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REPORT OF THE SPECIAL SENATE SUBCOMMITTEE ON HEALTH COSTS

Technical Appendicies

SENATE HEALTH, WELFARE AND CORRECTIONS COMMITTEE

MINNESOTA STATE SENATE

DECEMBER 1974

APPENDICIES

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A P P E N D I C I E S

APPENDIX A

HEALTH COSTS SUBCOMMITTEE MEETING DATES AND SPEAKERS

April 26, 1974: National Health Insurance

Dr. George B. Martin	Minnesota Medical Association Thief River Falls, Minnesota
Dr. Richard Hall	Acting Director Bureau of Quality Assurance HEW Chicago, Illinois
Dr. Charles H. Mayo II	National Health Security Council White Bear Lake, Minnesota
Mr. Gordon Williams	Northwestern National Life Insurance Company Minneapolis, Minnesota
Mr. Henry Bower	Hennepin County Health Care Coalition Minneapolis, Minnesota

May 17, 1974: Hospital Costs

Mr. Steve Rogness	Executive Director Minnesota Hospital Association Minneapolis, Minnesota
Mr. Ernie Lamson	Provider Reimbursement Section Blue Cross/Blue Shield of Minnesota St. Paul, Minnesota
Dr. Walter McClure, Ph.D.	InterStudy Minneapolis, Minnesota
Mr. Frank Baker	Executive Director Washington State Hospital Commission Olympia, Washington
Mr. Bob Nichols	Oklahoma Consumer Protection Agency Oklahoma City, Oklahoma

June 7, 1974: Hospital Costs

Mr. William N. Wallace	President and Chief Executive Officer United Hospitals St. Paul, Minnesota

Mr. Arne T. Moe	Administrator Buffalo Memorial Hospital Buffalo, Minnesota
Mr. Charles House, C.P.A.	Chairman I.C.E. Committee Minnesota Phase IV Committee for Health Care Institutions Duluth, Minnesota
Mr. Max Bennett	InterStudy Minneapolis, Minnesota
Dr. Chester Anderson	Minnesota Medical Association Hector, Minnesota

August 16, 1974: Health Manpower and Health Care Costs

Ms. Kirsten Kurtz	Assistant Executive Director Minnesota Nurses Association St. Paul, Minnesota
Mr. Aaron Lowen	InterStudy Minneapolis, Minnesota
Dr. Richard Anonsen	Foundation for Health Care Evaluation
Dr. John B. Coleman	St. Paul Radiology Clinic St. Paul, Minnesota
Ms. Mary Anne Ticen	Beltrami Health Center Minneapolis, Minnesota
Dr. Chester Anderson	Legislative Chairman Minnesota State Medical Association

September 13, 1974: The Effects of Health Care Costs on Consumers

Mrs. LaVonne Dickinson	(Consumer) 5319 Pennsylvania Avenue North New Hope, Minnesota
Dr. Warren Warwick	Director-Cystic Fibrosis Clinic Associate Professor - Department of Pediatrics University of Minnesota Minneapolis, Minnesota
Senator John Keefe	Hopkins, Minnesota
Ms. Carolyn McDonald	(Consumer) 2442 Ogena Place Minneapolis, Minnesota

Dr. Walter McClure	InterStudy Minneapolis, Minnesota
Mr. Rick Carlson	Independent Health Consultant West Village, Colorado

October 11, 1974: The Effects of Health Insurance on Health Care Costs

Dr. Paul Ellwood	InterStudy Minneapolis, Minnesota
Mr. Lou Orsini	Health Insurance Association of America New York City, New York
Mr. Harry Atwood	President, Northwestern National Life Insurance Company Minneapolis, Minnesota
Mr. John Tracy Anderson	Blue Cross/Blue Shield of Minnesota St. Paul, Minnesota
Mr. Bernard Brummer	Council 6 (State Employees) St. Paul, Minnesota
Mr. Andy Schneider	Staff Attorney, Health Law Project University of Pennsylvania Philadelphia, Pennsylvania

November 15, 1974: The Effects of Government Programs on Health Care Costs

Mr. Dave Van Wyk	Special Projects Department of Public Welfare State of Minnesota St. Paul, Minnesota
Mr. James Flavin	Minnesota Blue Cross/Blue Shield St. Paul, Minnesota
Mr. Carl Platou	President Fairview Hospitals Inc. Minneapolis, Minnesota

APPENDIX B

GEORGE R. CONZEMIUS
SENATOR 25TH DISTRICT
800 WEST HOFFMAN
CANNON FALLS, MINNESOTA 55009
AND
205 STATE CAPITOL
SAINT PAUL, MINNESOTA 55155

State of Minnesota
SENATE

MAJORITY WHIP

COMMITTEES
HEALTH, WELFARE AND CORRECTIONS, CHAIRMAN
RULES AND ADMINISTRATION, VICE-CHAIRMAN
COMMITTEE ON COMMITTEES
GOVERNMENTAL OPERATIONS
TAXES AND TAX LAWS

May 20, 1974

Dear Hospital Administrator:

The Special Senate Health Costs Subcommittee of the Senate Health, Welfare and Corrections Committee is investigating the escalating costs of health care. As a part of this investigation the Subcommittee has developed the enclosed questionnaire to aid them in this effort. This questionnaire is being sent to all of the short-term hospitals in Minnesota. We will supply you with a tabulation of the combined results when they have been compiled by our staff.

In order for the Subcommittee to accomplish their work on a timely basis, we will need the completed questionnaires returned by June 3 of this year. If you need clarification or guidance in completing the questionnaire, please contact Gene Piatek or Larry Fredrickson at (612) 296-6584, 6583.

I would like to take this opportunity to thank you for your cooperation with the Subcommittee and the legislature in this endeavor and to assure you that your suggestions for curbing the spiraling costs of health care will be seriously considered by the Subcommittee.

Sincerely,

George R. Conzemius

GEORGE R. CONZEMIUS
State Senator
Chairman, Special Senate Health
Costs Subcommittee

GRC/cjd
Enclosure

SURVEY FORM OF THE SPECIAL SENATE HEALTH COSTS SUBCOMMITTEE

I. General Information

Hospital Name:
Address:
Administrator:
Telephone Number:
Number of Beds:
1973 Occupancy Rate:
Estimated 1974 Occupancy Rate:
Geographic Area Served by Your Hospital:
Names and Occupations of Board of Trustees/Directors:

II. Salaries and Fringe Benefits of Selected Employees

Please provide (as of 1/1/74) the annual salary, other income, the annual value of fringe benefits and the expected percentage increase in the combination of these factors as of 12/31/74: (Names are not required and use mean averages when averages are requested.)

	Annual Salary	Other Income[1]	Annual Benefits	Estimated % Increase by 12/31/74
Administrator (each)				
Anesthesiologist (each)				
Pathologist (each)				
Radiologist (each)				
Charge Nurses (avg.)				
Other R.N.'s (avg.)				
L.P.N.'s (avg.)				
Occupational Therapists (avg.)				
Physical Therapists (avg.)				
Speech Therapists (avg.)				
Dieticians (avg.)				

(If any of the above are less than full time, indicate % of effort.)

Do you employ in your hospital any physician extendors (physician assistants, nurse practitioners, etc.)? If so, specify the number, type and compensation.

Specify what percentage of total hospital expenses were attributed to personnel costs for 1969, 1973, and the estimated percentage for 1974.

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1. Include in this category all compensation (less salary) which is received as a result of affiliation with the hospital. For example, include money paid hospital-based specialists when they are remunerated for a percentage of their departmental revenue.

III. Length of Stay and Charges Per Day/Procedure

Please provide the following information on length of stay and charges per day and per procedure for certain services.

	1969	1973	Estimated % Increase by 12/31/74
Average Length of Stay			
Average Daily Service Charge			
Average Daily Ancillary Service Charge			
Total Average Bill			
Average Daily Intensive Care Charge			
Average Daily Coronary Care Charge			
Average Operating Room Charge			
Outpatient Average Charge			
Cost of Selected Operations:			
Appendectomy			
Caesarean Section			
Normal Delivery			
Hysterectomy			
Cholecystectomy			
Cost of Diagnostic Procedures:			
Blood Test			
Electrocardiogram			
Electroencephalogram			
Chest X-Ray			

Please provide the subcommittee with your hospital's 1973 Financial Statement, including sources of revenue and categories of expenditures.

IV. Cost and Charges for Certain Drugs and Supplies

	Cost/Each (4/30/74)	Charge/Each (4/30/74)
Drugs:		
Aspirin		
Darvon Compound (65 mgs.)		
Ampicillin (250 mgs.)		
Tetracycline (250 mgs.)		
Supplies:		
Chux		
External Female Catheter		
Phisohex (specify ounces)		

V. Educational Costs

Briefly describe the major training and educational programs which occur in your hospital. What income do you derive from them and what is their cost?

VI. Scope of Services and Shared Services

Please indicate if your facility offers the following services, the percent of utilization in 1973 and estimated utilization for 1974.

	Date Established	1973 % Util.	Estimated '74 Util.
Intensive Care Unit			
Premature Nursery			
Coronary Care Unit			
X-Ray Therapy			
Cobalt Therapy			
Radium Therapy			
Burn Care Unit			
Open Heart Surgery			

For the service you have most recently established, indicate the initial cost of establishing the service (planning, construction, equipment, etc.) and the yearly operating cost of the service.

Please give the names and the distance from your hospital of the two nearest short-term hospitals. (Short-term as defined by the 1973 AHA Guide to the Health Care Field.)

Specify which of the above services are shared among your hospital and the two hospitals mentioned above.

Briefly describe other medical, support, or administrative (laundry, accounting, etc.) services which you share with the two nearest hospitals.

If your hospital shares services with another hospital (other than the two nearest) briefly describe these services.

VII. Perceived Causes of Health Care Costs Inflation and Recommendations for State Action

Briefly describe the major factors which have caused the expenses for health care to rise from $25.9 billion and 5.2% of the Gross National Product in 1960, to $94.1 billion and 7.7% of the Gross National Product in 1973. (You may want to limit your answer to the hospital portion of that increase.)

Briefly outline possible state actions which the special subcommittee should consider in dealing with the problem of escalating health care costs.

APPENDIX C

LOCATIONS OF EIGHT SPECIAL SERVICES AND FACILITIES IN MINNESOTA HOSPITALS *

Listed by Comprehensive Health Planning Areas

Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
METRO									
Abbott Northwestern Hospital	x		x	x					
Bethesda Lutheran Hospital	x		x	x		x			United Hospital-Miller Unit ♡ St. Josephs C
Children's Hospital	x								United Hospitals X, R
District Memorial Hospital	x		x						
Divine Redeemer Memorial Hospital	x	x	x						
Eitel Hospital	x		x			x			
Fairview Hospital	x		x						
Fairview-Southdale Hospital	x	x	x						
Gillette Children's Hospital	x								
Golden Valley Health Center	x		x						
Hennepin County General Hospital	x	x	x				x	x	Metropolitan Medical Center X, C, R
Lakeview Memorial Hospital			x						
Mercy Hospital	x		x						
Methodist Hospital	x		x						
Metropolitan Medical Center	x		x	x	x	x		x	Hennepin County General X, C, R

* Based on survey responses to question of availability and degree of sharing of these eight services. Hospitals with no x's listed none of these services.

◇ Intensive Care Unit ✳ Coronary Care Unit C Cobalt Therapy B Burn Care Unit

\+ Premature Nursery X X-Ray Therapy R Radium Therapy ♡ Open Heart Surgery

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
METRO CONT.									
Midway Hospital	x	x	x	x		x			
Mounds Park Hospital	x		x						
Mount Sinai Hospital	x			x				x	Northwestern X,C,R
North Memorial Hospital	x	x	x				x	x	
Queen of Peace Hospital			x						
Riverview Memorial Hospital	x		x						
Samaritan Hospital	x			x					
Sanford Memorial Hospital	x	x							
Shriners Hospitals for Crippled Children Twin Cities Unit									
St. Francis Hospital				x					
St. John's Hospital	x		x	x		x			
St. Joseph's Hospital	x	x	x	x	x	x		x	United Hospitals C
St. Mary's Hospital	x	x	x						
St. Paul-Ramsey Hosp. & Medical Ctr.	x	x	x				x		Bethesda Lutheran B St. Joseph's X,B
United Hospitals	x		x	x		x			
Unity Hospital	x		x						
University of Minnesota Hospitals	x		x	x	x	x		x	

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
METRO CONT.									
Waconia Ridgeview Hospital	x		x						
Watertown Community Hospital									
AGASSIZ									
Ada Municipal Hospital									
Bemidji Hospital	x	x		x					
Clearwater County Memorial Hospital									
Fosston Municipal Hospital									
Greenbush Community Hosp. & Convalescent & Nursing Care Unit									
Kittson Memorial Hospital			x						
Mahnomen County & Village Hosp. & Nursing Center		x							
Northwestern Hospital Services	x			x					
Riverview Hospital	x		x						

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
AGASSIZ CONT.									
Roseau Area Hospital									
St. John's Hospital		x	x						Northwestern Hospital Services ◇
St. Joseph's Hospital	x								
Trinity Hospital	x								
Warren Hospital			x						
ARCH (ARROWHEAD)									
Aitkin Community Hosp. & Convalescent & Nursing Care Unit									
Chisholm Memorial Hospital									Hibbing General ◇, ✳
Community Memorial Hosp. & Convalescent & Nursing Care Section									
Community Memorial Hospital of Deer River									(Did not answer question)
Cook County North Shore Hospital			x						
Ely-Bloomenson Community Hospital	x								

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ARCH CONT.									
Eveleth Fitzgerald Community Hospital									Virginia Municipal ✳ White Community ✳
Hibbing General Hospital	x								
Itasca Memorial Hospital	x		x						Northern Itasca ◇ ✳ Community Memorial ◇ ✳
Lake View Memorial Hospital									
Littlefork Municipal Hospital									
Mercy Hospital	x								
Miller-Dwan Hospital & Medical Center	x			x			x		
Northern Itasca Hospital									
St. Luke's Hospital	x	x	x	x	x	x			Miller-Dwan B
St. Mary's Hospital	x	x	x	x	x	x			Miller-Dwan B
Virginia Municipal Hospital	x		x	x		x			
White Community Hospital									

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
CENTRAL									
Albany Community Hospital									
Braham Community Hospital									
Buffalo Memorial Hospital									
Chisago Lakes Hospital	x		x						
Community Mercy Hospital				x					
Cuyuna Range District Hospital									
Glenwood Community Hospital									
Kanabec County Hospital	x								
Long Prairie Memorial Hospital	x								
Melrose Hosp. & Pine Villa Convalescent & Nursing Care Unit	x		x						
Memorial Community Hospital									
Memorial Hospital	x		x						
Milaca Area District Hospital	x								
Minnewaska Hospital									

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CENTRAL CONT.									
Monticello-Big Lake Community Hospital	x								
Paynesville Community Hospital	x								
Princeton Community Hospital			x						
Rush City Hospital									
St. Cloud Hospital	x	x	x	x	x				
St. Gabriel's Hospital			x						
St. John's Hospital									
St. Joseph's Hospital									
St. Michael's Hospital	x	x	x						
United District Hospital									
Wesley Hospital	x		x						
MIN-DAK									
Community Memorial Hospital									
Douglas County Hospitals	x								

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
MIN-DAK CONT.									
Holy Trinity Hospital	x								
Lake Regional Hospital		x	x	x					
Memorial Hospital									
New York Mills Community Hospital			x						
Ortonville Municipal Hospital	x								
Parkers Prairie District Hospital									
Pelican Valley Health Center									
Stevens County Memorial Hospital									
St. Ansgar Hospital	x		x						
St. Francis Hospital	x		x						
St. Marys Hospital of Detroit Lakes	x		x						
Wheaton Community Hospital			x						

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
SOUTHEAST									
Caledonia Community Hospital									
Community Hospital-Nursing Home									
Community Memorial Hospital			x						
Community Memorial Hospital, Convalescent, & Rehabilitation Unit	x	x	x	x		x			
Harmony Community Hospital									
Lake City Hospital									
Naeve Hospital		x	x	x		x			
Northfield City Hosp. & Nursing Care Facility									
Olmsted Community Hospital	x	x	x	x					
Owatonna City Hospital	x								
Rice County District One Hospital	x	x							
Rochester Methodist Hospital	x		x						St. Mary's(Rochester) +, ♡ Mayo Clinic X, C, R
St. Elizabeth Hospital									
St. John's Hospital of Red Wing	x	x	x			x			

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SOUTHEAST CONT.									
St. Mary's Hospital of Rochester	x	x	x	x	x	x		x	
St. Olaf Hospital									
Tweeten Memorial Hosp. & Convalescent Home									
Zumbrota Community Hospital									
SOUTHWEST									
A.L. Vadheim Memorial Hospital	x								
Appleton Municipal Hospital									
Arnold Memorial Hospital									
Canby Community Hospital District One			x						
Chippewa County Montevideo Hospital	x								
Community Hospital			x						
Community Memorial Hospital									
Dawson Hospital			x						

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SOUTHWEST CONT.									
Divine Providence Hospital and Home			x						
Dr. Henry A. Schmidt Memorial Hospital									
Glencoe Municipal Hospital	x		x						
Granite Falls Municipal Hospital and Manor	x								
Hendricks Community Hospital									
Hutchinson Community Hospital			x						
Jackson Municipal Hospital	x	x							
Lakefield Municipal Hospital									
Louis Weiner Memorial Hosp. & Nursing Home		x	x						
Madison Hospital									
Meeker County Memorial Hospital	x		x						Rice Memorial X, C
Mountain Lake Community Hospital	x		x						
Murray County Memorial Hospital			x						

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Hospital With Service	◇	+	✳	X	C	R	B	♡	Hospital(s) Used For Other Services
SOUTHWEST CONT.									
Pipestone County Hosp. & Nursing Unit									
Redwood Falls Municipal Hospital			x						
Renville County Hospital			x						Rice Memorial X
Rice Memorial Hospital	x	x	x	x	x				
St. Mary's Hospital and Home									
Swift County-Benson Hospital	x		x						Rice Memorial X,C
Tracy Municipal Hospital	x								
Windom Hospital									
Worthington Regional Hospital	x		x	x		x			
SOUTH CENTRAL									
Arlington Municipal Hospital			x						
Comfrey Hospital	x								
Community Hospital									
Fairmont Community Hospital	x			x		x			

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SOUTH CENTRAL CONT.									
Gaylord Community Hospital	x								
Immanuel-St. Joseph's Hospital	x		x	x					
Loretto Hospital	x			x					Union ✳
Madelia Community Hospital									Immanuel-St. Joseph's & Watonwan Memorial X
Minnesota Valley Memorial Hospital									
Sleepy Eye Municipal Hospital									
Springfield Community Hospital									
Trimont Community Hospital									
Union Hospital			x						
United Hospital District									
Waseca Memorial Hospital	x	x							
Watonwan Memorial Hospital			x						
Wells Municipal Hospital	x								

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APPENDIX D

GEORGE R. CONZEMIUS
SENATOR 25TH DISTRICT
800 WEST HOFFMAN
CANNON FALLS, MINNESOTA 55009
AND
205 STATE CAPITOL
SAINT PAUL, MINNESOTA 55155

State of Minnesota
SENATE

MAJORITY WHIP

COMMITTEES
HEALTH, WELFARE AND CORRECTIONS, CHAIRMAN
RULES AND ADMINISTRATION, VICE-CHAIRMAN
COMMITTEE ON COMMITTEES
GOVERNMENTAL OPERATIONS
TAXES AND TAX LAWS

September 18, 1974

SAMPLE OF LETTER WHICH WAS SENT TO ALL ADMINISTRATORS OF HOSPITALS SELECTED FOR SITE VISITS.

Dear Mr. Administrator or Director:

This letter will confirm the visit to your institution by the Special Senate Health Costs Subcommittee scheduled for (day, date) from 9:30 AM to 3:30 PM.

The visiting team will include one senator and one public member from the Subcommittee, a legislative staffer, and an accountant.

At this time we would like to review the following topics and see the related department people for each area:

1. Introduction to hospital administrative structure and overview of your hospital's current situation and future outlook in terms of finance and occupancy. (a chart of organization would be helpful)

2. Explanations of:

   a. How your reimbursement rates (including third party, Title XVIII, Title XIX) are set

   b. Hill-Burton agreements (including your procedures for providing free or part pay care)

   c. Purchasing agreements and procedures

   d. Any cost saving procedures you have implemented

3. Team questions on survey and financial statement submitted earlier to the Health Costs Subcommittee.

4. Medical Staff:

   a. List of physicians with admitting privileges, by speciality.

   b. What percentage of the time are an anesthesiologist, radiologist and pathologist available and how are they paid for their services?

   c. What are your special needs that are/aren't being met?

   d. Do you have bylaws?

   e. How many doctors take advantage of continuing education?

   f. What use do you make of physician extendors?

5. Personnel Department:

   a. Staffing patterns
      professional - nursing and technicians
      support - housekeeping, dietary, laundry

   b. Problems in obtaining and retaining staff

   c. Discussion of unionization and wage trends

6. Accounting Department:

   a. Review of budgets for capital expenditures and department operations, and budgeting procedures used by the hospital

   b. What other information and reports are produced for the administration relevant to review of cost controls and operation variances from expectations

   c. Attitude toward a uniform accounting system for hospitals and uniform cost reporting/billing forms to third party payors and government agencies

   d. Percent of out-patient services

   e. Overview of trends, by categories, in your income and expenses

7. Special Services:

   a. ICU, CCU, etc.

   b. See and explain machinery cost, need justification, and utilization rates; plans for expanding, decreasing or sharing.

8. Radiology Department:

   a. Out-patient services: What percent of daily volume?

   b. In-patient: What is average bill per patient day?

   c. How many x-rays are taken on a daily basis?

9. A board member's perspective on the cost issues.

10. Discussion of number and types of site visits by government and accrediting agencies, the amount of staff time involved, and possible ways to lessen the burden of numberous inspections.

11. Concluding commments by administration and subcommittee team.

We want our disruption of your operations to be as minimal as possible. We will be gathering general information for the Subcommittee. We do not expect you to make any special arrangements or reports. The day should be informal. The session will be informal.

We are looking forward to our visit. Thank you for your cooperation.

Sincerely,

GEORGE R. CONZEMIUS
State Senator

Chairman, Special Senate
Health Costs Subcommittee

GRC/cjd:pmu
cc: Mr. Doug Ewald
Minnesota Hospital Association

APPENDIX E

1. LONG PRAIRIE HOSPITAL VISIT, SEPTEMBER 23, 1974

SITE VISIT TEAM AND WHO THEY MET WITH

The site visit team included Senator William Kirchner, Ellen Vollmers, Dwight Smith and Larry Fredrickson. The team primarily met with Leo Ustick (the administrator), Gary Wright (the assistant administrator), and Jim Farrel (accountant). During lunch the team also met with Steve Koblish, a hospital board member and Mayor Lyle Smith.

HOSPITAL GOVERNANCE, BACKGROUND AND SERVICE AREA

Long Prairie Hospital is a municipal hospital with 32 beds. They are governed by a hospital board appointed by the city council.

Their current occupancy rate is about 50%. They attribute this low rate to the fact that approximately three years ago all three of the doctors in Long Prairie retired. The people of the town then started going to Browerville (eight miles away) for their medical care and hospitalization. Since then, Long Prairie has enticed four new young doctors to the town. These doctors practice in a clinic which is in one wing of the hospital building. There is a nursing home in a third wing of the building. All three buildings are owned by the city. The hospital administrator expects that the availability of the doctors will help them increase their occupancy rate. However, even before the problem with retiring doctors, their occupancy rate was only 52%.

Long Prairie is in Todd County which has twenty-two thousand people and three other hospitals. In addition, they are about sixteen miles from hospital at Sauk Centre and twenty-five miles from the hospital at Alexandria.

During a discussion with the board member, he described the role that board members actually play in the operation of the hospital. It is apparently a very minimal role. The hospital administator prepares the budget, and the board gives its' proforma approval. If the hospital administrator wants to buy or rent new equipment or hire personnel, it is almost always approved by the board.

FINANCIAL AND ECONOMIC SITUATION

In 1972 the hospital showed a profit of approximately $80,000. So far this year they have operated at a deficit of approximately $34,000; they have been using reserves to pay operating deficits. Until recently, their daily room rate was $28.00. It was raised to $36.00 after the lifting of wage-price controls, and was just recently raised again to $45.00. They attribute a large part of their financial problem to the problems created by the wage-price controls. In addition, they have a cash flow problem. One cause for this is the fact that Blue Cross takes approximately six weeks to process their claims.

The hospital in Browerville is about the same size as the one in Long Prairie. Browerville has a population of approximately 700 as compared to Long Prairie's population of approximately 2500 people. The hospital in Browerville is also having financial problems. If it were not for the financial support which it receives from a church, it probably would have to close. Long Prairie, Browerville, Staples, and Bertha hospitals all share a physical therapist.

The hospital uses the relative value system to determine the value of units in setting charges. (These are rate guides established by the Minnesota Foundation of Medical Care.) They currently have an outstanding backlog of 61 days of revenue and accounts receivable. This is lower than the statewide average of 72 days. Their average cost per patient day is about $103. They lose money on their coronary care, OB-GYN, nursing, physio-therapy, and operating room departments. They make money on x-ray, laboratory, and pharmacy operations. The administrator stated that without the $200,000 gross revenue from laboratory and x-ray services, they would be in very severe financial shape. They currently have $170,000 in outstanding accounts receivable and $100,000 in standing accounts payable.

One of their problems is the tremendous increase in the cost of supplies in recent months. They showed the team several letters from suppliers increasing prices, sometimes for the second or third time this year. They had just received a letter from a supplier which had previously provided free baby formula to mothers in the hospital (in the hopes that the mother would continue to use the formula once out of the hospital). The letter informed the hospital that this free baby formula could no longer be provided.

The boarding care home is in a separate facility. Since it was losing money, they combined it with the hospital in hopes that combined services would help alleviate the financial problem.

The hospital, nursing home, and city boarding care home employ 113 people. This makes them the second largest employer in the city.

The attached clinic is rented by physicians from the city. Since this is a municipal hospital there are state statutes regulating the minimum rental fees. The hospital is providing laboratory and radiology services to the clinics with exception of EKG's. The doctors in the attached clinic receive 35% of the gross billing for all x-ray and laboratory work which they refer to the hospital.

The hospital handles all billing for laboratory and x-ray services. All x-rays done while patients are in the hospital are credited to the account of the consulting radiologist who reads all x-rays. Doctors in the attached clinic may also read the x-rays themselves.

MANAGEMENT AND ACCOUNTING

They use the American Hospital Association standardized budgeting system. They have a contract with McDonald-Douglas Computerized Billing Systems in Peoria, Illinois. The cost of this is considerable, but they feel that it is cheaper than to hire the clerical help necessary to do it themselves. This computer hookup also enables them to get comparative figures with other hospitals, their current billing status on all patients, their occupancy rate, and so forth.

The administrator strongly recommends the use of HAS (Hospital Administration Service) - available through AHA subscription - adopted by the legislature in Colorado.

He says that some hospitals in the state, especially those in rural areas, have no inventory control and poor accounting systems. He feels that this contributes to high costs.

In order to streamline the administration of this hospital, he has made several changes in his one year's tenure. In addition to the computerized billing system which he had installed, they have computerized inventory control, and a new drug dispensing machine which they call Igor. With this machine, they keep an accurate accounting of all drugs dispensed. This helps them maintain their inventory and guarantees that the patients are billed for all drugs received. The machine is on a monthly rental basis and there is some added cost due to the need to package drugs to fit into the machine. They are more than able to pay for these costs by the increased volume of billings to patients for drugs due to the better controls. Since the machine was installed, the pharmacy department changed from a losing department to a money-making department. This

increased revenue is due to increased patient billings for drugs and to some direct cost savings.

The administrator has arranged a special purchasing contract with Will-Ross for their supplies. He claims that they have the same volume discount which is offered by this company to the entire Iowa Hospital Association.

The administrator admitted that the area around Long Prairie has too many hospital beds. At the same time, it is not clear what efforts they are making to arrange for more shared services.

MEDICAL STAFF

The hospital has four attending physicians and they also use a doctor from Little Falls as their consultant for OB-GYN and a consultant doctor from Willmar for cardiology. Some of their surgery patients request to be sent to Willmar, Brainerd or Little Falls for surgery. The two doctors in Browerville have staff privileges at the Long Prairie Hospital.

SPECIALIST

The consulting radiologist is there for about one and a half hours a day, four days a week. He receives 40% of the gross billing for the department, less 5% for debt services. The hospital estimates that this amounts to approximately $1800-2200 per month. The radiologist also serves several other hospitals in the area.

The hospital has a pathologist once a month for a $100 retainer fee. Any other charges by the pathologist are paid by the doctor in the attached clinic out of their receipts from laboratory billings.

The hospital has an anesthesiologist on call. He bills the hospital for his services, and they in turn bill the patient for those charges plus 15%.

NURSING

They have trouble in obtaining hospital personnel. They employ 15 nurses, but need 4 or 5 more. There is a regional AHECC program out of St. Cloud which trains former nurses so they can qualify for licensure again.

Long Prairie has one of the few operating nurse-midwife programs in the state. The midwife there works closely with the doctors. The doctors have hired a nurse practitioner who makes post-hospital visits. The county has only one public health nurse, and the doctors felt that they needed a nurse practitioner to supplement her work. There are no school nurses in the county.

The hospital uses a combined staff for its emergency room, operating room, and CSR. They have had over 1100 hours of in-service training of their health care personnel in the last 9 months. They do send some nurses to Brainerd and Little Falls for training in the hospitals there.

SPECIAL FACILITIES

The Long Prairie Hospital has a coronary care unit which has a capacity of two people. It normally has no, one, or two people in it. They have the only stress laboratory between the Twin Cities and Bemidji. They have the best equipped laboratory in the area. They have their own laundry facilities; it operates five days a week and their cost is 11-12¢ per pound.

HILL-BURTON

They provide little free care. They usually find some source to pay for health care that is provided. If a patient is unable to pay his bill, they will arrange a minimal monthly time payment plan. No one is turned away for lack of funds. They feel that some people stay away from the doctor's office because of inability to pay.

CONCERNS AND SUGGESTED REFORMS

The numerous inspections by state, federal, local and accrediting agencies are a burden, but not a severe problem. They recommended that the State accept the findings of the Joint Commission on Accrediting Hospitals with the exception of the life safety code provisions which should still be state administered. They feel that it is wasteful to have state Welfare Department audit teams visit them to check on Medicaid expenditures when the Blues are already auditing them for Medicare purposes using federal money to pay for the audit cost.

In the insurance area, they suggested several reforms, including the standardized insurance claim form. They feel this

would greatly lessen their administrative cost. A related problem is the fact that insurance companies will not accept an assignment of a claim from a patient to the hospital. The insurance company insists on paying the patient directly. The hospital then has to spend money to collect, if they can, from the patient.

They complained about a state law which said that all checks from a municipal hospital must be signed by the mayor and the city clerk of the municipality. Since these officials are part-time in Long Prairie, they are not readily available to sign the checks.

The administrator complained that the Department of Health is enforcing the federal standards for boarding care homes, but that the Department of Welfare will not pay for the increase in standards since they are not absolutely required at this point.

2. MILACA AREA HOSPITAL VISIT - SEPTEMBER 24, 1974

VISITING TEAM & WHO THEY MET WITH

The visit was made by Senator Conzemius, Mrs. Mary Brenny, Dwight Smith and Diana Thomas. The team met with the administrator, Mr. J. Kermit Lundgren, and his assistant, Mr. Glen G. Erickson. Also present during the morning session were two board members, Mr. Donald Christensen and Mr. Albert DeVries; and Dr. Keith, chief of staff, and Dr. Schroeckenstein, the family practice intern from the University who had just joined the staff.

HOSPITAL GOVERNANCE, BACKGROUND AND SERVICE AREA

The Milaca Area Hospital District consists of four villages and six townships. The hospital board of directors is composed of eleven members. One director is elected from each township and village and one director at large.

A recent expansion project was completed in 1972, bringing the bed capacity from 30 to 45. Milaca Area Hospital opened in November of 1966 and was licensed for 25 beds at that time. In the early 70's their occupancy rate climbed to 103%. Since their expansion of 45 beds their occupancy rate has fallen to approximately 80% for the current year. Construction for the expansion partially was funded by Hill-Burton in the amount of $103,810 which was 25% of the total cost (.245 thousand). The hospital has also added a two bed coronary care unit which is equipped with monitoring devices of the latest design. The need for this unit was determined due to having several patients that could not be transferred any great distance in their condition. Doctors also felt that they could better treat their patients and follow up on their care if they were able to admit patients suffering from these conditions to the hospital where they are on the staff. The percentage of utilization for this unit is low.

There is some concern among board members that the hospital's occupancy rate has fallen and they want to see Milaca retain as many patients as it possibly can. While transfers are recognized as a need in certain cases where risks of treatment could be reduced, the board desires that transfers be kept at a minimum. At present they transfer a number of patients per year. These transfers include patients moved

to nursing homes as well as those transferred to other hospitals. The majority of patients transferred to other hospitals are those requiring complicated major surgery and those requiring extensive orthapedic and neurologic care following major accidents. Some of those transferred to nursing homes are stroke victims.

The Milaca Area Hospital had 3,500 outpatient visits during the last year. This required adding a space for an examining room in the new wing of the hospital. The hospital could use more space in the lab because it was originally designed for a 25 bed hospital.

FINANCIAL & ECONOMIC SITUATION

Several hospitals in central Minnesota planning area have joined together and formed a bidding group for purposes of purchasing from area supply houses. We were given a list comparing supply cost increases from 1969 to 1974. Even in items that have been group bid, there has been a substantial increase. Examples are bassinet linen in 1969 - $14.30 a carton; 1974 - $20.35 a carton. The most dramatic cost increase from 1969 to 1974 has been in the area of fuel oil which has gone from 10.7¢ a gallon to 30.8¢ a gallon.

The decrease in percent of total expenses attributed to personnel is a reflection of the expansion, and it is expected to climb again. The employees are not unionized at the hospital, but the administrator feels that there is definitely an effect from the Twin City area for setting the pace for nursing compensation.

The Milaca Area Hospital is on a 95% reimbursement rate for Blue Cross claims. For Medicare, there interim payment rate is 85% of charges. From 40-45% of their patient days are under Medicare. This is a reflection of the higher average age in the area, 15% of the population is age 65 or over.

The allowance for bad debts is 2.5%.

MANAGEMENT AND ACCOUNTING

The hospital has an annual budget and has semi-annual audit reports and seems to keep abreast of how costs are going, related to their budget expectations, and they have a chance to make intermediate adjustments. The board is also constantly concerned about costs and utilization and asks serious questions in terms of adding services and of radiologist

costs and the like. They have been studying costs of radiologist service. In one instance they discovered a particular procedure which is costing $42.25 (40% of which went to the radiologist), it was noted that $9.18 of this procedural cost was for a special solution which the patient had to take for the x-ray. Now they have changed their procedure to charge this $9 to supply and the radiologist will only get 40% of the remaining dollars.

In October the hospital is starting a cost monitoring system to accompany inventory orders. They have studied the use of business machines to do some of the accounting, but have found no system that would be of real benefit for the amount of the investment. They will continue to hand post their accounts even though this takes many man-hours.

The hospital staff has also found that they could experience a savings on oxygen by using liquid oxygen rather than the tank supply system and have worked out a leasing agreement for the liquid oxygen tank with the supplier.

MEDICAL STAFF

The medical staff director, Dr. Keith, is a family practitioner, as are the other 3 doctors on the staff. Three practice in the same group. There are two physicians on courtesy staff who also have admitting privileges.

Dr. Keith is pleased about the family practice intern who recently joined his group. The intern will also be doing clinical work at the hospital.

Dr. Keith is concerned with the increase in paperwork that he has had since the onset of Medicare. He stated that he has added three full-time bookkeepers. He also complained about the Department of Public Welfare billing form which he called "an atrocious form". He feels that the impending monthly issue of Medicaid ID cards is also going to be a problem and this action does not seem to be consistent with cost consciousness.

SPECIALIST

The source for specialists on a counsulting basis is generally St. Cloud or Little Falls. There is an anesthesiologist from the Twin City area available for consulting purposes. They have a nurse anesthetist on staff who gives 24-hour coverage and seldom needs to consult with an anesthesiologist (in cases that are unusually complicated the

patient is usually transferred).

The doctors on the staff participate in a monthly meeting with the pathologist to review slides of cases in a continuing education effort.

The radiologist is available 3 times a week to do readings; he also works at the Mora and Princeton hospitals. He receives 40% of the gross departmental revenues as his fee.

The average bill from x-ray per patient day is $5.17. The average number of x-rays done per day is 16.

NURSING STAFF AND OTHER PERSONNEL

There is a total of 106 people on the payroll at the hospital, with 70 full-time equivalent employees. Blue Cross contracts with the hospital to do the hospital's payroll. They have 12.2 full-time equivalent nurses, 8.4 full-time equivalent LPNs, and 20 FTE aides. There is concern about the high turnover in aides, although 3 have recently gone for training in LPN programs. There is a higher turnover rate yearly in aides and other personnel. Mr. Lundgren explained that the turnover costs show up in the cost of the 3 week training needed for new people. He is quite concerned about the part-time commitment of nurses and aides. He feels that all too often these people are not willing to come in on call. The current policy for technicians is to give a compensatory fee for being near the telephone and available if needed. They are paid a time and one half fee when they come in if it puts them in excess of 8 hours a day. Mr. Lundgren noted that we must remember that hospitals are people-oriented and people-intensive in service. This will never change. This means that as a labor intensive industry, hospitals will not be as highly productive as other industries, or show as many ways of increasing productivity.

The hospital felt that they could do a better job with staff if a RN program were available for the housewife returning to the nursing market. These women would be more stable and willing to stay in the community for the next 20 or 35 years. However, currently they have difficulty passing the exams and getting accepted into the programs.

The hospital has an affiliation with the St. Cloud nursing school through which they have 6 students for 8 weeks during a year of their training. There is also a program where LPNs can enter in their sophomore year at the nursing school.

There are 2 medical technologists (ASCP), 2 part time ASCP certified lab assistants, 2 radiologic technologists (ARRT),

one part time radiologic assistant and one full-time nurse anesthetist (CRNA).

The office staff includes a full-time accounts payable, full-time accounts receivable, full-time insurance and payroll, full-time receptionist on daily charges, one half-time outpatient billing worker, two part-time night receptionists, for a total of 4 full-time and 3 part-time office staff.

Housekeeping has one full-time janitor. Engineering has one full-time engineer. Dietary has one full-time dietary supervisor, a full-time cook, two part-time cooks, two part-time dietary aides, two part-time students and one part-time delivery aide. The laundry has a full-time laundry supervisor, a full-time laundry aide and two part-time laundry aides.

One thing that was stressed was that the atmosphere and service in the hospital was good because of the closeness of the community and that extra effort was made on the part of the personnel to do a good job.

SPECIAL FACILITIES

A mobile EKG unit from which the readings are transferred to Chicago with analysis feedback relayed within two minutes has been leased by the hospital. Also, with the installation of the coronary care unit, the nursing director spent four weeks in a special course on administration of the equipment.

HILL BURTON

For Hill-Burton agreement compliance, the hospital policy is not to deny anyone service. They budget a certain amount which will either be for bad debts or uncollectible accounts. Every effort is made by the assistant administrator to urge people to apply for social services they may be eligible for. He also makes the determination of a family's ability to pay in cases that arise. These accounts are then added as the Hill-Burton portion of the estimate of bills that will not be collected. There is no double counting of Hill-Burton compliance and bad debts.

CONCERNS & SUGGESTIONS

There is some concern about the unemployment compensation coverage for their hospital in that as of January 1, 1974, new

legislation required governmental agencies to pay unemployment compensation. The staff offered to check into this matter. (Memo sent.)

Mr. Lundgren brought up the fact that there are about ten surveys that they are subjected to at different time intervals. Last week they had the intermediary audit for Blue Cross for three days and the State Department of Health utilization review and provider information review which is also once a year. Others include fire inspection once a year, Blue Cross quarterly, the Planning Council for EMS once a year, or a special service needed, the state boiler inspection is twice a year, the St. Paul fire insurance safety inspection once a year, the state sanitation annually, and the State Department of Health ambulance licensure. There is a concern for constantly being monitored and visited or responding to questionnaires. Senator Conzemius assured Mr. Lundgren that we understood the problem and that Senator Lewis was working on some legislation for uniform accounting and reporting systems which should reduce the necessity of reproducing the same information for state departments and agencies.

Another major concern at Milaca Hospital is ambulance personnel training. They feel that the increase in number of hours to 81 recommended by the State Health Department would overly burden their volunteers and also cause a cost increase. Presently they have 9 volunteers, all on a part-time basis, who have undergone about 40 hours of ambulance training. We said we would look into the difference between a rural and an urban service. We promised to look at North Memorial and Divine Redeemer in the city to compare the costs of ambulance service. There was a 50% matching fund in a federal fund for purchasing of the ambulance. The area originally had 2 ambulance services run by funeral homes and they currently have 4. The present cost per run is $30 for a local service and 60¢ per loaded mile for long distance. It is felt that the service does not completely pay for itself. The ambulance makes 250 runs annually. Mr. Smith pointed out that the losses on the operation were not substantial. There is also a concern over regionalization of emergency medical services. Physicians are concerned that they would lose control of their patients because they would be taken to distant hospitals.

There is a similar concern about nursing home beds. Currently Milaca is in need of nursing home beds. Mr. Erickson stated that he found it difficult to ask people to go to distant homes where they have no relatives and they also object to not having their own doctor.

Mr. Lundgren felt that HMOs are not the answer for areas where people have not had access to health care over a period of time. It would be costly to bring everyone up to a certain standard of care initially.

APPENDIX E

3. NORTH MEMORIAL HOSPITAL VISIT, SEPTEMBER 25, 1974

VISITING TEAM AND WHO THEY MET WITH

North Memorial Medical Center is owned by a non-profit corporation and is a short-term general medical and surgical hospital. The visit was made by Senators Lewis and Kowalczyk, Dwight Smith, Mary Breeny and Diana Thomas. We were received by the President, Mr. Vance DeMong, and also conferred with Mr. John Dyke, his financial assistant. Mr. Wesley Simmons, the controller, later joined our discussion. During the lunch hour Mr. Frank Griswold, Chairman of the Board, was in attendance; also with us during the entire visit was Miss Froemming, the Director of Nursing.

AREA HOSPITAL GOVERNANCE, BACKGROUND AND SERVICE

Mr. DeMong came to North Memorial in 1954 when it was a 30 bed hospital and has been with them through their growth to the present 546 beds (they added their last beds in 1970). He suggested that regionalization might be the next stage. North Memorial, Hennepin County General and Fairview Hospitals are all serving the patients in the North Minneapolis area. North Memorial has never received any Hill-Burton funds. Mr. DeMong described his position as a liaison between the board of directors and the administration; however, much of the day to day operation and financial matters are handled by the controller's office and Mr. Scott Anderson, the administrator. The hospital is incorporated and has recently changed its name to North Memorial Medical Center.

Mr. DeMong stated that the short length of stay (6 days) is a reflection of the young age population served in the area. These people tend to be younger and heal faster.

The emergency room has 40,000 visits per year. Thirty percent of their visits become in-patients at the hospital. North Memorial has their own ambulance service. Later on the tour the team was shown one of the ambulances. They have two ambulances stationed at the hospital and two stationed at other sites. The paramedics assigned to the ambulances are trained the 81 hours required by the State plus 20 hours of instruction by the hospital coronary care nurse director.

This extra training allows them to use the defibulator at the doctor's orders. They also administer drugs. They have the latest telemetric equipment and a physician is on duty in the ER at all times. They also have a triage person on duty in the ER.

The operating room is used 6 days a week, about 12 hours during week days, and 4-5 hours on Saturday. This is for elective surgery. There are no time constraints on emergency use.

The Health Department sits in on one of their Utilization Review committee meetings. There is a peer review committee, an audit committee and the professional department review committee.

The Oakdale Medical Building was opened in about the year 1970. That building is owned and operated by the hospital and space is leased to the doctors. They also own the attached parking garage. The clinic at Lyndale and Broadway is set up for the family practice residents from the University of Minnesota and is also owned by North Memorial.

April is the annual meeting of the board. This is the meeting where elections are held; otherwise they meet monthly. They have a seventeen member self perpetuating board. The medical staff is required to have one member on the board, and this is usually the chief of staff. He serves for a two year period. (They have several standing committees, including: finance, credentialing and the executive committee.) The board is heavily industrial owner oriented.

MANAGEMENT AND ACCOUNTING

There are administrative staff meetings every week; on alternate weeks the meetings are to discuss new ideas, problems and trends in health care. The other alternate week is concerned with financial matters and the group would be made up of Anderson, Dyke, and Simmons. During this inflationary period they are trying to buy fewer materials.

Currently they have many automated systems and they have NCR computers. Reports are made for department heads and reviewed with Mr. Simmons monthly. They are buying the equipment and have had no problem in programming with the assistance of NCR. Approximately 10% of operating revenues are generated from the outpatient department.

EDUCATIONAL PROGRAMS

North Memorial is affiliated with the University of Minnesota Medical School. They have extensive educational programs going

on in 18 different programs with 16 in the family practice program. The costs for these programs total $441,731 including direct and indirect expenses. Mr. DeMong feels that hospitals must stay involved in teaching if they are going to survive in the future.

MEDICAL STAFF AND SPECIALISTS

There are 257 doctors and 25-30 dentists with admitting privileges. Admission to the medical staff is made by application. It is reviewed by the medical staff credentialing committee who gather data and recommendations and vote on admittance to the staff. The board of directors okays the recommendations made by the medical staff.

The hospital is served by a group of six radiologists who bill patients directly for their services. Every patient admitted must have a chest x-ray. This is recommended by the medical staff so that doctors can become aware of any respiratory problems before surgical procedures. There are approximately 200 x-rays per day administered including outpatient and in-patient services. The five pathologists work full time at North Memorial. A combined bill is issued and the pathologist receives 17% of the gross departmental revenues.

The group of five anesthesiologists that serves the hospital bills the patient directly.

NURSING AND STAFF AND OTHER PERSONNEL

The hospital has no nurse clinicians and 50% of their RNs are part-time. They employ approximately 300 RNs, 200 LPNs and 100 aides. After the wage-price freeze the hospital hired 60-80 people. The hospital has a volunteer component made up of 200 pink ladies (women auxiliaries) and 150 candy stripers.

SERVICES AND FACILITIES

There is a home health care service which is rendered on a physician's order; the fee for this service is $35 per visit. Medicare clients are covered by this.

The hospital shares neurological services with Golden Valley Neurological Center.

North Memorial also has a heliport right outside the emergency room. This was originally developed with federal incentives

provided through project HASTE. The heliport is currently supported by the Medical Center.

The hospital has a special system for plant engineering which permits the chief engineer to monitor all plant systems throughout the hospital. If there is a breakdown the machine prints out the location of the problem. The machine also has push button display of various mechanical systems.

FREE CARE

Since the hospital receives no Hill-Burton funds they have no obligations to free care; however, they do provide free care clinics in a high rise building in their service area. It was noted by Mr. Smith that free care in such instances is a revenue deduction.

The hospital writes off only 1.35% of their revenues to bad debts. Pre-admission financial screening is done. However, they assured us that no one is turned down if they require service and they do not have any insurance coverage. Mr. DeMong stated that a pre-admission deposit is never required. Approximately 12% of the total patient service is delivered to welfare recipients. The percentage of patients covered under various third party policies is as follows: Medicare, 24%; Medicaid, 7%; Blue Cross, 17%; Commercial, 42%; private pay, 10%.

CONCERNS AND SUGGESTIONS

Mr. DeMong expressed concern about the present certificate of need procedure. He feels that a $100,000 threshhold is better for the urban hospital. They have had some problems with the long process involved. They are trying to expand a laboratory room area and have found that they have to begin the process over again which means going through the Metro Council, etc. They believe there needs to be legislation for agency coordination in inspections and certificate of need operations. It was also felt that certificate of need must be tied to quality of care as well as numbers and multiplicities of agencies and committees. Mr. DeMong also suggested that the approach to incentive reimbursements be reviewed.

Mr. DeMong is president of the Metropolitan Ambulance Association and also serves on the EMS committee of the State Board of Health. He feels that one service for emergency is better than having everyone trying to be in the business. They always have an emergency room triage person serving in their ER area.

Mr. Griswold expressed concern about recent increases in prices in all area of supplies and services. He stated that the companies they are dealing with are raising their prices because they are afraid of a price freeze and they would like to be caught at a more comfortable level. For example, paint and chemicals are items that have increased sharply. Last year they sank an extra oil tank so they would have gas for their ambulances and have room for storage of purchases at lower rates.

APPENDIX E

4. MIDWAY HOSPITAL VISIT - SEPTEMBER 26, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team members included Senator Milton, John Turner, Dwight Smith, and Diana Thomas. The visit consisted of a schedule of meetings with various department heads and managers throughout the hospital system. Mr. L. Melvin Conley is the administrator of Midway Hospital and Mr. Larry Johnson is the assistant administrator. We also met with Dr. Frye, radiologist and the chief of the medical staff. Mr. Harry Atwood, a board member, joined us at noon.

HOSPITAL BACKGROUND, GOVERNANCE AND SERVICE AREA

Midway Hospital was established in 1920 by the Northwestern Baptist Hospital Association which later became the Baptist Hospital Fund. In 1907, the Mounds Park Sanitorium was established by the same group. The Baptist Hospital Fund also established the Mounds-Midway School of Nursing - a three year diploma program. They have been on the present site since 1926. (1920-1926 located at 389 North Snelling Avenue.)

The hospital has a self-perpetuating board of directors. The board meets quarterly and it has 22 members. The executive committee meets once a month. The board, executive committee and some administrative and fiscal services are provided jointly for Midway and Mounds Park; Gordon Smith is their director of education and development.

Midway has 333 beds with an occupancy rate of 86.3%. The hospital feels they are operating close to capacity. In 1970 they opened 52 additional beds. They have shelled-in space for 100 more beds but the hospital does not have planning council approval to complete and open them.

A patient origin study has revealed that Roseville, Como, Hamline, Midway, Highland, St. Anthony Village and Downtown St. Paul are the main areas that they serve.

The length of stay for certain types of orthopedic surgery is generally 22 days, much longer than for many other surgical procedures. There are a number of total hip operations done

at Midway as the hospital has a wide reputation for this procedure. Both factors contribute to their overall longer average length of stay.

St. Joseph's is the next most active hospital in the area for orthopedic surgery. Samaritan Hospital is used by some members of the medical staff when Midway is full or they cannot obtain an operating room time at Midway.

The operating rooms are used from 7:00 AM to 5:30 PM. An emergency operating room schedule is followed on Saturday. The director of nursing has a good system for reviewing use of operating rooms. By keeping constant records they are able to note the trends and to pick up problems or changes that might be made. Some doctors operate on an alternate day schedule of OR service and office service.

Utilization review procedures were presented by the medical records director. Midway Hospital has been using guidelines for utilization review for all of their inpatients, not just for their Medicare patients. They utilize PAS (Professional Administrative Services - AHA) percentile data for the length of stay. Patient records are flagged on the recommended length and a member of the utilization review committee checks these records and finds out from the doctors if there are any complications or extenuating circumstances necessitating a patient stay longer than the recommended time. Their cutoff is the 75th percentile base. They find that this has an overall effect of decreasing their length of stay by one day. They are reviewing approximately 18% of all patients which means that most patients are being discharged before their review day comes up. There are nine members on the utilization review committee and this program has been operating for one and a half years.

The hospital has 20 pediatric beds which are only used approximately 56%, but they wish to maintain their pediatric beds for the physicians in family practice who have privileges at Midway and would like to treat their general pediatric cases which do not need to be transferred to Children's Hospital where they cannot be on the staff.

There are 24 OB beds and the hospital is one of the busiest OB facilities in St. Paul. (1300 deliveries in 1973 - estimated 1500 in 1974.) Midway is one of a few St. Paul hospitals coming close to meeting the Metro Health Board guidelines of 1500 births per year.

FINANCIAL AND ECONOMIC SITUATION

Midway is presently on a 90% preliminary reimbursement rate with Blue Cross. For Medicare they are on a 87%. There is

consistent lag in the auditing and adjustments of the reimbursement rates from Medicare. The 1972 audit was done in July of 1974 and the 1973 audit will not be done until 1975, approximately two years behind.

The hospital has only about 4% AFDC cases. The administration feels that this is low, but they do not feel it is inappropriate for the community. In 1973 Midway had 4200 AFDC patient days. Midway has no Hill-Burton loans. The percent of Blue Cross days was approximately 16.4, and Medicare days 39.2%. An estimated 5% of the patients have no third party payor coverage or Medicare. Their bad debt allowance is very low, .5% to .6%. Accounts receivable represent 58 days worth of billings.

Midway would like to expand their surgical suite and other ancillary services. The present dietary service area was originally built for 125 beds and is currently serving 333. Other ancillary services would also be inadequate if their bed capacity were to increase. The hospital feels that with the present utilization, more beds would be no problem to fill. Their current concern is that the loan rates for needed capital would increase patient fees by $1 to $2 per day.

There is much concern about the considerable increases in costs of needed supplies and services in the past year. For example, there has been a 35% increase in electric rates and natural gas rates and an increase in sewer rates. Fuel has increased from .1150¢ a gallon in April, 1973, to .2350¢ a gallon in February, 1974. In August, 1974, it was up to .3250¢ a gallon and is expected to have increased further the next time the hospital must purchase. X-ray film is up 30%, but Mr. Gene Cooper, the new department head in x-ray, has cut costs and losses by reducing waste of film. The hospital has an x-ray silver reclamation program from which they make about $600 a month. They also sell scrap film. Midway Hospital has received a considerable number of notices of increases in the prices from drug companies in the past year. They have had notices from the same drug companies on the same drugs which have increased prices twice within three months. The budget allowed for a 6% annual inflation but the pharmacy is losing money because the drug inflation rate has been greater than 6%.

MANAGEMENT AND ACCOUNTING

The hospital has a cost center accounting system on a department basis. There are some occasional problems with charges. In some departments it is hard to set costs and charges because of utilization. For example, OB charges have in the past often been less than cost. Mr. Johnson stated that one reason for this was that the hospital felt there was a social obligation being met by keeping these charges low.

The hospital is very aware of budgeting and do a budget variance analysis by department monthly. Their productivity index is compared with HAS system reports which come out regularly. In equipment review, their criteria for evaluating a need is "does it serve a useful function for the patient?".

Midway is a member of a 7 hospital purchasing group (others in this group include Methodist, Mt. Sinai and Waconia) which makes joint bids for medical supplies.

Midway also belongs to a joint drug purchasing group. The computer base for these services is at Mt. Sinai. Through this group generic equivalent substitutes of drugs are ordered, and they have obtained lower rates. The drugs are drop shipped so there is no tie up in warehousing. The group also does competitive bidding on food and staple items. They are not getting a full response to their bids. For example, on a recent round of bidding for food staples and canned goods, only one out of five suppliers submitted a bid. There is presently a committee of hospitals in St. Paul evaluating the feasibility of a joint purchasing and warehousing program for St. Paul hospitals.

There has been staff reduction based on a study of services needed and usage. Mr. Johnson feels that some staff could be replaced with less skilled workers. For example, the pharmacy area is the highest paid professional group in the hospital and they are often counting and pouring. There is a divergence of opinion among the pharmacists on this point.

MEDICAL STAFF

The hospital has 180 attending physicians, approximately 80 of whom are members of the active staff.

A nearby orthopedic clinic located 1/2 block from the hospital is headed by Dr. F.S. Babb. This group of six orthopedic surgeons uses Midway's orthopedic services almost exclusively. Doctors in the group are well known and patients frequently come from out of state. They feel their physicians are loyal to the hospital and increasingly use it because of the good care, good facilities and support that is provided. There is convenient parking, and the hospital's location saves on travel time.

The hospital had a two year family practice program which was discontinued because of the difficulty of recruiting residents and the amount of time required of the medical staff in the teaching function.

SPECIALIST

Midway has 5 anesthesiologists who practice in a group. There are 11 full-time nurse anesthetists and 5 part-time nurse anesthetists. The physicians are responsible for their work; they have a professional fee and bill directly to the patient. The anesthesiologist must start all cases and monitor them through the procedure. They are responsible for saying when a patient can leave the post-operative area, and they are on call 24 hours a day.

The pathologist group contracts with the hospital for a percentage of the gross departmental revenues with a $150,000 minimum and a $165,000 maximum set. This is divided according to status in the group; the chief pathologist earning the most. There are 3 in the group.

The radiologists bill directly for services to Medicare patients and for special procedures. They have instituted a system where they bill on the basis of procedures according to the Relative Unit Value System developed by the Minnesota Radiological Society. It tends to stabilize the professional fee by making it independent of the hospital charge.

NURSING AND OTHER STAFF

The nursing situation has changed in the past 3 years. There once was an excess demand; now there are numerous applications each spring. The hospital is trying to obtain stable people. The breakdown on nursing turnover is: 23% for RNs, 31% for LPNs, and 52% for aides. The average RN gets $5.10 an hour, LPNs $3.89 an hour, nursing aides $3.00 an hour. The starting salary for RNs (2 or 3 year program) is $791 a month. An RN with 7 years experience gets $946 a month. Contracts in this area of the country were settled for around a 9% increase; on the East Coast it is about a 15% increase. The hospital does not have a contract with MNA. However, it pays nurses according to scales negotiated by MNA with hospitals which do have contracts.

Patients are classified according to their needs in terms of care. Studies have been done on utilization and nursing man-hours needed for various types of cases. The census is reviewed daily, and staffing is adjusted accordingly. All nursing employees have every other weekend off. The staff emphasized that part-time people fill a definite need and save them money.

As part of the position control procedures personnel watches over the number of hires to see if they are within the budget.

Whenever a requisition comes in it is checked against the budget for salaries in that department.

There are 595 full-time employees and 445 part-time employees (900 female employees and 140 male employees). There are 400 professional people (supervisors, department heads); 155 technical, including LPNs; 350 nonprofessional; and 135 clerical. The turnover of clerical workers is almost 45%. These individuals are frequently lost to physicians or industry which offers attractive surroundings for clerical people. The turnover rate in dietary is 61.4% and in housekeeping it is 56.7%.

A 7% a year increase was given for non-contract people since the Economic Stabilization Act has been lifted. Union Local 113 is active at Midway. The hospital's pharmacy, x-ray techs, and engineers are unionized. Union goals are wage rates comparable with industry. The hospital engineers recently signed a new contract which gives them $6.29 an hour. Their old rate was $5.04 an hour; they would like to have this raised to $7.25 an hour. There are 11 engineers employed by the hospital and this rate has meant a 30-40¢ per patient day increase in cost. The administration is concerned about the ripple effect because engineers are now being paid as much, if not more, than some department heads. This causes resentment, and others will want a comparable rate of wages among various groups in the hospital. There is a need to maintain the difference in rate.

The hospital has call arrangements in which a beeper system is used for certain highly specialized employees who are infrequently needed but when needed must be available. The beeper covers a 35 mile range and this saves paying restrictive on-call costs. They pay a flat fee of $50 for any procedure these technicians would come in for. This is worked out by agreement among the staff as to who would be available the coming weekend. They pay no premium pay for weekend work. There is a shift differential for PM work of 8-29¢ an hour.

SPECIAL EQUIPMENT AND FACILITIES

It is estimated that the life of a piece of radiology equipment is approximately 10 years. However, new laws often affect the useful life of equipment. For instance, there is a new federal law, effective 8-1-74, which changed the standards for radiation exposure levels. Frequently, equipment becomes technically obsolete in less than 10 years. They have 10 diagnostic x-ray rooms. The hospital spends approximately $12,000 a year on x-ray maintenance and repairs. It seems that the repair companies, even with contract agreements, charge a large fee; for example, $27 an hour for a repairman

plus travel time must be paid at $20 per hour plus the hospital must pay for parts. They have made an effort to have their Engineering Department do some repairs but many times this really is not possible because parts are very closely controlled by the companies. There are three main companies for x-ray equipment. Two are American - Picker and GE, and a German company, Siemens. The administration feels that foreign producers have offered better prices and that the American producers seem to have stopped making an effort to compete in the area of x-ray machinery. They do not feel that maintenance contracts would really work to their benefit more than does the present arrangement because these contracts only cover general service and many of the things that break down are not specifically covered. Film costs in 1973 were $84,000, a 21% increase. The hospital has saved money by standardizing the calibration of all x-ray machines so that there is an even quality control. They have assumed cleaning of the processing equipment which previously had been contracted out; this has reduced the maintenance expense.

Midway Hospital has a 9 bed ICU and an 8 bed CCU, 4 beds together in a CCU and 4 through telemetry. These units are opposite each other and there is some congestion in the area. All nurses in the CCU area receive a three week course in coronary care nursing before being assigned to the unit. All staff in ICU have received special training also.

CONCERNS AND SUGGESTIONS

In regard to safety inspections they feel that the hospital's insurance company has been very helpful in making suggestions for improving safety. In general the staff feels that hospital questionnaires, visitations and inspections have been good opportunities for them to get feedback on what they are doing well and what areas they might need to improve on.

Mr. Atwood, a member of the board, brought out the point that the hospital must remember that they function to serve the patient and not just the physicians.

In discussing the things the Legislature could do to improve health care, the hospital staff suggested that health education and more preventive care could prohibit health care costs from being incurred in the first place. Since smoking is so widely accepted as the major cause of several serious health problems, any action taken by the Legislature that would reduce the amount of smoking (through control of advertising, tax, etc.) would make a significant contribution to reducing the State's over-all health care expense. Expanded nutrition educational programs would also be a great benefit to the public. People need to be more responsible for their own health care.

APPENDIX E

5. SAMARITAN HOSPITAL VISIT, OCTOBER 1, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team consisted of Mr. Mike Ahern, Ms. Ellen Vollmers, Mr. Dwight Smith, Patrick Byrne and Larry Fredrickson. They met with Mr. Cliff Gorak, the Administrator; Mr. Richard Redner, the Controller; and Mr. Byron Epland, the Business Manager.

HOSPITAL BACKGROUND, GOVERNANCE AND SERVICE AREA

Mr. Gorak sketched the history of the hospital from its inception in 1923 as a member hospital of the Northern Pacific Railroad Benevolent Association. In the 1950's, the Association servered its bonds with all but three of the member hospitals - Missoula, Tacoma, and St. Paul (Samaritan). These remaining facilities are under the control of the parent board, the Health Services Association (HSA). This board meets quarterly and has permitted Mr. Gorak to begin selection of a local community board. This new 15 member board will be autonomous. HSA approval is needed for annual budgets and property mortgaging. Mr. Gorak stated that the local board will have consumer representatives and business leaders from the Twin Cities.

On January 1, 1974, a Health Maintenance Organization, Share, Inc., began operation in space allocated to it without rent by the hospital. The HMO has its own local board and is open to group memberships. At present, however, the HMO has only about 6,000 members, most of whom are from the Railroad Benevolent Association. Marketing of the HMO is currently progressing.

FINANCIAL AND ECONOMIC SITUATION

The hospital had experienced a sizable deficit under previous administrators, and Mr. Gorak has been appointed to give this problem his immediate attention. Cost savings were realized by management controls and reductions in staff and plant. Further, savings have been impeded by several factors:

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1. Samaritan is a 151 bed hospital and is currently operating at 65% occupancy, an increase of 4% from 1973.

2. Several key departments, notably surgery and the emergency room are operating at a deficit.

3. Previous expansions have left 55 beds idle while burdening the hospital with substantial debt retirement costs.

4. Over 50% of Samaritan's reimbursements come from Medicare. Likewise, the advanced average age of the patients reduces the number of surgical, laboratory radiological and special procedures performed. Thus, these potential sources of revenue are less than average.

5. Until recently, historical reimbursement generated a lag of up to 120 days for Medicare payments. This lag presented a critical cash flow problem to the hospital. Now the hospital utilizes the PIP system to keep reimbursement relatively current.

Medicare, Medicaid, and Blue Cross reimbursement rates are set prospectively. Title XVIII funds are under the PIP system, wherein Samaritan receives funds bi-monthly based upon recent estimates and settles surplus or loss at year's end. Although PIP has improved cash flow, days of revenue in accounts receivable now average 45-65 days.

Cash flow problems were compounded when vendors raised prices and demanded payment during Phase III of ESP. Despite relaxation of controls and hospital price increases, costs continue to soar. Recent heating oil and plastic supply increases were mentioned. The controller sited several other factors he felt were contributing to the cash flow problem: the necessity to buy or lease additional equipment; discounts given to third party payors; and long term financial obligations for which the hospital had difficulty in generating sufficient reserves.

Mr. Gorak made several documents available to the Committee, including the hospital's financial statement and a copy of the Hospital Administrative Service's monthly report. This latter document served to highlight his contention that Samaritan compared favorably with similarly situated hospitals in the area, the state, and the nation.

MANAGEMENT AND ACCOUNTING

The hospital uses an in house computer to prepare reports,

charges, and billings. They admitted that the system provides "too much information" and is underutilized despite time sharing with the two other hospitals in the Health Service Association. Time sharing agreements are being explored with Honeywell with eventual goals of reducing costs and expanding capability. Although current capability was acknowledged to be wasteful, future uses will emphasize function over quantity of information.

From 40-55% of the hospital's market is Medicare. Another 20% comes from the attached HMO. (This percentage may increase as the HMO more closely approximates an optimal membership of 15,000.) Many of the HMO members are actually recipients of Medicare because of the advancing median age of railroad workers. Only about 10% of Samaritan's income is Blue Cross and, consequently, negotiations regarding discount are impossible. Other third party payors, write-offs and out-of-pocket expenditures constitute the remaining sources of revenue.

Purchasing agreements with a 14-member hospital group and a combined collective bargaining service currently represent the extent of shared services. Samaritan had recently realized a cost savings by switching from a cooperative laundry to inplant facilities. Although several hospitals are in the vicinity, the medical staff and other external and internal pressures have restricted sharing. Samaritan is installing a laminar air flow room. This equipment, which is costly and widely demanded, is expected to bring increased utilization and added revenue for their O.R.

Samaritan Hospital does not use fund accounting as recommended by the American Hospital Association. Endowments, construction monies, and cash or other assets for special purposes are placed in general non-operating revenue and not endowment, construction, or special purpose funds respectively. The hospital does not feel that the lack of fund accounting is in any way detrimental.

Mr. Gorak has a strong preference for the Canadian system and the concept of indemnity per unit of service. The unit of service being defined as the patient-day.

Also being explored is an adoption of the AHA chart of accounts. Statutory requirements for universal standardization of hospital accounts would be helpful in the opinion of Samaritan's staff.

MEDICAL STAFF

Because of the presence of the HMO, as well as a small group of internists with offices in the complex, the situation is

relatively unique. The site visit team was given the impression that there was considerable staff friction because of these peculiarities. Although the HMO physicians are in the minority of the 132-member staff, their power transcends their number because of their cohesiveness and because of the substantial impact of their group on hospital admissions.

The traditionalism of the medical staff has slowed efforts to utilize a problem oriented medical record or to initiate an audit committee. Both of these quality assurance measures have been endorsed by the nursing staff.

SPECIALISTS (See Note, page 274)

Professional service costs have been increasing. The anesthesiologists is guaranteed $5,000 per month despite the employment of a full-time CRNA at $15,000 and a surgical schedule which averages only two or three cases daily. The radiologist and pathologist received sizeable fees from contracts based on percentages of gross departmental revenues.

Hospital staff could recall only two instances when the $5,000 minimum anesthesiology charge had been supplemented by non-direct patient revenue. According to the HAS report provided, anesthesiology represented an average of 1.4% of expenses and generated 2.7% of total revenue for the previous six months.

OTHER STAFF

Mr. Gorak expressed disappointment that physician extenders were not employed by the hospital despite an attempt made earlier in the year on behalf of nurse practitioners which was thwarted by the medical staff.

They do not have the traditionally overstaffed, yet chronically underutilized, delivery room. The lack of many duplicative and costly departments was mentioned in the course of the discussion. Although there had been little pressure to add programs, there was a pressure by the specialists and medical staff to purchase sophisticated technology, including x-ray equipment recently installed for $79,000.

Wage trends are decidely upward, but discussion of this point was restricted since negotiations are conducted by a hospital group, not Samaritan as a separate entity. Originally, however, because of its history, one of the three bargaining units is a railroad group.

Mr. Gorak mentioned physical therapists and nurse anesthetists as professional personnel whose demand exceeded supply.

HILL BURTON

Samaritan has received two Hill Burton building grants and has chosen the option of not denying admission to any person regardless of ability to pay. Pre-admission financial screening is used on all elective admissions, but service is not refused under emergency conditions. Approximately 7% of their patients are medically indigent.

CONCERNS & SUGGESTIONS

Insurance reform, uniform inspection, and welfare reform were areas of concern. The business manager was in favor of creating a system of specialization and categorization of hospitals. Accordingly, facilities would be allowed to develop particular areas of expertise, orthopedics in the case of Samaritan. Certain basic service like OR and emergency room would not be forced to remain open regardless of the compatability of these services with specialization and profitability.

Mr. Epland was strongly in favor of catastrophic insurance. Yet, at Samaritan only 1% of patients' bills (which average $1,413) necessitate out-of-pocket expenses over $150-200. The team was however, asked to be mindful that even that sum was a burden to older patients on fixed incomes. The business manager noted that because so much of their care is rehabilitative, extended length of stay (average 11 days vs. state average of 7) may transcend Medicare benefits.

For all third party reimbursements, a single form would be desirable. Most private companies accept the Minnesota standard claim form. Yet, federal employees, welfare recipients, Blue Cross, and Medicare still demand separate applications. These multiple forms require manual compilation and generate some staffing problems due to specializations.

Other difficulties have arisen from policies of the State of Minnesota. The requirement by the Welfare Department of proof that the consumer has paid the first $500 engenders a delay in filing claims which extends over months.

Approval of a new hospital for Dakota County will mean a loss of about 15 patients a month to Samaritan Hospital. These points were raised in emphasizing the importance of hospital inputs into decisions affecting the industry. Another concern is the unstopping parade of inspection teams. Samaritan Hospital officials were not alarmed particularly by the number, but rather by the lack of coordination. Safety inspections were singled out as differing vastly in the conditions they

required. Administration feels that certain critical areas like the elevators receive scant attention while inspectors devote more time to other areas of the plant. Further codification and uniformity of both requirements and reporting would be helpful.

The controller's primary concern was the need for other institutions and consumers to be aware of the special needs of the hospital industry. Efforts in education must seek to inform banks and others of their responsibility and importance to hospitals. At present, hospitals are forced to deal with distant banks with an understanding of hospital finance given the dearth of local expertise. Local banks are reluctant to help finance hospitals.

Note:

As a result of the Subcommittee's visit and in-depth attention to their problems with specialists' salaries, the hospital's pathologist and the anesthesiologist have both re-negotiated their contracts for lesser amounts. The pathologist settled for almost half of the previous fee, and the anesthesiologist dropped the $60,000 a year guarantee.

It is believed that they took this action due to discussions among other staff physicians after the public disclosure of their fees.

Mr. Gorak has expressed his appreciation for the Subcommittee's work and its benefits for Samaritan Hospital.

APPENDIX E

6. BEMIDJI HOSPITAL VISIT, OCTOBER 2, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team included Senator Lewis, Dianne Heins, Dwight Smith and Sandy Smith. They met with Mr. Leon Swanson, the administrator, the director of nursing and Lyle Caughey, a member of the board. Members of the medical staff had lunch with the team.

HOSPITAL BACKGROUND, GOVERNANCE AND SERVICE AREA

Bemidji is located in Beltrami County in north central Minnesota. It is a city of approximately 11,500 residents. It is the site of a state college, which causes a certain influx of population during the school year; in addition, the summer population swells due to the many tourists visiting nearby lakes and resorts. Although the resident population in the city is largely white, there is a large Native American population on the Red Lake Indian Reservation, which is located within the boundaries of Beltrami County.

The hospital is formally known as the Bemidji Hospital and Rest Home. Both facilities are housed on the same premises. They are owned and operated under the auspices of the North Central Minnesota Lutheran Hospital Association. This organization is loosely connected with the Lutheran Church. It has, however, no funds available for investment. The fifteen member board of the hospital is self-perpetuating. Two-thirds of the board members are Lutheran. The members appear to be representative of the more traditional elements in the city: legal, business, academic, mercantile, agricultural, etc. There are no medical vendors on the board, although the chief of staff of the hospital is encouraged to attend all board meetings.

FINANCIAL AND ECONOMIC SITUATION

The hospital has recently been notified by its insurance carrier, Argonaut Insurance Company, that its liability rates will be increased 113% next year. The administrator has no idea why the rates would go up, and is going to check with the carrier

to see if there has been some error. He told the team that rumors were about that major court settlements on the east coast against hospitals were going to be absorbed by mid-western hospitals, but he could not verify this rumor. In any case, the hospital's rates, barring any error, will go from $13,000 to $28,000, and the cost will be born by the consumer.

Daily rates are up, according to the administrator, for the following reasons:

a. New physicians (nine in four years) are offering more specialized services, and cases which would have been referred are now being treated at the hospital.

b. The nursing home continues to lose money, and the hospital must charge its private patients increased costs in order to make up the deficit.

c. The cost of supplies is increasing. Natural gas is up 85% and still rising. Medical and surgical supplies are up 50%. The hospital has no choice but to pass on the increases to the consumer.

There has been a big increase in the number of outpatients undergoing surgery. The increase has not really affected the inpatient occupancy rate, although the administrator did believe the inpatient rate was increasing more slowly as a result of the increased outpatient surgery. Only very minor surgery was performed on an outpatient basis, because of the great distances (up to 100 miles) some of the patients must travel. The hospital administrator reported no problems in obtaining third party reimbursement for outpatient surgery.

Mr. Swanson offered an illustration to the committee of the effect of cost/reimbursement assuming a financial need for a 4% net on total business, which was the basis for the chart appearing earlier in the report (Table 8, page 43) which discussed the varying reimbursement rates in Hospital Finances Section.

MANAGEMENT AND ACCOUNTING

The hospital purchases everything except food and drugs through the Fairview Hospitals group purchasing and warehousing plan. Drugs are purchased directly from the manufacturers on a bid from Fairview, enabling a 15 to 30 percent saving on most items. The savings effected through the joint purchase of IVs alone, $17,000, is sufficient to cover the costs of joining the group. The savings are passed on to the consumer.

The hospital has also moved to a unit dose drug dispensal system at a cost of $1,000. The administrator believes that savings will be effected because patients will be billed only for the drugs they use; nurses will not have to spend as much time performing bookkeeping chores; medication errors will be easily traced; time will be saved; and a smaller inventory may be maintained.

In the nursing home, both the old system and the new system must be maintained in order to offer medical assistance patients a free choice of vendor. The administration feels this federal regulation is in direct conflict with the "prudent buyer" theory of reimbursement, since a prudent buyer would normally choose a lower priced drug (the hospital's) and hence the hospital may not be fully reimbursed for those drugs purchased elsewhere.

MEDICAL STAFF

There are twenty-five physicians on the hospital staff. There are two solo practitioners in the city, and four from neighboring towns. The remaining physicians are apparently in a group practice, which operates a clinic in the city. Most specialties are represented, with the exception of pediatrics, ENT, physchiatry, orthopedic surgery, and anesthesiology.

Although none of the board members are physicians, it would appear that the medical staff has a significant role in the administration of the hospital. Two recent incidents related to the visiting team seemed to indicate a certain amount of conflict exists between the board and the medical staff. First, the hospital has recently spent $175,000 for new radiology equipment and remodeling to house the equipment. The expenditure was apparently made at the urging of the radiologist. The new service can be expected to bring in an estimated 10% increase in revenues to the department. The hospital eventually was able to obtain financing for the project, but only with difficulty. Shortly after, there was intense pressure from the medical staff to purchase a scanner, but before the issue came to a head, the radiologist purchased a scanner in a van, and he will now sell the services of his equipment to the hospital.

In relating these stories, the administrator indicated that he believed some of the staff were oblivious to the problem of high costs when it came to the purchase of new equipment. Other administrative problems, such as lack of space, lack of funds, etc. were also of no apparent interest to some of the medical staff.

SPECIALIST

Radiologist: A radiologist has a contract with the hospital under which he spends three full days, two half days, and some weekends at Bemidji. He also has contracts with two other hospitals for his remaining work days. He rents "some office space", which turned out to be a modest working office; and he receives $500 per year for supervision of the x-ray department. The patients are billed directly for his services from his billing office in the city. The hospital bills patients for the services of the technicians, supplies, and the use of hospital equipment. This arrangement has been in effect for about fifteen months. In the previous arrangement, which was evidently unsatisfactory, a St. Paul radiologist was given 30% of the department revenues for one day a week of consultation.

Pathologist: The hospital has a contract with a full-time pathologist. He receives 20% of the adjusted gross of the department. The adjustment is contractual one on the medical assistance bills of 7.8%. In addition, he receives $50 per month from each of five surrounding hospitals for which Bemidji does lab work. His estimated income for 1974, the first year of this arrangement, is between $50,000 and $60,000.

Under the old arrangement (which was terminated six months ago), the pathologist received 20% of the gross for Bemidji Hospital lab work, and 80% of the gross for the work of the five other hospitals. This last provision caused the hospital to lose money. The pathologist's fees for the last year in which the old arrangement was in effect were $76,250. Thus, a 15%-22% reduction was negotiated six months ago.

The pathologist has been employed since 1968 and is credited with introducing sufficient new procedures to boost his income from $20,000 (1968) to $76,250 (1973).

Anesthesiologist: The hospital has no professional contracts for this service. There are three nurse-anesthetists employed by the hospital.

NURSING STAFF AND OTHER PERSONNEL

The hospital now employs 57 nurses (28 full-time and 29 part-time), for a full time equivalent of 42 nurses. The nurses are unionized.

The director of nursing has had great difficulty in obtaining and retaining nurses, especially during the summer months, which are the busy season for the hospital. A significant

percentage of the nursing staff are wives of students and they leave during the summer vacation. Other reasons which were cited for the difficulty in recruiting nurses were: the lack of employment opportunities for spouses; the low pay (if compared to that offered in the metropolitan area; but when compared to the regional average, Bemidji was about equal to most hospitals); and the lack of training for older nurses wishing to re-enter the employment market. The director of nursing made several efforts to attract the personnel she desired, including recruiting at secondary schools and offering free travel and lodging for the summer. However she was still unable to attract the personnel she desired. Administrative nursing jobs are also hard to fill.

The hospital does not use physician extenders (with the exception of three nurse anesthetists) because of the uncertainty of the issue of legal liability.

The recruitment of LPNs is slightly better, but the director of nursing feels that the scope of their practice is too limited to make up for the problems caused by a shortage of RNs.

Other personnel employed include: 16 technicians (assorted), 13 housekeeping, 23 FTEs in dietary, 2 in laundry (but laundry is sent out at 9 cents a pound), and 6 in maintenance.

THE CONVALESCENT AND NURSING CARE UNIT

The nursing home has been in operation nine years. During that period the facility has lost $249,000. The administrator estimates that current losses in the intermediate care sections of the unit average $4.00 per patient per day. DPW Rule 49, under which the reimbursement rates for medical assistance patients are calculated, puts a regional ceiling on the rates. The Bemidji C & NC unit is always above regional ceiling. The high cost in the Bemidji unit are explained as the result of the extra rehabilitation programs carried on there which are not provided elsewhere; and as the result of DPW's averaging freestanding homes with integrated units, which results in a skewed allocation of costs for the latter.

Nursing and administrative positions were very hard to fill in the nursing home unit. The director of nursing attributes the difficulty to the mass of conflicting federal and state rules and regulations which must be mastered in order to do an efficient job in the unit. She also indicated that an attempt to begin a geriatric nurse associate program in the home failed when none of the twenty-five hospital physicians would agree to accept a preceptor role for the program.

HILL BURTON

The hospital does have Hill Burton funds, but does not have a plan for free care. The hospital is waiting, the administrator said, for the Department of Health to promulgate guidelines, regulations, etc. Until then, the hospital will continue its present policy, which is not to turn any individual away, but also to attempt collection of the bill. The hospital does have a requirement that indigent patients apply for welfare.

Native American patients are admitted under the same conditions as all other patients. The hospital does have a contract with the two federal public health service hospitals in the area which obtensibly serve the Native American community. The contract calls for the referral of special cases (requiring surgery or other specialized care) to the Bemidji Hospital. Collection of the bills in these cases is made through the United States Public Health Service.

CONCERNS AND SUGGESTIONS

The hospital apparently has had a very unpleasant experience with the certificate of need process. There was some error in the notice of the public hearing, which then had to be held twice, and the resulting delay caused a three or four month wait for the installation of the new radiology equipment. The hospital administrator expressed concern that certificate of need will duplicate efforts under SS 1122. In addition, concern was expressed by the administrator and the medical staff over the fact that the certificate of need legislation only addressed the issue of quantity, not quality; and that the $50,000 limit was much too low in this era of expensive medical equipment.

The members of the visiting team were told by several of the members of the medical staff that there was strong opposition to increased governmental activity in the regulation of health care, particularly in the area of rate regulation.

APPENDIX E

7. CALEDONIA COMMUNITY HOSPITAL VISIT - OCTOBER 3, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team included Senator William Kirchner, Dwight Smith, and Michael Ahern, Administrative Assistant to the Senate Health, Welfare and Corrections Committee. They met with Hollis Onsgard, the administrator, Dr. Poston, the chief of the medical staff, and Mrs. McCarthy, chief of nursing.

HOSPITAL BACKGROUND, GOVERNANCE AND SERVICE AREA

The Community Hospital is actually a part of a complex that includes 35 I.C.F.-1 nursing home beds, located in a three story building that was originally constructed in 1918. In addition, there are approximately 13 CNC skilled nursing care beds occupying a 1972 addition to the complex. The actual hospital operation is housed in this building also, consisting of 13 licensed, acute care beds. Mr. Onsgard explained that in April of 1973 an addition to the present structure collapsed. It contained 19 acute hospital beds. No injuries occurred in that collapse; however, the hospital and nursing home have become cramped for space with the administrative offices being located in the former lobby of the hospital.

Presently a certificate of need application is before the State Board of Health to construct a facility containing 70 long-term skilled nursing home beds and 23 licensed acute beds (an addition of 10 to the present complement. They would re-designate the 30 ICF-1 beds to board and care. The State Board of Health will act on this application at its October meeting. (Certificate of Need was granted for 70 CNC new beds and reclassification of existing CNC beds.)

The hospital and nursing facility are owned by the village of Caledonia and are leased and operated by the Caledonia Hospital Association. The arrangement with the city calls for rent payment of $2,000 in addition to a $1,000 payment to retire a debt owed the city due to a nursing home addition.

Mr. Onsgard indicated that over the summer months the hospital conducts a considerable amount of deficit spending, estimating that in the last three months $25,000 was lost in the hospital's operation. This has been due to a low occupancy rate.

The hospital usage does increase during the winter months, with an average of about 50%. Approximately 50-60% of the nursing home patients are on Medicaid at Caledonia, and Mr. Onsgard indicated there was not a major problem with the Rule 49 reimbursement on medical assistance - it being only thirty to forty cents a day less than Medicare reimbursement.

In discussing the availability of health care in the community, it was pointed out that the town currently has two doctors - Dr. L.M. Poston and Dr. H.J. Vernig. Each of these doctors operates out of his own separate clinic. It was pointed out that the location of Caledonia, only 20 minutes from LaCrosse medical facilities, was responsible for the lack of more extensive equipment since a number of the area residents receive all their health services in LaCrosse. The hospital does not have an intensive care unit or extensive monitoring equipment that usually accompanies this type of care.

FINANCIAL AND ECONOMIC SITUATION

The hospital is in a tight cash problem and faces serious problems of meeting its monthly obligations. There is also a question of the source of funds needed to pay for the proposed facility, although a $1.2 million dollar bond issue was passed by the City of Caledonia. These expenses would have to be recouped by increased rent payments by the Hospital Association. The hospital is already in arrears in rental payments to the city. The expenses of reinforcing the existing buildings subsequent to the collapse of the east wing of the hospital is another debt owed the city by the Caledonia Hospital Association.

It was pointed out that the emergency room and x-ray laboratory are the major money-makers for the hospital, and it is hoped that the utilization of these facilities will increase in the future. It is contemplated that, in conjunction with the nursing home and hospital addition to the complex, a clinic for the town's doctors will be constructed out of separate funds. An arrangement can be worked out for a shared utilization of the hospital's lab facilities.

The average daily service charge of the hospital was just recently raised to $45 a day. One factor given for this relatively low rate was the fact that the dietitian comes in once a month at an annual salary of $360 a year. According to Mr. Onsgard, this has been adequate for the needs of the facilities and saves the expense of a full-time dietitian.

MANAGEMENT

On the specific issue of cost savings, Mr. Onsgard stated that the hospital currently had no cost savings procedures such as joint purchasing agreements and knew of only one in the area. He expressed some doubt about it since the joint purchasing agreement was coordinated by a proprietary supply company. One area in which the hospital possibly could reduce cost to patients is in the provision of drugs. Presently, the local pharmacist comes in twice a day, and the drugs are supplied from the two drug stores in Caledonia.

MEDICAL STAFF

Dr. Poston expressed his feeling that the hospital, as it currently exists, serves the needs of Caledonia. He stated that although extensive surgery is not performed at the hospital, and expensive monitoring equipment is not available, the treatment of the hospital is sufficient for the vast majority of the needs of the community. He feels the treatment is personalized as well as competent for the type of care that is dispensed.

In discussing the availability of health care, he also indicated that there are not, in his opinion, many people who go without care unless they simply choose not to come in. He indicated that Rochester and LaCrosse are close enough and more than adequate to fill the needs of the residents with more serious problems. As an organizer of the local PSRO, he expressed hope that it may be the vehicle to convince doctors that small community hospitals like Caledonia do not all need expensive monitoring equipment such as coronary care units.

SPECIALISTS

Currently, the hospital is serviced by a radiologist on every Thursday. This radiologist operates out of Decorah, Iowa, and circulates to a number of hospitals in the northern Iowa-southern Minnesota area. His contract is for 40% of the gross revenues of the radiology department.

A pathologist visits the Caledonia hospital on the 2nd and 4th Wednesday of every month. He is part of a group practice called the Association of Laboratory Medicine operating out of the St. Francis Hospital at LaCrosse. He is retained by the payment of $200 a month plus the lab charges for work that cannot be performed in the pathology lab at Caledonia.

An anesthesiologist is employed on an hourly basis, and he bills the hospital directly for his services. No indication was given of the hourly fee. He comes from the St. Francis Hospital group practice.

NURSING STAFF AND OTHER PERSONNEL

The nursing services of the hospital and nursing home are staffed separately except at night when the nursing home shares an RN with the hospital. Mrs. McCarthy serves as a coordinator of both units. The housekeeping staffs are separate for the nursing home and the hospital, with the kitchen staff and dietitian being shared, along with the laundry and maintenance departments.

There are no union employees at the hospital, and the starting wage for three and four year RNs is $3.32 an hour. This wage rate is apparently made possible by the fact that 70 to 80% of the nurses on the staff work on a part-time basis (part-time being measured by working five days or less out of a ten day pay period). The hospital also has two lab technicians who handle pathology and radiology laboratory procedures. The hospital has 24 hour coverage from them. However, each is only paid for time actually spent at the hospital. They receive $2 an hour and $3.00 when called back. It was also brought out that with the minimum wage the hospital only raised the wages of those below the minimum, and all employees received a 10¢/hour across the board raise October 1, 1974.

HILL-BURTON

Caledonia has received Hill-Burton funds and has elected the option of not refusing care to any person based on his ability to pay. The recorded bad debt write-off was $2,500 for the previous year.

CONCERNS AND SUGGESTIONS

Both Dr. Poston and Mr. Onsgard expressed their misgivings over the number and uncoordinated nature of the inspections of the hospital and the nursing home. Mr. Onsgard noted that between 20 and 30 inspections are annually made of the facility. Dr. Poston stated that if the hospital were accredited by the Joint Commission on Hospital Accreditation, it might cut down somewhat on total number of inspections, but the Medicare, Health Department, Life Safety Code, and other inspections

would still continue. Both expressed the hope that these inspections might be coordinated at some time in the future.

Before leaving, the group met briefly with Mr. Arthur Miller, administrator of the Valley View Nursing Home in Spring Grove. Mr. Miller expressed his concern over the never-ending series of inspections and forms an administrator is expected to deal with. He cited the continuous revisions of the Fire Code as an example of his frustrations. Mr. Miller also noted the lack of consistent enforcement, in general, as another concern. A consolidation of inspections and a uniform reporting procedure was supported by Mr. Miller.

APPENDIX E

8. MURRAY COUNTY HOSPITAL VISIT, OCTOBER 4, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team members included Senator John Milton, Dianne Heins, Dwight Smith, and Patrick Byrne. They were met by Mr. James Menk, Administrator, Ms. Shirley Pederson, Director of Nursing, and Mr. Smith, a county commissioner. At lunch the team was joined by Drs. Bader, Nywell, and Patterson along with a third year medical student from the University of Minnesota and Mr. R.F. Christiansen, a Murray County commissioner.

HOSPITAL BACKGROUND, GOVERNANCE, AND SERVICE AREA

Murray County Hospital began operation as a private institution in the early 1950's. Shortly following its opening it was purchased by Murray County. Since then it has been owned and operated by the county under the direction of the Board of Commissioners. Because of a number of management problems the county contracted for several administrative and departmental functions with the Metropolitan Medical Center, Inc. Under the terms of this agreement, the hospital receives the services of Mr. Menk, cooperative purchasing, third party payor negotiations, and inventory management information systems, for $1500 a month. The board feels that there is much room for improvement in this arrangement. The nearest hospital in any direction is 25-30 miles. Residents of the far northern and eastern townships of the county often utilize the other hospitals. Tertiary care is referred to Sioux Falls. Geriatric care is delivered in one of four nursing homes.

Public health programs are administered by a professional nursing staff of two. Current programs include: maternal and child health and rehabilitation. Immunizations are coordinated with a full-time school nurse. Nutrition programs for infants begin at the hospital and continue in the home at discharge. Chemical dependency is allegedly a small problem. Abuse is generally confined to alcohol. For this purpose, a detention room is maintained at the hospital, and patients are subsequently transferred to Granite Falls. This room has been used on an average of once a month. The extent of venereal disease is unknown as the patients gen-

erally seek private physicians at some distance from their community. The home health program is currently a problem. Nurses see patients on a rotating schedule, but usually only at the suggestion of the attending physician.

FINANCIAL AND ECONOMIC SITUATION

In the last two years, the county has been forced to support a hospital deficit of $70,000. Several factors contribute to the current deficit situation. The occupancy rate is quite low (40%) with an average daily census of only 20 patients. In the past five years the occupancy rate has exceeded 50% only once, in 1972. The daily room rate has been maintained at artificially low levels ($42.50 for semi-private, and $47.50 for private). The expensive purchase and maintenance of equipment for specialized tests and x-rays combined with the fees for contracted physicians and the low ancillary service charges cause the hospital to run a deficit on many procedures ordered by the four staff physicians. Normally high income departments cannot be operated optimally at Murray County because of the limited medical personnel.

All services must be maintained at a reasonable staffing level regardless of the utilization rate. The overhead burden that results is frequently greater than the income generated by various services and departments. A few operate at a profit; radiology is at the breakeven point.

A breakdown of revenue sources indicated that about 40% is from Titles XVIII and XIX, 10-15% from Blue Cross and the remainder divided among private pay, commercial insurance, and bad debts. Bad debts run about 1.8% per year.

The interim reimbursement rate for Medicare is 100% and 95% of charges for Blue Cross claims. A problem for the hospital is the time lag in receiving these sums. The delay in approval of claims is often three weeks, then another eighteen day waiting period commences before payment is received. This causes a crucial cash flow problem.

New equipment for emergency services have been purchased partially through revenue sharing funds. Two-way radios are being installed to improve in-transit care. Ambulances are staffed on an on-call basis on evenings and weekends. Driver training consists of a 54 hour Red Cross first aid course.

MANAGEMENT AND ACCOUNTING

Maintenance charges, delayed reporting and the constant need to update technology were mentioned as problems relative to

the radiology and pathology services.

Group purchasing is part of the hospital's agreement with MMCI. Administration says they have experienced savings of as much as 55% on supplies by participation in MMCI and three other groups as well as by reducing inventory levels.

Purchase of major equipment must be negotiated separately. Mr. Menk supports leasing over purchasing for the following reasons: prices from vendors are increasing; government reimbursement programs prohibit accelerated depreciation; and technology often is outdated before an item is fully depreciated. The hospital has a CHEC grant to implement a program for improving supervision and quality assurance in the dietary and housekeeping departments.

MEDICAL STAFF

There are four physicians serving over 12,500 people. The youngest doctor is 55 years old and the remainder are approaching retirement. They have delayed retiring until replacements can be attracted to the area.

They do not use the problem oriented medical record, nor is there a medical audit committee. The tissue and utilization committees of the medical staff meet regularly to discuss surgical pathology and length of stay.

The doctors seemed to feel that the hesitation of physicians to relocate in the country was largely illusory. Exposure through preceptorships or family practice residencies was deemed an important step. Residencies were preferable; although the rural physician program had potentially long range benefits, in the short term it was essentially an educational experience, with little meaningful assistance being delivered by the student.

The doctors were largely satisfied with the hospital but felt a need for a board certified surgeon to reduce the necessity for referrals. The consumers are seemingly even more reluctant about referral than the medical staff. The physicians alleged that bad debts were few and that people always paid something eventually.

Continuing education was cited as an ideal which was particularly hard to attain in rural settings. Although the resources are available through CHEC, the university, medical literature, the necessary time is not available. The regular consultation rounds sponsored by the university were viewed

quite favorably. Technical support capabilities were available from the cities, but distance constitutes a major drawback.

SPECIALISTS

The hospital has no anesthesiologist, and contracts with a radiologist and a pathologist to provide services as needed. The administrator said that the hospital usually had to negotiate from a disadvantageous position. As an example, the nurse anesthesist is guaranteed $12,000 per year, yet the hospital averages only one case a day.

NURSING STAFF AND OTHER PERSONNEL

Manpower concerns, other than physicians, are of low priority. With nine full-time, or full-time equivalent, RN's and eleven full-time, or full-time equivalent, LPN's the nursing staff is more than adequate. Technical staff is used in the laboratory and radiology with at least one technician possessing expertise in both fields.

The hospital has no programs for volunteers. Ms. Pederson felt that they "had to be constantly followed about", but Commissioner Smith expressed the widespread community interest in such a program.

The administrative staff has had few problems with recruitment or turnover. Salary and benefits are comparable to regional hospitals. Negotiations are yearly, but there are no unions and employee dissatisfaction with wages appears minimal.

CONCERN AND SUGGESTIONS

Although repeated inspections are a frequent complaint of other hospitals, Mr. Menk minimized this issue. With full accreditation by the Joint Committee on Accreditation of Hospitals, other inspection teams have not pressed Murray County. Mr. Menk felt that the accreditation requirements were within reach and emphasized that this was "not really a problem."

The physicians made some initial suggestions for legislative reform:

1. Reform of the child abuse law. The current laws are deemed inadequate.

2. Regionalization of certain services, especially those for chronic conditions; cancer, stroke or kidney failure (other chronic and all acute conditions were not deemed amenable to removal from the community.)

3. Different levels of requirements for hospitals. In order to obtain JCAH accreditation, Murray was expected to have separate functional committees for nearly every department represented. With a medical staff of four, manning individual councils and duplicating by-laws and minutes was not expedient.

APPENDIX E

9. MILLER DWAN HOSPITAL AND MEDICAL CENTER VISIT, OCTOBER 7, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team included Senator Kowalczyk, Tobey Lapakko, Dwight Smith, and Diana Thomas. Hospital administrative staff present included: J. Knoble, Administrator; R. Tusler, Controller; N. Good, Assistant Administrator; T. Kochever, Administrative Assistant; M. Janzig, Director of Nursing; and Mr. Jennings Johnson, Chairman of the Board. The staff provided the team with a binder of information and documents responding to the questions in our letter.

HOSPITAL BACKGROUND, GOVERNANCE, AND SERVICE AREA

Miller-Dwan was established as the city free and public hospital and for years took care of the area's "worthy sick and needy poor patients". The hospital was started with the help of funds donated to them under their previous name Miller Memorial Hospital. It is owned and operated by the city through a seven member Board of Trustees who are appointed by the district judges. Since 1972 the hospital has undergone dramatic growth. Their occupancy rate in 1972 was 47%. In 1974 they are hitting 75%. The reason for this upshot is the development of several new special service areas. Mr. Knoble explained that the hospital decided to develop the services that were not available at the other two hospitals in Duluth (St. Luke's and St. Mary's - both about twice the size of Miller-Dwan). The three hospitals are working closely together to avoid duplication in programs. They have formed the Duluth Hospital Council. Together they plan and coordinate their services to maximize each facilities utilization of the particular service areas they provide.

In November 1973 the Board of Trustees approved the creation of a Foundation made possible by the bequest of the late Mary C. Dwan. At the same time, the Foundation offers expanded opportunities for charitable gifts to be given by others. According to the law, the Foundation is required to spend a certain portion of its funds annually to improve the health services of Duluth and the region. The purpose of the Miller-Dwan Medical Center Foundation is to stimulate the development of medical research, education, para-medical and community education, and regional sharing of health services.

During our lunch the board chairman joined us. He discussed the costly federal mandate for all hospitals to have long range plans and expressed his fears that this would lead to excessive construction and expansion programs. He described the ideal board member as one who would be hard working and willing to learn a great deal about the health care industry. They are currently looking to replace several of their members. They take suggestions from the outgoing members for new people. All appointments must be made by the judges of the district court. When asked about consumer representation on the board the administrator felt that the best consumer input was from the board.

FINANCIAL AND ECONOMIC SITUATION

The hospital has 2.1 million dollars in long term debt. Questions were raised about their plans for this debt retirement and their choice of bonding. Their bond debt is in revenue rather than general obligation bonds. They have $360,000 in debt reserve.

The hospital has recently made additions and expansions in a building program which was partially financed by the late Mary C. Dwan. They are also planning to hire a director of continuing education who will be partially funded through the Miller-Dwan Medical Center Foundation.

A long range plan has recently been completed for the hospital. This is part of the PL 92-603 federal requirement that every hospital have long range plans. The approximate cost of the report was $12,000 and was considered fair for this type of work. Hospital personnel worked closely with the consultants and this saved time and money.

MANAGEMENT AND ACCOUNTING

Blue Cross Medicare and Medicaid reimburse the hospital on a reasonable cost basis. In 1969 the occupancy rate for these payors was 80%; in 1974 it will be 40-50%. Other third party insurors are billed the charges for patient services. Currently the hospital is having a problem with the St. Louis County Welfare Department in that they cannot identify Medicaid patients readily. The hospital has approximately 15% self paid patients at the current time.

The hospital aims at a 5% of net revenue margin on their operations. They pointed out that the depreciation allowance is not enough for plant replacement. They depreciate on a straight line basis for general operations, but on an accelerated basis for Medicare and Medicaid. Property is assumed

to have a 40 year life. The percentage of bad debts is about 3%.

The laundry service is done by the St. Louis County system which also serves the nursing home in the area. The joint laundry saves the hospital an estimated $750,000 if it had to be built by the hospital. They provide uniform service for all housekeeping staff.

Miller-Dwan contracts on a yearly basis for supplies from various vendors. Fuel oil is purchased through the city. Two years ago they joined the MMCI group for purchasing medical supplies. There is a standards committee at the hospital which looks at the utilization rates for various items and decides how much should be stocked. In the kidney dialysis area there is a high turnover for all supplies. A two week supply inventory must be kept because MMCI trucks come only once every two weeks. The transportation charge for each truck load delivery is $35.

They utilize the Blue Cross computer services for payroll and receivables and receive a monthly copy of their statements which they spot check for errors.

Their policy for high cost equipment and machines is to lease them. Mr. Knoble explained the needs for extra monies for more planning and innovative programs. He also expressed a desire for a systems analyst.

MEDICAL STAFF AND MEDICAL EDUCATION

In 1973 the hospital signed an affiliation agreement with the University of Minnesota Duluth Medical School. Their 180 attending physicians are on staff at all three hospitals in the city, and most are involved in medical education and teaching. Miller-Dwan has an outpatient area and family planning clinics which also serve pediatrics. The new physician attraction is for those who are interested in teaching as well as in practicing. The greatest need in the area of physician manpower is for internists, family practitioners and certain specialists. There is little need for more surgeons. The city hospitals have also formed a Graduate Medical Education Council to make decisions for the family practice medical program and other medical educational programs.

SPECIALIST

The five anesthesiologists on staff serve as needed on a fee basis and bill patients directly.

The two pathologists in a group do the work for Miller-Dwan and other hospitals in St. Louis County. The hospitals pay for this laboratory service. The pathologists are reimbursed on a percentage of the gross departmental revenues.

The radiology service is provided by a group of seven doctors who perform services on a rotating basis and bill patients directly.

NURSING AND OTHER PERSONNEL

They have 66 RNs and 54 LPNs. The hospital recently renegotiated the contract with the RNs with a 5.3% increase in salary for the first year base pay RN, but a higher increase for nurses with more experience. The overall percentage of increase for RNs was 10.3% for the first year of the contract.

They are currently instituting a nurse clinician training program for RNs in Nephrology, I.C.U., Burn Care and Cardiology. Coronary care nurses are sent to Rochester for a three week course. All tuition and salaries and expenses are paid by the hospital at a cost of $2,000. Nurses working the kidney dialysis unit must go through a three month training period. The hospital is studying the hours for nursing care needed for various levels of patient care. There is an ongoing in-service training program and continuing education for nurses.

They must compete with the county wage for nurse aides. The county civil service aide wage is 53¢ per hour higher.

The total number of full time equivalent employees is 324; the total number on payroll is 376.

SPECIAL FACILITIES

There are five recently added services. They are: Alcohol and chemical dependency unit (40 beds); open mental health unit (21 beds); concentrated care unit (5 beds); rehabilitation program and diabetes education care (ambulatory). The hospital has a total of 179 beds, with 96 general medical-surgical beds. This means that over 50% of their beds are in specialized units. Mr. Knoble stated Miller-Dwan serves many Wisconsin residents and it is a fact that 47% of their patients come from outside Duluth. The hospital has no emergency room, pediatrics, OB-GYN, or trama units. These units have been closed at Miller-Dwan and these services are provided at the other hospitals. The inter-hospital planning in the area has allowed a better occupancy rate for special services by reducing the competition.

HILL BURTON

The hospital has selected option number one to satisfy its Hill Burton obligation to provide free care. This option requires that the hospital "not intend to deny anyone admission to the facility or any of its services because of inability to pay".

APPENDIX E

10. MOUNT SINAI HOSPITAL VISIT - OCTOBER 10, 1974

VISITING TEAM AND WHO THEY MET WITH

The site visit team included Senator John Milton, Diana Thomas, Richard Hammel, Dianne Heins, and Dwight Smith. Members of the administrative team and board members met with the team. They were Samuel Davis, Executive President; Peter Sammond, Executive Vice President; Thomas Plantz, Associate Administrator Ancillary Services; Dale Whinnery, Controller; Stephen C. Schwartz, Director of Planning and Management Systems; Helen Jameson, Director of Patient Care Services; and Quinton Friesen, Administrative Resident, University of Minnesota. We also had the opportunity to meet with the Board President, Mr. Hyman Edelman and the Chairman of the Board's Budget Committee, Mr. Stephen Davis who were both with us for much of the discussion.

HOSPITAL GOVERNANCE, BACKGROUND AND SERVICE AREA

Mount Sinai was opened in 1950. It is a 273-bed facility located in South Minneapolis. Capital requirements are partially supported by contributions from the Jewish community. Patients are primarily from Hennepin County. Approximately twenty per cent are Black and twenty per cent Jewish.

The Board of Governors consists of 49 representatives from a wide variety of disciplines. The medical staff has representation on the board; the chief of staff, the chief elect and the immediate past chief. The role of the board is to establish policy, approve programs, and review management performance. The board as a group meets once a month, and committees also meet monthly.

FINANCIAL AND ECONOMIC SITUATION

Mount Sinai Hospital has an existing debt of $500,000 in construction costs. The initial expense was $2.5 million of which $1.2 million was in the form of a loan, which is being liquidated through pledges secured through a 1970 fund drive. The

controller estimated that a loan of $1.0 million in this institution costs the patient $1 per day, but at other institutions with higher debt, the cost would be between $5 and $10 per day.

Currently, operating rooms are run at 60% utilization, primarily from the hours of 7:00 a.m. - 1:00 p.m. The main reason for this trend is the reluctance of surgeons to operate in the afternoons. The prevailing practice of surgeons is to operate in the morning and to consult in the afternoon. On the other hand, patient care is improved since intensive nursing staffing, required for post-operative patients, is more readily available in the afternoon. It is more difficult to provide the intensive post-surgical care in the evening.

The Obstetrics Department was closed in 1971. This was done on a "planned basis." Hill-Burton requirements of free health care are covered by the hospital. They have elected option two. They also have a twenty-four hour emergency walk-in clinic.

MANAGEMENT AND ACCOUNTING

The philosophy at Mount Sinai has been total systems in management. They have been innovative in their approach to operational problems and cost management. A consulting group performed productivity studies in 1973. The hospital has modified and adopted most of the recommendations.

The hospital in the past two years has established several cost-cutting procedures. Purchasing costs have been decreased by becoming a member of the Allied Hospital Purchasing Group. They have also become part of a sixteen hospital drug purchasing group. Collections and printing have been contracted to Affiliated Hospital Services, a joint venture of a number of hospitals. Food services and housekeeping management is contracted out.

Management engineering programs were instituted in 1973. One aspect of this system was to review the ratio of full-time equivalent employees to patient days:

1966 = 3.43	1972 = 3.97	Projected for 1975 = 3.65

This improvement is particularly significant in that procedures became more labor intensive over this period. Management engineering also measures staffing according to productivity and utilization. By using these systems, 123 employees were eliminated, by attrition rather than layoff. The combination of these cost-cutting procedures has held the

overall cost increase to only 3.4% for 1974. The projected increase for 1975 is 11.2% due to inflation rather than inadequate cost-reduction. The administration believes there is "no fat left to trim."

MEDICAL STAFF

The current medical staff consists of 119 active staff, 16 associate staff, 106 courtesy staff, 6 senior active staff, 5 honorary staff, 10 emeritus and 2 on leave of absence. The team did not ask to visit with any of the staff members.

SPECIALISTS

Anesthesia services are contracted to a full-time professional group. The contract names the supplier as chief of anesthesia, who is also in charge of medical direction of the inhalation therapy service, ICU, and operating room scheduling. The chief received $15,000 per year from Mount Sinai for these administrative services and bills the patient directly for professional patient services. Approximately 15-20% of his time is spent in administrative functions.

The chief in turn supplies a total service to the institution by contracting independently with three other anesthesiologists. The chief anesthesiologist employs and remunerates the members of his group through fees charged to the patients. The institution contracts with the anesthesiologists to bill some of their patients through the hospital's electronic data processing system. The hospital charges a set fee for this service to the group.

Radiology services are contracted by the hospital with a full-time private group who guarantees coverage at all times. The hospital supplies the space, equipment, and allied personnel, in return for the radiology services. The contract is for five years, with discussion for renewal after three years.

The contract with the radiologists calls for at least three full-time radiologists and such part time radiologists as are necessary to provide vacation or educational leave coverage. In fiscal year 1973, the total patient bills for radiological service was $290,938. After August 1, 1974, radiologists will charge according to the Minnesota Relative Value Index with a maximum on annual compensation but this maximum was not disclosed.

As with the anesthesiologists, the hospital contracts with the

radiology group to bill the patients for the professional fees in return for a set service fee. Although the hospital supplies the necessary equipment, much of it is leased rather than purchased. The five year lease purchase agreement is financed through a local financial institution.

Pathologists are full-time employees of the institution. Salaries range from $71,385 to $77,334, plus $9,000 in benefits per year. Seventy per cent is paid by the hospital directly and 30% through the University of Minnesota. The pathologists supervise the medical laboratory operations and function as clinical instructors for the 150 medical students who rotate through the hospital for 18 weeks of pathology training.

NURSING STAFF

The hospital finds it difficult to hire nurses at times between graduation dates of most nursing programs.

CONCERNS AND SUGGESTIONS

Mount Sinai management suggests that the most pressing need is more primary care physicians. The staff consists of 30 internal medicine specialists, but only six to eight family practice specialists. If more primary care physicians were available, the hospital could expand the Senior Citizens Program, and the institution could increase its utilization of facilities by a significant degree.

In regard to government involvement in the distribution of health care, the administration believes that the Professional Standards Review Organization will cause the physician and the hospital to "get married." The following suggestions were offered by the administration for a potential rate regulatory agency:

1. Recognition of the total financial requirements of hospitals.

2. Uniformity of payment to all classes, government and private, of purchaser based on total financial requirements of hospital.

3. Establishment of a uniform financial report for hospitals.

4. Uniform rate setting process.

5. Built-in penalties and premiums.

6. Use of an advisory committee by agency with consideration of former health professionals now retired or not employed in health as consumer members.

7. Functional appeal system.

8. Recognition of the extreme time commitment required on the part of agency board members.

APPENDIX F

State of Minnesota
SENATE

August 16, 1974

Dear Hospital Administrator:

On May 20, 1974, we sent you a hospital cost survey as part of a study being undertaken by the Minnesota State Senate's Special Subcommittee on Health Care Costs. The letter accompanying the survey asked that it be returned by June 3, 1974. This deadline was later extended to July 15, 1974. Most hospitals in the state have returned their surveys.

According to our records, your hospital is one of the few that has not responded to the survey. We would ask that you respond by the end of the month. We feel that a complete response to the survey by all hospitals will enable the legislature to obtain a clearer picture of hospital costs and aid in developing constructive legislation.

We have enclosed another copy of the survey for your use. If you have any questions about the survey, please contact one of us or Diana Thomas (612-296-6584) or Larry Fredrickson (612-296-6583) of our staff.

Thank you for your cooperation.

Sincerely,

Senator George Conzemius Senator Al Kowalczyk

GRC/AK/cjd

APPENDIX G

GEORGE R. CONZEMIUS
SENATOR 25TH DISTRICT
800 WEST HOFFMAN
CANNON FALLS, MINNESOTA 55009
AND
205 STATE CAPITOL
SAINT PAUL, MINNESOTA 55155

State of Minnesota
SENATE

MAJORITY WHIP

COMMITTEES
HEALTH, WELFARE AND CORRECTIONS, CHAIRMAN
RULES AND ADMINISTRATION, VICE-CHAIRMAN
COMMITTEE ON COMMITTEES
GOVERNMENTAL OPERATIONS
TAXES AND TAX LAWS

October 24, 1974

Dear :

On behalf of the Special Senate Health Costs Subcommittee I would like to thank you and your staff for your cooperation and assistance during our recent visit to your institution.

We feel that from the knowledge and information obtained during our visit we will be better able to gain an understanding of the reasons for rising hospital costs.

Thank you again for participating in our study.

Sincerely,

GEORGE R. CONZEMIUS
State Senator

Chairman, Senate Health,
Welfare and Corrections
Committee

GRC:cjd/nak

APPENDIX H

GEORGE R. CONZEMIUS
SENATOR 25TH DISTRICT
800 WEST HOFFMAN
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AND
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State of Minnesota
SENATE

MAJORITY WHIP

COMMITTEES
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TAXES AND TAX LAWS

November 7, 1974

Mr. Leo Ustick, Executive Officer
Long Prairie Memorial Hospital
20 9th Street SE
Long Prairie, MN 56347

Dear Mr. Ustick:

On Friday, November 1, 1974, the Senate Health Costs Subcommittee held its first work session on preparing the report of the subcommittee's activities. At that time the subcommittee reviewed draft copies of reports on several of the areas it has studied. Among these working papers were the hospital site visit reports.

I have enclosed a copy of the site visit on your particular hospital. Although the subcommittee as a public fact-finding body has a duty to disclose its findings, it is not the intent of the subcommittee to single out individual hospitals for public criticism, particularly those that expended the time and effort to cooperate with the subcommittee's visit. For this reason, there will be no reference to the name of a specific hospital in the portions of the report dealing with individual findings. The subcommittee visited a cross section of hospitals within the state, and I believe the attributes of the ten hospitals we visited should reflect on the general status of hospitals in Minnesota rather than any individual hospital.

Thank you again for your cooperation and assistance. A copy of the final report will be sent to you when completed.

Sincerely,

George R. Conzemius
State Senator
Chairman, Senate Health Costs
Subcommittee