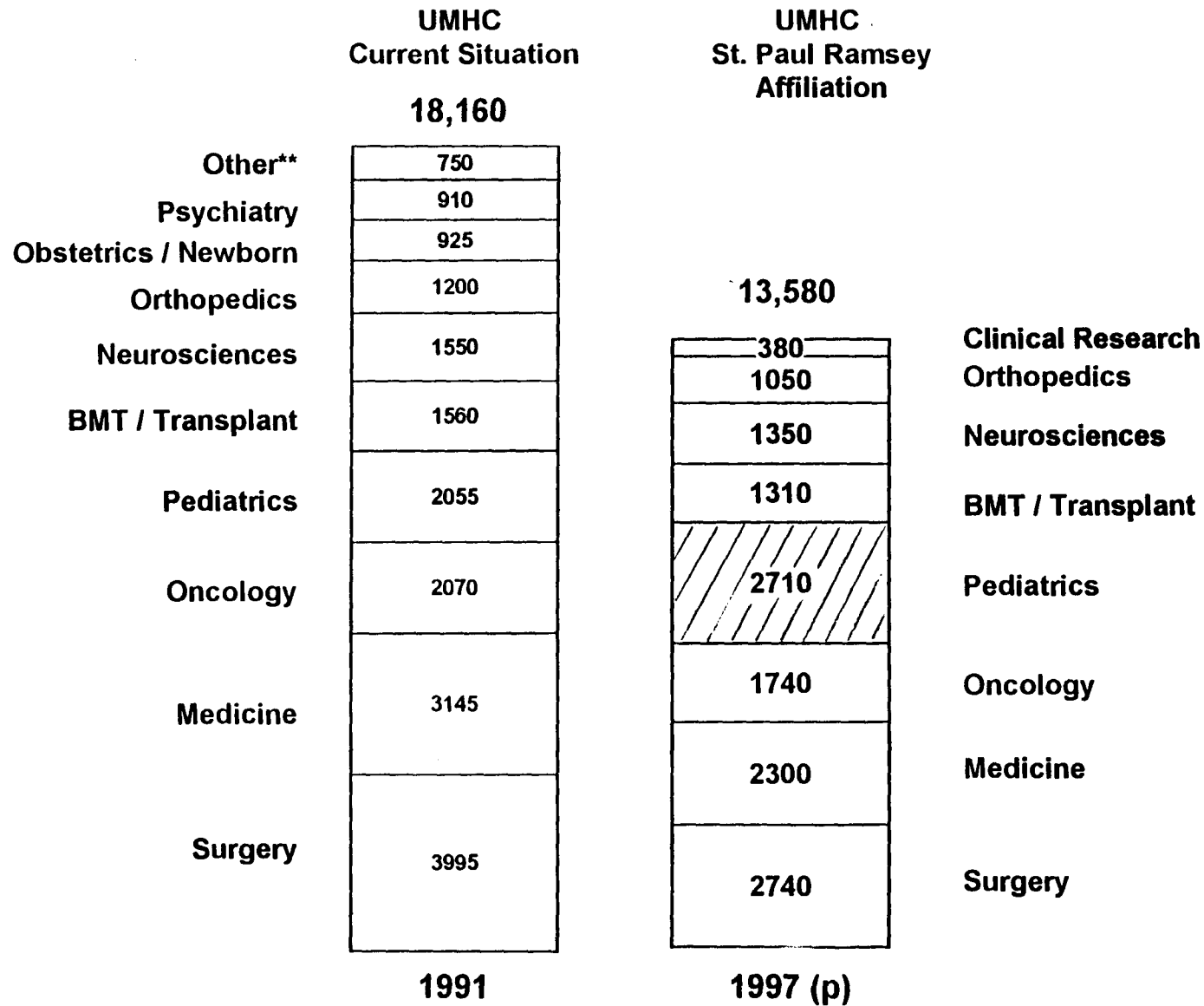


Option III:


Potential Impact of St. Paul Ramsey Affiliation on UMHC

UMHC Admissions

ILLUSTRATIVE



* Surgery includes: General Surg., Ophthalmology, Urology
 ** Other includes: Dermatology, Clinical Research, Gyn (general), Dentistry, Phys Med & Rehab

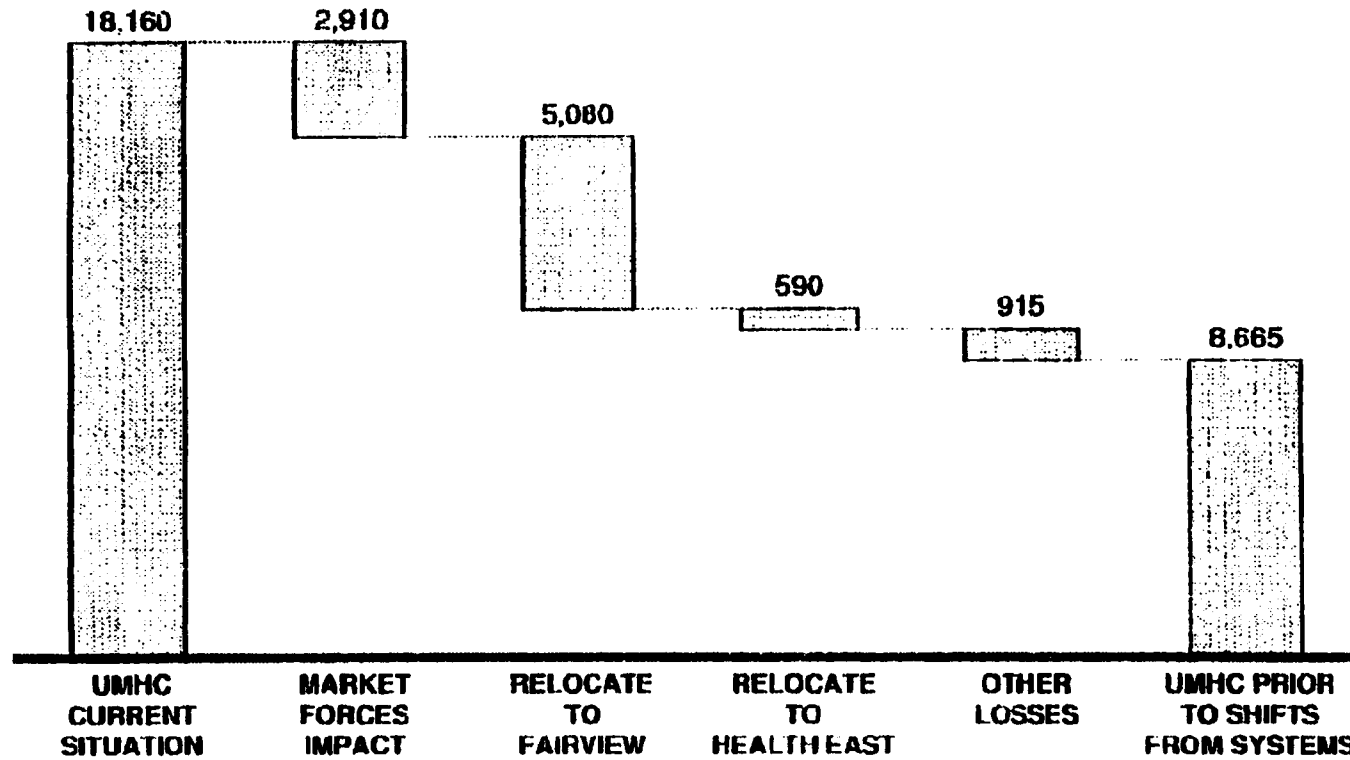
 Departments with volume growth from St. Paul Ramsey

Option III:

ILLUSTRATIVE

UMHC AND AREA SYSTEM AFFILIATIONS

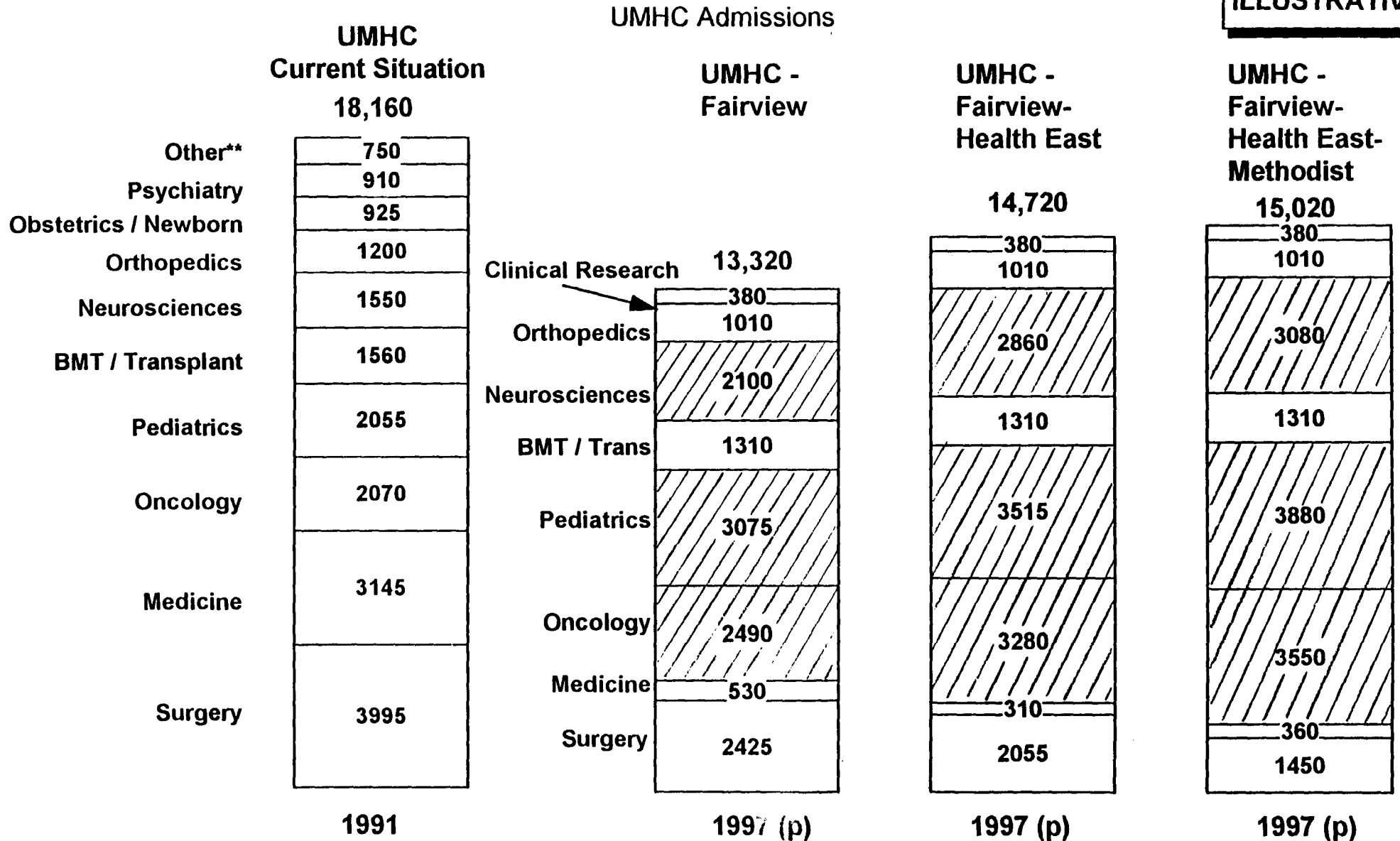
UMHC Admission Losses & Transfers



Option III:


Potential Impact of System Affiliation Options on UMHC

ILLUSTRATIVE



* Surgery includes: General Surg., Ophthalmology, Urology

** Other includes: Dermatology, Clinical Research, Gyn (general), Dentistry, Phys Med & Rehab

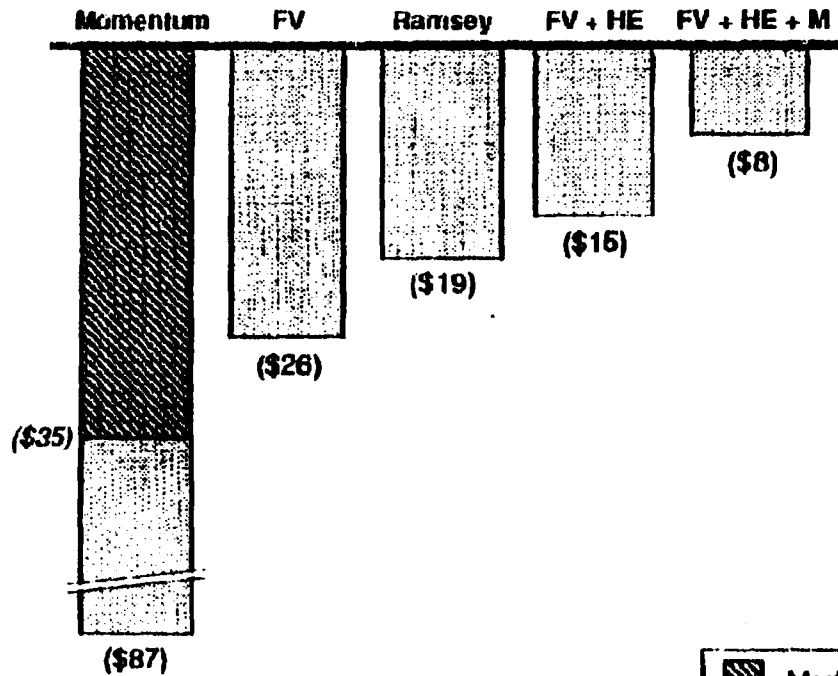
 Departments with volume growth from system deals

Option III:

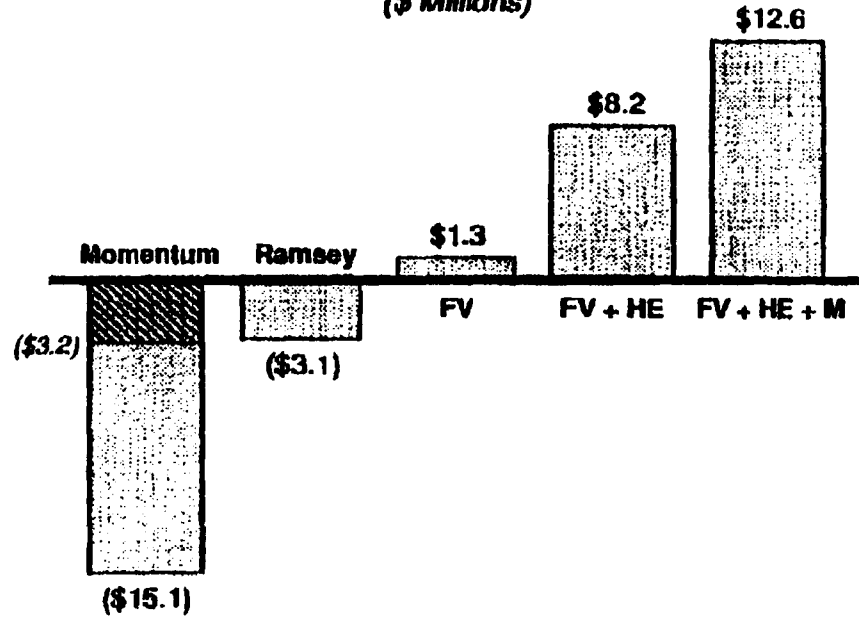
ILLUSTRATIVE

POTENTIAL FINANCIAL IMPACT OF AFFILIATION OPTIONS

UMHC Net Inpatient Revenue Losses*
(\$ Millions)



UMHC Net Operating Income — 1997
(\$ Millions)



 **Market Forces Only**

*Decrease from 1992 net revenues; 1992 dollars.
Note: Momentum = Market Forces + Program Departures.

Next Steps

- **Kick-off cost, service and clinical outcomes task forces**
- **Refine practice coordination principles / report back to Steering Committee**
- **Establish two external strategy working groups**
 - **UMHC network work group**
 - **Strategic alignment work group**
- **Report back to Steering Committee May 7**

Option II:

Elements of a Public Utility

- Shared responsibility for maintaining financial viability and academic integrity of the University's clinical enterprise
- Agreed upon franchise for services to be provided, e.g., through CON legislation
- State or industry oversight of costs, prices, etc.
- Potentially shared ownership of University clinical facilities