

## UNIVERSITY OF MINNESOTA TWIN CITIES

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

July 13, 1990

T0:

Planning and Development Committee Members

Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D.

Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.

Kris Johnson

FROM:

Robert Latz

The July meeting of the Planning and Development Committee will be held:

Thursday, July 19, 1990 3:00-5:00 P.M. The Board Room, University Hospital

The agenda and the background materials for the meeting are enclosed. Thank you for making time for this meeting.

cc: Fred Bertschinger Cliff Fearing Greg Hart Mark Koenig John LaBree, M.D. Shannon Lorbiecki Lisa McDonald

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## PLANNING AND DEVELOPMENT COMMITTEE

## THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC BOARD OF GOVERNORS Thursday, July 19, 1990 3:00 - 5:00 P.M. The Board Room (8-106), University Hospital

## **AGENDA**

I.	Approval of the June 21, 1990 Meeting Minutes	Approval
II.	Quarterly Purchasing Report	Endorsement
	-Mark Koenig	
III.	<u>Lithrotripsy Update</u>	Information
	-Greg Hart	
IV.	<u>Capital Plan Review</u>	Information
	-Bob Dickler	
٧.	Report of the Program Development and Evaluation Task Force	Information
	-Bob Dickler/Peter Lynch, M.D.	
IV.	Board of Governors Committee on Process	Discussion
	-Bob Dickler	
٧.	UMCA Update	Information
	-Peter Lynch, M.D.	
VI.	Other Business	
VII.	<u>Adjournment</u>	

### MINUTES

## Planning and Development Committee June 21, 1990

## CALL TO ORDER

Robert Latz called the June 21, 1990 meeting of the Planning and Development Committee to order at 3:15 p.m. in room 8-106 in the University Hospital.

Attendance: Present

Robert Latz, Chair

Clint Hewitt

Peter Lynch, M.D. Ted Thompson, M.D.

Absent

Leonard Bienias Robert Dickler

William Jacott, M.D. B. Kristine Johnson

Geoff Kaufmann

Staff

Cliff Fearing

Greg Hart

Shannon Lorbiecki Lisa McDonald Helen Pitt

Guests:

Sharon Bertrand Ann Kincaid David Link

Helen Pitt reported that University Hospital has made the cut to 30 hospitals still being considered for the Robert Wood Johnson Strategic Planning Grant.

## APPROVAL OF MINUTES

The committee members present had no objections to the minutes of the May 17, 1990 meeting. The minutes could not be approved because there was not a quorum at the meeting.

## SPECIAL PRESENTATION: SURVEY OF MINNESOTA PHYSICIANS

As part of a second year management course, four students conducted a survey of Minnesota physicians and their relationship to UMHC. Mr. Link distributed copies of a survey sent to 678 referring Minnesota physicians in greater Minnesota. The mailing excluded physicians in Duluth, Rochester and the seven county metro area. The return rate was 40%. Sixty-four percent of the respondents reported having a referring relationship and say that they are loyal to the physician rather than the hospital in which the physician works.

Mr. Link then reviewed the four tables included in the study. Overall, 74% said that the referring relationship had gotten better over the past five years. Seventy-eight percent said that new programs were not a factor in their referral patterns. The problem most often mentioned is communication.

A hospital needs more than expertise to draw patients because expertise is available in more places now than in the past.

Dr. Thompson shared what outreach is presently doing to address issues raised in the survey. The survey has been presented to the pediatric department and Chiefs and will be presented to UMCA Planning and Marketing. It was also reported that the nurse coordinators are helping with faster communications. Mr. Latz thanked the students for their report.

## SYSTEM AND NETWORK DEVELOPMENT TASK FORCE

Dr. Ciriacy reviewed the draft report of the System and Network Development Task Force Position Paper.

He noted the internal and external assumptions as well as specific goals for the future.

He said that outreach activities are an important part of the networking options available to accomplish the goals of the task force. Implementation strategies include the metro area, outstate, and out-of-state service areas. The approaches to each market must be geared toward that particular audience with our first priority being the metro area. General discussion of the report followed.

Dr. Ciriacy said that the report would probably be finalized in six weeks and that it would be presented at Planning and Development in August and then on to the Board and Governors for their retreat agenda in October.

## REMODELING OF OBSTETRIC UNIT

Mr. Hart reported that there are concerns about the volume of patients in obstetrics. The hospital has communicated to Dr. Work and the obstetrical department that the hospital is willing to provide for limited investment in current facilities and in the new facility contingent on a number of changes in the department's scope and volume during a specified time frame.

Discussion on the memo concerning future obstetrical service recommendations and plans followed. Mr. Hart said that an expenditure of about \$350,000 would be needed and that further program expenditures would be contingent on the department's ability to meet the stipulations noted in the memo.

## RED WING UPDATE

Mr. Fearing said that the agreement with Red Wing has been written and verbally accepted. Signatures will be obtained in a meeting in Red Wing on Tuesday, June 26. After that the media will be notified of the agreement. UMHC is optimistic about the relationship with the Red Wing group.

## AD HOC COMMITTEE ON BOARD OF GOVERNORS PROCESS

It was decided in the interest of time to postpone this topic until the next meeting. Ms. Lorbiecki requested that the committee members review the document and be prepared to discuss it at the next meeting.

## UMCA UPDATE

Dr. Lynch reported that the number of State Health Plan visits are lower than expected and are discouraging. PHP and UMCA have a contract that is waiting for PHP signatures. He told the committee that UMCA will have to vacate their space and move off campus.

Joint venturing with Group Health on affiliate campuses was also discussed

## ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 4:40 p.m.

Respectfully submitted,

Ann Frohrip Secretary

Planning and Marketing



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

July 13, 1990

T0:

Planning and Development Committee

FROM:

Greg Hart

RE:

Quarterly Purchasing Report

Attached please find the quarterly purchasing report for the period April - June, 1990. The report will be reviewed at the July 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.

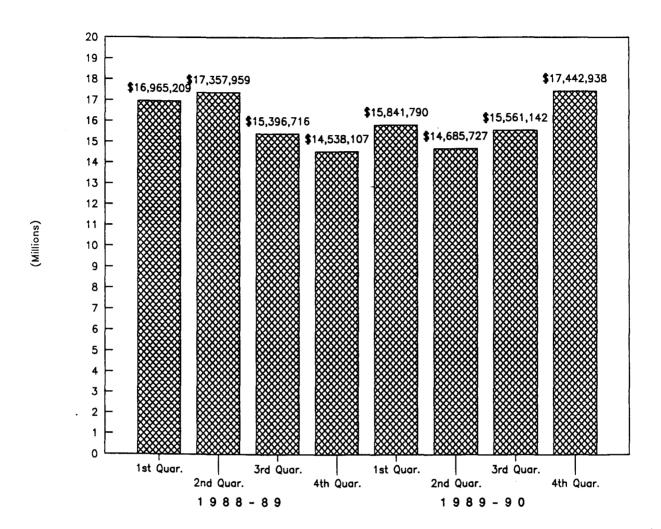
/gs

attachments

# UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY PERIOD OF APRIL – JUNE 1990

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

## **PURCHASE ORDER ACTIVITY**



## FOURTH QUARTER, FISCAL YEAR 1989-90, ACTIVITY:

	NUMBER	<u>VALUE</u>
PURCHASE ORDERS	8409	\$15,330,020.12
OTHER PAYMENTS	540	\$1,806,803.11
CONFIRMING ORDERS	323	\$306,114.51
TOTAL THIS QUARTER*	9,272	<u>\$17,442,937.74</u>

<sup>\*</sup>Total does not include a standing purchase order issued for the sale-leaseback of existing MRI equipment in the amount of \$2,988,849.60 over a period of 60 months.

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

	<u>ITEM</u>	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Isolation Gowns	Walter Mayer \$ 72,288.00	Standard Textile \$ 91,200.00	Materials
		The gown's body cloth was of insuffi and the seams puckered after washi		
2.	Slippers	Medix \$ 14,500.80	Bird & Cronin \$ 14,913.70	Materials
		The slippers fit poorly and did not pr	ovide adequate traction.	
3.	Robinson Catheters	General Medical \$ 10,312.74	Bard \$ 19,847.16	Materials
		The holes on the catheter are too big tip bends too easily, and the flanged an irrigation syringe.		
		LBB Marketing \$ 12,618.00	Bard \$ 19,847.16	Materials
		The catheter is too soft to handle an	d insert.	
4.	Cysto Pack	Boundary \$ 15,800.00	Surgikos \$ 18,160.00	Materials
		The screen drains poorly, the grippe and the package is not double wrap		
		Baxter \$ 13,874.00	Surgikos \$ 14,504.00	Materials
		The cover drape allows strike-through wrapped to ensure sterility.	h and the package is not double	

Cysto Pack (cont'd)

Medix

Surgikos \$ 14.504.00 Materials

The screen is too small, the outside packaging tears easily, and the

package is not double wrapped to ensure sterility.

Medline

Surgikos

Materials

\$ 14,369.60

\$ 14.084.00

\$ 14,504.00

The pack has an offensive odor, the drainage hole is too small, and the drapes are folded in a manner that makes it difficult to maintain aseptic technique.

5. Consultant for Contingency Management Plan

Sunbelt

Unisys/AIM

I.S.D.

ent Plan \$ 23,000.00

\$ 26,400.00

Proposal did not include a cost-benefit analysis, the plan required a full-time UMHC coordinator plus additional team support, and a word

processor was included for plan maintenance rather than a software planning

package.

6. Stereotactic Radiosurgery Equip. Leibinger & Fischer

Philips

Therapeutic Radiology

\$158,293.00

\$500,000.00

Beam target accuracy was not independent of the accuracy of either the gantry or the patient support system, equipment would not be made available for acceptance testing, and FDA approval is still pending.

 Consultant for Organizational & Operational Review of I.S.D. **Anderson Consulting** 

Coopers & Lybrand

I.S.D.

\$ 27,500.00 \$ 37,000.00 - \$ 42,000.00

Approach of developing a generic model against which to compare I.S.D. appeared ineffectual and the staff designated for the project did not have an acceptable depth of data management experience.

8. Laparotomy Drape

Mars White Knight

J & J

Materials

\$ 23,158.20

\$ 25,712.70

Drape has an offensive odor, the seams are weak and the aperture

is too small.

Baxter

J & J

Materials

\$ 23,868.00

\$ 25,712.70

The aperture is too stiff to fold around a small incision site.

9. Double Draw Sheet

Mars White Knight

Baxter

Materials

\$ 13,025.00

\$ 13,900.00

The drape is stiff and does not lay well on patients.

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

	CONTRACT/			
VENDOR	<u>P.O. #</u>	<u>VALUE</u>	DEPT.	PRODUCT
Riverside Market	90-396	OPEN	Amb. Care	Misc. Food
Playscapes	H107365	\$5,198.00	Amb. Care	Play Center
Baxter	H108771	\$16,950.00	Cardio.	Autosyringe Pumps
Applied Biometrics	H107357	\$9,500.00	Cardio.	Cardiac Monitor
CCI Survey	H106753	\$13,500.00	Human Res.	Assessment Surveys
Caere Corp.	H107352	\$5,445.00	I.S.D.	OCR/Bar Code Wands
Micromedex	H106740	\$13,485.00	I.S.D.	Software License
Therakos	90-349	\$17,575.00	Labs	Photopheresis Kits
Incstar	H099886	\$5,725.95	Labs	ACTH Kits
Pharmacia LKB	90-479	\$13,200.00	Labs	Mats & Sample Bags
Honeywell	H106761	\$10,762.35	M & O	Electronic Equip.
Mpls./St. Paul Magazine	H099873	\$17,000.00	Marketing	Advertising
Minn. Parent Magazine	H099874	\$8,000.00	Marketing	Advertising
Fashion Seal	H105981	\$24,757.20	M.S.	Surgeons' Gowns
Modern Bin	H106760	\$33,619.33	M.S.	Medical Records Shelving
Electronic Design	H107298	\$26,409.00	Nursing	Intercom/Nurse Call
Jansens	90B-51	OPEN	Nutrition	Misc. Food
Twin City Poultry	90-432	OPEN	Nutrition	Kosher Foods
Impra	90-469	OPEN	O.R.	Implantable Grafts
Lee Medical	90–434	\$10,000.00	O.R.	Bone Marrow Harvest Needles
Aesculap	90-433	OPEN	O.R.	Burs & Blades
Imaging Systems/3M	H107324	\$36,536.00	Radiology	Laser Imager Enhancement
Siemens	H108161	\$75,000.00	Radiology	MRI Updgrade
Siemens	H107307	\$75,000.00	Radiology	MRI Upgrade
Eastman Kodak	H094242	\$39,723.00	Radiology	Imaging System
TOTAL		\$457,385.83		

<sup>\*</sup> Over \$50,000

## IV. VENDOR APPEALS

1. VENDOR NAME/DOLLAR AMOUNT:
NATURE OF PURCHASE:
INTENDED VENDOR/DOLLAR AMOUNT:
REASON FOR APPEAL:

Lotus Healthcare/\$11,160 Static Air Mattresses Baxter/\$12,600

Vendor contended that their mattress had an automatic shut-off valve as specified, when, in fact, this feature was available on another product which was not offered on the bid.

STATUS:

Purchase order awarded to Baxter.

2. VENDOR NAME/DOLLAR AMOUNT:
NATURE OF PURCHASE:
INTENDED VENDOR/DOLLAR AMOUNT:
REASON FOR APPEAL:

P.M. Uniforms/\$ 8,562.36 Nutrition Uniforms American Linen/\$ 8,926.35

Vendor was initially found to have an unacceptably long delivery time. Vendor provided a clarification of delivery time on the initial order vs. subsequent orders, which made their terms acceptable to UMHC. This clarification was determined to be allowable within established purchasing procedure.

STATUS:

Contract awarded to P.M. Uniform.



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

July 13, 1990

TO:

Planning and Development Committee

FROM:

Bob Dickler

RE:

Program Development and Evaluation

Following the 1989 Board of Governors retreat three task forces were appointed to consider three broad areas discussed at the retreat. The Program Development and Evaluation Task Force was appointed to consider and make recommendations concerning the development of mechanisms for evaluating current programs, establishing priorities for current and new programs, resource allocation, and other general concerns related to program development and evaluation. The Task Force has completed its work and a report is enclosed.

Peter Lynch and I plan to discuss the report with you at the July 19 meeting. The Task Force recommendations have not been discussed within the Health Sciences. We anticipate that these discussions will occur over the next several months. The report and the results of these discussions will be presented at the Board of Governors retreat in October.

/gs

## REPORT OF THE PROGRAM DEVELOPMENT AND EVALUATION TASK FORCE

Margaret Doucette, D.O.
Cliff Fearing
Elwin Fraley, M.D.
Shannon Lorbiecki
Richard Palahniuk, M.D.
Norma Ramsay, M.D.
Barbara Tebbitt
Leo Twiggs, M.D.
Peter Lynch, M.D. (chair)

## SUMMARY OF THE TASK FORCE CONSIDERATIONS AND RECOMMENDATIONS

- 1. Established an operative definition of a "program" in the sense that this word was used in the title of our task force.
- 2. Identified and listed existing clinical efforts which met the newly established definition of a program.
- 3. Prepared and distributed a questionnaire which sought to identify potential new programs which might enhance the clinical activities at UMHC.
- 4. Recommended the establishment of, and the structure for, a standing committee for program development and evaluation.
- 5. Developed evaluation criteria which could be used both by those submitting program proposals and by the committee members in their review of new and existing programs.
- 6. Discussed generic issues which impact on program development and evaluation
  - o less than optimal referral by graduates of our institution
  - o lack of an assured base of primary and secondary care patients
  - o lack of mechanisms for the reconcilliation of whatever disharmony sometimes exists between departmental and institutional goals
  - o inadequate development of faculty who are recognized for their expertise in clinical care
  - o perception by referring physicians, and their patients, that UMHC can be a "difficult" place in which to receive clinical care

## **DISCUSSION**

The University of Minnesota Hospital and Clinic (UMHC) Board of Governors met for its annual retreat in October 1989. At that meeting there was recurring discussion about the importance of clinical programs to the future well-being of UMHC. course of these discussions it became apparent that those interdepartmental clinical programs which were currently in place had developed in a haphazard manner and that, historically, there had been no organized mechanism for evaluation of their effectiveness. Moreover, there was no system available for identifying new ideas for programs and no means by which ideas, as they somehow surfaced, could be evaluated, prioritized, and The recognition of this situation led to the recommendation that mechanisms for the development and evaluation of programs be developed. Consequently in the late fall of 1989, Mr. Robert Dickler established the Program Development and Evaluation Task Force and asked that this group develop mechanisms for the identification, implementation, and evaluation of patient care related programs.

The task force met for the first time on January 5th 1990 and subsequently held seven semimonthly meetings. The deliberations of this task force, as reviewed and revised by its members are discussed in the pages which follow. The report is presented in six sections:

- 1) Program definition
- 2) Identification of programs already in existence
- 3) Identification of proposals for new programs
- 4) Institution of a new standing committee for program development and evaluation
- 5) Development of evaluation criteria
- 6) Generic issues relevant to program evaluation and development

## PROGRAM DEFINITION

Much of the discussion at our first meeting revolved around the definition of the word "program" as it occurred in the title of our task force. We were concerned that, used loosely, it would encompass all of the clinical activities that now, or might in the future, exist under the umbrella of UMHC. Such a broad definition would create an evaluation task too daunting for even the most dedicated review body. After appreciable debate we were able to narrow the definition such that the programs to be considered would meet the following five criteria:

- 1) A program, to be considered in this setting, will be primarily clinical. Research and educational components should surely be present but would not represent the major thrust of the effort. For example clinical drug studies would likely not be considered within this definition.
- 2) A program will not represent the totality of a department's clinical effort. It might exist as a small thrust

within a department, or even more likely, might occur as an inter-disciplinary effort involving two or more departments.

- 3) A program will represent an effort which is innovative or unique within our marketing area. Or, if duplicative, it should have some feature, such as a technological advance, which clearly sets it apart from other similar programs. Alternatively, the program could be considered unique if the quality of care offered through it was <u>demonstrably</u> of higher quality than exists in competing programs.
- 4) A program might have inpatient, outpatient, or extramural components. If the program is extramural, some definable benefit other than "good will" should accrue to UMHC.
- 5) A program does not exist in a vacuum. It will have some impact on other units within UMHC. Most, if not all, of the parameters of this impact must be identified and be taken into consideration in the program's evaluation and development.

## IDENTIFICATION OF PROGRAMS ALREADY IN EXISTENCE

Our task force was aware that many programs, as defined above, were already in existence but we were unsure as to their titles, numbers or usefulness. Shannon Lorbiecki undertook the task of identifying as many of these programs as she could. list she developed (see Appendix A) came primarily from the materials found in the U ACCESS directory. The large number identified surprised us and our surprise suggested that if these programs were not well known to us, they were probably even less well known to the public and referring physicians that we were trying to serve. We sought to identify existing evaluation mechanisms for these programs but could find none existing on an institution-wide basis. This lack of critical evaluation has essentially guaranteed that the institution's limited resources could not be used in the most effective manner. Accordingly, the development of mechanisms for evaluation and prioritization became the most important goal for our Task Force.

## IDENTIFICATION OF PROPOSALS FOR NEW PROGRAMS

All of the task force members felt strongly that the future of UMHC lies in the continuous development of new programs and that this must be done expeditiously if we are to stay ahead of the competition. We were, however, uncertain as to how large a pool of new ideas existed. Since the mechanisms our task force would develop to evaluate, prioritize, and implement these proposals would be based in part on this number we evolved a short questionnaire to be sent to all faculty members. The magnitude of the response came as a welcome surprise. Nearly 100 questionnaires were returned and the quality of the ideas suggested appeared to be excellent. A collation of the proposals, divided into categories, was carried out. This list and a copy of the questionnaire itself can be found in Appendix B.

The large number of new proposals identified, together with the huge number of programs already in existence, clearly represented a task for evaluation well beyond what our small, ad hoc group could undertake. Thus we felt that a new standing committee should be empowered for this purpose.

## INSTITUTION OF A NEW STANDING COMMITTEE FOR PROGRAM DEVELOPMENT AND EVALUATION

In this day of increasing bureaucratization, one ought to be very wary of the creation of a new standing committee. Nevertheless, our task force believed that there was no other mechanism possible which would allow for the needed evaluation, prioritization, and implementation of clinical programs. In recommending that this new committee be formed we also recognized that the magnitude of work to be undertaken might make it difficult to find highly qualified individuals to serve on it. However, we believed that if this new committee had adequate staff assistance and were empowered with sufficient resources in the form of space and money, it would become one of the premier administrative assignments for faculty members.

Our task force spent appreciable time considering what the size and makeup of this committee should be. We concluded that it ought to consist of 8 to 10 members. The physician membership would be chosen much as is currently done for the Medical staff-Hospital council whereby all of the clinical departments are clustered into three districts from which two representatives are periodically elected. These individuals would serve staggered three year terms and Heads of departments would not be eligible. In addition to these physicians, there would be representation from hospital administration by way of the Director of Operations, Director of Finance, and Director of Nursing.

## CRITERIA FOR PROGRAM EVALUATION, PRIORITIZATION, AND IMPLEMENTATION

Our task force found that, even as there is now no existing group to carry out program evaluation, so is there no list of criteria for such evaluation. We were concerned that in the absence of set criteria, evaluation might be arbitrary and even political. Thus we felt that it might be best if our disinterested group develop the criteria rather than leave this task to the new standing committee. In formulating our criteria we recognized that although patient service was to be the main goal of these clinical programs, we do represent an academic institution and that excellence in the areas of clinical research and education must also be fostered. Our criteria are thus divided into the categories of patient care, education, research, and logistics.

The specifics within each of these groups are listed in the Evaluation Criteria in Appendix C. It is our intention that this list would be used both by those proposing new programs as well as by the committee in judging programs. With this in mind the

individual criteria are posed in the form of questions which would have fairly specific, short answers.

## GENERIC ISSUES RELEVANT TO PROGRAM DEVELOPMENT AND EVALUATION

At our second meeting we asked Geoff Kaufmann to present information regarding market share for various UMHC programs. At the conclusions of his remarks it was apparent that, in many key areas, we were being out-stripped by our competition. We agreed that the development of new programs, together with the evaluation and improvement of existing programs, was an important step in building our patient base but felt strongly that program development could not occur as an isolated event without the resolution of several intertwined generic issues. We then decided that, although these generic issues were not technically within the purview of our task force, we would briefly outline them in order to emphasize our concern about their importance.

First, Alumni of our medical school and residency programs seem not to establish consistent referral patterns to our Hospital and its faculty. We recognize, of course, that in an era of managed care, it is not always possible for a physician to choose his or her site for referral. Nevertheless, it is our impression that even when they are free to do so, our alumni are less "loyal" than are those from some competing schools and training programs. As one way of considering this problem we invited the chief resident of one of our major training programs to express her views on the subject. Some of her observations include: 1) residents have few interactions with faculty outside the area of their own discipline and, when interactions do occur, they are not always salutary; 2) where technology is available it will be used, thus some patients may be "worked up" and treated more aggressively than the referring physician might prefer; 3) in some areas such as oncology there is a belief that one's patients are too often "plugged into" a protocol without adequate consideration

of individual patient needs; and, 4) there may be a perception on the part of the referring physician that faculty members at UMHC are more interested in their research than they are in providing immediate, personal service to referred patients.

In addition to these remarks by the chief resident, we also considered the possibility that alumni might view the faculty members with whom they worked as truly knowledgeable only in rather restricted clinical areas owing to the small number of hours that many of our physicians devote to direct, hands on patient care. Other considerations included the possible view that too much of referred patient care is carried out by residents and students; that inter-departmental clinical cooperation in the evaluation of a single patient is difficult to arrange; and, that communication back to referring physicians, although greatly improved, still falls well short of the ideal.

Since most of the above represents anecdotal data, we believe that more information ought to be obtained from our alumni in all of these areas. It is our understanding that the

Medical School has initiated a pilot project to consider some of these items.

Second, There are no mechanisms in place to assure an adequate base of primary and secondary care for future referral. At the present time we depend on short term contracts with various managed care groups for these referrals. Given the increasing excellence of specialty care within these groups, it is apparent that maintenance of these ties is going to become even more difficult and will be economically disadvantageous when it does occur. In order to assure access to these patients, UMHC and its physicians will have to consider other options such as expansion of departmental based primary care, formation of an institutional group practice, more extensive effort in outreach clinical activities, acquisition of existing practices, and purchase of, or merger with, one or more managed care groups. Some of these possibilities are currently being explored by the System and Network Development Task Force which is chaired by Dr. Ciriacy.

Third, <u>Disharmony may</u>, and often does, exist between departmental and institutional goals in regards to patient care programs. Presently there is no forum for either discussion or resolution of these problems and there appears to be little willingness for the responsible people in individual departments to make the hard decisions that will be necessary if these concerns are to be addressed. Perhaps the setting in which these issues are to be debated and then resolved should become the responsibility of UMCA.

Fourth, There are currently few ways to assure availability of, and reward for, faculty who achieve excellence primarily in patient care. In academic institutions it is widely recognized that physicians cannot maintain competitiveness in grant acquisition unless they are willing to devote 70 percent or more of their time to research. It is appreciably less well recognized that a similar effort is necessary to remain competitive in the clinical arena. At the present time our reward system, while strong in the area of research, is inadequately developed in the area of clinical care.

Fifth, There is perception by some (students, residents, patients and referring physicians) that UMHC and its faculty are lacking in "warmth" and "user friendliness". Anecdotal and questionnaire information exists suggesting that patients experience appreciable difficulty in areas such as appointment scheduling, registration, billing, and parking. Some physicians are also criticized for lack of availability, delays in seeing patients at appointed times, and impersonal delivery of service. Such difficulties are carried back to referring physicians and are mentioned often to friends and relatives. These may be then reflected in fewer referrals or the cancellation of existing return appointments. Better surveys are needed regarding patient satisfaction; a better and more widely visible ombudsman system for patients needs to be created; and means for enforcing change

when problems are repeatedly identified must be instituted.

Our task force believes that these generic issues should be discussed in every possible forum and that consensus, when and where it can be reached, needs to be visibly documented and quickly implemented. We conclude that the development of first class, innovative programs together with the resolution of these generic issues, will allow UMHC and its faculty to be well positioned to compete in both the clinical and academic arenas during the decade of the nineties.

## APPENDIX A

Existent Interdisciplinary Programs

## A PRELIMINARY LIST OF INTERDISCIPLINARY PROGRAMS AT UMHC

Audiology clinic

Ambulatory surgery center
Anesthesia
All Surgical services
Nursing

Biomedical Engineering Center

Craniofacial and skull base surgery center
Craniofacial Anomalies Clinic
Plastic/Craniofacial Surgery
Neurosurgery
Ophthalmology
Oral Surgery
Otolaryngology
Pediatric Dentistry
Orthodontics
Maxillofacial Prosthodontics
Oral Pathology and Genetics
Audiology
Speech Pathology

Skull Base Surgery Program
Neurosurgery
Otolaryngology

Social Work

Cleft Palate Maxillofacial Clinic
Surgery
Oral Surgery
Speech Pathology
Audiology
Otolaryngology
Pediatric Dentistry
Orthodontics
Prosthodontics
Genetics

Reparative Medicine Program
Surgery
Physical Medicine and Rehabilitation
Medicine

Brain tumor program
Neurology
Neurosurgery
Medical Oncology
Pediatric Oncology

Eating Disorders program
Psychiatry
Psychology

Adolescent Health Program
Pediatrics
Psychology
Nutrition

Alzheimer's Disease Clinic Neurology Psychiatry

Arthritis Center

Medicine (Rheumatology)

Orthopaedic Surgery

Physical Medicine and Rehabilitation

Bone Marrow Transplantation Program
Medicine
Pediatrics
Lab Medicine and Pathology

Breast Diagnostic Clinic
Surgery
Therapeutic Radiology-Radiation Oncology
Medicine

Cancer Detection Center
Surgery
Diagnostic Radiology

Cardiac Rehabilitation Program
Cardiology
Physical Medicine and Rehabilitation

Center for Autism and Developmental Disabilities
Psychiatry
Psychology

Clinic for Attention Deficit and Learning Difficulties Psychiatry Psychology

Cochlear Implant Program
Otolaryngology
Psychoacoustics
Audiology

Coleman Leukemia Research and Treatment Center
Medicine
Radiotherapy
Laboratory Medicine and Pathology
Pediatrics

Comprehensive Cancer Care Program

Physicians from all departments

Comprehensive Clinic for Abused and Traumatized Children
Psychiatry
Pediatrics
Obstetrics and Gynecology

Comprehensive Hemophilia Center
Laboratory Medicine and Pathology
Hematology
Pediatrics
Orthopaedics
Dentistry
Nursing
Infectious Disease
Physical Therapy

Cranio-Maxillomandibular Clinic
Otolaryngology
Neurosurgery
Orthodontics

Cystometrogram/Electromyography Laboratory
Urologic Surgery
Physical Medicine and Rehabilitation

Diabetes Center Medicine Pediatrics

Diabetic Retinopathy Clinic
Ophthalmology
Medicine
Surgery
Pediatrics

Equilibrium and Balance Clinic Otolaryngology Neurosurgery

Feeding/swallowing disorders program

Gastroenterology Clinic Surgery Medicine Genetics Clinic

Medicine

Pediatrics

Institute of Human Genetics

Genetics Eye Clinic
Ophthalmology
Medicine
Pediatrics

Genodermatoses Clinic Dermatology Medicine

Headache Management Program
Psychology
Neurology

Head and Neck Oncology Program
Otolaryngology
Therapeutic Radiology-Radiation Oncology
Surgical Oncology
Oral Surgery

Heart disease prevention clinic

HIV Clinic Medicine

Human Papilloma Virus Surveillance Program
Obstetrics and Gynecology
Dermatology
Molecular Biology
Microbiology
Institute of Human Genetics

Hyperthermia Treatment in Cancer Patients
Therapeutic Radiology-Radiation Oncology
Medicine

Implantable Pump Program
Surgery
Medicine
Pediatrics

International Adoption Clinic Pediatrics Others as necessary

Interstitial Implant for Brain Tumor Program
Neurosurgery
Therapeutic Radiology-Radiation Oncology

Intracavitary/Interstitial Radiation Therapy for Gynecological Cancer
Obstetrics and Gynecology
Therapeutic Radiology-Radiation Oncology

Laser surgery program

Liver Disease Center

Medicine
Surgery
Pediatrics
Laboratory Medicine and Pathology
Biochemistry

Masonic Day Hospital
All Medical Departments

Heart and Lung Institute
Surgery
Medicine
Pediatrics
Diagnostic Radiology

Lipid Clinic Surgery Pediatrics

Male Sexual Function Center
Urologic Surgery
Diagnostic Radiology
Program for Human Sexuality

Molecular Diagnostics Laboratory

Laboratory Medicine and Pathology
Pediatrics
Medicine

Musculoskeletal Tumor Clinic
Orthopaedic Surgery
Radiation Therapy
Pediatric and Adult Oncology

Myelodysplasia Clinic
Physical Medicine and Rehabilitation
Neurosurgery
Urology
Orthopaedic Surgery
Pediatrics
Social Work
Nursing
Nutrition

Neurofibromatosis Clinic

Medicine
Pediatrics
Neurology- adult and pediatric
Ophthalmology
Institute of Human Genetics

Neromuscular Disease Clinic Neurology Pediatrics Medical Genetics

Neuro-Ophthalmology Clinic Ophthalmology Neurology Neurosurgery Medical Genetics

Ocular Trauma Program Ophthalmology

Pain clinic and treatment program

Pancreaticobiliary Disease Center
Diagnostic Radiology
General Surgery
Interventional Radiology
Laboratory Medicine and Pathology
Medicine
Pediatrics
Physical Medicine and Rehabilitation
Therapeutic Radiology-Radiation Oncology

Pediatric Brain Tumor Task Force
Pediatrics
Pediatric Neurology
Neurology
Neurosurgery
Therapeutic Radiology-Radiation Oncology
Neuropathology

Pediatric Liver Transplant Program
Pediatrics
Surgery

Pediatric Radiation Oncology
Pediatrics
Therapeutic Radiology-Radiation Oncology

Pediatric Renal Dialysis and Transplant Program
Pediatrics
Surgery

Prenatal Detection Center
Obstetrics and Gynecology
Genetics
Laboratory Medicine and Pathology
Radiology

University perinatal center

Program in Human Sexuality
Family Practice and Community Health
Psychiatry
Psychology

Prostatic Cancer Screening Clinic Urology Surgery Diagnostic Radiology Pathology

School Refusal Clinic Psychiatry Psychology

Speech language pathology services

Spinal Cord Center
Neurosurgery
Orthopaedic Surgery
Urology Surgery
Physical Medicine and Rehabilitation
Surgery
Psychology
Diagnostic Radiology

Sports Medicine Institute Orthopaedic Surgery Physical Therapy

Children's Lung Center
Pediatrics
Institute of Human Genetics
Physical Medicine and Rehabilitation
Surgery
Medicine
Epidemiology

Transplant Center Surgery Medicine

Thyroid Eye Disease Clinic Medicine Ophthalmology Total Body Irradiation for Bone Marrow Transplantation Program
Therapeutic Radiology-Radiation Oncology
Bone Marrow Transplant Service

Kidney Stone Center
Urology Surgery
Diagnostic Radiology

Low Back Center
Orthopaedic Surgery
Neurosurgery
Physical Medicine and Rehabilitation

Nutrition Support service Neonatology Pediatrics Medicine Surgery Pharmacology

AIDs Treatment Evaluation Unit Laboratory Medicine and Pathology Medicine

Comprehensive Home Alimentation Management Program (CHAMP)
Pediatrics
Medicine
Surgery

Obesity Surgery Program
Surgery
Medicine

Upper Midwest Center for Specialized Intensive Care (UMCSIC)
Cardiology
Cardiovascular and Thoracic Surgery
Medicine
Neonatology
Neurology
Neurosurgery
Oncology
Pediatrics
Perinatology
Surgery
Trauma

Upper Midwest Trophoblastic Disease Center Obstetrics and Gynecology Pathology

Vital Initiation of Pregnancy (VIP) Program Obstetrics and Gynecology Mammalian Physiology

University of Minnesota weight management program

## APPENDIX B

Questionnaire Seeking New Proposals for Programs

List of Programs Proposed Compiled from Completed Questionnaire



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

TO:

All Clinical Faculty/Hospital Medical Staff

FROM:

Program Development and Evaluation Task Force

Margaret Doucette, D.O.

Elwin Fraley, M.D. Richard Palahniuk, M.D.

Barbara Tebbitt

Cliff Fearing

Peter Lynch, M.D. Norma Ramsay, M.D.

Leo Twiggs, M.D.

DATE:

March 15, 1990

SUBJECT:

Future Program Development

Our task force was created by hospital administration at the request of the Hospital's Board of Governors, to help in the evaluation of the many clinical programs which currently exist and to help identify and to help support new programs that might lead to increased patient care activities for all of us.

With this in mind, we are interested in hearing from you regarding new directions and programs in clinical care. We are particularly interested in areas which would provide services unique to our marketing areas or, if not unique, are demonstrably superior in quality to those already in this geographic area. These programs could range from individual efforts to interdepartmental programs.

Please list any ideas for programs you might have. We are thinking in terms

of future planning (one to three years) thus your ideas do not need to represent fully developed concepts or plans.
Does this idea represent an approach for which you believe there is a need which is currently unmet?
Does this represent an approach to clinical research which might have educational or scholarly value in addition to its clinical usefulness?
Return to Peter J. Lynch, M.D., Box 98 UMHC by March 30, 1990.

## Summary of Faculty Survey Results

## New Interventions Within Existing Programs

Liquid ventilation (Peds critical care)
Adolescent sexuality
Intrathecal morphine for treatment of spasticity
Partial ileal bypass surgery for lipid lowering
Implantable pump for chemotherapy, diabetes, etc.
Testing skeletal muscle to detect malignant hyperthermia
Gait and foot analysis
Q-switched ruby laser treatment for tattoos and pigmented lesions
Immune modulation therapy in conjunction with the BMT program
Photodynamic therapy for GI malignancies and GI inflammatory diseases

## New Treatment Modalities

Convalescent care
Step down care for long term and/or intermediate care
Low level nursing care for Peds patients who cannot currently meet admission guidelines
Rural physician expansion with 40 students/year

## Things we do or plan to do

High risk OB
CHAMP
Complicated post-op surgical patients with serious complications/organ failure

## Various cancer programs (6)

Biologic response modifiers in cancer chemotherapy
Clinical/diagnostic/therapeutic approaches to solid tumor malignancies
Clinical/diagnostic/therapeutic approaches to leukemias and lymphomas
Cancer center blanketing Medicine Oncology and Hematology/Pediatric
Oncology/BMT(2)
Combined oncology/gurgory program

Combined oncology/surgery program
Tumor conferences and centralized tumor registry

Lyme Disease Center (2)
Computer assisted analysis of EEGs
Derm-Peds Immunology Clinic
Craniofacial/Skull Base Surgery Center
Center for Vascular and Interventional Radiology
Behavioral treatment for anxiety disorders

## New Multidisciplinary Areas of Emphasis

Management of acute hand injury
Vascular surgery service
Clinic for persons with chronic recurring undiagnosed problems
Vertigo center
Fetal surgery
Maternal ICU
Morbid obesity management

Management of acute and chronic pain in Peds patients Prenatal diagnosis of renal abnormalities (2)

Geriatrics programs, behavior management or seniors clinic (5)

Evaluation program for persons over 75 years of age

Ambulatory seniors clinic, assessment unit, extended care/rehab unit

Geriatric behavioral management unit

Comprehensive geriatric program with assessment, transitional care, and
education

Prosthetics lab
Foot care clinic
Program for pregnant women addicted to cocaine or other substances (2)
Osteoporosis clinic
Molecular diagnostics program
Evaluation of primary immunodeficiencies
Clinic for management of temporomandibular disorders and facial pain
Registry of patients with limb hypertrophy
Adult congenital heart disease (2)
Environmental/occupational toxicology
Heart treatment for infants with hypoplastic left heart
Hand and upper extremity surgery and rehabilitation (Arthritis Center)

#### APPENDIX C

Evaluation Criteria for Programs

#### **EVALUATION CRITERIA FOR PROGRAMS**

- A. PATIENT CARE ASPECTS
- 1. Is this a new patient population to UMHC?
- 2. If not new, does the program represent an increase in patient days or outpatient encounters without substituting or conflicting with an existing program?
- 3. Do the patients come for "one time" visits only, if not, how frequently would they need to visit?
- 4. What is the number of potential patient days or outpatient encounters annually for the program?
- 5. What is the level of payment?
- 6. Are they patients who will use services of other departments in the medical center? If so, which departments?
- 7. If they will be using services of other departments what benefit will this program have for those departments?
- 8. If the program requires services of other departments, have the affected departments been contacted regarding their level of interest in the program? Please attach a letter of support from those department(s).
- 9. Does the program use other Hospital ancillary services such as radiology, labs, respiratory therapy, etc.?
- 10. Can the quality of care be demonstrated as higher than other healthcare institutions providing the service? If so, in what way?
- 11. How will patient satisfaction be measured? If an existing program, how satisfied are current patients?
- 12. Are the services marketable locally? Regionally? Nationally?
- 13. Is the program unique in a given market area?
- 14. If the program is not unique, what will make it viewed as more desirable than existing programs in its market area?
- B. EDUCATIONAL ASPECTS
- 1. Will "learners" be involved?
- 2. How is the role of "learners" truly educational?
- 3. How is the role of "learners" service oriented?

- 4. Have the "learners" evaluated the program? If so, how highly was it rated?
- 5. In what way is the educational aspect unique? Is the educational aspect duplicative?
- 6. Do the patients come for "one time" visits only, if not, how frequently would they need to visit?
- 7. Do the patients view the educational component as "attractive" regarding their care? Do the patients view the educational component as a "deterrent" regarding their care?
- C. RESEARCH ASPECTS
- 1. Can new knowledge be obtained through the program?
- 2. Is the new knowledge such that it is "grantable" and publishable? Has a grant been requested or is an application in preparation?
- 3. Do the patients view the research component as "attractive" regarding their care? Do the patients view the research component as "deterrent" regarding their care?
- 5. Does the research compliment research done in other departments or programs? If so, in what way?
- D. LOGISTICAL ASPECTS
- 1. Where will be the program be located? (inpatient, outpatient, extramural).
- 2. What is the space requirement?
- 3. Does the program generate money for resource support? Does the program generate professional fee income?
- 4. What is the cost of the program?
- 5. Is the program budget neutral or positive for the Hospital? What is the expected time frame for a break even budget? Please submit a budget, including separation of costs for education, research, and patient care as appropriate.
- 6. Does the success of the program depend upon a key leader?
- 6. If the key leader were to leave would the program leave also?
- 7. What new resources would be needed? Where will new resources come from?
- 8. Is recruitment of personnel necessary? Is purchase of additional equipment necessary? Is location of additional space necessary?

- 9. Are adequately prepared medical and other staff available for the program?
- 10. What is the projected time line for implementation of the program?

#### MINUTES

## Ad Hoc Committee on Board of Governors Process Board of Governors May 7, 1990

Minutes Revised: May 23, 1990

#### CALL TO ORDER:

Chairman Heenan called the May 7, 1990 meeting of the Ad Hoc Committee on Board of Governors Process to order at 9:00 A.M. in Room 8-106 in the University Hospital.

Attendance:

Present:

Leonard Bienias

Robert Dickler

George Heenan, Chair Margaret Matalamaki

Staff:

Nancy Janda

Shannon Lorbiecki

### BACKGROUND DISCUSSION: BOARD OF GOVERNORS ATTENDANCE, MEETING FREQUENCY, AND AGENDA CONTENT

From time to time, attendance at Board meetings has been problematic. Board members have commented, informally and formally, through the self-evaluation survey, that Board of Governors responsibilities could potentially be met with fewer meetings. Board members have suggested that a two month committee and a two month Board cycle may not be necessary for some routine business items. If meetings were structured to allow for more active discussion and participation by the members, there would be an increased perception that they are making a worthwhile contribution.

A desire for focused meetings in addition to the yearly retreat has also been expressed. The Committee discussed structuring future Board of Governors agendas so that priority issues are more thoroughly discussed and routine or repeat agenda items are de-emphasized. The basis for the annual operating budget and associated resource allocation decisions were cited as one topic the Governors wish to discuss in more depth. Routine Credentials Committee reports, purchasing reports, and capital equipment expenditures were cited as topics that could be de-emphasized at the Board level, presuming prior Committee endorsement.

BACKGROUND DISCUSSION:
COMMITTEE ATTENDANCE, MEETING FREQUENCY, AND AGENDA CONTENT

In discussing Board Committee attendance and meeting frequency, the Committee on Process did acknowledge some difficulties. The Joint Conference Committee has adhered to a regular meeting schedule but has some difficulty in maintaining attendance for the duration of their meetings. The Planning and Development Committee has been difficult to schedule and has difficulty agreeing upon a regular schedule. The Finance Committee routinely meets just prior to the Board of Governors meeting, but includes out of town Board members, who's attendance depends on travelling a distance.

The Committee on Process recognized the Board of Governors Committee forum as being appropriate for in-depth detailed review of agenda items. Further, the Committee on Process felt each Board Committee most qualified to recommend the management of their agenda items at the full Board; whether a one or two month review cycle is necessary and whether the agenda items require a substantive or a non-substantive review.

#### RECOMMENDATIONS

1. The Committee on Process seconded and passed a motion directing staff to develop a list of major Board of Governors agenda items. The list will be reviewed in an effort to establish a Board of Governors meeting schedule. This calendar should include a combination of short business meetings and some longer meetings designed to focus on such topics as the operating budget or the year end financials.

#### RATIONALE:

The specific agenda items which need to be covered should drive the frequency and duration of meetings.

2. The Committee seconded and passed a motion recommending the establishment of a consent agenda for use by the Board of Governors. A consent agenda would include any item recommended for non-substantive review. Items would be placed on the consent agenda by the Committing conducting the substantive review. Review of the consent agenda should preced the review of all other agenda items at the Board of Governors Meeting. Any Board member desiring more detailed discussion of an item on the consent agenda could request a more detailed review.

#### RATIONALE:

Development of a "consent agenda" would enable the Board of Governors to focus attention on the most substantive items and more efficiently manage items not requiring an in-depth or substantive review by the full Board.

3. The Committee on Process seconded and passed a motion recommending that Committees take a more active role in determining the review process for their agenda items. Beyond recommending items for the consent agenda, Committees would govern the purpose for which and the timing in which agenda items are brought to the Board of Governors. Solutions to the attendance and meeting frequency difficulties are best found by the Committees themselves.

#### RATIONALE:

At the conclusion of the substantive review, the Committee is best equipped to evaluate the level of review necessary by the Board of Governors.

4. The Committee recommended no change to the current practice of inviting enrichment speakers to the monthly Board meetings.

#### RATIONALE:

Enrichment speakers at the Board meetings are viewed as very educational in furthering the members' knowledge of the Hospital. The presentations also increase visibility of the Board with the medical staff.

#### ADJOURNMENT

There being no further business, the meeting was adjourned at 10:45 A.M.

Respectfully Submitted:

Thannon & Lordiecki

Shannon L. Lorbiecki Administrative Fellow

SL

### BOARD OF GOVERNORS RECURRING RESPONSIBILITY LIST

#### BY MONTH

#### PROPOSED

January

Annual Meeting \* Quarterly Financials (2) \* Quarterly Bad Debt Report (2) \* Quarterly Development Report (1) \* Quarterly Purchasing Report (1) \* Quarterly Capital Expenditure Report (1) \* End Stage Renal Disease Policies

#### **FEBRUARY**

Mid Year Retreat

March

No Meeting

<u>April</u>

Operating Budget \* Rate Increase Approval \* Capital Budget \* Quarterly Financials (3) \* Home Health Program Policies \* Quarterly Bad Debt Report (3) \* Quarterly Development Report (2) \* Quarterly Purchasing Report (2) \* Quarterly Capital Expenditure Report (2)

May

Operating Budget \* Capital Budget

<u>June</u>

Compensation Plan \* Biennial Credentials \* MSHC Chair Appointments \* Clinical Chief Appointments

July

Year End Financials \* Quarterly Bad Debt Report (4) \* Quarterly Development Report (3) \* Quarterly Purchasing Report (3) \* Quarterly Capital Expenditure Report (3)

August

No meeting

#### SEPTEMBER

Annual Retreat

October |

Quarterly Financials (1) \* Quarterly Bad Debt Report (1) \* Quarterly Development Report (4) \* Quarterly Purchasing Report (4) \* Quarterly Capital Expenditure Report (4)

November

No meeting

December

External Audit \* Officer Elections

(#) = Quarter of the Fiscal Year

# Board of Governors Planning & Development Committee Recurring Responsibility List

Quarterly Development Office Report

January April July October

Quarterly Purchasing Report

February May August November

Quarterly Capital Expenditure Report

February May August November

Major Capital Expenditures

As Needed

Special Projects

As Needed

UMCA Update

Monthly



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

August 8, 1990

TO:

Planning and Development Committee Members

Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D. Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.

Kris Johnson

FROM:

Robert Latz

The August meeting of the Planning and Development Committee will be held:

Monday, August 13, 1990 2:30-4:30 P.M. The Board Room, University Hospital

The agenda and the background materials for the meeting are enclosed. Thank you for making time for this meeting.

cc: Fred Bertschinger Cliff Fearing Greg Hart Mark Koenig John LaBree, M.D. Shannon Lorbiecki Lisa McDonald

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#### PLANNING AND DEVELOPMENT COMMITTEE

# THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC BOARD OF GOVERNORS Monday, August 13, 1990 2:30 - 4:30 P.M. The Board Room (8-106), University Hospital

#### **AGENDA**

I.	Approval of the July 19, 1990 Meeting Minutes	Approval
II.	<u>Capital Plan Review</u> -Bob Dickler/Greg Hart	Information
III.	Cardiac Catheterization Lab Expansion Proposal (To be distributed at the meeting)  -Greg Hart	Information
IV.	UMCA Update -Peter Lynch, M.D.	Information
٧.	Other Business	
VI.	Adjournment	

# MINUTES Planning and Development Committee July 19, 1990

#### CALL TO ORDER

Robert Latz called the July 19, 1990 meeting of the Planning and Development Committee to order at 3:07 p.m. in room 8-106 in the University Hospital.

Attendance: Present Robert Latz, Chair

Leonard Bienias Robert Dickler Clint Hewitt

B. Kristine Johnson Peter Lynch, M.D. Ted Thompson, M.D.

Absent William Jacott, M.D.

Geoff Kaufmann Gerald Olson

Staff Cliff Fearing

Greg Hart

John LaBree, M.D. Shannon Lorbiecki

It was discussed and decided that the members of the committee should be polled as to meeting days and times so that a more convenient time for all members could be chosen.

#### APPROVAL OF MINUTES

The minutes of the May meeting were approved at this meeting because there was not a quorum at the June meeting. The minutes of the June meeting were also approved as distributed.

#### QUARTERLY PURCHASING REPORT

Mr. Koenig reviewed the April - June 1990 Quarterly purchasing report included in the committee packet. The report was unanimously endorsed.

#### LITHOTRIPSY UPDATE

Mr. Hart reported that this topic will probably be presented again in one to two months if a purchase agreement is negotiated with a lithotripter manufacturer. It is an information only item for this meeting.

Mr. Hart gave a brief history of the lithotripter program at University Hospital and said that because of advanced technology and increased competition, in the form of a mobile unit, our lithotripsy volume has declined. UMHC is considering development of a multi-site mobile unit which could provide renal and biliary lithotripsy services.

The University Hospital has been involved in trials with a Siemens Lithotripter that treats gallstones. The Siemens Lithostar also treats kidney stones without anesthesia. It has been found that multiple treatments are needed to treat some gallstones with lithotripsy and this technique will be applicable to a small segment of the population with symptomatic gallstones.

Although the Siemens unit is anesthesia-free, our current Dornier unit can be adapted to be anesthesia-free for approximately \$100,000. Dornier also has a new machine that is anesthesia-free that can be put in a mobile van. In exchange for participating in clinical trials, UMHC would have the opportunity to purchase the machine at a reduced price.

#### CAPITAL PLAN REVIEW

Mr. Dickler gave an update of the capital plan. He said that the financial projections are being done in a different way, turning the analysis around to find out how much we can spend on capital and remain financially stable. He said that the figures will be available next week.

The options available for Renewal Project II are to proceed with the project as planned, to proceed with the building but on a smaller scale, or to remodel existing areas to accommodate the programs affected. An analysis will be done by August 17 for the Clinical Chief's retreat where some basic conclusions will be reached on how we should or should not proceed and to get thoughts from the group on how they think we should proceed.

#### REPORT OF THE PROGRAM DEVELOPMENT AND EVALUATION TASK FORCE

Mr. Dickler reported that the report of the program development and evaluation task force has not been shared with the Clinical Chiefs. The report will be discussed at an August meeting of the Clinical Chiefs and by the Board of Governors at the October retreat.

Dr. Lynch said that the task force was appointed by Mr. Dickler as a result of discussions at the Board Retreat last year. He reviewed with the committee the report included in the packet. He said the major areas of consideration are: 1) program definition; 2) identification of existing programs; 3) identification of potential new programs; 4) process of identification and evaluation; 5) formulation of a new standing committee; and 6) criteria for evaluation, prioritization, and implementation.

He also discussed five generic issues which are: 1) alumni of our medical school and residency programs seem not to establish consistent referral patterns to our Hospital and its faculty; 2) there are no mechanisms in place to assure an adequate base of primary and secondary care for future referral; 3) disharmony may, and often does, exist between departmental and institutional goals in regards to patient care programs; 4) there are currently few ways to assure availability of, and reward for, faculty who achieve excellence primarily in patient care; and 5) there is perception by some (students, residents, patients and referring physicians) that UMHC and its faculty are lacking in "warmth" and "user friendliness".

#### UMCA UPDATE

Dr. Lynch reported that discussions to establish an on-campus HMO clinic are proceeding. He said that UMCA will support a weight management program; that UMCA showed its first profit this year; and that they overestimated patient volumes from state health plan enrollees.

#### BOARD OF GOVERNORS COMMITTEE ON PROCESS

Mr. Dickler said that the Ad Hoc Committee on Board of Governors Process has put together a proposed recurring responsibility list, by month, for board meetings. The proposed calendar would reduce the number of board meetings to nine per year and would have implications for the committees that report to the board. Mr. Latz expressed concern that some meetings could be overloaded and that the decision-making process could be affected if things moved too quickly. Mr. Dickler responded by saying that the business meetings are routine and usually do not require a lot of time.

#### ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 4:55 p.m.

Respectfully submitted,

Ann Frohrip Secretary

Planning and Marketing

#### Cardiac Catheterization Lab

#### Expansion Proposal

#### Introduction and Rationale

The Cardiac Cath Lab currently consists of three procedure rooms with radiographic capabilities, and support space for registration, storage, and patient recovery. Two of the procedure rooms are equipped to do interventional angiographic studies, the third is used primarily for electrophysiologic procedures. The Lab is located on the second floor of Unit J, adjacent to the CV Radiology area. The equipment for the two angiographic rooms was purchased in 1986, along with the opening of Unit J. The equipment in the third room was purchased in 1980.

The volume of patients seen in the Cardiac Cath Lab has grown significantly since the unit was planned in the early 1980s and opened in 1986. This growth is in part a function of changes in technology (especially angioplasty) and also clearly the result of the arrival in 1986 of Drs. Carl White and Robert Wilson. Dr. Wilson is currently the Medical Director of the Cardiac Cath Lab. Dr. White and Dr. Wilson have led an extensive, successful medical outreach program in conjunction with University Hospital.

Attached are graphs which depict the growth in number of cases for six month increments beginning in 1985, through June 1990. We are now seeing nearly 3,000 cases per year, compared to approximately 1,200 cases per year in 1985. Almost all of the growth has been in adult patients. While the pediatric procedure volume has been relatively constant, it is anticipated that we will see growth in the number of pediatric cases when Dr. Rocchini arrives later this year. Dr. Rocchini will be the Head of the Division of Pediatric Cardiology and is a pediatric interventional cardiologist.

The dramatic increase in volume has led to the current procedure rooms being used to capacity. A fourth procedure room is thus needed to handle additional anticipated growth. "Industry standard" is that each procedure room should accommodate approximately 70 procedures/month. We are currently at 80-85 procedures per room per month. The non-angiographic room has a utilization rate of 86%, while the two angiographic rooms are in use 98% of the time from 7:00 a.m. to 7:00 p.m. The rooms are consistently used well into the evening and night.

The congested schedule which results from such a high utilization rate has become problematic. The frequent occurrence of emergency cases results in patients being sent home or delayed in the Hospital. When the equipment is down for repair or maintenance, patients care is further delayed or, at times, must be transferred to another hospital.

Accommodating additional growth in this situation will be very difficult. A growth potential of 450-650 cases per year over the next three years is projected. Additional capacity will need to be created in order to handle this growth in patient demand.

A key component of this projected growth is related to the Hospital's continuing outreach efforts. The volume from Red Wing and Eau Claire should add approximately 200-300 cases per year to the Cath Lab activity. It is important that we have the capacity to be responsive to these new referral sources.

Additional growth is expected to come from an increase in pediatric cardiology cases (100-150 cases per year); volume from the continued growth in the number of patients in the Cardiac Transplant Program, who return for biopsies and angiography (100-150 cases per year); and some additional increase in electrophysiologic studies, with the arrival of Dr. Pineda, an expert in electrophysiologic cardiovascular surgery (50 cases per year).

Beyond the above short term opportunities, additional growth is probable. It is anticipated, within the next three to four years, that technological advances in catheterization, particularly in interventional and electrophysiologic cardiology may increase the number of patients suitable for treatment in the Catheterization Laboratory. In interventional cardiology, the patients amenable to coronary angioplasty may be substantially increased by the use of 1) intracoronary stents (devices to hold open arteries after coronary dilation), and 2) laser or radio-frequency ablation of atherosclerosis and "vascular welding".

Additional advances have been made in electrophysiology that may increase the number of patients who can undergo ablation of cardiac tissue responsible for heart rhythm disturbances. Many of these patients are currently treated with surgery. Advances in radio-frequency devices and other tissue ablation methods (chemical, electrical) may substantially increase the number of patients that can be treated in the Catheterization Laboratory. In pediatric interventional cardiology, a multitude of devices have been developed over the last several years that allow closure of defects within the heart, and permit the dilation of valves and other stenotic structures.

There has been a great deal of commercial interest applied toward the development of new devices for use in the Catheterization Laboratory. It is likely that over the life of a new radiographic facility, these devices will increase further the number of patients treated in the Catheterization Laboratory.

#### Proposal

It is proposed that the Cardiac Catheterization Lab capacity be increased by one additional angiographic room in order to handle current volume and anticipated growth. The estimated cost of the project is \$2,800,000. This project has been anticipated in the Hospital's long-range capital plan.

The project involves both equipment purchase and remodeling of space. Space adjacent to the existing Cath Lab will be utilized. This space is now used by Nuclear Medicine; space on the first floor of Unit J will be remodeled for the displaced Nuclear Medicine functions. The cost of remodeling both the first floor space for displaced Nuclear Medicine and the second floor space for the new Cardiac Cath procedure room is estimated at \$400,000.

Estimated equipment cost for the project is \$2,400,000. The new unit will be equipped with biplane cine-angiographic and digital angiographic capabilities. The unit will be used primarily for interventional procedures. In addition to the radiographic equipment, the project cost includes supporting equipment, including physiologic monitoring technology.

It should be noted that the cost estimates for the project are preliminary at this point. More refined costs, hopefully based on actual bids, will be included when the project is brought to the Board of Governors for approval. We are targeting for the October Board meeting for project approval.

#### Financial Analysis

We have approached the financial analysis for this project from more of a "product line" perspective than we have done in the past for major equipment purchases, such as CT scanners and MRI units. That is, the full range of revenue and expense for patients seen in the Cath Lab has been reviewed, as opposed to just revenue and expense generated in the Cath Lab itself. This methodology gives a more complete perspective on the financial impact of the Cath Lab activity, and, in particular, an increase in Cath Lab activity.

As indicated earlier, current Cath Lab volume is just under 3,000 patients. These patients generated over \$42 million in charges during their hospital stays, in 1989-90 dollars. Reimbursement on these charges was at 80% in 1989-90.

The patients seen in the Cath Lab generally fall into three categories. The first group, those for whom a cath procedure is the primary reason for admission, account for about 38% of the patients seen in the Lab. The second group, who have a heart biopsy or electrophysiologic study done in the Lab as part of (typically) a cardiac transplant evaluation or follow-up, account for 34% of the patients. The third group, with 20% of the patients, are those patients who are seen in the Cath Lab, but whose primary reason for admission was something other than the Cath procedure. These groupings are important, because the first two groups generate a "profit" for the Hospital (on a fully-loaded cost allocation basis) of about \$750,000 per year, while the third group generates a loss of approximately \$1,100,000 per year.

The project proposal is based upon additional volume of 500 cases per year. The additional volume will fall primarily in the first two above categories of patients. Estimated additional annual revenue (after revenue deductions) for those 500 cases is \$4,013,000.

The incremental operating costs of the additional caseload are estimated at \$1,856,000 (exclusive of depreciation). Thus before considering depreciation, the additional revenue generated exceeds the operating expense by \$2,157,000, and the project has a payback period of less than two years.

Assuming a six year life for the project, the annual depreciation on the \$2,800,000 investment is \$467,000. Subtracting this figure from the \$2,157,000 incremental profit, the after depreciation incremental annual margin is \$1,690,000.

#### To summarize:

Project investment: \$2,800,000 Additional volume: 500 cases/year Additional revenue: \$4,013,000/year Incremental expense (pre-depr.): \$1,856,000 \$2,157,000 Operating margin: Payback period: 1.3 years Depreciation expense: \$467,000/year Net margin: \$1,690,000 Rate of return: 60%

Cardiac Catheterization Laboratory: case load 1985-90 2000 -■ Jan-June 1985 ☑ Jul-Dec ■ Jan-June 1986 ☑ July-Dec ☐ Jan-June 1987 Number of  $\cdot 00$ July-Dec cases **■** Jan-June 1988 July-Dec ☐ Jan-June 1989 ☐ July-Dec ■ Jan-June 1990 Total Adult **Total Pediatric** Total cases

Figure 1

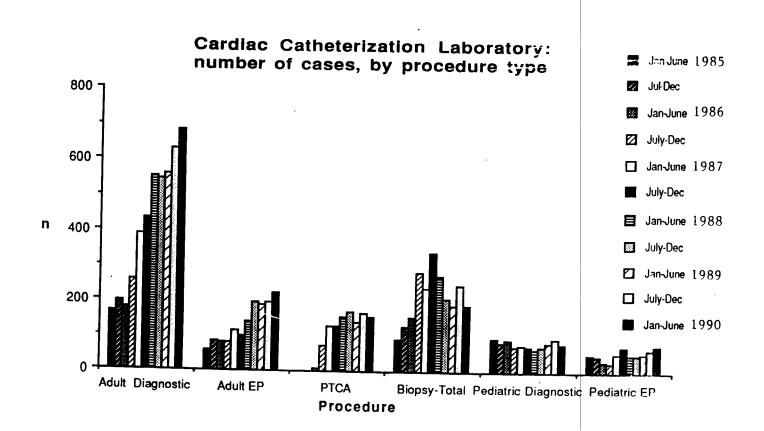


Figure 2



### UNIVERSITY OF MINNESOTA

TWIN CITIES

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

September 20, 1990

T0:

Planning and Development Committee Members

Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D. Geoff Kaufmann Peter Lynch, M.D. Gerald Ölson Ted Thompson, M.D.

Kris Johnson

FROM:

Robert Latz

The August meeting of the Planning and Development Committee will be held:

Wednesday, September 26, 1990 12:30-2:00 P.M. The Board Room, University Hospital

Lunch will be served at 12:00 Noon. The agenda and the background materials for the meeting are enclosed. Thank you for making time for this meeting.

Fred Bertschinger cc: Cliff Fearing Greg Hart Mark Koenig John LaBree, M.D. Shannon Lorbiecki Lisa McDonald

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#### PLANNING AND DEVELOPMENT COMMITTEE

# THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC BOARD OF GOVERNORS Wednesday, September 26, 1990 12:30 - 2:00 P.M. The Board Room (8-106), University Hospital

#### **AGENDA**

I.	Approval of the August 13, 1990 Meeting Minutes	Approval
II.	Development Office Update -Fred Bertschinger	Information
III.	Quarterly Capital Expenditure Report -Bob Dickler/Greg Hart	Information
IV.	Major Capital Expenditure: Image Processing Workstations -Al Dees	Information
٧.	System and Network Development Task Force Report -Bob Dickler/Edward Ciriacy, M.D.	Discussion
VI.	<u>UMCA Update</u> -Peter Lynch, M.D.	Information
VII.	Other Business	
VIII.	Adjournment	

# MINUTES Planning and Development Committee August 13, 1990

#### CALL TO ORDER

Robert Latz called the August 13, 1990 meeting of the Planning and Development Committee to order at 2:35 p.m. in room 8-106 in the University Hospital.

Attendance: Present

Robert Latz, Chair Leonard Bienias Robert Dickler William Jacott, M.D.

Peter Lynch, M.D. Ted Thompson, M.D.

Absent

Clint Hewitt

B. Kristine Johnson

Geoff Kaufmann Gerald Olson

Staff

Cliff Fearing Greg Hart Mark Koenig

John LaBree, M.D. Shannon Lorbiecki Lisa McDonald

Guest

Carl White, M.D.

#### APPROVAL OF MINUTES

The minutes of the July 19 meeting were approved as distributed.

#### CARDIAC CATHETERIZATION LAB EXPANSION PROPOSAL

Mr. Hart distributed a handout which detailed the cardiac cath lab proposal, and provided the financial analysis and graphs depicting the volume growth in the cath lab. Mr. Hart said that the plans for expansion are being accelerated because the cath labs are at 98% capacity, whereas 85% is optimal. The outreach affiliations, new procedures and faculty will further increase volume.

Remodeling costs are estimated at \$400,000 including the relocation of nuclear medicine on the first floor and cardiac cath's renovation on the second floor. The equipment cost is estimated at \$2,400,000 with a payback period of 1.3 years for the entire project.

Dr. White reported that they are pleased with the growth of the cardiac lab since 1986. He said that outreach efforts have helped a great deal in increasing the volume in the cath lab. He said that procedures are being done as late as 9:00 or 10:00 p.m. which causes stress and frustration for both faculty and patients. He said that present volume alone requires another procedure room. Dr. White added that cardiac cath procedures are becoming

more an outpatient procedure but that shouldn't affect the need for these improvements. This project was presented for information only and will be brought back for final endorsement to the full board.

#### CAPITAL PLAN REVIEW

Mr. Dickler said that the capital plan will be discussed at the Chief's retreat at the end of this week.

He said that there are three components of the plan 1) operating expenses and revenue; 2) non-renewal capital; and 3) renewal project.

Mr. Dickler said that these three components must be rebalanced using new volume assumptions. Mr. Hart said we need increased volume, better reimbursement, and more efficient operations.

Various options for the renewal project are still being discussed. Several options and issues will be addressed at the Chief's retreat this week to get their thoughts and input. Discussions will continue and this topic will be presented to the Planning and Development Committee at a later date. three Board retreat task forces will also present reports at the Chief's retreat.

Questions and discussion followed Mr. Dickler's and Mr. Hart's report.

#### UMCA UPDATE

Dr. Lynch reported that discussions with Group Health are proceeding and that all parties are working very hard to make this affiliation a reality. He said that Family Practice will be the gatekeeper for the potential Group Health Clinic at the University. Mr. Dickler said that Group Health and the State Health Plan provide different options. Group Health participants can only see a specialist if referred by their primary care whereas State Health Plan enrollees can choose any specialist they wish.

#### OTHER

Mr. Dickler discussed CHAMP. This home-aliemention program which is one of the best in the U.S., is exploring expansion potential beyond UMHC's patient population. In order to expand and accommodate third party contracts UMHC and UMCA are looking at a joint venture opportunity. More information will be presented at a future meeting.

#### ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 4:10 p.m.

Respectfully submitted,

Ann Frohrip Secretary

Planning and Marketing



**Development Office** The University of Minnesota Hospital and Clinic Box 612 UMHC Harvard Street at East River Parkway Minneapolis, Minnesota 55455

DATE:

September 20, 1990

TO:

Planning and Development Committee

FROM:

Fred Bertschinger F.B.

SUBJECT: Development Office Quarterly Report

Attached for your information are summary reports of activities and donations received during the fourth quarter of FY 1990 (April-June) and for the fiscal year.

If you have any questions about this report, please call me at 626-6008.

/ng

#### Contributions Received UMHC Development Office FY 1990

	I 7 <b>-</b> 9/89	II 10 <b>-</b> 12/89	III 1 <b>-</b> 3/90	IV 4-6/90	Totals
Patients Fund	\$2,078	\$1,920	\$1,770	\$313	\$6,081
Transplant Ass. Fd.	. 3,260	21,930	6,712	1,165	33,067
Variety Club Pldg.	2,010	185,717	2,775	229,370	419,872
Other Funds	522,747	155,866	1,106,281	3,245	1,788,139
Totals to Funds	\$530,095	\$365,433	\$1,117,538	\$234,093	\$2,247,159
				Goal = \$9	950,000
Irrevocable Future Gifts	0	1 \$100,000	1 \$659,000		2 \$759,000
Revocable Future Gifts	1	0			

#### \*\*\* PRELIMINARY \*\*\*

#### VARIETY CLUB PLEDGE PLEDGE REDUCTIONS AND DISBURSEMENTS

DATE	CONTRIBUTIONS	RUBEN-BENTSON	DISBURSEMENTS	BALANCE
As Of 09/30/90	1,913,591.06	200,000.00	1,600,000.00	313,591.06
10/31/89	15,556.00		ļ	329,147.06
11/30/89	44,441.66		 	373,588.72
12/31/89	22,865.72	 		396,454.44
01/31/90	61,025.82	 	,	457,480.26
02/28/90	29,963.95	200,000.00		487,444.21
03/31/90	19,200.00	 	!	506,644.21
04/30/90	228,555.97	 	726,725.00	8,475.18
05/31/90	61,424.30			69,899.48
6/30/90	1,070.00	 		70,969.48
7/31/90	100.00	 	1	71,069.48
		 	<u> </u>	
SUBTOTAL	\$2,397,794.48	\$400,000.00	\$2,326,725.00	\$71,069.48

TOTAL CONTRIBUTIONS:

\$2,797,794.48

TOTAL DISBURSEMENTS:

\$2,726,725.00

\$71,069.48

CASH AVAILABLE FOR USE:

\$8,000,000

BALANCE TO BE RECEIVED: 5,202,205.52

Contributions from the Variety Club of the Northwest Contributions to UMHC, credited against the pledge in accordance with the pledge agreement Total Contributions

\$1,078,225.00 \$1,719,569.48 2,797,794.48

#### VARIETY CLUB PLEDGE DISBURSEMENTS BY PURPOSE SEPTEMBER 1, 1990

	VARIETY CLUB RESEARCH CENTER	RUBEN-BENTSON CHAIR	OTHER VCCH	TOTALS
ALLOCATION OF \$8,000,000 PLEDGE	\$2,000,000.00	\$1,000,000.00	\$5,000,000.00	\$8,000,000.00
TOTAL DISBURSEMENTS	(\$650,000.00)	(\$400,000.00)	(\$1,661,725.00)	(\$2,711,725.00)
* COMMITTED DISBURSEMENTS			(\$15,000.00)	(\$15,000.00)
BALANCE TO BE DISBURSED	\$1,350,000.00	\$600,000.00	\$3,323,275.00	\$5,273,275.00

<sup>\*</sup> Total committed disbursements for fiscal year 1989/90 is \$919,225.

Of the areas to be funded, \$15,000 has not been disbursed.

This a Van (VCCH) for \$15,000.



Development Office
The University of Minnesota Hospital and Clinic
Box 612 UMHC
Harvard Street at East River Parkway
Minneapolis, Minnesota 55455

#### Activities and Events UMHC Development Office FY 1990

1909		
July 19	Kick-off	E

1000

Kick-off for the Communications Workers of America, Local

#7200, and U.S. West joint charity project to support the UMHC

Transplant Assistance Fund.

August 24 Annual Campaign direct mail solicitations of UMHC medical

staff and employees; support for the Transplant Assistance

Fund is urged.

August 25 Complete interviews with potential consultants for the CUHCC

capital campaign.

September 14 Recognition luncheon for Commodores Chorus.

October 9 Recognition breakfast for WCCO-AM.

November 17 Visit Kresge Foundation in Troy, Michigan.

November 25 DRAKKAR NOIR Tennis Challenge to benefit BMT Assistance Fund.

Net \$4,400.

December 16 CWA Local 7200 meeting. \$31,600 to benefit the Transplant

Assistance Fund.

December 28 Annuity Trust signed - \$100,000.

1990

January 23 Planning begins for Fourth Annual Turtle Derby, June 22.

January 25 Planning begins for Sigma Chi Derby Days, May 23-26.

February 28 Planning begins for Delta Chi Duluth Trek '90, May 26.

March 14 Unitrust signed; UMHC to receive 80% of \$659,000.

March 20 Grant proposal submitted to Kresge Foundation for \$150,000

challenge grant for CUHCC.

April 18 UMHC hosted U of M Development Officers for a seminar on

deferred gifts with a retained income interest.

April 23	Telemarketing begins to previous donors; calls are made by U of M students from the central development office in Morrill Hall.
May 4	Gerald B. Fischer, former CFO at First Bank System, Inc., was appointed as the new CFO of the U of M Foundation.
May 6	Variety Club's Affair of the Heart a la Française to benefit the CUHCC clinic. Net approximately \$25,000.
May 8	UMHC hosted donors at the annual meeting and program of the MN Alumni Association. Featured speaker is Lesley Stahl.
May 23-26	Sigma Chi Derby Days to benefit Child/Family Life. Net approximately \$2,000.
May 26	Delta Chi Duluth Trek 90 to benefit Child/Family Life. Net approximately \$400.
June 22	4th Annual UMHC Turtle Derby to benefit Child/Family Life. Net approximately \$5,000.



**Development Office** The University of Minnesota Hospital and Clinic Box 612 UMHC Harvard Street at East River Parkway Minneapolis, Minnesota 55455

#### Activities and Events UMHC Development Office FY 1991

1990

August 9 Begin first of six luncheons and tours for solicitors for the CWA Local 7200/U.S. West Charity Project.

September 8 Donor recognition event hosted by Bob and Sue Dickler - tour and dinner at UMHC followed by Gopher football game.

September 13 Kick-off for CWA Local 7200/U.S. West United Way and UMHC Transplant Assistance Fund Campaign. Goals of \$30,000 and new organ donors.

October 17 U of M President's Club Annual Dinner Meeting.

#### UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC CAPITAL EXPENDITURES 7-1-89 THRU 6-30-90

		ANNUAL B	UDGET AND ROLLFO	DRWARD		ACTUAL	EXPENDITURES		
RECURRING EQUIP & REMODEL:		BUDGET	ROLL FORWARD FROM 6-30-89	TOTAL		89-90 ACTUAL	88-89 ROLL FORWARD	TOTAL	
EQUIPMENT PURCHASES 89-90 Budget Rollforward		\$6,699,010	\$4,418,612	\$6,699,010 \$4,418,612		\$3,051,311	\$2,156,951	\$3,051,311 \$2,156,951	
		\$6,699,010	\$4,418,612	\$11,117,622		\$3,051,311	\$2,156,951	\$5,208,262	
REMODELING PROJECTS		\$1,600,990		\$1,600,990		\$494,397	\$535,252	\$1,029,649	
		\$8,300,000	\$4,418,612	\$12,718,612		\$3,545,708	\$2,692,203	\$6,237,911	
PRINCIPLE PAYMENTS Lithotripter CT SCANNER COMPUTER EQUIP MRI 2		\$304,670 \$192,600 \$8,909 \$0						\$308,115 \$192,600 \$8,909 \$49,814	
		\$506,179						\$559,438	
TOTAL:		\$8,806,179						\$6,797,349	
BOND PAYMENTS:		\$2,215,000	(PAID FEB. 1,19	990)					
CAPITAL PROJECTS:	UMHC FUNDS FROM RESERVES	ADDITIONAL FUNDS FROM OTHER SOURCES	TOTAL AUTHORIZED BUDGET	1st Quarter EXPENDITURES 1989-90	2nd Quarter EXPENDITURES 1989-90	3rd Quarter EXPENDITURES 1989-90	4th Quarter EXPENDITURES 1989-90	TOTAL 1989-90	Current & Prior Year EXPENDITURES
ARCHITECT FEES C-3 MRI II DERMATOLOGY MAYO 4 SURG CUHCC MASONIC HOSP COMPUTER UPGRADE NEURORADIOLOGY UPGRADE MISC. CAPITAL EXPEND.	\$3,600,000 \$679,069 \$1,029,350 \$2,200,000 \$835,000 \$850,000 \$909,000	\$233,889 \$150,000 \$800,000	\$3,600,000 \$912,958 \$1,029,350 \$2,350,000 \$1,635,000 \$850,000 \$909,000	\$521 \$18,135 \$96,796 \$4,895 \$314,905	\$876,983 \$22,999 \$49,886 \$1,280 \$369,428   \$24,398	\$11,399 (\$9,637) \$37,870 \$14,139 \$142,965	\$299,509 \$120,277 \$38,312 \$31,692 \$240,915 \$0 \$0 \$8,270	\$299,509 \$888,903 \$151,774 \$222,864 \$52,006 \$1,068,213 \$0 \$0 \$33,963	\$299,509 \$3,626,628 \$867,732 \$1,036,487 \$398,005 \$1,601,490 \$0  \$33,963
TOTAL	\$10,102,419	\$1,183,889	\$11,286,308	\$435,252	\$1,344,974	\$198,031	\$738,975	\$2,717,232	\$7,863,814



Planning & Dev. Committee I	Review:	
Finance Committee Review:		
Board of Governors Review:		

#### MAJOR CAPITAL EXPENDITURE REPORT

**EQUIPMENT:** 

Image Processing Workstation for CT Section

Image Processing Workstation for MRI Section

**PURCHASE PRICE:** 

\$120,000 each

#### **DESCRIPTION:**

Manipulation of the digital images acquired from CT and MRI procedures to improve clarity, obtain multi-angle views, etc. is becoming an indispensable component of image interpretation and usage. Recently, image processing and computer graphics techniques have been combined to enable three-dimensional (3-D) displays. These 3-D images are being utilized to improve detection and characterization of musculoskeletal disorders, guide reconstructive surgery, and aid in the planning for surgical implantation of prosthetic devises. 3-D display of soft tissue structures such as tumors and blood vessels is also being refined.

Extensive image manipulation requires a powerful microcomputer and specially designed software. To eliminate interference with performance of procedures, vendors are developing these capabilities on independent computer workstations. While the techniques for CT and MRI image manipulation are similar, the computer software required for each modality is unique. At present, the best quality workstations available in the marketplace are usable for only one modality. Consequently, the Diagnostic Radiology Department intends to purchase one workstation equipped to process CT and another for MRI images.

Submitted By: Associate Director Title: Senior Associate Director

### System and Network Development Task Force Position Paper August 13, 1990

#### A. Committee Charge:

UMHC has traditionally remained independent and worked with referring physician groups primarily through affiliation agreements. UMHC has not been agressive in the development or purchase of physician practices or alternative delivery systems. The viability of our traditional approach is questioned as other providers have become more aggressive in their efforts to attract tertiary patient care activity through the purchase of hospitals or physician practics. Because UMHC has had a very small primary and secondary care base, it has a heavy dependence upon referring physicians for patient care activity. The specific charge to the task force is:

- 1. What should UMHC's strategy be in relating to other providers and physicians in our region?
- 2. What specific action or actions should UMHC be taking (e.g. acquiring hospitals, acquiring physician practices, developing a long-term care program for alternative delivery arrangements) to assure an adequate patient base?

#### B. Current Realities and Observations:

- 1. Within the University
  - The basic mission of the institution will be maintained. The co-equal missions of education, patient care, and research require an adequate patient base.
  - The size of the University Hospital inpatient facility will remain unchanged, i.e., 577 beds.
  - The current governance structure cannot provide timely decisions, adoption of organizational priorities and/or the direction required to survive in this competitive milieu. The absence of a single governance organization for all clinical departments compromises planning, implementation, and corporate position.
  - The number and types of patients required for educational and research programs has not been identified and specified by the departments.
  - All educational and research programs involving patient care, cannot be accommodated on the University campus.
  - o New clinical programs will be increasingly multidisciplinary in nature.

- O Patient care revenue will continue to play a major role in the funding of medical school activities.
- O Current outreach programs will be maintained and expanded as opportunities present themselves.
- O CME programs will be maintained and expanded as opportunities and needs become apparent.
- O Specific contracting activities for patient care will be maintained and expanded if available reimbursement is adequate.
- The continuation of our relatively exclusive interest in tertiary care and the lack of growth of clinical activity, will result in decreasing availability of financial and personnel resources required to develop new systems and networks. It will further compromise the institution's ability to provide internal subsidies upon which existing and new development is so dependent.
- Competition within this metropolitan area will require that UMHC will provide a physically attractive environment with state-of-the-art clinical facilities, excellence in clinical care, and modern organizational and financial structures.
- Without necessary internal changes and aggressive positioning within this very competitive environment, the University Hospital will experience an eroding patient base and lower patient volumes.

#### 2. Within the Community

- Managed care programs in a variety of forms in the Metropolitan area will persist at the same current or higher market penetration level (estimated by some as high as 90%) in the Metropolitan area.
- The penetration of managed care programs in rural areas will be slower than in the urban areas but will include an increasingly significant portion of the population (currently approximately 16%).
- Indigent care for Minnesota residents will be provided through a capitated managed care program in the Twin Cities and is likely to be extended to include outstate areas.
- o Further consolidation of health care providers into networks will occur.
- Cost containment will continue to be emphasized.
- The pattern of hospital and physician consolidations into systems and networks will continue.
- There will be a continuing shift from inpatient to outpatient care and other alternative forms of health care delivery.

- Quality assurance will be increasingly emphasized.
- Reimbursement for the costs of secondary care will likely continue to be better than reimbursement for the costs of tertiary care.
- o Increased government subsidization of the University Hospital is unlikely.
- o Increasing sophistication of community health care providers is reducing UMHC's lead in technology, development and subspecialization.

#### C. Discussion:

In a recent publication Richard L. Reese, M.D., stated, "...Minneapolis - now the most mature managed care market of them all, is at 90% market penetration." He also noted that, "The managed care market shares currently are Key West - 5%, Las Vegas - 5-10%, Oklahoma City - 15-20%, Nashville - 20%, New Orleans - 20-25%, Detroit - 30-35%, Santa Barbara - 35-40%, Boston - 50-60%, and Denver - 60-65%."

The University of Minnesota Hospital and Clinic acquires approximately 44% of its total admissions from the Twin Cities Metropolitan area,33% of patients from the remainder of Minnesota and approximately 23% from out-of-state areas.

The development of systems and networks within the Metropolitan area has excluded the University Hospital and its physicians from providing all, except the most unique elements of tertiary care. These networks and systems are now moving to incorporate ever increasing segments of the outstate area as well as the metropolitan centers.

At the same time that these changes are taking place, the ever increasing number of subspecialists trained by the university carry their skills into the community hospitals and effectively compete with the university for procedures and care previously uniquely available only at the university.

From the standpoint of a tertiary care referral center, the most significant result of this managed care penetration of the health care market, is the loss of the primary and secondary care physician's ability to make referral decisions. Referral decisions are now predicated upon contractual relationships of the organizations involved. The choice of a tertiary care center to which patients will be referred is no longer the prerogative of the individual physician.

In a continuing effort to reduce costs, managed care organizations attempt to include a broader array of services within their established provider system and as this occurs, referrals to the University tertiary care center are further reduced.

The increasingly competitive arena within which the University Hospital operates is further complicated by the amount of effort, time and expense required to deal with the HMOs. Negotiations of specific contracts, the operational details including specifics of authorization and expansion of

15.

authorized procedures and services is extremely time consuming and personnel intensive which further decreases the net financial benefit of these activities.

At the present time, there is no comprehensive identification of the number or types of patients required for the support of research, service, and educational programs in each of our departments. Current needs and specific goals for the future must be developed for each of the departments. This would include patients required for educational programs at all levels and patients involved in current or proposed research and service needs of the departments.

Many patients required for these programs might well be institutions other than the University proper. Departments should specify the availability of patients in other geographic would be available to meet these needs. Those patients required on the University campus must be specifically identified. Collectively, the departments must provide an adequate patient base so UMHC remains viable and can meet the needs of each of the departments individually.

In the absence of any way to assure continued participation in contracting for care to be provided at the University Hospital, there is little stability or assurance that our traditional flow of patients from the Metropolitan area (44%) will continue.

Given the increasing competition for tertiary care and the relatively lower reimbursement available for the provision of tertiary care, both fiscal and educational needs suggest the need for the University to become increasingly involved in primary and secondary care. The involvement of the University Hospital in a managed care system would require increasing primary care capabilities with a comprehensive secondary care support system.

The stabilization of the flow of patients with tertiary care illness to a referral center of this type from a managed care environment can occur only through two mechanisms:

- 1) The University of Minnesota Hospital and Clinic becoming an integral part of a managed care system currently in operation. This could occur through the University Hospital becoming a part owner of an established managed care system with a specific designation as a tertiary care component of that system.
- The development of a new managed care system which has fully developed capabilities of providing primary and secondary as well as tertiary care under the auspices of the University of Minnesota Hospital and Clinic.

One option that could possibly negate the above conclusion would be obtaining legislative assistance to mandate that the University services could not be excluded from the list of available providers for any managed care program if those services were price competitive.

Such a mandate could result in an adversely selected population from multiple managed care programs in which the incidence of severe disease

in the University's component of these managed care programs might well result in higher than average costs which could be financially disasterous.

The pursuit of such a legislative mandate also puts at risk our current support and funding from the legislature as well as potentially increasing the adversarial relationship between the HMOs and ourselves.

In outstate Minnesota the market penetration of managed care programs is 16%. As a result of this fact, more traditional ways of attracting patient referrals has been demonstrated to be effective. The strategies utilized for our three targeted geographical areas (metro, outstate, and out-of-state) should be individualized. Appendix A shows the manner in which the State has currently been divided into systems and/or networks as of the present time (see attached Appendix A). It is clear that those segments of the Metropolitan area and State that have been incorporated into systems and networks with contractual commitments to other tertiary care centers, will refer patients at a decreasing volume to the University of Minnesota Hospitals. As a result, the University of Minnesota Hospital must develop its own networks and systems if a patient referral base is to be maintained.

The networking options which might be applied to various geographic sections throughout this State and surrounding states are as follows:

- Outreach activities (enhancing relationships)
  - a. Educational/research components
    - 1) Continuing medical education
    - 2) Local presentations
    - 3) Mini residency at the University
  - b. Service
    - 1) Subspecialty consultation
    - 2) Patient care coordination
    - 3) Computer network
    - 4) Communication with referring physicians
- 2. Contracting
- 3. Purchase existing practices/hospitals
- 4. Develop consortium network of physicians and/or hospitals
- 5. Develop a University-owned managed care system
- 6. Develop the University as a tertiary care component of a managed care system
- 7. Develop a network of training sites (e.g., RPAP program)
- 8. Various combinations of the above
- D. Conclusions:

- 1. Without internal changes and an aggressive positioning within this very competitive environment, the University Hospital will experience an eroding patient base and lower patient volumes.
- 2. There should be a renewed commitment and emphasis on excellence of clinical care at the primary, secondary, and tertiary care levels.
- 3. The provision of comprehensive coordinated patient care services at the primary, secondary and tertiary care levels should be available through the University.
- 4. There should be a comprehensive identification of the number and types of patients required for support of research, service and educational programs in each of the departments.
- 5. A single governance structure which has the ability to make expeditious and binding decisions, should be established for hospital, medical school and clinical departments.
- 6. The maintenance of tertiary care patient referrals within a managed care environment will require:
  - a. The sole ownership or significant investment in a managed care organization.
  - b. The development of a substantial primary and secondary care capability which would allow for developing contracts for comprehensive care of employee populations.
  - c. Continuation of contractual agreements for patient referrals, recognizing that such referrals will continue only as long as the contract is in effect.
- 7. Specific strategies for maintaining and increasing patient care referrals from metropolitan, outstate and out-of-state areas must be developed.

#### E. Recommendations:

#### 1. General

- A single governance structure capable of making expeditious and binding decisions for all clinical departments, hospital and medical school should be developed immediately. The decisions referenced are those which can be viewed as having significant corporate (institutional) impact in the areas of education, research and service.
- b. A group practice should be developed on the University campus which has a primary and secondary care capability and the ability to negotiate contracts with payers.
- c. A survey designed to identify specific patient care volume requirements should be taken of all departments.
- d. Specific strategies for geographic areas:

#### 1) Metropolitan -

- a) Maintain and expand contracts for patient care referrals.
- b) Market comprehensive and specific health care services to large employers.
- c) Assess the advantages and disadvantages of developing formal relationships with each of the major provider networks and/or payers within the Twin Cities area.
- d) Explore the feasibility of a possible purchase and/or investment in a managed care organization with University provision of tertiary care within that organization or establish a new University HMO. One option would be to expand and develop UCare to provide services to additional patient groups.
- e) The development of other types of primary/secondary care networks through purchases of practices and/or hospitals.
- f) Concentrate marketing to current managed care program patients with PPO options and encourage those patients to go outside of the preferred provider's network to utilize University physicians and facilities.
- g) Establish a mechanism to assess and regularly monitor the financial and academic return on each of our organizational affiliations and contractual relationships.
- h) Reconsider the role of the emergency room as a mechanism of increasing hospital admissions.
- i) Reassess and perhaps establish new understandings upon which clinical appointments are offered.
- j) Improve relationships with students and residents as a method of ensuring referrals back to the University in the future.

#### 2) Outstate -

- a) Our current outstate, outreach program has been very successful. It should be continued and expanded in scope and intensity and should primarily target outstate areas in which managed care penetration has been minimal.
- b) The very successful CME program which has been run at the University of Minnesota Medical School for years should be continued and expanded as an effective way to have patients referred to this institution.

- c) Purchase selected practices and/or hospitals in select settings.
- d) In the event that the University develops/purchases an HMO of their own, such programs should be offered in both urban and rural settings.
- e) As managed care programs move into rural settings, consider the appropriate strategies listed under the current "Metropolitan" category.

#### 3) Out-of-State -

- a) CME has been shown to be a significant source of patient referrals from outside of Minnesota to this institution. These efforts should be continued and expanded.
- b) Contracts with third party payers should be enthusiastically pursued as a mechanism of obtaining referrals on a multistate and/or national basis. Although primarily relating to very specialized services (i.e., transplant contracts), the expansion of the scope of these contracts should be pursued.
- c) In select instances it may be feasible to develop both hospital/physician relationships with select communities in surrounding states.

#### F. Summary:

Without aggressive pursuit of the recommended strategies, the University Hospital will become "a smaller and smaller institution doing stranger and stranger things to fewer and fewer people."

EWC:cm

Attachments

Respectfully Submitted by Members of the System and Network Task Force:

R. Morton Bolman, M.D.
Edward W. Ciriacy, M.D., Chair
Cliff Fearing
David Homans, M.D.
William Jacott, M.D.
Geoff Kaufmann
John LaBree, M.D.
Shannon Lorbiecki
Alfred Michael, M.D.
Richard Price, M.D.
Preston Williams, M.D.

## Metropolitan Hospital Networks (1988 Data)

#### Life Span

Hospitals - Staffed Beds = 1,343, Admissions = 50,712

Abbott Northwestern Methodist Minneapolis Childrens Gillette Childrens

### Outstate Clinics

Buffalo Litchfield Grantsburg, WI

### Health East

Hospitals - Staffed Beds = 777, Admissions = 34,641

Bethesda Lutheran Divine Redeemer Midway St. John's St. Joseph's

Clinics - None

#### Health One

Metropolitan Hospitals - Staffed Beds = 1,416, Admissions = 56,114

Mercy MMC/Mt. Sinai United Unity

#### Outstate Hospitals

Buffalo
Owatonna
New Ulm
Granite Falls
Long Prairie
Monticello
Thief River Falls
River Falls, WI
St. Croix Falls, WI

## Outstate Clinics

Hastings River Valley Northfield Cottage Grove

## <u>Fairview</u>

Hospitals - Staffed Beds - 491, Admissions - 24,533

Ridges Southdale Riverside Medical Center

Clinics - 0

## Independent Hospitals

	Staffed Beds	Admissions
Childrens, St. Paul	105	4,793
Golden Valley	248	2,166
Hennepin County	341	16,919
North Memorial	369	19,983
St. Paul Ramsey	304	13,435
University of Minnesota	538	18,597
Shriner's Hospital	29	759
Veterans Administration	678	16,252

#### Physician Networks

#### Metropolitan

Park Nicollet Ramsey Hennepin Faculty Association UMCA Aspen Group Health

#### Outstate

Duluth Clinic - F.P. clinics in Duluth, Ely, Deer River

Fargo Clinic - F.P. clinics in Bemidji, N.Y. Mills, Detroit Lakes, Breckenridge, & N. Dakota clinics

Dakota Clinic - F.P. clinics in Park Rapids, Walker, Fosston, Detroit Lakes, Thief River Falls, Red Lake Falls, Pelican Rapids, & N. Dakota clinics

Sioux Falls groups -

Willmar (10 affil. clinics) - Marshall, Redwood Falls, Benson, Clara City, and several one man offices in Western Minnesota.

Mayo -

Gunderson - Several single physician offices.

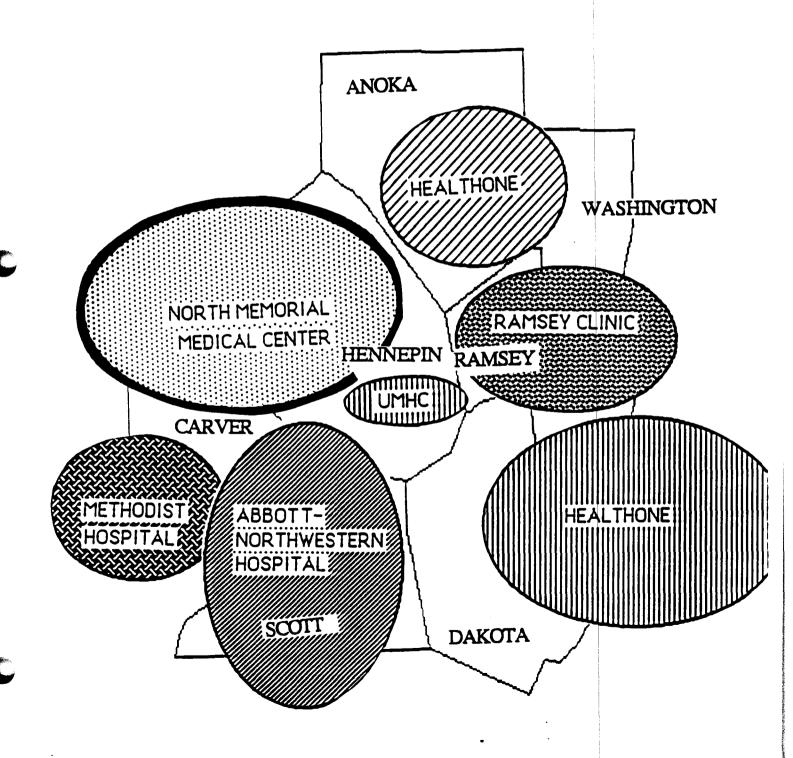
St. Cloud -

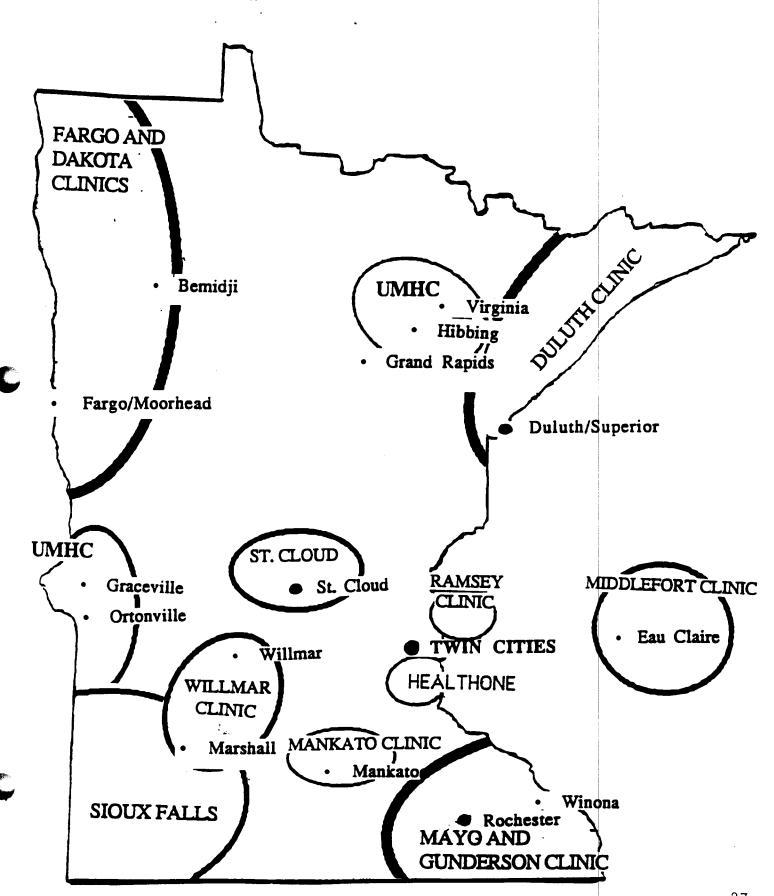
Mankato - Several satellite clinics.

## HMOs (As of 1/1/90)

	# of Members		
Minneapolis/St. Paul, MN-WI			
Blue Plus	28,746		
Group Health, Inc.	203,991		
Med Centers Health Plan	237,323		
Metropolitan Health Plan	10,000		
NWNL Health Network	4,850		
Physicians Health Plan of MN	256,021		
Share Health Plan (Bloomington)	145,010		
UCare Minnesota	2,000		
Rochester, MN			
Mayo Health Plan	4,503		
St. Cloud, MN			
Central Minnesota Group Health Plan	14,484		
Non-Metropolitan			
First Plan HMO/Community Health Center (Two Harbors)	6,676		

# MINNEAPOLIS, MINNESOTA METROPOLITAN HOSPITAL NETWORKS







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

October 12, 1990

T0:

Planning and Development Committee Members

Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D. Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.

Kris Johnson

FROM:

Robert Latz

The August meeting of the Planning and Development Committee will be held:

Thursday, October 18, 1990 3:00-5:00 P.M. The Board Room, University Hospital

The agenda and the background materials for the meeting are enclosed. Thank you for making time for this meeting.

cc: Fred Bertschinger
Cliff Fearing
Ann Frohrip
Greg Hart
Mark Koenig
John LaBree, M.D.
Shannon Lorbiecki
Lisa McDonald

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#### PLANNING AND DEVELOPMENT COMMITTEE

# THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC BOARD OF GOVERNORS Thursday, October 18, 1990 3:00 - 5:00 P.M. The Board Room (8-106), University Hospital

## **AGENDA**

Ι.	Approval of the September 26, 1990 Meeting Minutes	Approval
II.	1990-91 Capital Budget -Greg Hart	Endorsement
III.	Capital Planning-Renewal Project -Bob Dickler/Greg Hart	Information
IV.	Cardiac Catheterization Lab Expansion Proposal -Greg Hart	Endorsement
٧.	Major Capital Expenditure: Frontal Plane Image Chain Upgrade -Al Dees	Information
VI.	Other Business	
VII.	Adjournment	

#### MINUTES

#### Planning and Development Committee September 26, 1990

#### CALL TO ORDER

Robert Latz called the September 26, 1990 meeting of the Planning and Development Committee to order at 12:30 p.m. in room 8-106 in the University Hospital.

Attendance: Present

Robert Latz, Chair Robert Dickler

Clint Hewitt

William Jacott. M.D. B. Kristine Johnson

Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.

Absent

Leonard Bienias

Staff

Fred Bertschinger

Al Dees

Cliff Fearing Greg Hart

Shannon Lorbiecki Lisa McDonald

Guest

Ed Ciriacy, M.D.

#### APPROVAL OF MINUTES

The minutes of the August 13 meeting were approved as distributed.

#### DEVELOPMENT OFFICE UPDATE

Mr. Bertschinger reviewed the Development Office Quarterly Report noting that the past fiscal year was very successful. He pointed out that the goal for FY 1990 was \$950,000 while \$2,247,159 was raised. He explained that the Variety Club pledge was on target in both contributions and disbursements. He noted some of the activities and events that raised monies for Child Family Life and said that we are the "charity project" for CWA Local #7200, who supports the UMHC Transplant Assistance Fund. A non-monetary goal of the Development Office is to obtain new organ donors.

Mr. Bertschinger also indicated that the Variety Club will hire a grant proposal writer to assist in raising money to fund large projects in which the Variety Club, Variety Club Children's Hospital, and the Department of Pediatrics have major interests and needs.

Mr. Latz asked if other unions had expressed interest in sponsoring programs at the University. Mr. Bertschinger said he would pursue the matter.

#### **UMCA UPDATE**

Dr. Lynch reported that UMCA is close to completing work on the Group Health Contract. He said that we cannot limit usage of the clinic to University employees. He also noted that there is continued dissatisfaction with the volume from State Health Plan enrollees. UMCA will have to vacate its current office space on the Boynton Bridge so they are looking for a new location. Concerns are that space off campus will be more expensive and that a remote location is not an ideal situation. Dr. Lynch also said that as a result of the two recent faculty retreats a committee will be formed that the decision-making process that involves the hospital, medical departments and the medical school.

#### SYSTEM AND NETWORK DEVELOPMENT TASK FORCE REPORT

Dr. Ciriacy reported on the System and Network Development Task Force and summarized their August 13, 1990 Position Paper. He said that the committee's charge is: 1) What should UMHC's strategy be? and 2) What specific action or actions should UMHC be taking? He discussed the current realities and observations from within the University and the Community. He reviewed the networking options which included outreach activities, contracting, purchasing of existing practices/hospitals, developing consortium network of physicians and/or hospitals, developing a University-owned managed care system, developing the University as a tertiary care component of a managed care system, developing a network of training sites, and various combinations of the above.

The report also suggested that collectively we examine: 1) alternatives to change, 2) increasing clinical emphasis, 3) providing comprehensive coordinated clinical services, 4) identifying number and type of patients needed, 5) modifying governance structure, 6) becoming an owner of a managed care organization, 7) Developing and/or increasing primary and secondary care capability, 8) continue contracting, and 9) develop geographically targeted plans.

The recommendations are: a) to create a single internal governance structure; b) develop a group practice; c) identify specific patient care needs; d) develop specific strategies by geographic area.

Mr. Dickler said that the report was comprehensive and that all task forces will report at the full retreat.

#### QUARTERLY CAPITAL EXPENDITURE REPORT

Mr. Hart reviewed the capital expenditure report for the period 7/1/89 - 6/30/90. He said of the \$12,718,000 budget, \$6.2 million was spent. The capital plan is currently being reviewed and recommendations will be made within the next few months. Mr. Hart reported that the CUHCC project is underway.

Mr. Hart told the committee that meeting had been held with the Minneapolis School District who owns the Mt. Sinai facility. The school district does not want to sell a portion of the property and the building has been torn up to remove asbestos so that renovating and renting the property would not be cost efficient.

#### MAJOR CAPITAL EXPENDITURE: IMAGE PROCESSING WORKSTATIONS

Mr. Dees said that the money for these workstations was budgeted last year but that they had been working with vendors since last December to find a suitable unit. UMHC wanted one unit to handle both the CT and MRI functions but no vendor bid. It was necessary to purchase two workstations - one for CT and one for MRI at a cost of \$120,000 per workstation.

#### ADJOURNMENT

Mr. Latz adjourned the Planning and Development Committee at 1:40 p.m.

Respectfully submitted,

Ann Frohrip

Secretary

Planning and Marketing



#### UNIVERSITY OF MINNESOTA TWIN CITIES

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

October 16, 1990

TO:

Members, Planning and Development Committee

FROM:

Greg Hart

SUBJECT: 1990-91 Capital Budget

You may recall that we have not yet asked for Board approval of the 1990-91 capital budget, given the reassessment of the long-range capital plan. We would request approval of the annual capital budget this month.

In August, the Board endorsed a general approach to the reassessment which called for a \$20 million reduction in "non-Renewal Project" capital expenditures through 1998. This reduction was to include both major equipment purchases (greater than \$600,000) and the annual capital budgets.

The original capital plan projected an \$8,550,000 annual capital budget for 1990-91. We are recommending that this figure be revised to \$7,000,000. A summary departmental breakdown of the recommended \$7,000,000 budget is attached.

As you know, the Board must explicitly approve major capital projects during the year, in addition to the annual capital budget. At this point we foresee bringing the following projects for approval during the year:

<u>Project</u>	Approximate Cost
Replacement CT Scanner	\$1,200,000
Replacement Linear Accelerator	2,100,000
Computer Upgrade	1,518,000
Neuroradiology Upgrade	1,809,000
Heart Cath Expansion	2,800,000
CV Radiology	800,000
Practice Acquisition	5,973,000
Bone Marrow/ICU Reconfiguration	700,000

We will be reviewing the annual capital budget with the Clinical Chiefs' Capital Advisory Committee on Wednesday. We will share any pertinent information from that meeting with the Planning and Development Committee.

Thank you for your consideration of this recommendation.

GH/k.i

attachment

## Capital Budget Allocation Fiscal year 1990-91

## <u>Equipment</u>

Ambulatory Care	\$ 320,000
Cardio-Respiratory	800,000
Diagnostic Radiology	1,240,000
Information Services	600,000
Laboratories	950,000
Materials Services	400,000
Medical Records	35,000
Nursing	180,000
Operating Rooms	530,000
Radiation Therapy	9,000
Biomedical Engineering	12,000
CCTV	45,000
Communications Center	13,000
Environmental Services	40,000
Finance	31,000
Healthcare Network	180,000
Infection Control	5,100
Maintenance and Operations	6,500
Pharmacy	12,000
Protection Services	1,000
Rehabilitation	34,000
Social Work	17,000
Patient Transport	9,000
Table Hansport	
	\$5,469,600
Unallocated	200,000
Total Equipment	\$5,669,600

## <u>Remodeling</u>

## Projects Over \$50,000

Labs - Outpatient Lab Expansion Therapeutic Radiology - Hyperthermia Dialysis - Water Supply Same Day Admit Eye Clinic Orthopaedic Clinic	\$	145,000 41,000 56,000 100,000 63,000 75,000
	\$	480,000
Remodeling Support	\$	148,000
Projects \$5,000 - \$50,000	\$	417,400
Projects Less Than \$5,000	\$	285,000
Total Remodeling	<u>\$1</u>	330,400
Total Capital Budget	\$7	,000,000



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

October 16, 1990

T0:

Members, Planning and Development Committee

FROM:

Greg Hart

SUBJECT: Heart Cath Expansion

At the August meeting of the Committee we presented a proposal for expansion of the Cardiac Catheterization Laboratory. The project involves the addition of a fourth procedure room. The proposal presented earlier is attached.

The estimated cost for the project, as presented earlier, was \$2,800,000. Several variations to facility remodeling are still being considered. The estimates for these variations range from \$2,640,000 to \$2,990,000. Given the growing volume in the Lab, we would ask for Planning and Development Committee and Board approval to proceed with the project this month, using the higher (\$2.99 million) cost estimate. We will report back to the Committee on final project cost when remodeling plans are finalized and bids are received.

Thank you for your attention to this project. We look forward to answering any questions you may have.

GH/kj

attachment

#### Cardiac Catheterization Lab

#### Expansion Proposal

#### Introduction and Rationale

The Cardiac Cath Lab currently consists of three procedure rooms with radiographic capabilities, and support space for registration, storage, and patient recovery. Two of the procedure rooms are equipped to do interventional angiographic studies, the third is used primarily for electrophysiologic procedures. The Lab is located on the second floor of Unit J, adjacent to the CV Radiology area. The equipment for the two angiographic rooms was purchased in 1986, along with the opening of Unit J. The equipment in the third room was purchased in 1980.

The volume of patients seen in the Cardiac Cath Lab has grown significantly since the unit was planned in the early 1980s and opened in 1986. This growth is in part a function of changes in technology (especially angioplasty) and also clearly the result of the arrival in 1986 of Drs. Carl White and Robert Wilson. Dr. Wilson is currently the Medical Director of the Cardiac Cath Lab. Dr. White and Dr. Wilson have led an extensive, successful medical outreach program in conjunction with University Hospital.

Attached are graphs which depict the growth in number of cases for six month increments beginning in 1985, through June 1990. We are now seeing nearly 3,000 cases per year, compared to approximately 1,200 cases per year in 1985. Almost all of the growth has been in adult patients. While the pediatric procedure volume has been relatively constant, it is anticipated that we will see growth in the number of pediatric cases when Dr. Rocchini arrives later this year. Dr. Rocchini will be the Head of the Division of Pediatric Cardiology and is a pediatric interventional cardiologist.

The dramatic increase in volume has led to the current procedure rooms being used to capacity. A fourth procedure room is thus needed to handle additional anticipated growth. "Industry standard" is that each procedure room should accommodate approximately 70 procedures/month. We are currently at 80-85 procedures per room per month. The non-angiographic room has a utilization rate of 86%, while the two angiographic rooms are in use 98% of the time from 7:00 a.m. to 7:00 p.m. The rooms are consistently used well into the evening and night.

The congested schedule which results from such a high utilization rate has become problematic. The frequent occurrence of emergency cases results in patients being sent home or delayed in the Hospital. When the equipment is down for repair or maintenance, patients care is further delayed or, at times, must be transferred to another hospital.

Accommodating additional growth in this situation will be very difficult. A growth potential of 450-650 cases per year over the next three years is projected. Additional capacity will need to be created in order to handle this growth in patient demand.

A key component of this projected growth is related to the Hospital's continuing outreach efforts. The volume from Red Wing and Eau Claire should add approximately 200-300 cases per year to the Cath Lab activity. It is important that we have the capacity to be responsive to these new referral sources.

Additional growth is expected to come from an increase in pediatric cardiology cases (100-150 cases per year); volume from the continued growth in the number of patients in the Cardiac Transplant Program, who return for biopsies and angiography (100-150 cases per year); and some additional increase in electrophysiologic studies, with the arrival of Dr. Pineda, an expert in electrophysiologic cardiovascular surgery (50 cases per year).

Beyond the above short term opportunities, additional growth is probable. It is anticipated, within the next three to four years, that technological advances in catheterization, particularly in interventional and electrophysiologic cardiology may increase the number of patients suitable for treatment in the Catheterization Laboratory. In interventional cardiology, the patients amenable to coronary angioplasty may be substantially increased by the use of 1) intracoronary stents (devices to hold open arteries after coronary dilation), and 2) laser or radio-frequency ablation of coronary atherosclerosis and "vascular welding".

Additional advances have been made in electrophysiology that may increase the number of patients who can undergo ablation of cardiac tissue responsible for heart rhythm disturbances. Many of these patients are currently treated with surgery. Advances in radio-frequency devices and other tissue ablation methods (chemical, electrical) may substantially increase the number of patients that can be treated in the Catheterization Laboratory. In pediatric interventional cardiology, a multitude of devices have been developed over the last several years that allow closure of defects within the heart, and permit the dilation of valves and other stenotic structures.

There has been a great deal of commercial interest applied toward the development of new devices for use in the Catheterization Laboratory. It is likely that over the life of a new radiographic facility, these devices will increase further the number of patients treated in the Catheterization Laboratory.

#### Proposal

It is proposed that the Cardiac Catheterization Lab capacity be increased by one additional angiographic room in order to handle current volume and anticipated growth. The estimated cost of the project is \$2,800,000. This project has been anticipated in the Hospital's long-range capital plan.

The project involves both equipment purchase and remodeling of space. Space adjacent to the existing Cath Lab will be utilized. This space is now used by Nuclear Medicine; space on the first floor of Unit J will be remodeled for the displaced Nuclear Medicine functions. The cost of remodeling both the first floor space for displaced Nuclear Medicine and the second floor space for the new Cardiac Cath procedure room is estimated at \$400,000.

Estimated equipment cost for the project is \$2,400,000. The new unit will be equipped with biplane cine-angiographic and digital angiographic capabilities. The unit will be used primarily for interventional procedures. In addition to the radiographic equipment, the project cost includes supporting equipment, including physiologic monitoring technology.

It should be noted that the cost estimates for the project are preliminary at this point. More refined costs, hopefully based on actual bids, will be included when the project is brought to the Board of Governors for approval. We are targeting for the October Board meeting for project approval.

#### Financial Analysis

We have approached the financial analysis for this project from more of a "product line" perspective than we have done in the past for major equipment purchases, such as CT scanners and MRI units. That is, the full range of revenue and expense for patients seen in the Cath Lab has been reviewed, as opposed to just revenue and expense generated in the Cath Lab itself. This methodology gives a more complete perspective on the financial impact of the Cath Lab activity, and, in particular, an increase in Cath Lab activity.

As indicated earlier, current Cath Lab volume is just under 3,000 patients. These patients generated over \$42 million in charges during their hospital stays, in 1989-90 dollars. Reimbursement on these charges was at 80% in 1989-90.

The patients seen in the Cath Lab generally fall into three categories. The first group, those for whom a cath procedure is the primary reason for admission, account for about 38% of the patients seen in the Lab. The second group, who have a heart biopsy or electrophysiologic study done in the Lab as part of (typically) a cardiac transplant evaluation or follow-up, account for 34% of the patients. The third group, with 20% of the patients, are those patients who are seen in the Cath Lab, but whose primary reason was something other than the Cath procedure. These groupings are important, because the first two groups generate a "profit" for the Hospital (on a fully-loaded cost allocation basis) of about \$750,000 per year, while the third group generates a loss of approximately \$1,100,000 per year.

The project proposal is based upon additional volume of 500 cases per year. The additional volume will fall primarily in the first two above categories of patients. Estimated additional annual revenue (after revenue deductions) for those 500 cases is \$4,013,000.

The incremental operating costs of the additional caseload are estimated at \$1,856,000 (exclusive of depreciation). Thus before considering depreciation, the additional revenue generated exceeds the operating expense by \$2,157,000, and the project has a payback period of less than two years.

Assuming a six year life for the project, the annual depreciation on the \$2,800,000 investment is \$467,000. Subtracting this figure from the \$2,157,000 incremental profit, the after depreciation incremental annual margin is \$1,690,000.

#### To summarize:

\$2,800,000 Project investment: Additional volume: 500 cases/year Additional revenue: \$4,013,000/year Incremental expense (pre-depr.): \$1,856,000 \$2,157,000 Operating margin: Payback period: 1.3 years \$467,000/year Depreciation expense: Net margin: \$1,690,000 Rate of return: 60%

## Cardiac Catheterization Laboratory: case load 1985-90

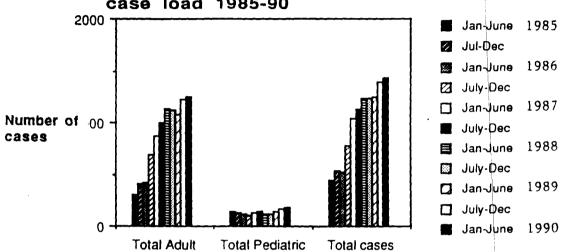


Figure 1

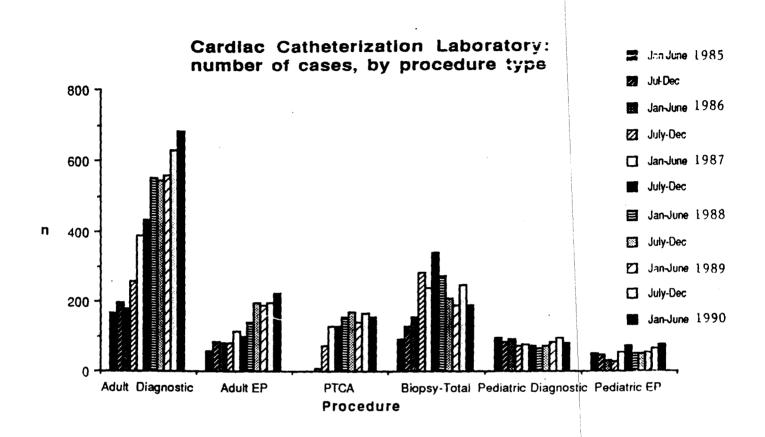


Figure 2



Planning & Dev. Committee Review:	
Finance Committee Review:	
Board of Governors Review:	

## MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Frontal Plane Image Chain Upgrade

Heart Cath Lab: Room 3

PURCHASE PRICE: \$110,000

#### **DESCRIPTION:**

The University of Minnesota Hospital and Clinic (UMHC) purchased the fluoroscopic x-ray equipment for Rooms 2 and 3 in the Heart Cath Lab from CGR Corporation during fiscal year 1985-86. The quality of the fluoroscopic images produced was deemed to be acceptable for the types of procedures being performed in the lab at that time by the Cardiology and Radiology staff involved in reviewing and recommending the equipment to be purchased.

Subsequent to the selection and purchase of this equipment, recruitment of Carl White, M.D., and Robert Wilson, M.D., resulted in the use of the rooms and the equipment for high volumes of coronary angioplasty procedures. For these procedures the fluoroscopic image quality achievable on the video monitors with this equipment is very marginal. The resolution is inadequate to enable accurate visualization of the fine guidewires (0.014 inch diameter) utilized during angioplasty. Frequently, a procedure must be interrupted for 15-30 minutes while film is developed to provide adequate images for decision making. This results in prolongation of the procedure, increased patient discomfort and increased risk of complications.

In early 1989, CGR was purchased by General Electric (GE). GE has developed an upgraded camera, image intensifier, and TV monitor to improve the fluoroscopic image quality for the CGR equipment. The Board was the intent to purchase this upgrade for Room 2 in February 1990. Installation of this upgrade in that room has resulted in the image quality improvement promised by the vendor. Consequently, the decision has been made to purchase the same upgrade for the other room in which angioplasty procedures are performed, Heart Cath 3.

Submitted By: Helpe Dead	Approved By: Jan
Title: Associate Director	Title: Senior Associate Director



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

#### **CANCELLATION NOTICE**

The November, 1990 Planning and Development Committee meeting was cancelled because of lack of agenda items.

Shannon Lorbiecki

Secretary Board of Governors



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

November 12, 1990

T0:

Members, Planning and Development Committee

FROM:

Robert Dickler

General Director

SUBJECT: Meeting Schedule/Renewal Project

You should have already received a notice that this week's meeting of the Planning and Development Committee has been cancelled. The next meeting of the Committee is scheduled for December 6.

In lieu of a meeting this month, we are writing to bring you up to date on the status of Renewal Project planning. We anticipate bringing recommendations for Committee and Board endorsement in December, at least for the major components of the Renewal Project.

You may recall when we last left the Renewal Project discussion with the Board we were working with a \$35,000,000 budget. That continues to be the case; the challenge is to get the most, from both a short-term and long-term perspective, from that \$35,000,000. The most significant choices recently have revolved around the addition to Unit J versus the use of the "triangle site" for a Psychiatry facility.

We are no longer pursuing the "triangle site" option, primarily for three reasons: (1) the cost of this option - the University has informed us that the Hospital will be responsible for relocation of current occupants of the site; (2) the ambiguity of this option - Park Board issues, etc., which lead to timing concerns; (3) the fact that the Department of Psychiatry is not in favor of this option, due to concerns about timing and the fact that Psychiatry offices would not be in the new facility.

Having tested and rejected the triangle site, we return to the top of Unit J for inpatient Psychiatry. We continue to believe that it is important to add the shell floor if we are to build on Unit J. Thus the primary recommendation we anticipate making in December is the addition of two floors to Unit J, (one floor for inpatient Psychiatry, one floor shelled), at a cost of \$22-\$23 million.

We are continuing to work with the other programs in the Renewal Project, especially Urology, OB, and Rehab, to solidify our plans for these components of the project. If we are not able to resolve all the issues relative to these programs in the next two or three weeks, we may recommend a two-stage

Board approval, with the first stage being the addition to Unit J and those programs for which we have a definitive plan, and the second stage being those programs where a definitive plan may be another 30-60 days away.

Please let Greg Hart or me know if you have any questions about the project prior to the December 6 meeting. We will, of course, provide you with additional information as part of the agenda and proposal presentation. Thank your for you continued assistance in our deliberations of this complex and important project.

/kj

cc Board of Governors Finance Committee



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

November 30, 1990

T0:

Planning and Development Committee Members

Leonard Bienias Robert Dickler Clint Hewitt William Jacott, M.D.

Geoff Kaufmann Peter Lynch, M.D. Gerald Olson Ted Thompson, M.D.

Kris Johnson

FROM:

Robert Latz

The December meeting of the Planning and Development Committee will be held:

Thursday, December 6, 1990 12:00-2:00 P.M. The Board Room, University Hospital

Lunch will be served at 12:00 Noon with the meeting starting at 12:30 p.m. The agenda and the background materials for the meeting are enclosed. Thank you for making time for this meeting.

cc: Fred Bertschinger
Cliff Fearing
Ann Frohrip
Greg Hart
Mark Koenig
John LaBree, M.D.
Shannon Lorbiecki

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#### PLANNING AND DEVELOPMENT COMMITTEE

# THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC BOARD OF GOVERNORS Thursday, December 6, 1990 12:00 Noon - 2:00 P.M. The Board Room (8-106), University Hospital

## **AGENDA**

Approval of the October 18, 1990 Meeting Minutes	Approval
Capital Planning-Renewal Project	Endorsement
-Bob Dickler/Greg Hart	
<u>Special Capital Project:</u> <u>Neuroangiography System Replacement</u>	Information
-Al Dees	
Major Capital Expenditure: CUHCC Computer System	Information
-Mary Ellen Wells	
Major Capital Expenditure: Laboratory Computer System Expansion	Information
-Greg Hart	
Development Office Update	Information
-Fred Bertschinger	!
Quarterly Purchasing Report	Endorsement
-Mark Koenig	
External Relations Update	Information
-Robert Dickler	
Other Business	
<u>Adjournment</u>	
	Capital Planning-Renewal Project  -Bob Dickler/Greg Hart  Special Capital Project: Neuroangiography System Replacement  -Al Dees  Major Capital Expenditure: CUHCC Computer System  -Mary Ellen Wells  Major Capital Expenditure: Laboratory Computer System Expansion  -Greg Hart  Development Office Update  -Fred Bertschinger  Quarterly Purchasing Report  -Mark Koenig  External Relations Update  -Robert Dickler  Other Business

#### MINUTES

# Planning and Development Committee Board of Governors October 18, 1990

#### CALL TO ORDER:

Chairman Latz called the October 18, 1990 meeting of the Planning and Development Committee to order at 3:12 P.M. in Room 8-106 in the University Hospital. There was not a quorum for the meeting.

Attendance:

Present:

Leonard Bienias

Robert Dickler

Bob Latz

Ted Thompson, M.D.

Absent:

Clint Hewitt

William Jacott, M.D. B. Kristine Johnson Geoff Kaufmann Peter Lynch, M.D.

Gerald Olson

Staff:

Al Dees Greg Hart Mark Koenig

John LaBree, M.D. Shannon Lorbiecki Robert Wilson, M.D.

# APPROVAL OF MINUTES

The minutes of the September 26, 1990 meeting were acceptable to those present. The minutes will be brought forward for approval at the next meeting due to the lack of a quorum.

# CARDIAC CATHETERIZATION LAB EXPANSION PROPOSAL

Mr. Greg Hart summarized the proposal to add a fourth procedure room to the cardiac catheterization laboratory. The proposal was presented to the Planning and Development Committee in detail at the August meeting. Recent estimates indicate that the project may be somewhat more expensive than the cost estimates which were presented at the August meeting. The cost of relocating radiology functions which currently occupy the space may be higher than anticipated. The Committee and the Board of Governors are asked to approve the project at \$2.99 million.

The possibility of establishing a mobile or modular unit on an interim basis is being considered. The time lag to establish the fourth procedure room will jeopardize staff retention and patient referral patterns, therefore, a temporary measure is necessary to maintain patient volume.

Dr. Bob Wilson emphasized the urgency in approving the project and moving forward as rapidly as possible with the expansion. Although the modular unit is less than ideal, it is preferred to long waiting periods or turning patients away.

Although a quorum was not present, those members present supported the proposal.

#### MAJOR CAPITAL EXPENDITURE: FRONTAL PLAN IMAGE CHAIN UPGRADE

Mr. Al Dees reported that the Board was notified of the purchase of an upgraded camera, image intensifier, and TV monitor for the second cardiac catheterization room in February of 1990. This upgrade has resulted in significant improvement in the fluoroscopic image quality achievable for coronary angioplasty procedures. Therefore, the decision has been made to purchase the same upgrade for the third cardiac catheterization procedure room. This purchase will ensure that both rooms were angioplasty procedures are performed have adequate imaging technology. This item was brought to the Committee for information.

## CAPITAL PLANNING-RENEWAL PROJECT PHASE II.

Mr. Robert Dickler presented an update on planning for the Renewal Project. Although an update will be presented to the Board on October 24, a definitive proposal will not be presented at that time.

Two options which are being explored are an addition to the top of Unit J and building a freestanding Psychiatry hospital on the triangle site.

Planning for an addition to Unit J has proceeded with the assumption that two floors would be added, one primarily for the inpatient psychiatry program and one shell floor. To accomplish this addition within the project budget Urology, Obstetrics, and Rehabilitation and many support departments which were included in the initial renewal project face significant reductions in their programs. Additional cost savings would be achieved through timing changes.

Current estimates indicate that a building can be put on the triangle site to meet the inpatient, outpatient, and day hospital needs of the Psychiatry program within the budget for the project. This proposal would include a tunnel to Unit J but would not include any additional parking or funds to build departmental offices at the site.

The triangle site proposal would meet several additional immediate needs including relocation and expansion of the heart cath lab and expansion of the operating rooms. This operating room expansion would facilitate closing of the ambulatory surgery in Phillips-Wangensteen. Under the proposal, the

current ambulatory surgery suite would be utilized cystoscopy procedures. This proposal would not solve bed issues, either bed number or bed type, or several other high technology needs.

Additional discussions and planning with affected parties will be completed prior to bringing a recommendation to the Board of Governors.

#### 1990-91 CAPITAL BUDGET

Mr. Hart presented the 1990-91 capital budget. Board approval of an annual capital budget for 1990-91 has been delayed due to the reassessment of the long-range capital plan. In August, the Board endorsed reducing major equipment purchases and annual capital budgets by \$20 million through 1998. This reduction would be accomplished through a \$9-10 million reduction in major equipment purchases and a \$10-11 million reduction in annual capital budgets.

The original capital plan projected an \$8,550,000 annual capital budget for 1990-91. It was recommended that this figure be revised to \$7,000,000. A summary of departmental breakdown of the recommended \$7 million budget was presented.

#### OTHER BUSINESS

An agreement has been signed with Group Health, Inc. to provide a primary clinic site for State and University employees on the University campus. The State has approved this employee option. Information to all University employees announcing this option will be mailed shortly.

#### **ADJOURNMENT**

There being no further business, the meeting was adjourned at 4:15 P.M.

Respectfully Submitted:

Shannon J. Lorbiecki

Shannon L. Lorbiecki Administrative Fellow



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

November 27, 1990

MEMO

To: Members, Board of Governors Planning and Development Committee

FROM: Greg Hart

RE: Neuroangiography System Replacement

There are currently two rooms in the Diagnostic Radiology Department equipped with neuroangiographic x-ray machines. Due to the age and technological limitations of these systems, radiology staff is not able to produce the type and quality of images required to support new, interventional radiology procedures. Attached is a proposal to replace one of these systems.

This proposal will be presented to this committee, the Finance Committee and the Board for information during December meetings and for approval during January meetings.

Thank you for your attention to this proposal. We look forward to answering any questions you may have.

GH/ad

attachment

# PROPOSAL FOR PURCHASE OF NEUROANGIOGRAPHY SYSTEM DIAGNOSTIC RADIOLOGY DEPARTMENT THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

# INTRODUCTION

The University of Minnesota Hospital and Clinic (UMHC) currently has two radiology procedure rooms equipped with single plane neuroangiographic systems. One system was acquired in 1980. The other was acquired in 1983 and upgraded with the addition of a digital biplane module in 1986. These systems are not capable of providing acceptable biplane imaging required for the new highly differentiated adult and pediatric neurointerventional procedures and other neuroangiographic studies which have been and are being developed.

## **PROPOSAL**

Acquire a new biplane radiographic, fluoroscopic, digital neuroangiographic system to replace the Siemens/Fischer system originally installed in 1983.

# RATIONALE

- A. A new imaging system is required to enable performance of neurointerventional procedures currently required to support the neurosurgical staff including vascular occlusion, vascular recanalization, and vascular perfusion in addition to treating aneurysms, arteriovenous malformations, arteriovenous fistulas, tumors, thrombosis, stenosis, and vasospasm. Currently, these imaging/interventional procedures cannot be performed at UMHC and are being referred to Abbott-Northwestern Hospital (see attached letter from Dr. Roberto Heros, Chief of Neurosurgery).
- B. Concern regarding the inadequacy of the existing equipment was voiced by Dr. William Thompson, Chief of Diagnostic Radiology, during his recruitment to the University of Minnesota in 1986. Replacement was postponed, however, pending selection of a new chairperson for Neurosurgery. While that postponement was appropriate, it has impeded Dr. Thompson's ability during the past three years to recruit neurointerventional radiologists.
- C. Neurointerventional radiology is an expanding technology. Dr. Heros' projection of 104 156 cases requiring 208 312 procedures annually is comparable to the growth experienced at Massachusetts General Hospital (MGH). MGH has experienced a 30% growth rate per quarter, moving from 130 procedures in 1988 to 260 in 1989.
- D. The projected pay back period is 3.6 years. This is based on 208 neurointerventional procedures annually, the low end of the projected volume, with an average procedure charge of \$2,400, coupled with the \$200,000 in charges generated annually at present and utilizing a 75% reimbursement rate.

# ESTIMATED COST

Biplane neuroangiographic system Installation & remodeling

\$1,655,000 245,000

TOTAL

\$1,900,000

The estimated cost for the equipment is based on bids received. This cost does not include a stereotactic module which would add \$400,000. If that module is determined to be required for specific new procedures, it will be budgeted for and presented as a separate proposal in a future fiscal year.

The existing room is not large enough to accommodate all of the racks for the peripheral equipment included with this system. Consequently, it appears that x-ray equipment and a reading room located in adjacent space will need to be relocated and the space remodeled to create a separate room for the peripheral racks. Therefore, the estimated installation and remodeling cost is higher than that normally incurred for installation of new equipment.

This equipment is included in the long range capital plan as a major equipment purchase to be made during the 1990-91 fiscal year.

# FINANCING

Several financing alternatives are available. The alternative used will be the one which is determined to provide the least costly approach at the time the acquisition contracts are written.

# UNIVERSITY OF MINNESOTA

Department of Neurosurgery Medical School Box 96 UMHC B590 Mayo Memorial Building 420 Delaware Street S.E. Minneapolis, Minnesota 55455

(612) 624-6666 FAX: (612) 624-0644

October 16, 1990

William Thompson, M.D. UMHC - Box 292

RE:

Interventional Neuroradiology

Room

Dear Bill:

This letter is to support in the strongest possible terms your justification of need for an interventional neuroradiology room. As you know, presently our facilities for these procedures are simply inadequate and much below par. In fact the facilities are so inadequate that we are sending routinely our patients for these procedures to Abbott Hospital where they do have first-class facilities.

Currently we are sending at least one patient a week to Abbott and on the average such a patient has at least two different sessions of interventional neuroradiology. Each session may take from four to six hours. In other words, presently our patients are utilizing the facilities at Abbott Hospital for an average of eight to twelve hours a week. This utilization is increasing quite significantly and I project that within six months there will be an average of two to three patients per week at the University Hospital in need of interventional radiology. This means that a conservative projection would be that in six months we would be utilizing this facility, if it were available at the University Hospital, for an average of 12-18 hours per week.

As you well know, I think it is an embarrassment to have to refer these patients to an outside institution for lack of adequate facilities at our own. I hope that you make every effort to correct this major deficiency and I do hope that your efforts are successful. We simply cannot continue to run a first-class clinical neurosurgical service without adequate interventional neuroradiology.

Sincerely,

Roberto C. Heros, M.D. Lyle A. French Professor

and Department Head

RCH/bm



Planning & Dev. Committee Rev	riew: 12-6-90
Finance Committee Review:	12-19-90
Board of Governors Review:	12-19-90

# MAJOR CAPITAL EXPENDITURE REPORT

**EQUIPMENT:** 

Interactive Clinic Management Computer System

**PURCHASE PRICE:** 

\$120,555

# **DESCRIPTION:**

The Community University Health Care Center (CUHCC) must replace its current billing and management reporting system. The IBM computer, purchased in 1978, is at capacity. The software is cumbersome to use and does not interface with the Hospital's mainframes. Also, during the last University audit, recommendations were made that the Hospital develop better audit trails and billing procedures for CUHCC. These deficiencies cannot be corrected with the current computer.

The Experior system was chosen after a thorough review of potential vendors. It will reside on the Hospital's Unisys Al5 mainframe and will meet all of CUHCC's billing, scheduling and reporting needs. The system will be able to interface with other Hospital programs such as the General Ledger and Patient Accounting systems. CUHCC will be able to increase Medical Assistance and other insurance billing accuracy and estimates that it will reduce billing turnaround time from 45 days to 30 days.

Funds for this purchase will come from the Hospital's 1990-91 capital budget.

CUHCC plans to have the new system installed in time for the opening of the new facility in March.

		971)/
Submitted By: _	Mary Ellen Wells	Approved By:
Title:	Assistant Director	Title:



Planning & Dev. Committee Review: 12/6/90

Finance Committee Review: 12/19/90

Board of Governors Review: 12/19/90

# MAJOR CAPITAL EXPENDITURE REPORT

**EQUIPMENT:** Expansion of Clinical Laboratory Computer - 2 Tandem VLX Processors,

memory and installation

PURCHASE PRICE: \$306,000

# **DESCRIPTION:**

The Clinical Laboratory Information System (CLIS) supports information processing and management related to test ordering, laboratory processing, analysis, data acquisition, verification, quality control and result reporting for over twenty laboratories located throughout UMHC. Computer support is provided 24 hours a day, 365 days a year, for a workload in the range of 1 million results per month. Updated cumulative summary reports are printed daily for inclusion in the medical record. The CLIS is interfaced to the Hospital Computer System making laboratory results available to Patient Care Units within moments of test completion. Billing data is communicated daily.

The CLIS requires expansion in order to maintain adequate levels of service and laboratory productivity. The demands on the system are such that user response times are reaching unacceptable levels. Current response time is in the range of 10 seconds, even after careful system "tuning" done to minimize response times. Within the next few months two additional clinical labs will be brought up on the system. This will allow for productivity and service increases in those labs, but will add an additional load to the laboratory computer.

Load projections and system performance analysis indicate that an increment of computer capacity involving two additional processor modules is required to provide adequate support. The availability of reconditioned processors has been identified, at a cost (including installation) of \$306,000. This project is part of the capital budget planned for 1990-91.

	, 1   / /
Submitted By:	Approved By: Approved By:
Title:	Title:



**Development Office** The University of Minnesota Hospital and Clinic Box 612 UMHC Harvard Street at East River Parkway Minneapolis, Minnesota 55455

DATE:

November 30, 1990

TO:

Planning and Development Committee

FROM:

Fred Bertschinger F.B.

SUBJECT: Development Office Quarterly Report

Attached for your information are summary reports of activities and donations received during the first quarter of FY 1991 (July-September).

If you have any questions about this report, please call me at 626-6008.

/ng

# Contributions Received UMHC Development Office FY 1991

	I 7-9/90	II 10-12/90	III 1-3/91	IV 4-6/91	Totals
Patients Fund	\$1,916			\$	1,916
Transplant Ass. Fund	1,830				1,830
Variety Club Pldg	4,460				4,460
Other Funds	138,148			1	.38,148
Totals to Funds	\$146,148	<del></del> -		\$ 1	46,148

Goal = \$1,050,000

Irrevocable Future Gifts	0	C
Revocable Future Gifts	2	



Development Office
The University of Minnesota Hospital and Clinic
Box 612 UMHC
Harvard Street at East River Parkway
Minneapolis, Minnesota 55455

# Activities and Events UMHC Development Office FY 1991

1990

August 9 Begin first of six luncheons and tours for solicitors for

the CWA Local 7200/U.S. West Charity Project.

September 8 Donor recognition event hosted by Bob and Sue Dickler - tour

and dinner at UMHC followed by Gopher football game.

September 13 Kick-off for CWA Local 7200/U.S. West United Way and UMHC

Transplant Assistance Fund Campaign. Goals of \$30,000 and

new organ donors.

October 17 U of M President's Club Annual Dinner Meeting.

November 4 Gopher Exhibition Basketball Game to benefit Child/Family Life.

November 15 Philanthropy Day recognition for Dr. Neal Gault and

Genevieve Stelberg.

# VARIETY CLUB PLEDGE PLEDGE REDUCTIONS AND DISBURSEMENTS

DATE	CONTRIBUTIONS	RUBEN-BENTSON	DISBURSEMENTS	BALANCE
As Of				***************************************
09/30/89	1,913,591.06 	200,000.00   	1,600,000.00	313,591.06
10/31/89	15,556.00	 	]	329,147.06
11/30/89	44,441.66		į	373,588.72
12/31/89	22,865.72			396,454.44
01/31/90	61,025.82			457,480.26
02/28/90	29,963.95	200,000.00	]   	487,444.21
03/31/90	19,200.00		! 	506,644.21
04/30/90	228,555.97	 	726,725.00	8,475.18
05/31/90	61,424.30	 		69,899.48
6/30/90	1,070.00	 		70,969.48
7/31/90	160.00	! 		71,129.48
8/31/90	2,959.58	 		74,089.06
9/30/90	1,540.50		!	75,629.56
SUBTOTAL	\$2,400,814.06	\$400,000.00	\$2,326,725.00	\$75,629.56

TOTAL CONTRIBUTIONS:

\$2,800,814.06

TOTAL DISBURSEMENTS:

\$2,726,725.00

\$75,629.56

CASH AVAILABLE FOR USE:

\$8,000,000

BALANCE TO BE RECEIVED: 5,199,185.94

Contributions from the Variety Club of the Northwest Contributions to UMHC, credited against the pledge in accordance with the pledge agreement Total Contributions

\$1,078,225.00 \$1,722,589.06 -----2,800,814.06

# VARIETY CLUB PLEDGE DISBURSEMENTS BY PURPOSE SEPTEMBER 1, 1990

	VARIETY CLUB RESEARCH CENTER	RUBEN-BENTSON CHAIR	OTHER VCCH	TOTALS
ALLOCATION OF \$8,000,000 PLEDGE	\$2,000,000.00	\$1,000,000.00	\$5,000,000.00	\$8,000,000.00
TOTAL DISBURSEMENTS	(\$650,000.00)	(\$400,000.00)	(\$1,661,725.00)	(\$2,711,725.00)
* COMMITTED DISBURSEMENTS			(\$15,000.00)	(\$15,000.00)
BALANCE TO BE	\$1,350,000.00	\$600,000.00	\$3,323,275.00	\$5,273,275.00

<sup>\*</sup> Total committed disbursements for fiscal year 1989/90 is \$919,225.

Of the areas to be funded, \$15,000 has not been disbursed.

This a Van (VCCH) for \$15,000.



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

November 30, 1990

T0:

Planning and Development Committee

FROM:

Greg Hart

RE:

Quarterly Purchasing Report

Attached please find the quarterly purchasing report for the period July - September, 1990. The report will be reviewed at the December 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.

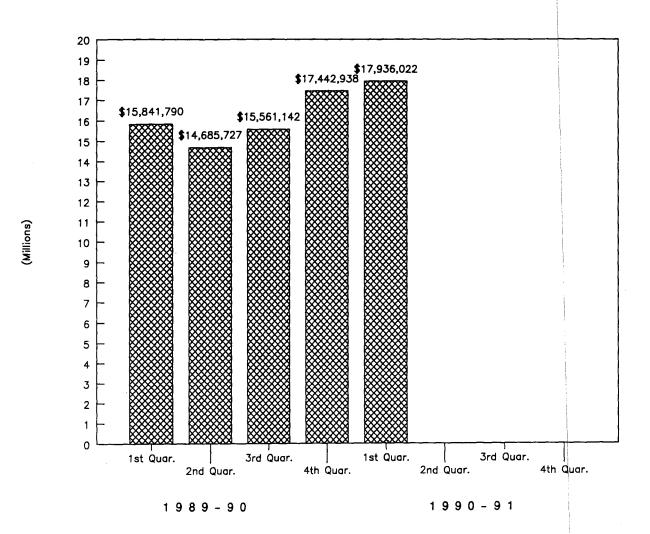
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attachments

# UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY PERIOD OF JULY – SEPTEMBER 1990

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

# **PURCHASE ORDER ACTIVITY**



# FIRST QUARTER, FISCAL YEAR 1990-91, ACTIVITY:

	NUMBER	VALUE
PURCHASE ORDERS	8314	\$16,481,273.93
OTHER PAYMENTS	478	\$956,109.23
CONFIRMING ORDERS	<u>374</u>	\$498,638.71
TOTAL THIS QUARTER*	9,166_	\$17,936,021.87

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

UNSUCCESSFUL **VENDOR/AMOUNT** ITEM

SUCCESSFUL

**VENDOR/AMOUNT** 

**DEPARTMENT** 

CO2 Laser 1.

Surgilase \$ 48,000.00 **Surgical Lasers** 

\$ 64,500.00

The wattage is insufficient for our intended uses.

**Oral Thermometer Kits** 2.

Medix

Owens & Minor

Materials

Materials

O.R.

\$ 13,755.00

\$ 14,760.90

Thermometers slide out of the container easily if not held upright when

being opened.

Surgeons' Gowns 3.

Lintex

\$ 48,915.00

CharmTex \$ 34,293.75 **Angelica** \$ 37,665.00 **Fashion Seal** 

\$ 67,050.00

The barrier fabric on the gowns developed pin holes after laundering

and sterilizing a minimum number of times.

**Elevator Controls** 4.

Lagerquist

Otis

Maintenance & Operations

\$ 15,800,00

\$ 18,160.00

Vendor never provided detailed description of work to be done despite repeated

requests.

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

CONTRACT/					
	VENDOR	P.O. #	VALUE	DEPT.	PRODUCT
*	St. Mary's Medical Center	H108787	\$175,000.00	Cardio.	Used Monitoring Equipment
	Triangle Maintenance	H099968	\$16,800.00	CUHCC	Custodial Service
	Polymedco	H099919	\$17,280.00	Labs	Estradol Kits
	American Red Cross	H099917	OPEN	Labs	Blood & Blood Products
	Amersham	H099992	\$21,600.00	Labs	RIA Kits
	Scientific Assoc.	H108782	\$8,631.00	Labs	Software
	Alternative Resources	H099908	\$13,440.80	Labs	Temporary Employees
	Imre	90-558	\$5,148.00	Labs	Prosorba Columns
	Baxter	90–559	\$16,810.00	Labs	Haemonetic Cell Saver Paks
	Sachs Group	H108183	\$5,000.00	Marketing	Software License Fee
	Medical Transcription Service	H099969	OPEN	Med. Rec.	Transcribing Services
	St. Paul Red Cross	90–504	OPEN	O.R.	Bone Graft Testing & Materials
	Gammex	H108197	\$5,573.00	Radiology	Laser Positioner
*	Northern X-Ray	H108791	\$94,400.00	Radiology	Computer Upgrade & Monitors

TOTAL

\$379,682.80

<sup>\*</sup> Over \$50,000

# **VENDOR APPEALS**

1. **VENDOR NAME/DOLLAR AMOUNT:**  Americable/\$345,990

\$334,279

\$370,475

**NATURE OF PURCHASE:** 

**INTENDED VENDOR/DOLLAR AMOUNT:** 

**REASON FOR APPEAL:** 

**Backbone Network** Not yet finalized.

Vendor was originally eliminated from further consideration because it was not among the top three in the ratings system used by I.S.D. to rank each bid. The vendor disagreed with the ratings given in many areas, such as fault tolerance, costs, overall and demonstrable solution, delivery, training, and network security. I.S.D. re-evaluated their proposal but found only one area that they were willing to adjust the rating. This one adjustment was not sufficient to change their overall ranking and to be considered further. Vendor was notified of this and has not responded further.

STATUS:

The top three proposals are still under evaluation. No award has been

made.