St. Paul-Ramsey Medical Center. Hospital and Medical Center Records.

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Version 3
August 20, 2018

ST. PAUL-RAMSEY HOSPITAL

GILLETTE ADDITION

COUNTY BOARD

BOARD OF
RAMSEY COUNTY COMMISSIONERS
STATE OF MINNESOTA

File No. _____

Resolution No. 9-2619

October 28 19 74

The attention of LaVand Syverson, Hospital & Sanitarium Comm.;
Gary Davis, Assist. Cty. Attorney; Budget & Accounting;
County Administrator; Mike Ettel, Chairman, Hosp. & Sanit. Comm.;
is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on October 28, 1974

By Commissioner De Courcy

RESOLVED That the Ramsey County Board of Commissioners hereby grants the Architect a delay under the Agreement for Architectural Services for the furnishing of the construction documents from September 15, 1974 to October 15, 1974. That said delay is granted because of the additional time required by Ellerbe Architects to redesign the Project in order to reduce the scope of the Project pursuant to the directions of the Owners.

RECEIVED
OCT 29 1974
Ramsey County Administrator

EUGENE F. MACAULAY County Administrator

By _____ Executive Secretary

Form ADM 201

COUNTY BOARD

File No. _____

Resolution No. 9-2618

BOARD OF

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

October 28 19 74

The attention of La Vand Syverson, St. Paul Ramsey Hospital;
Gary Davis, Assit. Cty. Attorney; Budget & Accounting;
County Administrator; Mike Ettel, Chairman, Hospital & Sanitarium Comm.;
is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on October 29, 1974

By Commissioner De Courcy

RESOLVED That the Ramsey County Board of Commissioners hereby approves the construction documents furnished by the Architect on October 15, 1974, and authorizes the Architect to proceed with the bidding phase of its services; and Be It Further

RESOLVED That said approval shall be subject to the approval of the construction documents as to legality by the Office of the Ramsey County Attorney, and Be It Further

RESOLVED That nothing herein shall be construed as to indicate the approval of the Ramsey County Board of Commissioners as to the cost of the project as stated in the Agreement for Architectural Services, and the County Attorney is requested to continue negotiations with the Architect for a reduction in the stated cost of the Project based on the reduction of the scope of the Project.

RECEIVED

OCT 29 1974

Ramsey County Administrator

EUGENE F. MACAULAY County Administrator

By _____ Executive Secretary

Form ADM 201

Office of
ADMINISTRATOR
COUNTY OF RAMSEY

EUGENE F. MACAULAY
County Administrator

Room 945 Court House
St. Paul, Minnesota 55102
298-5591

July 25, 1974

Mr. Dave Gitch
Assistant Administrator
St. Paul-Ramsey Hospital
640 Jackson Street
St. Paul, Minnesota 55101

Dear Mr. Gitch:

I have been asked to develop a position description and employee specification for 1) Clerk of the Works, and 2) Project Coordinator.

There are, of course, infinate ways to go about this, but I have chosen the standard Ramsey County Civil Service format to use in this instance.

Also, we "brain stormed" the Hospital Commission's needs, as well as we could understand them, within this office and with Gary Davis and Richard Hoffman of the County Attorney's staff.

Our conclusion was that there is a very complex set of inter-agency relationships involved in this project. There are, for example, owners, developer-operators, owner-tenant-providers, tenant-providers, client-providers, regulatory bodies, and who knows what else.

It is in recognition of this complex set of inter-agency relationships that we have proposed the title and position description for coordinator of inter-agency relations.

We ask that these descriptions be viewed as suggestions only and should be carefully reviewed by the appropriate people at St. Paul-Ramsey prior to proposing them to the Commission or County Board.

If I can be of further assistance, do not hesitate to call upon me.

Sincerely,

M. Earl Marlow

M. Earl Marlow
Development Coordinator

MEM/mcw

P R O P O S E D

CLERK OF THE WORKS

ST. PAUL-RAMSEY HOSPITAL - GILLETTE ADDITION

Duties and Responsibilities:

Under general direction of the Hospital and Sanitarium Commission, will represent the Commission in its day-to-day relations with the architect and the general contractor to insure that the Commission's directives, specifications and requirements are appropriately reflected in the design and construction of the building.

Desirable Knowledge, Skills and Abilities:

Thorough knowledge of architectural engineering and construction tools, techniques and practice.

Thoroughly conversant with architectural drawings, specifications and construction documents.

Thoroughly conversant with the concepts for delivery of medical services adopted by the Commission.

The ability to articulate and communicate the Commission's philosophy, decisions and directives to the architect, the contractor and others.

Examples of Work Performed:

1. As the owners agent, he maintains liaison with the Project Architect and the Construction Superintendent, their principals and agents as necessary.

2. Attends all planning and scheduling meetings and job-site conferences with the Project Architect and Contractor's representatives.

3. Reviews, considers and evaluates suggestions and/or recommendations submitted by the architects, engineers or contractors, after which he may:

   a) Render a decision in line with the Commission's philosophy, decisions and directives, or

   b) Refer the matter to the Commission for decision.

4. Maintains (or causes to be maintained) orderly and current files at the project site for (1) correspondence; (2) conference minutes and reports; (3) working drawings, prints and specifications; (4) reproductions of original contract documents including addenda, change orders and supplementary drawings issued subsequent to award of the contract.

5. Conducts continual on-site observations and inspections, including spot checks of the work in progress for determining continuance of work, materials, equipment with the contract plans and documents.

6. Observes tests at project site required by the contract documents and reports to architect or other responsible parties relative to test procedures and results.

7. Accompanies local, state and federal inspectors on tour of construction site and prepares any special reports pertaining to inspections.

8. Reviews contractors applications for payments and approves or prepares special reports if payments are to be held up. Sign forms indicating partial completion as project is under construction.

9. Inspects and prepares report on all items requiring corrections.

10. Reports immediately on any situation arising which could require notice of work stoppage.

Minimum Qualifications:

Should have an appropriate degree in architecture or engineering with several years of related experience. Appropriate experience may surplant the degree requirement.

EM/dq
7/24/74

PROPOSED
COORDINATOR OF INTER AGENCY
RELATIONS
ST. PAUL - RAMSEY - GILLETTE
EXPANSION PROJECT

Duties and Responsibilities:

Under general direction of the Hospital and Sanitarium Commission and its Building Committee, he will establish and maintain a two-way information flow with the following:

a) Appropriate committees of the State Legislature
b) Ramsey County Board of Commissioners and its Administrator
c) St. Paul Mayor's office and the St. Paul City Council
d) Gillette Hospital Authority and the Hospital Administrator
e) Minnesota Educational Research Foundation Board of Trustees and its Administrative Director.
f) Others as directed

Desirable Knowledge, Skills and Abilities:

Thorough knowledge of the intricate relationships existing between the various agencies and public and private bodies concerned with legislative authority, regulative approval, funding, ownership, development of facilities, operation, tenancy and provision of consumer services.

Thoroughly conversant with the program for merging of Gillette Children's Hospital and the expansion of primary care facilities programmed for the St. Paul-Ramsey-Gillette complex.

The ability to articulate and communicate the Commission's philosophy, decisions and directives; project plans, problems and progress to the appropriate constituent bodies.

Examples of Work Performed:

1. Attends all Building Committee meetings and sessions of the Commission which deal with the project and the job-site planning and scheduling meeting when necessary.

2. Maintains close liaison with the Clerk of the Works, Project Architect and Contractor to remain abreast of plans, problems and progress.

3. Attends meetings of Legislative Committees, County Board, Gillette Authority, M.E.R.F. Board of Trustees and others, making periodic reports and receiving information requests and/or concerns.

4. Prepare information materials, graphic aids and other reports for information distribution.

Minimum Qualifications:

Should have a four year degree, or its equivalent, in science or humanities. Must be articulate in verbal and written communications with a warm and personable style.

EM/mcw
7/24/74

ADMINISTRATOR
COUNTY OF RAMSEY

EUGENE F. MACAULAY
County Administrator

Room 945 Court House
St. Paul, Minnesota 55102
298-5591

July 25, 1974

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M. Earl Marlow

M. Earl Marlow
Development Coordinator

MEM/ncw
Enclosures

P R O P O S E D

CLERK OF THE WORKS

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5. Conducts continual on-site observations and inspections, including spot checks of the work in progress for determining continuance of work, materials, equipment with the contract plans and documents.

6. Observes tests at project site required by the contract documents and reports to architect or other responsible parties relative to test procedures and results.

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E. M. 07/23/74

PROPOSED
COORDINATOR OF INTER AGENCY
RELATIONS
ST. PAUL - RAMSEY - GILLETTE
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EM/mcw
7/24/74

SPR, U of M Building Plans Win Approval

By Bob Goligoski
Staff Writer

Two controversial multimillion-dollar building projects at St. Paul-Ramsey Hospital and Universi-

Another story on Page 17.

ty of Minnesota Hospitals won unanimous approval Thursday from the Metropolitan Council.

The council overruled

Hospitals: Plans Okayed

Continued from Page 1

my, and that if Gillette moved to St. Paul-Ramsey the stage would be set for the major pediatric facility to be at St. Paul-Ramsey, not Children's Hospital.

To allay those fears the council said its recommendation "is in no way prejudging the future location of a children's medical center in the metro area nor forecloses in any way the plans of Children's Hospital, currently under way, to establish such a center at the United Hospital-St. Luke's site."

Among conditions at-

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Version 3
March 18, 2019

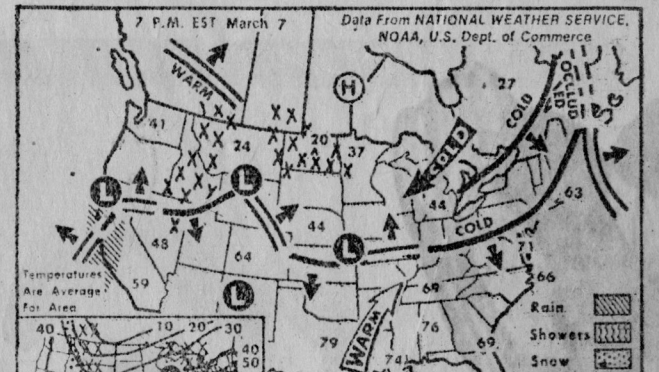
Metro Panel Favors Gillette Relocation

A Metropolitan Council committee Thursday asked the council to differ with the Metropolitan Health Board over plans to relocate Gillette Hospital into an expanded St. Paul-Ramsey Hospital.

In a recent close vote of members of sources Committee said there is a need to relocate Gillette to St. Paul-Ramsey.

The Metro Council is expected to take up the question soon. The state Health Board has final say in the matter.

Complicating the issue is an attempt



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Version 3
March 18, 2019

St. Paul Pioneer Press

TUESDAY, FEBRUARY 26, 1974 C Thirteen

County Board OKs Gillette-SPR Plan

By Karl Karlson
Staff Writer

The Ramsey County Board, in a split vote Monday, gave its approval to the Gillette Hospital addi-

which will continue "to draw into its eye county tax money long after it is built." Mrs. DeCourcy said she would not even consider the project until

lature approves the bonding authority.

An effort by Mrs. Knaak to require a public referendum on the bond-

Hospital: Plan Wins Approval

Continued from Page 13

part of the building would have to be maintained with county taxes.

The board also heard objections to the Gillette addition from Dr. Stanley Leonard of Children's

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Version 3
March 18, 2019

M E E T I N G N O T I C E

TO: RAMSEY COUNTY HOUSE AND SENATE DELEGATION

FROM: REP. BRUCE F. VENTO, CHAIRMAN

RAMSEY COUNTY HOUSE AND SENATE DELEGATION
MEETING

* *

FRIDAY, FEBRUARY 22, 1974
5:00 p.m. or immediately
following House Session.
STATE OFFICE BUILDING, ROOM 83

* *

A G E N D A

1. St. Paul-Ramsey - Gillette Hospital proposal.
   Commissioner Finley, Dr. Leonard, Dr. Winter, Dr. Geist.
   This presentation was made by John Finley assisted by Mayor Cohen. Additional testimony was taken but the matter was not put to a vote, pending further testimony and County Board action. E.M.
2. Jail and Detention Center - Commissioner John Finley

Since we will not be having many more delegation meetings this Session, please try to attend.

2/22/74

ST. PAUL-RAMSEY HOSPITAL - GILLETTE

Medical Education and Research Foundation	$ 1,946,664	26,168 sq. ft.
St. Paul-Ramsey Hospital - New Construction	5,960,352	64,470 sq. ft.
Gillette	4,278,128	52,430 sq. ft.
	$12,230,144	143,068 sq. ft.

St. Paul Ramsey Hospital	$5,960,352	
Remodeling	1,405,099	
		$7,365,451
Previously Authorized Architects Fees	($400,000)	
Bonding Request to County Board		$6,965,451

All architect's fees, contingencies and equipment are included.

Prepared by Sue Shaw for Comm DeCoursey's special 1:00 pm meeting of County Board and 5:00 pm Delegation meeting.
E.M.

Pioneer Press 02/21/74

Gillette Bond Snag Rapped

By Bob Goligoski
Staff Writer

The chairman of the Gillette Hospital Authority Wednesday "questioned the integrity" of Ramsey County commissioners and charged them with employing "delaying tactics" to scuttle the relocation of Gillette to an expanded St. Paul-Ramsey Hospital (SPR).

Moreover, said Clifford Retherford, if the board doesn't act soon and ask the legislature for $7 mil- acts on a certificate of need SPR is seeking for the proposal.

Obtaining the certificate involves a sometimes lengthy process. One hearing on the certificate application has been held by the Metropolitan Health Board and another is set for Wednesday.

Retherford fears that if the commissioners delay acting until the state board decides on the certificate, there will be in-

Children's Hospital is making its pitch even though a site committee appointed by the governor and a study review committee of the metropolitan agency both have recommended that Gillette relocate at SPR in preference to other hospitals in the area. Gillette says its present quarters in St. Paul are too old and inefficient to operate.

Retherford contended

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March 18, 2019

marginal notes by Dick Anglen

Health Board
of the
METROPOLITAN COUNCIL
Suite 300 Metro Square Building, Saint Paul, Minnesota 55101
227-9421

MEMORANDUM

February 12, 1974

TO: St. Paul-Ramsey - Gillette Hospital Study Review Committee

FROM: Staff

SUBJECT: The Joint St. Paul-Ramsey-Gillette Certificate of Need Application

The following in continuing staff discussion of the major issues relating to the above Certificate of Need application, and is meant to provide the study committee with alternative points of departure in arriving at decisions on the major issues.

1. The need for the proposed ambulatory expansion of St. Paul-Ramsey Hospital.

The previous staff paper pointed out that the Study Review Committee must address the issue of the need for the total ambulatory expansion as proposed. Regarding this decision the following considerations should be explored:

1. Analysis of each program area to determine the impact such an expansion may have on other similar services in the area.

2. Analysis as to whether the services proposed are needed at the St. Paul-Ramsey site.

3. Analysis as to whether existing space is presently available or could be available to house its proposed programs.

4. Analysis of the potential impact such an expansion may have on medical and allied health education.

Regarding point number one, the applicant outlines on page 16 the respective proposed increases in square feet for each major program area (activity description). Likewise in Appendix 7 of the Additional Material requested by the staff and the Study Review Committee, are identified the clinics which will be relocated, the historical volume (growth statistics) for each clinic and the rationale for the expansion of space.

Appendix 7, page 2 displays the historical growth of the major outpatient-medical departments of St. Paul-Ramsey Hospital. Of the 11 clinic departments listed, seven have shown an average growth in units of 6 percent a year or more. These include medicine, OB-GYN, ENT, Ophthamology,

Orthopedics, Dental and Urology. The overall growth in visits inclusive of all departments listed was 5.2 percent a year.

However, in making projections of future volume of visits, no attempt was made by the applicant to differentiate between clinics. An overall increase of a compounded 6 percent per year was used on each individual clinic and on the total: resulting in an overall growth of 81,537 visits by 1984, or 172,306 total visits. Staff agrees that it is difficult to predict the future growth for outpatient visits at any hospital site. No available data has been produced which can reliably predict the effect of Professional Standards Review Organization (PSRO) criteria, the impact of better insurance coverage for outpatient services, the greater acceptance of the physician to use outpatient services for many treatments formerly done on an inpatient basis, and the greater acceptance of the patient to use of outpatient service. Nevertheless, staff notes that the applicant in this case has projected the growth to 1984 using the 1973 figures as a base and compounding each years growth. This results in a percentage increase from 1973 to 1984 of 90 percent or 9 percent a year. This is markedly higher than a projection using 1973 as the base and adding the average annual increment of 5,446 visits to each successive year, resulting in a 1984 total of 150,677 visits.

Another approach would be to take the average annual increment between each successive year from 1966 through 1973 and project this forward to 1984. If the decrease in visits in 1969 could be considered an "off" year and this drop eliminated from the calculation, the average annual increase is 5,677 visits per year. Projecting such an increase to 1984 would result in 107,800 visits in 1976, 130,508 visits in 1980 and 153,216 visits in 1984. If the decrease in 1969 is included in the average increment, the annual increase is 817 visits a year or 102,209 visits in 1976, 117,488 visits in 1980 and 132,751 visits in 1984.

Based on the above discussion, it is staff opinion that the projection used by the applicant are unrealistically high based upon historical data. In addition, the patient origin data contained in sections 1 and 2 of the application indicate that the population in the defined primary service area declined from 1960 to 1970. The Metropolitan Council population forecasts show only a slight increase in St. Paul's total population by 1980 (less than one percent) and an increase in Ramsey County population of 8.6 percent by 1980. While forecasts are not available for each neighborhood, it is staff opinion that there will be no significant increase in population in the defined service area and probably a continuing decline. As a result, the outpatient volume may not increase as fast as projected. Also, some of the demand may be met by increasing the availability of neighborhood clinics. Therefore, it is felt that the Study Review Committee should take a rather conservative approach to approving a large outpatient expansion at this time at St. Paul-Ramsey.

Concerning the impact of this project on other hospitals in the St. Paul area, staff agrees with the applicant that this is difficult to predict since no overall patient origin information is yet available on outpatient activity in the Metropolitan Area. In the origin analysis provided in

the application, St. Paul-Ramsey has viewed the neighborhoods in terms of the numbers of patients "seen" at the hospital. A more important analysis would look at the hospitals in St. Paul from the neighborhoods point of view and determine where all outpatients from each area receive care. Only in this way can impact be more precisely measured. Nevertheless, it is felt that the outpatient volume at St. Paul-Ramsey will not decrease because of more conscious efforts to treat patients on an outpatient basis whenever possible. In addition, the Health Chapter of the Metropolitan Development Guide clearly places an emphasis on the delivery of primary care on an outpatient basis. With a more conservative view of the projected increase in outpatient visits at St. Paul-Ramsey, it is staff opinion that there would be little adverse effect on the utilization of existing outpatient services in the St. Paul Area.

Regarding the need for the proposed expansion at the St. Paul-Ramsey site the foregoing discussion indicates that it is staff's opinion that the projections as detailed in the application are unrealistically high. A more realistic projection is in the area between 117,485 and 130,000 visits in 1980 and 132,751 and 150,000 visits in 1984. What is the need for space based on these projections?

To answer this question it is felt necessary to establish a means by which to judge the need for service capacity. In the inpatient service, the bed is used as a "proxy" indicator of the level of service provided. It is recognized that the capacity of support services is related to the bed capacity of the institution. In much the same way, it is staff opinion that the exam room can be used in the outpatient area as a "proxy" indicator of the level of service provided. It is again recognized that support services needed may vary with the type of clinic being established but the level of service capacity is directly related to the number of patients which can be seen in each exam room per day.

In this regard, the applicants stated at an earlier meeting of the Study Review Committee that the average utilization of an examination room is 8-10 patienta a day. Using the figure of 8 as a conservative estimate of the capacity of each room per day and 250 days (five day week) as a conservative estimate of yearly capacity, staff calculates the following demand for exam rooms:

Using St. Paul-Ramsey Projections:

1976	1980	1984
54	68	86

Using staff projections based on an annual increment increase of 5,677 visits a year:

1976	1980	1984
54	65	77

Using staff projections based on an annual increment increase of 817 visits a year:

1976	1980	1984
51	58	66

Relating these figures to the proposal as presented, the applicant has stated that approximately 40 exam rooms will be maintained in the remodeled area of the existing building. In addition, 76 exam rooms will be completed for use in the new construction for a total of 116 exam rooms. An additional 18 exam rooms will be constructed but used for office space that is being displaced by the new construction. However, the applicants have stated that up to 24 of the 116 exam rooms may be used by the HMO as enrollment increases and would result in less available exam rooms for St. Paul-Ramsey. To measure their impact staff has made the following calculations based on data in the application:

Enrollment in the Ramsey Health Plan:

1973	1976	1984*
2,000	6,000	17,000

Patient visits at 4 visits per patient per year:

1973	1976	1984
8,000	24,000	68,000

Exam rooms needed at 10 visits per room and 250 days a year:

1973	1976	1984
3	10	27

Based on the above discussion, it is staff opinion that a maximum of approximately 80 (66 + 24) to 100 (77 + 24) exam rooms are needed by 1984. Since 40 rooms are being maintained in the existing building there would be a demand for approximately 50 to 60 exam rooms in the new construction instead of the 76 proposed, excluding the 18 to be used as office space.

How many square feet are needed?

The applicant has indicated that the available clinic space on the second and third floor including supporting space for waiting areas and internal corridors will be 20,700 net square feet. This does not include the designated office space for physicians. Therefore, the average square feet per exam room with support area is approximately 272 net square feet per room. Using this as a guide to calculate demanded space, the 50 exam rooms would indicate a demand for 13,500 net square feet and the 60 exam rooms, 16,320 square feet.

Staff has already stated their opinion that the uncertainty regarding

*Assuming a continual incremental increase in enrollees of 1,333 per year.

the projected demand for outpatient space at St. Paul-Ramsey demands that a conservative approach be taken at this time for the approval of expanded and completed space. Also, the projected demand of either 50 or 60 new exam rooms assumes the maximum use of 24 rooms for the Ramsey Health Plan with a rapid growth rate. Since all exam rooms are being designed so they can be used interchangeably by all services, it is again felt that a conservative approach should be taken.

In addition, almost all calculations have been based on what is felt to be a conservative figure of eight visits a day per exam room and 250 days of operation a year. No consideration has been given to the effect of evening hours and Saturday hours.

Therefore, it is staff opinion that the proposal from St. Paul-Ramsey should be modified to permit the present completion of fifty exam rooms with supporting space and approximately 13,000 net square feet. As such, the entire completed clinic space could be housed on the second floor and the third floor be shelled for future expansion or used as suggested in discussion of a later issue.

Regarding point number three, little information is provided in the application which clearly defines the existing capacity which could house the proposed programs. Nevertheless, it is felt that it would be possible to house the offices which are proposed on the third floor of the new construction either in the existing hospital or the nurses residence. It is staff opinion that with the limitation recommended in the discussion above, the entire third floor, excluding the ambulatory surgery area, could be shelled.

NEIGHBORHOOD CLINICS ARE SEEN TO BE MORE ATTRACTIVE FOR PATIENTS FOR THE CENTRAL HOSP.

Regarding point number four, it should be stated that a primary reason for the relatively low use of exam rooms (8 patients per day pre room) is the fact that consideration has been given to the time requirements of teaching medical and allied health personnel. The facilities are being designed with the student in mind. It is felt that the increased capacity will better enable St. Paul-Ramsey to provide needed quality education programs with support to care provided on a neighborhood basis.

2. The role of County government for developing a comprehensive plan for delivering primary care services within their county.

The present draft of the Metropolitan Development Guide Health Chapter states the following:

> County Governments should have the responsibility for developing a comprehensive plan for delivering primary care services within their county to identified areas of health scarcity which is consistent with the Development Guide. This Policy is not intended to preclude comprehensive primary health care planning at the municipal level but such plans must be reviewed by both the County and the Metropolitan Council for consistency.
>
> The County shall solicit the assistance of the private sector, consumers, providers, planning agencies, cities and other elements of the public sector in the development of primary care services in health scarcity areas.

In a previous Certificate of Need Application from Hennepin County General Hospital and the Metropolitan Medical Center, the Metropolitan Council modified the hospitals' proposal by attaching the condition that the County agree to develop a plan for the provision of primary care on a decentralized basis, hold public hearings in the community, and submit this plan to the Metropolitan Health Board for approval. Should a similar modifying condition be placed on the St. Paul-Ramsey proposal?

There has been a great deal of discussion regarding the need to develop primary care services on a decentralized basis to care for the needs of the population as near to their neighborhoods as possible. The detailed description of the outreach programs contained in the material submitted by the applicants indicate that St. Paul-Ramsey Hospital has a good record in terms of supporting neighborhood level services. In this regard it is staff opinion that the circumstances in Ramsey County are different than existed in Hennepin County when that Certificate of Need was reviewed. In addition, St. Paul-Ramsey Hospital is governed by a Hospital Commission appointed by the County Commissioners as opposed to the County Commissioners themselves being the Governing Board as in Hennepin County.

Nevertheless, it is staff's opinion that the role of St. Paul-Ramsey Hospital in the delivery of Primary Care within the County and its specific relationship with other primary care providers in the County remains to be defined. The review of this project indicates the need for a long range plan specifically defining St. Paul-Ramsey Hospital's role in the delivery of Primary Care Services in Ramsey County. Therefore, it is staff's opinion that a modifying condition be placed on St. Paul-Ramsey Hospital's Certificate of Need application as follows:

A. That St. Paul-Ramsey Hospital commit itself to identify and define its specific role in the delivery of Primary Care within Ramsey County.

B. That St. Paul-Ramsey define its relationship to other primary care providers in Ramsey County.

C. That Ramsey County submit their proposed plan to the County and to the Metropolitan Health Board within one year of attachment to their Certificate of Need.

3. The role of existing and potential resources on a neighborhood level for delivery of services and the training of health manpower.

St. Paul-Ramsey has demonstrated that it is pursuing an active role in the support of primary care on a decentralized basis. The Health Chapter of the Metropolitan Development Guide reflects that in planning for the delivery of primary care services, emphasis should be given to provision of those services in the persons neighborhood or local community. It is expected that any plan developed by St. Paul-Ramsey Hospital will contain this emphasis. It is staff opinion that the proposal as modified

would provide the ~~care~~ core services necessary to support delivery at the neighborhood level.

The role of existing neighborhood level services for the training of health manpower remains somewhat undefined. The impact of this specific project on the education of health manpower is also unclear. Nevertheless, this does not appear at this time to be substantial reasons present which would warrant denial of the project as modified. It is expected that the plan prepared as outlined in the previous discussion would include the needs of using neighborhood level services to their capacity for training of health manpower.

4. M.E.R.F.

Based on the recommended modification it is staff opinion that the fifth floor presently proposed for M.E.R.F. not be constructed and the functions contained there be transfered to the vacant area on the third floor of the new building.

5. H.M.O.

The Metropolitan Development Guide Health Chapter as presently drafted indicates the position that in addition to finding ways to keep improving the present system, new systems should be studied and developed. By developing them along with the present systems, the range of choices will be broadened and each should be stimulated to find its most effective role. Based upon the information contained in the application and supporting documents, the HMO ~~is~~ AS PROPOSED APPEARS prepared to be self-supporting. While the specific future enrollment might be challenged, it is felt that there is no basic conflict in providing an HMO in a public hospital setting.

MM/pp
2.12.74

REVIEW BOARD REQMS

FLR

1.
2.
3. VACANT – BUT RESERVE FOR MERF
4. GILLETTE ADDITION
5. DO NOT CONSTRUCT

Mr. Marlow - Per your telephone conversation with Mr. Gitch I am enclosing a copy of the supplement to the Proposal to the Study and Review Committee for the Certificate of Need.

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4. Response to Question raised by Stanley A. Leonard, M.D. in his memorandum to Study Committee, January 23, 1974.

APPENDIX

Appendix - 1 St. Paul-Ramsey Medical Staff Roster

Appendix - 2 Questions Relating to Ramsey Health Plan, Inc.

Appendix - 3 Future Utilization of Nurses' Residency Building.

Appendix - 4 Medical Education Programs at St.Paul-Ramsey Hospital.

Appendix - 6 Total Project Cost Estimate, January 28, 1974 - Ellerbe Architects.

Appendix - 7 a) St. Paul-Ramsey Hospital Outpatient and Emergency Service Statistics.

b) Rationale and Square Footage for Proposed Outpatient Clinic Expansion.

M E M O R A N D U M

TO: Saint Paul-Ramsey / Gillette Hospitals

FROM: Staff - Study Review Committee

DATE: January 25, 1974

RE: Additional Information Requested By Study Review Committee

Please provide the Study Review Committee with the following additional information:

1. Roster of the medical staffs - including specialty and office location(s)

2. Description of the Ramsey Health Plan including:

   a. organization
   b. physician membership by specialty (full time, part time consultant)
   c. arrangements with St. Paul-Ramsey Hospital
   d. families and persons enrolled
   e. basis for projected increases
   f. eligibility requirements - relationship to Blue Cross/Blue-Shield
   g. financing
   h. utilization since opening
   i. who shares the risk?

3. Description of the Nurses' Training Program, status of facilities, and use of space, if to be vacated

4. Medical Education programs at both Gillette and St. Paul-Ramsey

5. Space in both new facility and existing facility allocated to Gillette and space allocated to St. Paul-Ramsey by activity description

Memo of January 28, 1974

6. Cost Report to Chairman ---Dick Shay

7. Why architect's fee reduced - page 21 revised

8. SPRH clinic expansion:

   a. Which clinics to expand?
   b. What are present: Historical volume figures for <u>each</u> clinic
   c. Rationale behind each clinics expansion

9. Where will SPRH clinic activities be? What floors/space?

10. Where will Gillette Clinic activities be? What floors/space?

ST. PAUL-RAMSEY HOSPITAL
and
MEDICAL CENTER
ST. PAUL, MINNESOTA 55101

M E M O R A N D U M

TO: Staff - Study Review Committee

FROM: Mr. LaVand Syverson
Executive Director
Saint Paul - Ramsey Hospital and Medical Center

DATE: January 30, 1974

RE: Reply to Your Requests for Additional Information in Memoranda Dated January 25 and 28, 1974

JANUARY 25, 1974 MEMORANDUM

1. Roster of the Medical Staff

The Medical Staff roster in Appendix # 1 lists the full time, part time and attending staffs by Department.

2. Description of the Ramsey Health Plan

The description of the program and data relative to staff questions is enclosed in Appendix # 2.

3. Description of Nurses' Training Program, Facilities and Space

3.1 Nurses' Program

Saint Paul - Ramsey Hospital has conducted a very successful three (3) year Diploma Program in Nursing since 1891. In recent years, enrollment of the entering class of 120 students has been completed by January or February for the following September. While the program has cost both patients and local taxpayers an amount in excess of tuition fees and federal support, the Hospital Commission has maintained the concern of previous Boards that a quality program be continued to meet the nursing personnel needs of health care institutions in the County until some other agency could take over this educational responsibility.

We have become increasingly concerned over the difficulties which three year diploma graduates were having in securing a four year baccalaureate degree. In effect, they found themselves in a "dead-end" situation. Further to this, we have been concerned that upward career mobility was being inhibited by failure to recognize the merits of the nurse aide training program, the licensed practical nurse program, etc., when graduates of these programs sought to continue their education at the next level. Also, we felt that if an institution primarily concerned with education could provide a quality Associate Degree (2 years) in Nursing, then the Hospital which is primarily concerned with the delivery of health care (coupled with clinical education related to that care) should discontinue such a program.

- continued -

Therefore, when Lakewood and Inver Hills Junior Colleges approached us about the possibility of their offering an Associate Degree Program in Nursing with Saint Paul - Ramsey Hospital serving as a primary clinical facility we responded immediately. Details of the Affiliation Agreement are being worked out at the present time. All being well, we plan to phase out the Diploma Program when the present freshman class graduates in 1976.

3.2 Status of Facilities

3.21 Education Building

This multi-purpose facility is presently being used for a variety of education programs including nursing, undergraduate and postgraduate medical education, post graduate medical seminars, paramedical training programs, dietetic intern program, medical technologist training, ophthalmological technologist training and several other paramedical activities. The Medical Library will need to be expanded shortly to accommodate additional volume, bound journals and audio-visual educational materials. The Amphitheater and the Gymnasium are used frequently for public meetings. In addition, the gymnasium is being used for the Child and Adult Psychiatry Therapy Programs, and will be a welcomed addition to Gillette's armamentarium of therapy and handicapped recreational activities.

3.22 Nurses Residence - Description and Limitation

There are approximately 54,000 square feet of gross space (40,000 net) in six floors of the Nurses Residence. Ellerbe's evaluation of the facility indicates that alternative uses are rather limited. Two 4'6" corridors run the length of each floor with 22 bed rooms on the outside perimeter. With sinks just inside each door and bathroom facilities in the central core, various uses are limited unless the entire interior is gutted. The building is not air conditioned. As a result one concludes that space ideally suited for sleeping accommodations could be utilized for offices and related activities.

4'6"

3.3 Use of Residence

Appendix # 3 completed by Doctor Vicente Tuason, Chairman of the Department of Psychiatry and Mr. John Catlin, Director of the Community Mental Health Center, outlines a program which would be accommodated quite well in the residence facility.

4. Medical Education Programs at Saint Paul - Ramsey Hospital

Appendix # 4, developed by Doctor John Perry, Chief of the Department of Surgery and Chairman of the Faculty Steering Committee at Saint Paul - Ramsey Hospital identifies the various Medical Education Programs carried on in conjunction with the University of Minnesota and in affiliation with a number of hospitals and health care facilities in the East-Metro area.

5. Space Allocated in New Facility for Gillette, Medical Education and Research Foundation and Saint Paul - Ramsey Hospital

The following identifies the gross square feet in the new building by owner/occupant and the area which will be used in common by all three institutions.

GILLETTE	Gross Square Feet		
Fourth Floor Clinical Facility	23,500		
Occupational Therapy, Physical Therapy, Cast, etc.	18,208		
Subtotal		41,708	
Percent to total			24 %
MEDICAL EDUCATION AND RESEARCH FOUNDATION			
* Research Space	14,000		
* Education Facilities	2,060		
Administration and Insurance	10,108		
Subtotal		26,168	
Percent to total			15 %
SAINT PAUL - RAMSEY HOSPITAL			
Medical Records	12,699		
Outpatient Facilities	20,700		
Offices	11,950		
Ancillary Servides	3,850		
Subtotal		49,199	
Percent to total			27 %
FACILITIES TO BE SHARED			
Orthotic and Prosthetic Laboratory	6,000		
Medical Photography	1,460		
Therapeutic Pool	3,262		
Volunteers Office	750		
Mechanical Equipment	13,408		
Surgi-Center	4,250		
Telephone and Personnel Facilities	3,400		
Circulation and Miscellaneous	27,041		
Subtotal		59,571	
Percent to total			34 %
G R A N D T O T A L	176,646		

* - Research Space and Educational Facilities provided by Medical Education and Research Foundation could in fact be listed under "Facilities to be Shared" since it will be used by the staffs of Saint Paul - Ramsey and Gillette Hospitals.

JANUARY 28, 1974 MEMORANDUM

6. Cost Report

A cost report based on the preliminary schematic design and cost estimates for new construction and remodeling developed by Ellerbe dated January 28, 1974 is contained in Appendix # 6. It should be pointed out that the existing facilities could be utilized with very little remodeling expense, and that the outside limit for remodeling costs is $1,500,000.

7. Why Architects Fees Reduced - Page 21

The original figures for Ramsey identified new construction at a cost of $7,719,800, which included equipment, fixutes and architects fees and contingencies. Unfortunately, these items were then detailed and added to the "new construction" to produce a $10,018,600 capital expenditure figure. To further compound the error, contingencies for design changes, change orders and escalation costs were included with the architect's fees. The cost report in Appendix # 6 sets forth the appropriate figures in detail.

8. Saint Paul - Ramsey Hospital Clinic Expansion

Appendix # 7 identifies the clinics which will be relocated, the historical volume (growth statistics) for each clinic and the rationale for the expansion of space. The Emergency Service is also included in this Appendix.

9. Where will Saint Paul - Ramsey Hospital Clinic activities be? Floors and Spaces?

Ellerbe's Schematic Design and Construction Cost Estimates already distributed to members of the Study Committee detail the spaces in the new building which will house the clinics. Page 16 displays the 48 exam rooms clustered in four units of 12 each served by a central service aisle. Up to one-half of this space may be utilized by the Ramsey Health Plan depending upon the size of their enrollment, or 6,000 square feet and 6,500 square feet by the Medical, Dermatological and Neurological Clinics. The third floor houses the remaining clinics consisting of 28 exam rooms in an 8,200 square foot area to be utilized by SPRH clinics to include Pediatrics, Obstetrics and Gynecology, and Surgery. Eighteen of the exam rooms on the east end will be utilized inconjunction with the adjacent spaces as offices to house the Departments of Pediatrics and Obstetrics and Gynecology; the Maternal and Infant Care Program and the Child Development Program. The present offices located on the fourth and fifth floors of the existing building accommodating these departments and activities will be dislocated by virtue of the new building being joined to the existing building.

10. Where Will Gillette Clinic Activities Be?

Just briefly, because I believe Ms. Jean Conklin may have already replied to this question, Gillette Clinics will be housed on the fourth floor as detailed on page 21 of Ellerbe's Schematics.

ST. PAUL-RAMSEY HOSPITAL
and
MEDICAL CENTER
ST. PAUL, MINNESOTA 55101

MEMORANDUM

TO: St. Paul-Ramsey - Gillette Study Review Committee

FROM: Staff - St. Paul-Ramsey Hospital

DATE: January 31, 1974

RE: Response to questions raised by Frank Tiffany, M.D. in his letter to Malcolm Mitchell dated January 21, 1974.

1.1 Question:

The most important consideration, on the basis of the welfare of the children served, is that the basic rationale for moving Gillette Children's Hospital in the first place was to facilitate sharing of services with a major medical center and to have immediately available the services of a large, active and sophisticated Pediatric Department. Figures for the in-patient census and out-patient visits in the Pediatric Department of St. Paul-Ramsey Hospital are conspicuously absent from the report.

Answer:

Statistics for inpatient days and outpatient visits are displayed in the answer to Dr. Leonard's question 1.2. The rationale for the move is found in the answer to Dr. Leonard's question 1.1

1.2 Question:

What is the number of full-time equivalent staff members in Pediatrics?

Answer:

Staff related to Pediatric activities includes the following:

FULLTIME

1. Homer Venters, M.D., Chief, Pediatrics
2. N. Virnig, M.D., Pediatrician
3. E. Davis, M.D. Pediatrician
4. D. Thompson, M.D. Pediatrician
5. R. Kriel, M.D. Pediatric Neurologist
6. R. Hippchen, M.D. Pediatrician, Family Practice
7. R. Dutt, M.D. Pediatrician, Ambulatory Care
8. Vacancy Pediatrician, to be filled in mid February
9. Louis DeCubas, M.D., Pediatrician, Family Practice

1.2 Answer: (continued)

PART-TIME
1. R.Faville, M.D., Pediatrician - ½ time
2. F. Bessinger, M.D., Pediatrician - 1/5 time
3. R. Milan, M.D., Child Psychiatrist - ½ time

2 Question:

The proposal requests a total of 172,200 gross square feet in the construction, of which Gillette would occupy 54,200 square feet, or something less than a third of the total square footage. Consequently, the proposal is primarily the expansion of St. Paul-Ramsey Hospital, which needs careful justification in view of the fact that the hospital is less than ten years old and serves a population which has remained rather static. In addition, in order to justify the space needs for Gillette, it would be helpful to see their 1973 in-patient census and a five or ten year summary of annual out-patient visits to determine if any trends are evident for future utilization.

Answer:

A total of 176,646 gross square feet of space is proposed in the new building. The answer to this question is explained in full in our response to Mr. Mitchell's question #5 in his memorandum dated January 25, 1974. The highlights are that Gillette will have 24% of the space; MERF will have 15%; St. Paul-Ramsey Hospital will have 27%; and all three will share in common the remaining 34%. It would be difficult to characterize the proposal as "primarily the expansion of St. Paul-Ramsey Hospital. Gillette 1973 inpatient census is found on revised page 23 of the Proposal.

3 Statement:

The patient origin studes are of interest, but very incomplete in that they need to be compared to total out-patient services in the community. To compare the St. Paul-Ramsey out-patient visits to those at other hospitals is absurd since the bulk of ambulatory medical care in this community is provided by physicians in private offices. Even more incredulous is the projection to an annual usage rate on the basis of only nine days data collection, which any student of vital statistics would recognize as totally naive.

Response:

Patient origin studies identify the neighborhoods in which patients served by St. Paul-Ramsey live. These statistics were not utilized to develop a "projection to an annual usage rate" except to provide an indication as to where they originate. The suggestion that outpatient services of the total community be measured in terms of patient origin is a good one. Perhaps the Ramsey County Medical Society could undertake such a project.

4. Statement:

Under the proposal out-patient space would be more than doubled, and yet the figures show increase from 75,000 out-patient visits per year to only 79,000 per year from 1968 to 1972. The apparent bulge to 91,000 visits for 1973 could be just as much of a fluke as the drop to 68,000 in 1969, and hardly justifies a clear demonstration of unmet need in terms of space. As one studies the proposal, a good par tof the new out-patient space will actually be utilized by the Ramsey Health Plan. While in general I favor the development of such a health plan as an alternative form of medical care, it is purely speculative what their future success will be. Even more important, I would question the propriety of Ramsey County tax dollars funding the Ramsey Health Plan, thereby putting it in an unfair competitive position with other health maintenance organizations.

Response:

The proposed outpatient space will be increased by 69.7%. Complete informatin is provided in Appendix #7 of our reply to Mr. Mitchell's question number 8. Our answer to Dr. Leonard's question #3.1 speaks to utilization of the proposed space. Of the total 24,850 potential square feet of space for outpatient clinics, 25% or 6,000 square feet may be utilized by the Ramsey Health Plan. An additional 4,150 square feet or 17% will be used by the Departments of Pediatrics and OB-GYN for their offices plus Child Development, M.I.C., and Cervical Cancer programs. The Ramsey Health Plan is similar in nature to the successful Group Health program. The Ramsey Health Plan has not been and does not intend to be "subsidized" by the Ramsey County Tax Dollars. The Plan has reimbursed the Hospital for all lease and maintenance costs. Furthermore, it has saved the Hospital, County and employees premium dollars through a lower premium.

5. Statement:

Under the proposal new office space amounting to 15,000 square feet for administration and medical records is proposed, and it is also noted that administrative employees have increased from 164 to 277 during the years that the new facility has been in operation. While I do not have the background to evaluate these figures, I would consider it appropriate for someone skilled in hospital administration to determine if all of this new space is required, and if the number of employees is fully justified.

Response:

The figure of 109 employes for 1966 as found on page 45 of the Proposal should be 164. The 55 employees for the combined departments of Admitting, Business Office, Accounting, Administration and Personnel was omitted. The 277 figure for 1973 and the 68% increase are correct.

5. Response: (continued)

The breakdown in the number of employees is as follows:

		1966	1973	Increase
1.	Emergency & Outpatient Department	65	121	56%
2.	Medical Records	25	35	10%
3.	Social Service	11	14	3%
4.	Purchasing & Stores	8	11	3%
5.	Data Processing	--	10	10%
6.	Admitting	21	21	---
7.	Business Office & Credit/Collections	21	43	22%
8.	Accounting	3	9	6%
9.	Personnel	5	5	---
10.	Administration	5	8	3%
	TOTALS	164	277	113

One notes that 61% of the total increase is attributed to Emergency Service - Clinics, Medical Records and Social Service; and all related to the medical aspects of hospital operation. Medical Records has doubled the number of records since relocation and is now responsible for well over 400,000 records (St. Paul-Ramsey Hospital used the central unit record system). Demands for documentation by Medicare/Medicaid; utilization of P.A.S. - M.A.P.; and the Utilization Review Program have placed considerable demands upon the Department.

Insofar as the Fiscal and Administrative Service is concerned, most people forget that back in 1966, St. Paul-Ramsey Hospital was on an appropriation and whatever services were needed were provided for by the Welfare Department. From limited data processing requirements in 1966 performed by Welfare, today the Hospital is on a highly sophisticated and totally integrated hospital shared data processing system. From 21 employees in a business office concerned with the processing and collection of perhaps $2,000,000 inpatient accounts in 1966, today the department of 43 is concerned with the processing of 75,000 accounts a year amounting to $20,000,000. The Accounting Department in 1966 was concerned basically with budgeting and expense management. Again, the Welfare Department handled the Payables and Payroll. Today, a department of nine is responsible for General Ledger, Accounts Payable, Payroll, Inventory, Property Ledger, Cost Allocation, Responsibility Reporting, Financial Statements, Budgeting, Cost Central, Economic Stabilization, and Statistics for a $23 million operation.

ST. PAUL-RAMSEY HOSPITAL
and
MEDICAL CENTER
ST. PAUL, MINNESOTA 55101

MEMORANDUM

TO: Saint Paul - Ramsey Hospital/Gillette Study Review Committee

FROM: The Staff of Saint Paul - Ramsey Hospital

DATE: January 31, 1974

RE: Response to Questions Raised by Stanley A. Leonard, M. D., in Memorandum Submitted to the Study Committee on January 23, 1974

PART A

1. STATEMENT: In an opening paragraph, you make a statement regarding a complete Children's Medical Hospital Complex --

1.1. QUESTION: What is your definition of a complete Children's Health Center and Hospital?

ANSWER: In large measure, the answer to this question is to be found on Page 41 of the Certificate Proposal. In addition to the services identified in this paragraph, one should stress the complementary nature of the well developed services including Physical Medicine and Rehabiliation, Neurology Orthopedics and Urology which have much in common with Gillette's program. Specialized support services such as neurological radiology, specialized neurological diagnostic services and laminar flow operating suite, and recreational facilities will augment Gillette's program. This base of support would prove to be of considerable value to Saint Paul - Ramsey Hospital as well, in that Gillette's Prosthetics and Orthotic Service, Medical Photography and the therapy pool would enhance Saint Paul - Ramsey Hospital programs in Rehabilitation, Orthopedics, Neurology and Child Psychiatry.

1.2. QUESTION: What is the actual inpatient census during the past year for pediatrics? What is the average length of stay of pediatric patients in the hospital. Please compare them with other hospitals.

ANSWER: Table I presents the Pediatric Inpatient Census for the last five years (see below) and includes the number of admissions; the average length of stay for pediatrics, child psychiatry and newborn; and the number of occupied beds.

Table II sets forth the number of outpatient and emergency visits for Pediatrics.

Table III compares the pediatric inpatient days at the Saint Paul-Ramsey and Childrens with total pediatric days for hospitals in Ramsey County for the years 1969 - 1972. It is interesting to note that Childrens Hospital had 30.7 % of the total pediatric days in 1972.

TABLE I

SPRH PEDIATRIC TOTALS
(including Child Psychiatry & Newborn)

	1969	1970	1971	1972	1973
Inpatient Days	16,313	14,141	16,862	16,061	14,087
Admissions	2,059	2,146	1,943	1,680	1,576
Length of Stay:					
Pediatrics	10	8	8	8	7.2
Child Psych.	21	19	25	21	28.6
Newborn	4	4	3	3.3	3.7
Occupied Beds	44	39	46	44	36

TABLE II

OUTPATIENT AND EMERGENCY VISITS

Outpatient Visits	1969	1970	1971	1972	1973
Pediatric Clinic	4,942	4,874	4,349	4,576	4,849
Specialty Clinics	1,567	4,240	6,911	5,544	5,294
Total	6,509	9,114	11,260	10,120	10,143
Emergency Room Visits	-	5,765 (6 months)	10,177	9,891	9,319

TABLE III

PEDIATRIC INPATIENT DAYS IN RAMSEY COUNTY
SPRH & CHILDRENS COMPARED WITH ALL HOSPITALS FOR YEARS

1969 - 1972

YEAR	SPRH 1. PEDIATRIC PATIENT DAYS	SPRH % OF THE TOTAL	1. CHILDRENS PATIENT DAYS	1. CHILDRENS % OF TOTAL	TOTAL 2. PEDIATRIC PATIENT DAYS
1969	16,313	18.6 %	28,353	32.4 %	87,507
1970	14,141	17.5 %	28,134	34.9 %	80,613
1971	16,862	21.3 %	25,107	31.8 %	78,837
1972	16,061	21.5 %	22,883	30.7 %	74,390
1973	14,087	N. A.	N. A.	N. A.	N. A.

NOTES:

1 - The pediatric patient days account for all patients 14 years of age and under, including Child Psychiatry and Newborn.

2 - Total Pediatric Patient Days was obtained from the Metropolitan Health Board Statistics and modified to include SPRH patient days for all children 14 years of age and under. Gillette Hospital patient days are not included in the totals. In 1972 they had 18,396 days and in 1973 there were 15,242 days of care.

13. QUESTION: What is your general inpatient census based on the last five years? Please state not only the occupancy rates based on the maximum number of beds in your hospital, but also the total number of inpatients seen per year over the past five years. Can you justify more space with these figures? Could the inpatient space available be used for many of your stated programs?

ANSWER: Table IV provides the inpatient census data for the last five years. In 1974 SPRH is projecting an average daily census of 342 with the opening of the maximum security facility and with the increased utilization of the psychiatric services. Please see also the Analysis of Bed Complement distributed to the Study Committee on January 23, 1974.

TABLE IV

SPRH INPATIENT STATISTICS, 1969 - 1973

ADULT AND CHILDREN	1969	1970	1971	1972	1973
Patients Admitted	14,703	13,654	11,733	12,142	12,563
Patient Days	144,959	131,132	118,063	115,199	117,421
Av. No. of Occupied Beds	397.1	359.3	323.5	315.6	321.7
NEWBORN					
Patients Admitted	991	1,027	885	776	686
Patient Days	3,965	3,478	2,888	2,480	1,990
Av. No. of Occupied Beds	10.9	9.5	7.9	6.8	5.5

2. STATEMENT: Regarding your statements in the report on Page 5, that you are the hospital of primary care for residents in much of the downtown areas--

2.1 QUESTION: Why are you comparing statistics of individual hospital to your outpatient department when you should be comparing total outpatients seen by physicians in Saint Paul areas outlined by you compared to the number seen in your outpatient department? For example, you list approximately an average of 75,000 or 80,000 adults and children seen in your outpatient department during the past five years. If one only takes three pediatric groups who are not seeing adults, the fifteen physicians see a total of almost 80,000 pediatric patients per year in their offices. This does not include hospital visits and does not include their procedures in emergency rooms in hospitals. I would like you to justify your reasoning that you are the one who gives majority primary care at St. Paul Ramsey Hospital for the area stated.

ANSWER: A revised page 5 modified our statement to the effect that SPRH is the predominate source of medical care for the majority of persons residing in the Downtown, Mount Airy, Summit-University and Inner West Seventh Neighborhoods. It would be of considerable interest if the three pediatric physician groups referred to above were to do a patient origin study of their 80,000 pediatric patients to determine the neighborhood distribution.

3. STATEMENT: On statistics based on your increase in outpatient flow and your increase in emergency flow, you have asked for an increase in space of many times that compared to the percentage increase in your statistics.

3.1 QUESTION: How do you justify this on the basis of number recorded? Last year there were 91,000 visits to the outpatient department at Saint Paul-Ramsey Hospital.

ANSWER: In Appendix # 7 of material submitted on January 31 to the Study Committee, we point out that the total Outpatient space being proposed increases from 18,500 to 31,400 square feet or 69.7%. Based on our growth over the last eight years, we will reach the same intensity of use by 1983 as we are now experiencing. The Emergency Service would be increased by 37.4% or 9,100 to 12,500 square feet. Again by 1980, we will reach the same intensity of use as that realized at the present time.

3.2 QUESTION: How do you account for the increase of 79,000 to 91,000 visits compared to only an average increase of markedly less than that over the past several years? Would you please clarify this in terms of listing the types of categories of patients who are seen in the outpatient department? Does this include HMO and does this include simply laboratory visits, such as hemoglobins, chest x-rays, etc.?

ANSWER: The 91,000 visits do not include Ramsey Health Plan, Laboratory, Radiology, Physical Medicine and Rehabilitation or Psychiatry. There are several factors which have contributed to the remarkable increase including: (1) guaranteed parking; (2) ready access to medical care through the walk-in clinic; (3) immediate triage of patients when they present themselves for care; (4) full time staff physicians in the Emergency Service 24 hours a day; (5) establishment of a primary care section in Medicine; (6) a commitment to serve patients when they need care ; (7) utilization review process which ensures care being given in the outpatient setting when appropriate, and (8) above all involvement with and referrals from community outreach programs.

4. STATEMENT: You have mentioned on Page 42, that the increase in outpatient visits to your emergency room and outpatient services is less than the national norm and yet you are asking for a dramatic increase in space.

4.1 QUESTION: Could you justify this?

ANSWER: See answer to Question 3.1.

5. STATEMENT: The Ramsey County Health Plan on Page 44, mentions that you expected to jump from 2,000 to 40,000 in a period of 10 years.

5.1 QUESTION: This is a speculation - can you give any justification for giving space to this type of institution which is not yet been proven and is still in the experimental stage all over the country?

ANSWER: The Ramsey Health Plan is a prepaid method of delivering health care. Eighteen years ago skeptics did not give Group Health a ghost of a chance to survive, much less grow. In eighteen years they have grown to over 50,000 subscribers and had to curtail enrollment for a period pending expansion of facilities and the addition of personnel. It should be pointed out that space is being provided in the new facility on the basis that their membership will grow from 2,000 to 6,000 in the next three years, not an unreasonable projection. The figure of 40,000 subscribers in ten years, as pointed out in the narrative on page 44 is a "perhaps" projection.

6. STATEMENT: The next point of contention is on Page 41, which states the Children's Hospital could merge with St. Paul-Ramsey Hospital. Could you explain the fact that Children's Hospital has said to you and the Metropolitan Health Board in a recent formal statement that they will not move with the Saint Paul Ramsey Hospital as part of a project development, but have elected to merge with Miller-St. Luke's Complex? Could you explain your justification for making a statement that includes the Children's Hospital?

ANSWER: We wish to apologize to anyone who might have been offended by our reference to Childrens Hospital. The sincerity of our apology may be measured by the fact that we removed all references to Childrens in the revised copy distributed to the Study Committee on January 23, 1974. However, we are unaware of having received a "recent formal statement that they will not move with the SPRH as part of a project development". Nor, are we aware of any action on the part of the Metropolitan Health Board to approve the proposed merger with Miller-St. Luke's Complex.

7. STATEMENT: The experience with Gillette Hospital outpatient trends for the last five years were not included in this proposal.

7.1. QUESTION: Would you please include them?

ANSWER: Gillette Hospital will be providing the outpatient visit statistics which indicate there has been a growth over the past five years leading to the present 25,000 visits per year.

STATEMENT: Also, the number of inpatient statistics for 1973 are not included in this report, either on inpatients or outpatients.

8.1 QUESTION: Could you please include them in order to justify the amount of space required?

ANSWER: Revised page 23, Table X in the proposal contain the inpatient census for the 1973. Please correct the date in the heading to read: Gillette Occupancy Rates for Months in 1973.

PART B

9. STATEMENT: If a 7 million dollar bond issue is being raised by the people of Ramsey County, it is important that these people obtain the facts related to many problems of finance in the St. Paul-Ramsey Hospital.

9.1 QUESTION: Is St. Paul Ramsey a public hospital?

ANSWER: St. Paul Ramsey Hospital is owned by the City of St. Paul and the County of Ramsey. Ultimate responsibility for any operating deficit belongs to the County. The County has not contributed anything to offset operating deficits since 1967. In 1973, the hospital had a $21,000,000 operating budget including the debt service, of which the county contributed $750,000 (3.6%) for Community Service programs and the City and County paid the $850,000 debt service (4.0%). Also the County reimbursed the Hospital $500,000 for uncollectible accounts (2.5% of patients accounts receivables). The remaining $19,400,000 come from patients and third party agencies, non-patient services and State and Federal grants and appropriations.

9.2 QUESTION: Is MERF a private corporation within St. Paul-Ramsey Hospital?

ANSWER: The Medical Education and Research Foundation is a non-profit corporation. Its relationship with SPRH is governed by an affiliation agreement.

9.3 QUESTION: Is the HMO a private corporation?

ANSWER: The Ramsey Health Plan is a non-profit corporation and is licensed as an H.M.O. by the State Department of Health.

10. STATEMENT: If the HMO is a private corporation within your hospital, how do you justify the 7 million dollar bond issue to serve the use of a private practice HMO in the Saint Paul-Ramsey Hospital?

ANSWER: The Ramsey Health Plan, a health maintenance organization, was incorporated on June 16, 1972 as a non-profit corporation pursuant of the Minnesota Non-Profit Corporation Act, Chapter 317 of Minnesota Statutes and amended. The Corporating Board for the Ramsey Health Plan was formed by the Ramsey County Board of Commissioners and was composed of three union members, two physicians, the Ramsey County Civil Service Administrator, two County Commissioners and a health care professional.. The Internal Revenue Service has determined that the Corporation is exempt from Federal Income Tax under the provisions of Section 501 (c) (4). The seven million dollar bond issue referred to abœ would be intended to be used for the share of the costs associated for the entire Saint Paul-Ramsey portion of the combined project. Space to be used by the Ramsey Health Plan would constitute only a small portion of the total project. Therefore, it is not a matter of trying to justify an expenditure of seven million dollars for space to be occupied by the Ramsey Health Plan. As noted above, Ramsey County had a key interest in the development of Ramsey Health Plan as an alternative health care delivery system on a prepaid basis. That same interest is still present. Furthermore, as is the case now, the Ramsey Health Plan would continue to pay rent for the space that it occupies and uses within the hospital complex.

11. STATEMENT: The Ramsey County Health Plan has asked for approximately 6,000 new square feet.

11.1 QUESTION: How many visits have there been to the Ramsey County Health Plan over the past year? Your statistics are not available in this report.

ANSWER: Ramsey Health Plan began accepting patients on October 1, 1972. The table which follows indicates the number of ambulatory visits of Ramsey Health Plan members occuring for the 15 month period that the Plan has been in operation between October 1972 and December 1973 by type of visit. A further table illustrates the average number of visits per year for the 12 month period January through December 1973. On an annual basis primary clinic visits total four visits per member per year which is in keeping with the national statistics for prepaid health plans.

Outpatient visits October 1972 - December 1973 (15 months)

	Primary Care Clinic	Referral Clinics	Emergency Room	Total Visits
Oct. - Dec. 1972	801	174	22	997
Jan. - Dec. 1973	7,412	1,145	519	9,076
Total (15 months)	8,213	1,319	541	10,073

Inpatients - October 1972 - December 1973 (15 months)

	Admissions	No. Patient Days	Average Length Of Stay
Oct. - Dec. 1972	26	158	6.1
Jan. - Dec. 1973	255	1,163	4.6
Total (15 months)	281	1,321	4.7

Average Number of Visits per Member Per Year - January - December 1973

Type Visit	No. Visits	Visit/Member/Year
Primary Clinic	7,412	4.0
Referral Clinic	1,145	.6
Emergency Room	519	.3
Total Outpatient Visits	9,076	4.9

12. STATEMENT: What is the financial status of the Ramsey County Health Plan, who originally financed the Ramsey County Health Plan and if there is a loss sustained by the Ramsey County Health Plan at St. Paul Ramsey Hospital, who pays for it? It is my understanding that MERF and the hospital may take a loss under these circumstances.

12.1 QUESTION: Is this true?

ANSWER: Regarding the financial status of the Ramsey Health Plan, it is important to note that the Plan opened its doors to its first members just seven months after the idea began to grow in the minds of the organizers. It did so without any direct financial assistance, but not without the efforts of the Ramsey County Board of Commissioners, the initial organizing board, the hospital and its medical staff through the Medical Education and Research Foundation, and Group Health Plan, Inc. who provided assistance through the H.E.W. grant awarded to them. During 1973 Group Health provided, through the H.E.W. grant, a marketing consultant.

The Plan was incorporated on a membership basis without capital stock. Therefore, since its opening all financing of the plans operations have been from premium income. The Plan entered into contracts with the Ramsey County Hospital and Sanitarium Commission and with the Medical Education and Research Foundation to provide the necessary health care facilities and services to its members. The major expenditures of the Plan is for medical care delivered to its members and is covered to a large extent through the agreement with SPRH and with the Foundation. It has been and continues to be the intent of the Ramsey Health Plan to finance its own program without "subsidy". During the first nine months the Plan, without capitalization, had only a 3% loss, or $6,485 on total income of $215,457. As of December 31, 1973 or for the first six months of the current fiscal year, operating expense had exceeded premium income by $9,831. However, an adjustment in the premium rate, the first in 16 months, will serve to eliminate this deficit by the end of the Plan's second fiscal year, June 30, 1974.

The Plan is totally on risk for any deficits that many occur. Any deficits will not be shared by either Saint Paul-Ramsey Hospital or the Medical Education and Research Foundation.

13. QUESTION: What is the relationship of MERF to the Ramsey County Health Plan?

ANSWER: The full and part time medical staff of Saint Paul - Ramsey Hospital through agreement with the Medical Education and Research Foundation provides consultative and referral medical services to members of the Ramsey Health Plan. Under this agreement such medical services are paid for by the Ramsey Health Plan on a capitation basis (a specific rate per member, per month). The current rate was in effect through December 31, 1973. Meetings with the Foundation are currently under way for a rate to be determined for 1974.

14. QUESTION: What is the relationship of St. Paul - Ramsey Hospital to the Ramsey County Health Plan?

ANSWER: The Ramsey Health Plan, Inc., entered into a formal agreement with the Ramsey County Hospital and Sanitarium Commission. This agreement provides for:

1. Ramsey Health Plan to pay rent for the space it occupies within the hospital. The rental charge is at the rate of $6 per square foot per year. In addition, the Plan is paying to the hospital the amortization costs of remodeling and Group II and III equipment put into the remodeled area. (see paragraph one of the attached agreement.)

2. Ramsey Health Plan to pay on a capitation basis (per member per month rate) for inpatient facilities and services. (see paragraph 3-a and b of the attached agreement), and inpatient services (see paragraph 3-c of the attached agreement).

3. Ramsey Health Plan to reimburse the hospital for actual cost of personnel assigned to the primary clinic (see paragraph 2 of the attached agreement). This provision is being used for providing the primary care physicians, nursing, clerical and administrative personnel. In addition to the physician complement of 1.4, there is 1.0 registered nurse, .5 nursing assistant, 1.2 clerical and .6 administrative.

14.1 STATEMENT: Regarding these questions, it is my understanding that a lesser amount of money is being charged to patients by MERF as a consultant for HMO patients. Also, in such areas as anesthesia, is a lesser amount being charged to HMO by the hospital? Also, insofar as beds, we would like to know what the room rates are for the HMO compared to room rates for ADC patients and regular patients.

ANSWER: The Medical Education and Research Foundation used as a base for the capitation rate agreed to their regular and customary fees charged. Since one of the chief advantages of a prepaid health plan and agreements such as described above is that the administrative work required with respect to billing, collection, bad debts are reduced substantially. With this factor in mind allowance was built into the final capitation rate agreed to. The answer, therefore, is "no" to the question as to whether a lesser amount is being charged to HMO patients by the Foundation.

The hospital likewise makes no differentiation in the charges made to Ramsey Health Plan patients than to any other patient using the services

and facilities of Saint Paul-Ramsey irregardless of the payor. Room rates for the Ramsey Health Plan patients are identical to room rates for ADC patients and regular patients.

14.2 QUESTION: We would like to know the statistics of the per diem cost of patients in your hospital?

ANSWER: During the year 1973 the revenue per stay of the average patient at Saint Paul Ramsey Hospital was$1,213.54. The average revenue per day per patient was $131.91.

14.3 QUESTION: If there are lesser inpatient, outpatient and service charges to HMO patients than Welfare-ADC type patients and private patients, we feel that this is not proper. If this is true, ADC and private patients would be subsidizing the HMO.

ANSWER: It can categorically be stated that there are not lesser inpatient, outpatient, and service charges to Ramsey Health Plan Members then to Welfare-ADC type patients and private patients. The Ramsey Health Plan in no way desires to be or intends to be "subsidized". The fact that the Ramsey Health Plan exists is due to a desire to provide an alternative delivery and financing mechanism for health care, to elect the health maintenance organization route to provide that alternative, and to give that alternative a fair opportunity to succeed and finally to evaluate the results of that alternative compared with Health Maintenance organizations on the local and national scenes and with the traditional systems of delivering and paying for health care.

15. QUESTION: How does the HMO pay Saint Paul-Ramsey Hospital and who pays the deficit if they run at a deficit?

ANSWER: The Ramsey Health Plan submits payment to the Saint Paul-Ramsey Hospital on a monthly basis an amount equal to the agreed capitation rates for both inpatient and outpatient services and for rental to the hospital for space used and any direct and indirect costs associated with personnel working in the Ramsey Health Plan. The Ramsey Health Plan, Incorporated is responsible for any deficit.

16. QUESTION: If Saint Paul-Ramsey Hospital runs at a deficit due to decrease in charges through the HMO, even in part, who would then make up the deficit financing? Is it not true that a general room rate increase would occur? This would mean that both private patients and the County welfare patients would be paying for the private corporate finances of your HMO.

ANSWER: Since there is not a decrease in charges to the HMO, the Saint Paul-Ramsey Hospital will not run at a deficit for that reason. Therefore, it is not true that a general room rate increase would occur. Likewise, neither private patients nor the County welfare patients would be paying in any way for underwriting the Ramsey Health Plan.

17. QUESTION: What is the relationship of the private physician to MERF and MERF to HMO and the HMO to the private physician?

ANSWER: In answering this question, it is assumed that the definition of a private physician is a physician on the staff of Saint Paul-Ramsey Hospital other than a full time or part time member of the medical staff. A physician joining the staff at Saint Paul-Ramsey Hospital also becomes a member of the Medical Education and Research Foundation.

There is a written agreement between the Medical Education and Research Foundation and the Ramsey Health Plan under which the Ramsey Health Plan agrees to pay a set rate per member per month to the Foundation for medical services of a specialty, referral and consultative nature provided to members of the Ramsey Health Plan.

Almost without exception the majority of medical services provided to members of the Ramsey Health Plan under that agreement is provided by members of the full time and part time medical staff at SPRH. If for some reason some member of that category of staff is not available to provide the required service the Plan then arranges for that service to be provided by a private physician who may or may not be a member of the hospital staff. During the past year there have been a minimum of such referrals required but when they are necessary these referrals were made on the traditional fee for service basis.

17.1 QUESTION: It is my understanding that a private physician who is a member of the Saint Paul Ramsey Hospital cannot bill a patient directly or cannot bill the HMO directly.

ANSWER: Again, for purposes of answering this question it is assumed that a private physician is a physician who is on the medical staff at Saint Paul-Ramsey Hospital but is not a full time or part time member of the staff. Should that physician provide care to a member of the Ramsey Health Plan at the Saint Paul-Ramsey Hospital, that physician as a member of the Foundation can submit a bill for that patient through the Foundation. Payment for that care by Ramsey Health Plan is then covered under the previously referred to agreement with MERF. However, as mentioned above, when and if it does become necessary to make a referral of a patient for medical services not available at the Saint Paul-Ramsey Hospital or by the staff at the Saint Paul Ramsey Hospital, the physician to whom the patient is referred has an option of either billing the Ramsey Health Plan directly or billing the patient directly who in turn may submit the bill to the Ramsey Health Plan. In these cases the medical referral must be approved by the Medical Director of the Ramsey Health Plan prior to the referral.

17.2 QUESTION: MERF must do this and there have been physicians who have complained that MERF subsidizes the Saint Paul-Ramsey physicians who in turn renders a service to the HMO patient. The private physician is not interested in subsidizing the HMO in this manner. Have any private physicians refused to serve the HMO because of this?

ANSWER: The Ramsey Health Plan does not receive subsidy from the Medical Education and Research Foundation. Therefore, if any private physican has refused to serve a member of the HMO because he is not interested in subsidizing the Ramsey Health Plan he is doing so on an assumption that is not fact.

During the past year there have been at least two cases requiring plastic surgery which were referred out to a private physician and with the patient being hospitalized at a hospital other than Saint Paul-Ramsey. Even though the private physician was on the staff at Saint Paul Ramsey he preferred not to do the case at the hospital. This, of course, meant an "extra" expense to the Plan since the cost of hospitalization would have been covered by the capitation rate in the agreement with the hospital. However, in the interest of the patient's welfare, the medical referral was made, the case completed, and both the physician's bill and the hospital bill paid for by the Ramsey Health Plan.

18. QUESTION: On HMO patients, under the present situation, three types of physicians are being paid - theprivate physician, MERF and the primary HMO physician. The reason for that being is that MERF does the charging and does not pay the private referral physician his share to HMO for his services. Therefore, does part of the monies of the private referral go to both Saint Paul-Ramsey Hospital physicians and HMO physician? Is this not a form of fee splitting?

ANSWER: It is unclear as to exactly what question 18 means. It can be stated, however, that the prorata share of the salary paid to a physician working in the primary clinic of the Ramsey Health Plan as well as a prorata share of the stipend paid to thatsame physician by the Medical Education and Research Foundation is reimbursed in full togehter with any fringe benefit costs, etc. to both the hospital and the Foundation. Any other specialty and/or consultative services furnished by the staff through the Medical Education and Research Foundation is covered by the capitation agreement with the Foundation, and in those rare instances when a referral is made outside of that agreement to a private physician, the Ramsey Health Plan pays that physician directly under the traditional method. Based on this the answer is "no" to the question as to whether part of the monies of a private referral go to Saint Paul Ramsey physicians and the Health Plan physicians.

19. QUESTION: Why is there so much administrative space being allocated for MERF? Are they going into the administrative business for the HMO and for the hospital? Why?

ANSWER: The Medical Education and Research Foundation has their portion of the combined building program which would provide both administrative and research space. The administrative space being allocated to the Foundation is to serve strictly the administrative needs, the Medical Education and Research Foundation has and for which they intend to underwrite the construction. The Foundation is not going into the administrative business for the Ramsey Health Plan or for the Hospital.

19.1 QUESTION: If MERF and the hospital do the administrative business for HMO, is it not true that both private patients and ADC patients indirectly subsidize the administrative business through MERF?

ANSWER: Since the answer to question 19 is no, then it is not true that private patients or ADC patients, or any other group of patientsindirectly or directly subsidize the administrative business through the Medical Education and Research Foundation.

QUESTION: Regarding space requirements, the outpatient department wants 100% more space based on your figures for increased outpatient utilization. Why?

ANSWER: See appendix 7 of the reply of Saint Paul-Ramsey to the Staff-Study Review Committee of the Metropolitan Health Board dated January 30, 1974.

20.1 QUESTION: The emergency room wants 50% more space. Based on your figures for increased utilization - why?

ANSWER: See Appendix 7 of the reply of the Saint Paul - Ramsey Hospital to the Staff-Study Review Committee of the Metropolitan Health Board dated January 30, 1974.

20.2 QUESTION: Ramsey County Health Plan wants 6,000 feet and the total outpatient would ask for 26,000 feet. Please justify this on the basis of your present patient flor or projected patient flow.

ANSWER: See appendix 2 of the reply of Saint Paul Ramsey Hospital to the Staff-Study Review Committee of the Metropolitan Health Board dated January 30, 1974 under the section "Basis for Projected Increases".

20.3 QUESTION: Medical Records wants 50% more space. Why could you not utilize better systems rather than ask for more space?

ANSWER: The Medical Records Department has doubled the number of records since relocation from the Ancker Hospital and is now responsible for well over 400,000 records. (Saint Paul-Ramsey Hospital uses the Central Unit Record System). Demands for documentation by Medicare/Medicaid, Utilization of PAS-MAP, and the Utilization Review Program have placed considerable demand upon the department.

20.4 QUESTION: Administration wants 50% more space. Does the number of patients justify this or is this related due to your Health Maintenance Organization? Should the public be asked to finance this?

ANSWER: See appendix 7 of the reply of Saint Paul-Ramsey Hospital to the Staff-Study Review Committee of the Metropolitan Health Board and dated January 30, 1974 .

21. QUESTION: Related to the HMO, could you please list the number of primary HMO physicians who you have hired and what is their background?

ANSWER:

The Ramsey Health Plan has a physician complement of 1.4 full time equivalents. These physicians provide care in the primary clinic of Ramsey Health Plan and any emergencies referred through the Emergency Room of Saint Paul-Ramsey Hospital

The listing is as follows:

Irene Duckett, M.D., Medical Director	Family Practice
J. Curtis Kovacs, M.D.	Family Practice
Newell Howe, M.D.	Family Practice
Thomas D. Maher, M.D.	Internal Medicine
Kusum Saxena, M.D.	Internal Medicine (Board Tests taken 1973)
Clarence R. Henke, M.D.	Internal Medicine (Master of Public Health 1967)
Dale L. Anderson, M.D.	Surgery (Board Certified 4-6-67)
Robert A. vanTyn, M.D.	Surgery
Raj Dutt, M.D.	Pediatrics

The full and part time medical staff of Saint Paul-Ramsey Hospital, through agreement with the Medical Education and Research Foundation provide consultative and referral care. (See full and part time physician roster.)

22. QUESTION: Do resident physicians do HMO work?

ANSWER: Resident physicians do not perform services in the primary clinic of Ramsey Health Plan. When members of the Ramsey Health Plan are referred to specialty clinics or admitted to the hospital resident physicians under the supervision of staff physicians could relate to the Ramsey Health Plan member in a similar way that they do to all patients at Saint Paul-Ramsey.

22.1 QUESTION: Is the teaching program tied in with the HMO?

ANSWER: Patient education is the most prominate within the primary clinic for the Ramsey Health Plan. Teaching of medical students, interns or residents within the primary clinic is not being done other than to acquaint these individuals with the concepts of health maintenance organizations. One of the points of interest is whether a health maintenance organization can successfully operate within a teaching hospital setting. Perhaps as ultimate means of funding medical education are developed that too would become an appropriate and integral function within the primary clinic of the Ramsey Health Plan.

22.2 QUESTION: It is my understanding that many patients are seen by residents rather than the MERF referral physician who has been contracted by the HMO. Please explain.

ANSWER: See answer to Question 22.

22.3 QUESTION: Should not the HMO then subsidize the educational program as do the ADC and private patients through MERF?

ANSWER: The Medical Education and Research Foundation does not subsidize residents at the Saint Paul Ramsey Hospital. Since Ramsey Health Plan is not receiving any "preferential" treatment from either the hospital or the Foundation, then any costs associated with education are included in the final rates arrived at in the agreements previously mentioned.

23. QUESTION: Who takes night call and emergency call for the HMO? Do the primary physicians take call, partial call, or are the patients seen by the Emergency Room physician and house staff? (interns, residents and medical student). If seen by the emergency room staff, are they properly compensated by HMO? If so, is the compensation proportionate to that paid by MERF to the regular staff?

ANSWER: The primary physicians in the Ramsey Health Plan, who are members of the Ambulatory Care Department at Saint Paul-Ramsey Hospital respond to any emergencies that occur after hours, weekends or holidays. The prorata share of these physician's salaries paid by the hospital and stipends paid by the Foundation are reimbursed to those organizations by the Ramsey Health Plan. The Emergency Room physician staff and the primary physicians of the Ramsey Health plan belong to the same group.

24. QUESTION: Have you asked permission for each private medical doctor to use their names as HMO consultants under MERF? To my knowledge you have not. This represents misrepresentation to the HMO patient and physicians.

ANSWER: Private physicians are not listed as Ramsey Health Plan consultants. Therefore, the question rais d above is not applicable. Also, please refer to the answer provided to Question 17.

25. QUESTION: HMO's are experimental and should be able to succeed under their own merit. Taxpayers and physicians do not question this. This is a free enterprise. The question, again, is should taxpayer have to subsidize his own medical care plus the HMO at Saint Paul-Ramsey Hospital? Please justify.

ANSWER: It is agreed that if health maintenance organizations are to be a viable alternative as a health care delivery system they should be able to succeed under their own merit. It is for exactly that reason that the Ramsey Health Plan was established to provide an alternative first of all to the employees of Ramsey County as well as to other interested groups within the Plan's marketing area, and to further evaluate the effectiveness of this alternative means of delivering andpaying for health care. It never has been planned to have anyone other than the members of the Ramsey Health Plan pay for that alternative. As to their experiemental nature one would have to point to some of the more successful health maintenance organizations such as Kaiser and locally Group Health. It is obvious that there is a strong desire in this nation to establish and evaluate health maintenance organizations. It could well be that such organizations will be one of seferal alterantives that will and should be available to members of our society to receive health care. It is unclear as to what is meant by the second part of this question which indicates that the taxpayer is subsidizing his own medical care plus the Ramsey Health Plan.

26. QUESTION: It is my understanding that the nurses' training program is going to be phased out and the building next to St. Paul Ramsey Hospital will be free over the next few years. Is this true?

Could you not use this space in addition to the space in your hospital which is not being utilized by inpatients for your purposes of expansion?

ANSWER: See Appendix 3.

SAINT PAUL - RAMSEY HOSPITAL
MEDICAL STAFF ROSTER

1. FULL TIME AND PART TIME MEDICAL STAFF BY DEPARTMENT OFFICED AT SAINT PAUL - RAMSEY:

DEPARTMENT OF AMBULATORY CARE

Robert A. vanTyn, M.D., Acting Chief - Full Time

Madeline S. Adcock, M.D. - ½ Time
Dale L. Anderson, M.D. - Full Time
Irene Duckett Cass, M.D. - 2/3 Time
Raj Dutt, M.D., Full Time
Clarence R. Henke, M.D. - 3/4 Time
Newell Howe, M.D. - Full Time
J. Curtis Kovacs, M.D. - Full Time
Thomas D. Maher, M.D. - Full Time
Kusum Saxena, M.D. - Full Time

DEPARTMENT OF ANESTHESIOLOGY

G. Thomas Wier, M.D., Chief - Full Time

Po Myaya, M.D. - Full Time
Jose C. Reyes, M.D. - Full Time
Jose B. Romero, M.D. - Full Time
Claude R. Swayze, M.D. - Full Time
Dorat Thienprasit, M.D. - Full Time

DEPARTMENT OF DENTISTRY

Kenneth J. Richter, D.D.S., Chief - 3/4 Time

DEPARTMENT OF DERMATOLOGY

H. Irving Katz, M.D. ½ Time

DEPARTMENT OF FAMILY PRACTICE

Vincent R. Hunt, M.D., Chief - Full Time

Luis A. deCubas, M.D. - Full Time
Robert A. Derro, M.D. - Full Time
Ray C. Hippchen, M.D. - Full Time
Alan R. Johnson, M.D. - 1/10 Time
J. Anthony Malerich, Jr., M.D. - 1/10 Time
John A. McLeod, M.D. - Full Time
Kenneth O. Nimlos, M.D. - 1/10 Time
Robert W. Reif, M.D. - 1/10 Time
Donald E. Roach, M.D. - 1/10 Time

DEPARTMENT OF MEDICINE - Robert O. Mulhausen, M.D., Chief - Full Time

Brian C. Campion, M.D. - Full Time
James E. Hoffman, M.D. - Full Time
Paul B. Johnson, M.D. - Full Time
John W. McBride, M.D. - Full Time
Michael T. Spilane, M.D. - Full Time
Wayne L. Stern, M.D. - Full Time
Pradub Sukhum, M.D. - Full Time
Luigi Taddeini, M.D. - Full Time

DEPARTMENT OF NEUROLOGY

Robert J. Gumnit, M.D., Chief - Full Time

Charles S. Bland, M.D. - 1/4 Time
W. Allen Hauser, M.D. - Full Time
Manuel Ramirez-Lassepas, M.D. - Full Time
Hsien-Hwa Hsieh Lee, M.D. - 1/4 Time

DEPARTMENT OF NEUROSURGERY

Donald L. Erickson, M.D., Chief - 1/2 Time

Walter L. Bailey, M.D. - 1/4 Time
Willis E. Brown, M.D. - 1/4 Time
Max E. Zarling, M.D., - 1/4 Time

Full Time and Part Time Medical Staff By Department Officed At Saint Paul - Ramsey

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

Erick Y. Hakanson, M.D., Chief - Full Time

Ismail Barrada, M.D. - Full Time
Laura E. Edwards, M.D. - Full Time

DEPARTMENT OF OPHTHALMOLOGY

Robert Hugh Monahan, M.D., Chief - 3/4 Time

Yale C. Kanter, M.D. - 1/10 Time
Larry Londer, M.D. - 2/5 Time

DEPARTMENT OF ORTHOPEDICS

Thomas H. Comfort, M.D., Chief - Full Time

Daniel W. Gaither, Jr., M.D. - 1/2 Time
Lloyd L. Leider, M.D. - 1/2 Time

DEPARTMENT OF OTOLARYNGOLOGY

Lawrence R. Boies, Jr., M.D., Chief - Full Time

DEPARTMENT OF PATHOLOGY

Erhard Haus, M.D., Chief - Full Time

. Donald Kapps, M.D. - Full Time
avid J. Lakatua, M.D. - Full Time
Zoltan Posalaky, M.D. - Full Time
Bertram F. Woolfrey, M.D. - Full Time

DEPARTMENT OF PEDIATRICS

Homer D. Venters, M.D., Chief - Full Time

F. Blanton Bessinger, M.D. - 1/5 Time
Eunice A. Davis, M.D. - Full Time
Ralph Faville, M.D. - 1/2 Time
Robert L. Kriel, M.D. - Full Time
Leonard Mattson, M.D. - 1/10 Time
Norman L. Virnig, M.D. - Full Time
David Thomspon, M.D. - Full Time

DEPARTMENT OF PHYSICAL MEDICINE

Michael Kosiak, M.D., Chief - Full Time

DEPARTMENT OF PSYCHIATRY

Vicente B. Tuason, M.D., Chief - Full Time

Roger A. Johnson, M.D. - Full Time
Burtis J. Mears, M.D. - Full Time
Ramon Milan, M.D. - 1/2 Time
John M. Scanlan, M.D. - Full Time
Richard R. Teeter, M.D. - Full Time
Thomas E. Weier, M.D. - Full Time

DEPARTMENT OF RADIOLOGY

Robert G. B. Bjornson, M.D., Chief - Full Time

Adrian L. Kapsner, M.D. - Full Time
Donald G. Marsh, M.D. - 3/4 Time
Robert R. McClelland, M.D. - Full Time
Donald H. Peterson, M.D. - 2/5 Time
Robert D. Pilgrim, M.D. - Full Time
Daryl P. Williamson, M.D. - Full Time

Full Time and Part Time Medical Staff By Department Officed at Saint Paul - Ramsey Hospital

DEPARTMENT OF SURGERY

John F. Perry, Jr., M.D., Chief - Full Time

Albert Mowlem, M.D. - Full Time
Frank W. Quattlebaum, M.D. - Full Time
Richard G. Strate, M.D. - Full Time

DEPARTMENT OF UROLOGY

Alexander S. Cass, M.B.B.S., Chief - Full Time

2. ATTENDING MEDICAL STAFF BY DEPARTMENT WITH OFFICE ADDRESS

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QUESTIONS RELATING TO

RAMSEY HEALTH PLAN, INC.

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DESCRIPTION OF RAMSEY HEALTH PLAN, INC.

A Health Maintenance Organization, known as HMO, has been established and is functioning within the walls of the Saint Paul-Ramsey Hospital. This is an innovative type program in keeping with today's efforts to provide low cost prepaid health care delivery. The history of this organization is unique in that it was conceived, organized and implemented, within a period of seven months, as a consumer-oriented health care system within a teaching hospital, and without outside funding.

Ramsey Health Plan was made possible through the cooperation of our separate units:

1. The Board of Commissioners of Ramsey County who sought an optional health care plan for the 3,000 county employees. Blue Cross-Blue Shield of Minnesota was the only health plan available to the employees.
2. Saint Paul-Ramsey Hospital which became the site for the new plan. Once the hospital was chosen as the site for the clinic, the HMO contracted and is paying for space and services within the hospital.
3. The full time hospital medical staff of nearly seventy members. Each member of this staff holds a faculty appointment at the University of Minnesota. Each physician is a member of the Medical Education and Research Foundation, which supports education and research and supplements faculty salaries through the collection of professional fees. This physician group serves as a backup and supplies the referral system for the HMO clinic.
4. Group Health Plan, Inc., the largest prepaid health plan in the upper Midwest. Group Health was awarded a grant in 1971 from HEW to aid and advise in the formation of HMO's in this community. Since the inception

of the Ramsey Health Plan, and up to the present time, Group Health has acted as our insurance mechanism. With Minnesota's new HMO law, and with the viability of the current plan Group Health has agreed to separate itself from our insurance mechanism control and Ramsey Health Plan will now be independent.

An incorporating board for Ramsey Health Plan was formed by the County Board of Commissioners. This Board was composed of three union members, two physicians, the County Civil Service Administrator, two County Commissioners and a health care professional. The Board met for the first few months at frequent intervals and was eventually to thirty members, sixty percent being plan members.

A very innovative part of this health plan was its original contract with Saint Paul-Ramsey Hospital to provide the inpatient and outpatient services on a capitation basis. In addition, it contracted with the Medical Education and Research Foundation for its medical services. It paid Group Health a percentage for carrying out its marketing and insurance mechanism.

The medical staff was kept advised of the plans and agreed with this concept of health care delivery, particularly inasmuch as this hospital could provide a setting for an experimental effort along these lines. Hopefully, the results would be availavle to other hospitals in the community. Contracts and agreements were drawn up between the incorporating board, Ramsey Hospital Commission, the Medical Education and Research Foundation and Group Health. Copies of the agreements with the Hospital Commission and the Foundation are attached. As of February 1, 1974 there is no longer a formal agreement with Group Health. In October of 1972 the doors of the clinic were opened on the first floor of the Saint Paul-Ramsey Hospital adjacent to the Emergency Room area.

The initial enrollment effort during September 1972 was very successful. Over twenty-five percent of the target group enrolled in this plan resulting in 572 contracts (forty percent family and sixty percent single) covering 1,257 members.

Another open enrollment for the same target group was held in December 1972 resulting in an increase of 228 contracts for a total of 800 contracts (forty percent family) covering 1,800 members. During this enrollment, the Village of Roseville elected to offer Ramsey Health Plan as an option to its employees, which fifty percent of the eligible employees elected. Currently there are 511 single contracts and 335 family contracts covering 1,930 members with this latter gain occurring from new employees electing this option. An annual open enrollment period from Ramsey County employees and Roseville employees is just being completed.

The Plan has just entered into its second year of service. It is well integrated into the hospital mechanism but remains an independent corporation governed by its own Board and its own medical staff. The staff of Saint Paul-Ramsey Hospital continues to supply its backup medical service needs. Group Health has withdrawn from the insurance managerial role effective February 1, 1974. This role will be carried out by employees of the Plan itself.

It would appear that in general the medical service supplied by Ramsey Health Plan has been well accepted and approved by its membership. At the end of its first fiscal year (nine months of operation) there is a total operating deficit of $6,000 or 3% loss. This was considered to be acceptable for the first year of operation. Attached is a copy of the auditors report covering the first fiscal year and a copy of the most recent financial statements for the Plan.

Projections for the balance of the fiscal year ending June 30, 1974 indicate that the Plan will be at a "break-even" point by that time. This is due to the Plan organizationally being on its own as of February 1, 1974, an increase in premium effective February 1, 1974 and that as of December 31, 1973 an advance on premiums provided by Group Health as working capital during the early months of operation was paid back in full.

Plans for the immediate future: The Plan maintained its current strong position in the County employee area when enrollment was opened in January 1974. We would also like to be an option in the City which is currently reviewing its program. The Plan is marketing its program to other municipalities, school districts and governmental agencies. It further is developing its marketing strategy to other target groups. As enrollment increases beyond the capacity of the current clinic, additional space will have to be found.

Long Range Plans: We expect Ramsey Health Plan to prosper and grow. Its activities fit in well with the current concept of providing as much ambulatory care as possible. Such a change is mandatory if we are to reduce the evermounting cost of medical care. This problem obviously presents a paradox in that we are supporting ambulatory care not only in this Health Plan but also in the Hospital's own Outpatient Clinics while the hospital is constantly struggling to maintain its census.

If the new Gillette/SPRH building is completed within a two-year period, Ramsey Health Plan can move into its own planned area in the new building. We hope to utilize the new space jointly when possible with the hospital's own outpatient services. This use of space would be more efficient and effectively lower expenses. This would allow us to provide care at a lower rate for the people of this community.

The mechanism and the financial balance sheets of Ramsey Health Plan have been made available to anyone in the medical hospital community. We like to think of the Plan as being an experimental project, operating within the confines of a hospital but still independent of the hospital. The results, trials and hopefully the successes of this Plan will then be available to other hospitals to aid them in similar efforts.

PHYSICIAN MEMBERSHIP BY SPECIALTY

The Ramsey Health Plan has a physician complement of 1.4 full time equivalents. These physicians provide care in the primary clinic of Ramsey Health Plan and any emergencies referred through the Emergency Room of Saint Paul-Ramsey Hospital.

Irene Duckett, M.D., Medical Director	Family Practice
J. Curtis Kovacs, M.D.	Family Practice
Newell Howe, M.D.	Family Practice
Thomas D. Maher, M.D.	Internal Medicine
Kusum Saxena, M.D.	Internal Medicine (Board Tests taken 1973)
Clarence R. Henke, M.D.	Internal Medicine (Master of Public Health 1967)
Dale L. Anderson, M.D.	Surgery (Board Certified 4-6-67)
Robert A. vanTyn, M.D.	Surgery
Raj Dutt, M.D.	Pediatrics

The full and part time medical staff of Saint Paul-Ramsey Hospital, through agreement with the Medical Education and Research Foundation provide consultative and referral care. (See full and part time physician roster.)

ARRANGEMENTS WITH SAINT PAUL-RAMSEY HOSPITAL

The Ramsey Health Plan, Inc. entered into a formal agreement with the Ramsey County Hospital and Sanitarium Commission (see copy attached). This agreement provides for:

1. Ramsey Health Plan to pay rent for the space it occupies within the hospital. The rental charge is at the rate of $6 per square foot per year. In addition, the Plan is paying to the hospital the amortization costs of remodeling and Group II and III equipment put into the remodeled area. (see paragraph one of the attached agreement.)

2. Ramsey Health Plan to pay on a capitation basis (per member per month rate) for inpatient facilities and services. (see paragraph 3-a and b of the attached agreement), and inpatient services (see paragraph 3-c of the attached agreement).

3. Ramsey Health Plan to reimburse the hospital for actual cost of personnel assigned to the primary clinic (see paragraph 2 of the attached agreement). This provision is being used for providing the primary care physicians, nursing, clerical and administrative personnel. In addition to the physician complement of 1.4, there is 1.0 registered nurse, .5 nursing assistant, 1.2 clerical and .6 administrative.

   The attached agreement constitutes the total agreement between the hospital and Ramsey Health Plan.

Families and Persons Enrolled

Membership in the Plan is currently provided on a group basis to eligible employees of Ramsey County and other municipalities in Ramsey County electing to participate in the County's insurance program, i.e., Roseville, members of the Plan's Board of Directors,

employees, members of the Hospital Commission. Individual contracts are available to former members of the group contract. The marketing area for Ramsey Health Plan is considered to be Ramsey County, Southern Anoka County, most of Washington County and Northern Dakota County.

Following is a recap of current membeers as of December 31, 1973:

	No. of Contracts			
	Single	Family	Total	Total Members Covered
October 1972	343	229	572	1,257
January 1973	480	320	800	1,800
December 1973	511	335	846	1,930

The average number of members per family contract is 4.2.

BASIS FOR PROJECTED INCREASES

It is contemplated that Ramsey Health Plan would occupy up to 6,000 square feet in the new ambulatory care building. This space is predicted on projected membership growth, locally and nationally developed data as to number of square feet per member, and utilization of current facilities.

The Board of Ramsey Health Plan, in developing marketing strategy, has developed plans to increase their membership to 4,000 members by 1975 and 6,000 members by 1976. In light of the local and national climate encouraging the development of Health Maintenance Organizations this appears to be a very realistic goal. At least two local health maintenance organizations have accomplished a marked increase in membership, with Group Health doing so even in the absence of the national spotlight on health maintenance organizations. Even within one target group - Ramsey County employees, membership increased 54% from the initial enrollment in September 1972 through 1973.

Due to the flexibility of facilities planned and the joint utilization of ancillary services such as x-ray, laboratory, pharmacy services for which the Plan pays the hospital, the number of square feet per member required is reduced below the suggested one square foot per member.

As the Plan grows the need for office space for medical administrative and general administration will be required and in fact is provided for in the new plans.

ELIGIBILITY REQUIREMENTS - RELATIONSHIP TO BLUE CROSS/M.I.I.

Current eligiblity requirements for membership in the Plan is discussed under Families and Persons Enrolled.

Blue Cross/M.I.I. approached the Ramsey Health Plan with the proposal to serve as a provider under their HMO network plan. Ramsey Health Plan expressed interest in the proposal and the Board signed a letter of intent with no further obligation than to further review the proposal in detail. Ramsey Health Plan must discuss further the philosoplical question as to whether it can pursue the goals of developing a health maintenance organization and at the same time serve as a provider for another HMO program. It is too early to predict the outcome of those negotiations.

FINANCING

The Ramsey Health Plan opened its doors to its first members just seven months after the idea first began to grow in the minds of the organizers. It did so without any direct financial assistance but not without the efforts of the Ramsey County Board of Commissioners, the initial organizing Board, the hospital and its medical staff through the Medical Education and Research Foundation, and Group Health Plan, Inc. who provided assistance through the HEW grant awarded to them. A total of $5,000 was through that grant for marketing consultation.

Since its opening all other financing of the Plan's operation has been from premium income. The major expenditures of the Plan is for medical care delivered to its members and is covered to a large extent through the agreement with Saint Paul-Ramsey Hospital and the Medical Education and Research Foundation.

It has been, and continues to be, the intent of the Ramsey Health Plan to finance its own program without "subsidy." During the first nine months of operation the Plan, without capitalization, had only a 3% loss (see auditor's report attached). At the end of fourteen months operation, the Plan has only a 4% loss. Effective February 1, 1974, new premium rates go into effect for the County group. That coupled with its separate organizational structure results in the projection that the total loss will be eliminated by the end of its second fiscal year and the member's equity reflecting a positive balance.

Utilization Since Opening

The Ramsey Health Plan began accepting patients on October 1, 1972 at which time it had an enrollment of 1,257 members. By January 1973 enrollment was 1,800 members and by December 1973 there were 1,930 members.

A summary of services provided follows:

Outpatient visits October 1972 - December 1973 (15 months)

	Primary Care Clinic	Referral Clinics	Emergency Room	Total Visits
Oct. - Dec. 1972	801	174	22	997
Jan. - Dec. 1973	7,412	1,145	519	9,076
Total (15 months)	8,213	1,319	541	10,073

Inpatients - October 1972 - December 1973 (15 months)

	Admissions	No. Patient Days	Average Length Of Stay
Oct. - Dec. 1972	26	158	6.1
Jan. - Dec. 1973	255	1,163	4.6
Total (15 months)	281	1,321	4.7

Average Number of Visits per Member Per Year - January - December 1973

Type Visit	No. Visits	Visit/Member/Year
Primary Clinic	7,412	4.0
Referral Clinic	1,145	.6
Emergency Room	519	.3
Total Outpatient Visits	9,076	4.9

It has been calculated that Ramsey County Government and its employees who have elected Ramsey Health Plan will spend $41,000 less for premiums alone in 1974 compared with the traditional indemnity plans.

WHO SHARES THE RISK

The Ramsey Health Plan does have some unique features relative to risk sharing. First, the Plan is on risk for providing the in-area medical care for all of its members at a predetermined rate for the term of the contract (one year). The Plan in turn has a per capita rate (monthly rate per member) with the hospital (see agreement attached) for inpatient and outpatient services and with the Foundation for consultative and referral specialist services. The hospital and the Foundation are on risk in that both agree to provide these services for a predetermined rate. In the case of the hospital, this rate was set on assumptions being made on volume of services and the cost for providing those services. Per the agreement, if inpatient utilization is less than anticipated the plan would be refunded 4% of the capitation premium for every twenty days below the minimum established per 1,000 members. On the other hand, the plan would reimburse the hospital 4% for each additional twenty hospital days above the maximum established per 1,000 members. This payment would be made over the entire following year by increasing the monthly capitation rate by the appropriate amount.

The Plan has also purchased out-of-area insurance to cover emergency hospital and medical benefits required by members who are out of the service are at the time. The insurance carrier then is on risk for these benefits.

The members are also on risk in as much as their over utilization of services could result in higher premiums being charged. Since a majority of the governing board are members there is considerable interest in this.

CERTIFICATION

The Ramsey Health Plan was advised in December that it was one of several in the State of Minnesota receiving a certificate of Authority to operate as a Health Maintenance Organization as defined in the 1973 Minnesota Statues.

BALANCE SHEET

JUNE 30, 1973

ASSETS		
Current		
Cash on Hand and in Bank	$12 842	
Premiums Receivable	27 972	
Total Current Assets		$40 814
LIABILITIES AND MEMBERS' EQUITY		
Current		
Accounts Payable - St. Paul Ramsey Hospital	22 147	
Accounts Payable - Medical Education and Research Foundation	13 526	
Accounts Payable - Other	543	
Advance From Group Health Plan, Inc.	11 083	
Total Current Liabilities		47 299
Members' Equity (Deficit)		(6 485)
Total Liabilities and Members' Equity		40 814

Subject to certificate on page 1.

The accompanying notes are an integral part of the financial statements.

INCOME STATEMENT

FOR THE NINE MONTH PERIOD ENDED JUNE 30, 1973

Income		
Health Care Premiums	$215 256	
Contributions	201	
Total Income		$215 457
Expense		
Per Capita Agreement - St. Paul Ramsey Hospital	132 259	
Per Capita Agreement - Medical Education and Research Foundation	24 680	
Salaries - Physicians	33 072	
Salaries - Staff	12 556	
Payroll Taxes and Fringe Benefits	5 663	
Rent	5 424	
Office Supplies and Expense	3 238	
Professional Services - Special Medical	1 265	
Professional Services - Legal	1 065	
Drugs	523	
Medical Supplies	346	
Benefits Expense - In Area	212	
Benefits Expense - Out of Area	586	
Telephone and Telegraph	535	
Conference and Travel	412	
Miscellaneous	106	
Total Expense		221 942
Net Loss		(6 485)

MEMBERS' EQUITY (DEFICIT)

Net Loss for Nine Months Ended June 30, 1973	$ (6 485)
Balance, June 30, 1973 (Deficit)	(6 485)

Subject to certificate on page 1.

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FINANCIAL POSITION

JUNE 30, 1973

Sources of Funds	
None	$ -0-
Uses of Funds	
Net Loss for Nine Months	6 485
Decrease in Working Capital	(6 485)
Balance, Beginning of Period	-0-
Balance, End of Period	(6 485)

SUMMARY OF CHANGES IN WORKING CAPITAL COMPONENTS

Increases in Working Capital:		
Cash	$12 842	
Receivables	27 972	
Total		$40 814
Decreases in Working Capital:		
Accounts Payable	36 216	
Advance From Group Health, Inc.	11 083	
Total		47 299
Decrease in Working Capital		(6 485)

Subject to certificate on page 1.

The accompanying notes are an integral part of the financial statements.

NOTES TO FINANCIAL STATEMENTS

1) Significant Accounting Policy:

The corporation records its transactions by using the accrual method of accounting.

2) Ramsey Health Plan, Inc., was incorporated June 16, 1972, on a membership basis without capital stock. Membership consists of those persons who are health care subscribers to the health maintenance contract offered by the corporation.

3) The corporation entered into contracts with the Ramsey Hospital Commission and the Medical Education and Research Foundation to provide the necessary health care facilities and services to its members. In addition, certain administrative and marketing services have been contracted by Ramsey Health Plan, Inc. to Group Health, Inc., St. Paul, Minnesota.

4) The Internal Revenue Service has determined that the corporation is exempt from federal income tax under the provisions of Section 501 (c)(4).

RAMSEY HEALTH PLAN, INC.

640 Jackson Street, St. Paul, Minnesota 55101
225-7867

STATEMENT OF OPERATIONS

December 31, 1973

	December 1973		November 1973		Fiscal Year To Date	
INCOME						
Premiums	$28,500.00		$28,776.99			
Adjust Oct.,Sept.	55.66		40.38		$169,519.11	
Special Grant	833.34		833.34		5,000.04	
Total Income		$29,389.00		$29,650.71		$174,519.15
OPERATING EXPENSE						
Per Capita Agreement						
SPRH	$17,756.00		$17,746.80			
Adjust Sept.			611.90		$104,247.90	
MERF	4,149.50		4,147.35			
Adjust Oct., Sept.	95.75		96.45		24,441.20	
Salaries	5,859.00		6,159.00		36,424.00	
Fringe Benefits	745.00		755.00		4,471.00	
Rent	645.00		645.00		3,870.00	
Medical Supplies	41.00		68.00		390.00	
Drugs	---		---		39.00	
Office Supplies	23.00		177.90		374.90	
Telephone-Telegraph	53.10		53.10		320.04	
Special Medical Serv.	100.00		250.00		1,024.00	
Misc.	---		---		500.17	
Special Grant	833.34		833.34		5,000.04	
Medical-In Area Ben.	89.50		67.95		2,768.46	
Medical-Out of Area	25.00		---		297.60	
Conference & Travel	---		10.00		181.97	
Total Expenses		$30,415.19		$31,621.79		$184,350.28
		($1,026.19)		($1,971.08)		($9,831.13)

RAMSEY HEALTH PLAN, INC.
640 Jackson Street, St. Paul, Minnesota 55101
225-7867

BALANCE SHEET

December 31, 1973

	December 1973		November 1973	
ASSETS				
Cash	$ 368.24		$ 4,393.99	
Accounts Receivable Premiums	60,797.18		60,497.18	
Total Assets		$61,165.42		$64,891.17
LIABILITIES				
Accounts Payable				
SPRH-Capitation	$35,502.80		$34,746.80	
MERF-Capitation	8,198.37		8,048.87	
Salaries & Fringe Benefits	23,909.39		24,097.39	
Other Payables	4,091.79		4,796.13	
Total Current Liabilities	71,702.35		71,689.19	
Advance Payable - Group Health	2,374.94		4,749.96	
Total Liabilities		$74,077.29		$76,439.96
Plan Balance		($12,911.87)		($11,547.98)

RAMSEY COUNTY EMPLOYEES
HEALTH PLAN OPTION

PROVIDED BY

RAMSEY HEALTH PLAN, INC.
640 JACKSON STREET
ST. PAUL, MINNESOTA 55101

The Ramsey County Board of Commissioners is pleased to again make availavle to County Employees and their dependents a HEALTH BENEFITS OPTION. This Option offers improvements over the existing benefit coverage. These health benefits are in the area of medical service. They include such important services as office visits, immunizations, eye examinations, checkups and the doctor services that families use most frequently, all without additional charge.

This new program of comprehensive health services means that you and your dependents will have expanded health care service without extra charges. This program is made available to you through the joint effort of Ramsey County and the Ramsey Health Plan, Inc., a non-profit program of comprehensive medical and hospital services designed especially to better serve the needs of County Employees.

Ramsey Health Plan makes use of the tremendous medical resources of Saint Paul-Ramsey medical staff and hospital. It has its own tastefully decorated separate office suite leased from Saint Paul-Ramsey Hospital. Free parking is provided for subscribers. Ramsey Health Plan and its medical facilities have been developed for the exclusive use of families who elect the new Ramsey Health Plan Option.

Employees electing the Ramsey Health Plan Option will retain all life and disability benefits they now have or may elect to take in the future.

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COMPREHENSIVE MEDICAL SERVICES

BENEFITS PROVIDED

This plan will provide to the member medical-surgical and related services by licensed physicians and surgeons associated with the Ramsey Health Plan Medical Center. The premium *covers the full cost* of all such services except as otherwise noted below. Services to be provided are:

Office Visits — Hospital Visits and Consultations

Covered in full. In addition to family doctors, the RHP Medical Center is staffed by physicians in many specialties (other specialities are provided upon referral).

Surgical Care

Major and minor surgery, including all specialized surgery, is covered in full. No surgical schedules; no deductibles, no extra charges.

X-ray and Laboratory Services

Diagnostic X-rays, laboratory procedures, cardiograms, hearing evaluations at the RHP Medical Center — all without extra fees.

Preventive Health Care

Health evaluations, basic immunizations including diptheria and pertussis toxoid, tetanus toxiod, and polio vaccine. Measles vaccinations is administered subject to a service charge for the vaccine.

Eye Examinations

Eye refractions and treatment without cost. Glasses, repairs, and lens replacement at special member cost.

Drug Prescriptions

Prescriptions for drugs written by RHP physicians are filled at the RHP Medical Center at a cost of $.50 per prescription up to a 34 day supply. The usual and customary cost for prescriptions for drugs written by RHP physicians and filled in a public pharmacy is covered after a $2.00 deductable per prescription for up to a 34 day supply. Expenses for prescriptions filled in a public pharmacy are not to be submitted more often than quarterly or when $25.00 is incurred, whichever is first.

Maternity Care

Complete maternity care is provided by specialists in obstetrics and gynecology, including prenatal care, delivery and any complications of pregnancy. Medical services for pregnancy is available without waiting period.

Child Care

Complete pediatric care of babies and other children.

Physical Therapy

Physical therapy will be given when authorized by a RHP physician.

Additional Medical Services

Includes allergy testing and treatment (members pays for cost of extracts used in desensitization injections); administration of ansthesia; blood and blood plasma; heat therapy; prescriptions for drugs (member pays 50c per prescriptions for drugs (member pays 50c per prescriptions for a 30 day supply).

Home Care

Home visits are provided in the service area by RHP physicians within their discretion, subject to a service charge of $3.00 for each visit requested and made between 7:00 a.m. and 7:00 p.m. and $5.00 for each visit between 7:00 p.m. and 7:00 a.m.

SUPPLEMENTAL BENEFITS — Full payment of nursing services, appliances, and equipment prescribed by RHP's Medical Director, when the cost for such exceeds the sum of $50.00 in any calendar year, but not to exceed $5,000.

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COMPREHENSIVE HOSPITAL SERVICES

BENEFITS PROVIDED

This plan will provide the following hospital benefits in St. Paul-Ramsey Hospital while confined as a bed patient under the order and care of a RHP physician for diagnosis and treatment of illness or injury.

Daily Benefit – Full payment of hospital charges for room and board when confined in a semi- private room, or up to the hospital's average semi-private room rate if confined in other than a semi-private room, up to 365 days per confinement.

Other Hospital Services – Full payment for other services and supplies furnished by the hospital during each day of confinement for which room and board benefits are payable. Such services and supplies include use of operating, recovery and treatment rooms and equipment; drugs, dressings, intravenous injections and sera supplied by the hospital; laboratory services; diagnostic X-ray examination, electrocardiograms and basal metabolism tests; oxygen and its administration; radiation therapy; diathermy, inhalations; administration of blood and blood plasma, regular local ambulance service.

Maternity Care – Full payment for hospital maternity care is limited to pregnancy including complication or sequalae thereof, conceived after the date the member becomes qualified for maternity benefits.

Nervous, Mental and Tuberculosis Care – Benefits for nervous, mental and tuberculosis care are provided for up to 365 days when under the care of a RHP physician.

Alcoholism/Chemical Dependency– Benefits for alcoholism, chemical dependency or drug addiction are limited to 20% of the number of days shown under the daily benefit; in each calendar year (73 days).

OUT-OF-AREA HOSPITAL AND MEDICAL INDEMNITY BENEFITS

HOSPITAL BENEFITS

When the member is traveling outside of the geographic area served by the Ramsey Health Plan Medical Center, away from his permanent place of residence, and requires hospital and/or physician's care for a medical emergency, the following schedule of benefits is provided:

Hospital - Inpatient – Benefits as described under Comprehensive Hospital services provided up to a maximum of $10,000 for out-of-area emergencies.

Hospital - Outpatient – The cost of emergency room, anesthetic, operating room, drugs, dressing, X-rays and laboratory, all rendered in a hospital out-patient department for a medical or surgical emergency.

PHYSICIAN SERVICES

Surgical Benefits – Based on $6.00 per unit schedule based on 1964 California Relative Value Schedule with a maximum of $1,200.

Office and In-Hospital Call Benefits – $6.00 per vist to the doctor's office and for each doctor visit to the hospital.

Out-Patient Diagnostic X-ray and Laboratory Examination Benefits – $50.00 maximum allowance per medical emergency.

Accidental Medical Benefits – $100.00 maximum allowance for outpatient medical care of any one injury.

Obstetrical Benefits – The following surgical allowances are payable for out-of-area pregnancy expense:

$75.00 Miscarriage

$125.00 Obstetrical Delivery (payable for delivery occurring while the member is temporarily residing outside of the Service Area for at least 30 days but less than one year).

The maximum hospital benefits for an out-of-area emergency shall be limited to $10,000.00.

The hospital, medical and surgical indemnity benefits described herein are underwritten for Ramsey Health Plan, Inc. by MidAmerica Mutual Insurance Company, 2021 East Hennepin Avenue, Minneapolis, Minnesota.

Claims for out-of-area hospital and medical services are to be submitted to Ramsey Health Plan, Inc., 640 Jackson Street, Saint Paul, Minnesota 55101, 225-7867. Claim forms are available upon request.

GENERAL INFORMATION

EMERGENCIES WITHIN THE SERVICE AREA – RHP Medical Center is responsible for providing emergency medical and out-patient services to members 24 hours per day. When an emergency occurs you can go directly to the RHP Center for emergency care, or to the emergency room at Saint Paul-Ramsey Hospital. If possible, call 225-7867 first. Just identify yourself as an RHP member.

CHOICE OF DOCTORS – Members of RHP can choose one of a number of physicians on the staff of the particular clinic as their family doctor.

THIRD PARTY ACTIONS – If a member or eligible dependent is injured through the act of a third party, RHP has the right to be reimbursed, to the extent damages are collected, for the reasonable value of the medical care rendered to the person for that injury.

COORDINATION OF BENEFITS – The Coordination of Benefits provision is intended to prevent payment of benefits which exceed expenses. It applies when a person covered by Ramsey Health Plan is also covered by another Health Plan or Plans. When more than one such plan exists, one normally pays its benefits in full and the other pays a reduced benefit. In applying the Coordination of Benefits provision Ramsey Health Plan will always either pay its benefits in full or a reduced amount which when added to the benefits by the other plan or plans, will equal 100 percent of the allowable expenses.

DEPENDENTS – Spouse and all unmarried children under 19 years of age or to age 25 if a student, unmarried and dependent on employee. To any age if unmarried dependent child was physically handicapped or mentally retarded before reaching age 19, or if a student, age 25.

CONVERSION – If eligiblity for coverage through the group ceases, an application for an individual conversion membership will be accepted up to 30 days after the group coverage terminates. For details call Ramsey Health Plan at 225-7867.

GENERAL EXCLUSIONS APPLICABLE TO ALL SERVICES AND BENEFITS – Claims arising directly or indirectly from war or any act of attributed thereto; services and facilities provided by or in institutions owned or operated by the Federal Goverment; cases compensable under Workmen's Compensation Acts or similar law; cosmetic surgery other than restorative surgery; attempted suicide; rest cures and custodial care; chronic dialysis for kidney failure; transplantation of organs. diagnostic work when curative treatment is not given during hospital confinement, except when authorized by Medical Director.

EXCLUSIONS & LIMITATIONS APPLICABLE TO PREPAID MEDICAL SERVICES ONLY – Services of physicians who are not associated with Ramsey Health Plan, Inc., unless authorized by the Ramsey Health Plan Medical Director; nervous and mental disorders after diagnosis for which psychiatric care is required; tuberculosis; dental care and dental surgery except cuttery surgery as required; congenital malformations requiring referral for surgery shall be covered on a schedule basis up to $400.00.

Eligible employees may apply for benefits by contacting the Ochs Agency, Inc., 345 Cedar Street, St. Paul, Minnesota: TELEPHONE 298-3789.

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ST. PAUL-RAMSEY HOSPITAL and MEDICAL CENTER
ST. PAUL, MINNESOTA 55101

MEMORANDUM

TO: Mr. LaVand Syverson
Executive Director

FROM: V.B. Tuason, M.D.
Head, Department of Psychiatry

DATE: January 31, 1974

RE: A Proposal for the Utilization of the Ancker Nursing School Dormitory Building

The essential services for the diagnosis and treatment of the mentally ill population in Ramsey County are operative. However, a gap in the health care delivery system implicates the need for a program that would deal with those persons whose condition requires assistance beyond what services are currently offered. Examples of these consumer needs are:

A. The mentally ill who do require further treatment and rehabilitation prior to being involved in open community function.

B. The elderly whose needs require brief but vigorous clinical and social assistance.

C. The chemically dependent persons who should be cared for in a setting beyond the Detoxification Center and short of the specialty medical department in a general hospital.

D. The rape victims that require compassionate and sympathetic handling.

E. The alienated persons comprising the family and group home tolerance emergency.

F. The abused child or the abusing person that requires evaluation for determinative care.

These service gaps require the development of a program that can be brought about by a further alliance between Ramsey County Mental Health Center and SPRH. The aforementioned services can be programmed within the Ancker Nursing School Dormitory Building. Conceptually, a 24-hour walk-in psychological emergency service can be organized that would blend in with the current operations of the Mental Health Center and the SPRH Emergency Room. Concurrently a crisis and care service that would assist those persons previously defined can be planned and developed. This calls for establishing a consortium of agencies organizationally, dealing with the consumers, courts, police, welfare and other concerned health care professionals.

VBT/kk

ST. PAUL-RAMSEY HOSPITAL
ST. PAUL, MINNESOTA 55101

MEDICAL EDUCATION PROGRAMS AT SAINT PAUL-RAMSEY HOSPITAL

Saint Paul-Ramsey Hospital is a major teaching affiliate of the University of Minnesota Medical School and has had ongoing programs in medical education on a formal basis with the University of Minnesota since 1946. At the present time there are forty-four interns, ninety-two residents and seventy medical students who are receiving their undergraduate or graduate medical education at the hospital.

The following medical education programs are being conducted by the medical departments of the hospital:

1. Department of Ambulatory Care

This department which operates a walk-in clinic and the Emergency Room on a 24-hour basis, has four medical students and eight interns assigned for instructional purposes at any time. There are also residents from Medicine and Pediatrics who are assigned for consultative purposes.

2. Department of Anesthesiology

The department has one or two Phase D medical students assigned to the department for instructional purposes at any one time. The department aids in the instruction of Family Practice residents.

3. Department of Dentistry

The department has one third-year resident on rotation from the School of Dentistry's oral surgery program at all times.

4. Department of Dermatology

There are two residents in Dermatology on six-month rotation from the University Department of Dermatology. Medical education for up to twenty medical students is carried on with clinics and conferences for a full day once a week. The department also participates in training of Family Practice residents.

5. Department of Family Practice

The department is responsible for the education of eight interns and fourteen residents for the instruction of medical students in Phase A, B and D of the Medical School curriculum.

6. Department of Medicine

The department is responsible for the education of ten interns and ten junior residents on the General Medical Service. In addition, there are seven senior residents and fellows in subspecialty activities (hematology, endocrinology, pulmonary disease and cardiology). The Department of Medicine is also responsible for the education of approxi-

mately twenty-four Phase A medical students, twenty Phase B medical students and forty-eight Phase D medical students.

7. Department of Neurology

Educational programs are conducted for occasional Phase A medical students, six Phase B medical students and four to six Phase D medical students and three residents in Adult Neurology. Also there are often two Neurology residents receiving special instruction in EEG and one resident on a pediatric/neurology rotation. In addition, there is a post-doctorate research student.

8. Department of Neurosurgery

The department is responsible for the training of one general surgery resident who rotates through the department on a three-month basis. In addition, the department has assigned for training one Phase D medical student and helps in the training of Family Practice residents.

9. Department of Obstetrics and Gynecology

The department is responsible for the training of four Phase B and four to six Phase D medical students at all times. There are also approximately six advanced Phase D students per year in the department. There are two or more rotating interns assigned to the Service and eight residents. The department has a four-year accredited residency program in Obstetrics and Gynecology. The department aids in the training of Family Practice residents.

10. Department of Ophthalmology

The department has three residents in Ophthalmology on rotation from the University of Minnesota Medical School at all times and one or two Phase D medical students at any given time. Fifteen Phase B medical students receive instruction once weekly.

11. Department of Orthopedics

The department trains three orthopedic residents who rotate from the University of Minnesota Medical School and the Veteran's Administration Hospital. There is also a resident in General Surgery assigned to Orthopedics at all times. There are one or two interns and one or more Phase D medical students on the Service at all times.

12. Department of Otolarynoglogy

The department has three residents on rotation from the University of Minnesota Medical School. In addition, there are one or two Phase D medical students on the Service at all times. The department aids in the training of Family Practice residents.

13. Department of Pathology

The department currently has eight residents in a fully accredited residency training program. There are two Rotating 5 (Pathology) interns and other interns taking Pathology on an elective basis. Two or more Phase D medical students elect this rotation at any given time.

There is also a three-month medical student fellowship. The department conducts many interdepartmental conferences with the clinical departments of the hospital. In addition, the staff is responsible for core lectures and electives for Phase B medical students at the University. The department also aids in the training of Family Practice residents.

14. Department of Pediatrics

The department has three residents on rotation from the University of Minnesota Medical School. There are five interns, six Phase B medical students, three Phase D medical students plus an occasional senior elective. The department also aids in the training of Family Practice residents.

15. Department of Psychiatry

There are four first-year Psychiatry residents assigned to the department. In addition, there are one to three Phase D medical students assigned to the department. The department also aids in training Family Practice residents.

16. Department of Radiology

The department has two or three residents in Radiology assigned for training from the University. There is often a Phase D medical student elective in Diagnostic Radiology. The department provides numerous teaching conferences with the clinical departments for the training of graduate and undergraduate students and participates in the training of Family Practice residents.

17. Department of Surgery

The department has thirteen residents in training in a fully accredited residency program. There are three to five interns and two Family Practice residents assigned for training at all times. There are five Phase D students and four to five Phase D (Family Practice) students assigned to the Service at all times. The department also participates in lectures and training for Phase A and B medical students.

18. Department of Urology

The department has four residents in a fully accredited residency training program. There are also four Phase B medical students when scheduled on a weekly basis. The department also participates in the training of Family Practice residents.

The Saint Paul-Ramsey Hospital has developed education programs with other east metropolitan hospitals and this trend is expected to continue. The departments of Orthopedics, Urology, Neurology and Anesthesiology provide regular consultative services to the Gillette State Hospital. This provides an opportunity both for improved care for the Gillette patient and unique educational opportunities for the training of residents in these disciplines.

The Departments of Surgery and Pediatrics have joint education programs with the Children's Hospital of Saint Paul. A Saint Paul-Ramsey resident in General Surgery is regularly assigned to the Children's Hospital on a three-month rotation for experience in Pediatric surgery.

The Department of Surgery at Saint Paul-Ramsey Hospital provides an opportunity for residents in General Surgery in the Miller Hospital program to rotate for training in surgery of trauma.

The Department of Otolaryngology of Saint Paul-Ramsey Hospital has a cooperative program with Saint Joseph's Hospital for the training of residents in Otolaryngology. Resident training is also conducted at the Stillwater State Prison Hospital under the direction of the department.

The Department of Obstetrics and Gynecology conducts a cooperative program with the Miller and Saint Luke's Divisions of United Hospitals, Inc. A Saint Paul-Ramsey Hospital resident rotates to these institution for training.

Saint Paul-Ramsey Hospital is an essential part of the University of Minnesota Medical School graduate and undergraduate training program. For example, the Department of Medicine at Saint Paul-Ramsey Hospital is at present developing a major effort in training in ambulatory care for residents in Internal Medicine. Saint Paul-Ramsey Hospital is especially suited for this role because of its large outpatient population. The University Medical School's increased enrollment of undergraduate medical students has also placed a major responsibility on Saint Paul-Ramsey Hospital for clinical experience and training of these students.

jra
1/30/74

ST. PAUL RAMSEY HOSPITAL
THE MEDICAL EDUCATION & RESEARCH FOUNDATION
GILLETTE CHILDREN'S HOSPITAL

TOTAL PROJECT COST ESTIMATE

JANUARY 28, 1974

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APPENDIX VI

NEW BUILDING - SUMMARY OF COSTS

	ST.PAUL RAMSEY	M.E.R.F.	GILLETTE	TOTAL
FIRST LEVEL	925,870	259,504	221,816	1,407,190
SECOND LEVEL	1,470,000			1,470,000
THIRD LEVEL	1,326,250			1,326,250
FOURTH LEVEL (INCLUDES $25,000 FOR GILLETTE REMODELING)			2,423,740	2,423,740
FIFTH LEVEL	273,456	1,095,216		1,368,672
SUB-TOTAL	3,995,576	1,354,720	2,645,556	7,995,852
SPECIAL FOUNDATIONS	203,274	10,841	56,916	271,031
PARKING RAMP	1,070,430	172,650	517,950	1,761,030
SITE WORK	85,000			85,000
HEATING AND COOLING PLANT	610,000			610,000
SUB TOTAL	5,964,280	1,538,211	3,220,422	10,722,913
ESCALATION: 7 1/2%	447,321	115,365	241,531	804,217
CONTINGENCY: 7%	451,864	116,007	243,699	811,570
SUB TOTAL	6,863,465	1,769,583	3,705,652	12,338,700
GROUP II AND III EQUIPMENT	399,558	135,472	325,000	860,030
ARCHITECTS FEE	455,807	119,898	247,476	823,181
SUB TOTAL	7,718,830	2,024,953	4,278,128	14,021,911
SUB-SOIL INVESTIGATION AND SITE SURVEY FEES	6,000			6,000
TOTAL	$7,724,830	2,024,953	4,278,128	14,027,911

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ST. PAUL RAMSEY - REMODELING

FIRST LEVEL	461,250
THIRD LEVEL	348,960
FOURTH LEVEL	200,000
SUB-TOTAL	1,010,210
ESCALATION @ 10% ANNUAL RATE 30% FOR 36 MONTHS	303,063
SUB-TOTAL	1,313,273
POST CONTRACT CONTINGENCY @ 3%	39,398
SUB-TOTAL	1,352,671
ARCHITECTS FEE @ 10%	135,267
SUB-TOTAL	1,487,938
GROUP II & III EQUIPMENT	81,021
TOTAL	1,568,959
NEW BUILDING COST CARRIED FORWARD	7,724,830
TOTAL ST. PAUL RAMSEY PROJECT COSTS	9,293,789

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ST. PAUL RAMSEY - NEW BUILDING

	AREA	$/S.F.	TOTAL
FIRST LEVEL			
OFFICE, MEDICAL RECORDS	2,805	40.00	112,200
MEDICAL RECORDS	9,894	38.00	375,972
VOLUNTEERS OFFICE	750	40.00	30,000
MECH. EQUIPMENT ROOM	9,700	30.00	291,000
CIRCULATION & MISCELLANEOUS	3,071	38.00	116,698
TOTAL 1ST LEVEL	26,220	35.31	925,870
SECOND LEVEL			
CLINICAL FLOOR	35,000	42.00	1,470,000
THIRD LEVEL			
CLINICAL FLOOR	25,000	42.00	1,050,000
SURGI-CENTER	4,250	65.00	276,250
TOTAL 3RD LEVEL	29,250	45.34	1,326,250
FIFTH LEVEL			
MECH. EQUIPMENT ROOM	3,708	32.00	118,656
CIRCULATION	3,870	40.00	154,800
TOTAL 5TH LEVEL	7,578	36.08	273,456
TOTAL 1ST, 2ND, 3RD, 5TH FLOORS	98,048	40.75	3,995,576

SPECIAL FOUNDATIONS (HOSP. BLDG.) 75% OF $271,021 ADDITIONAL COSTS BUDGETED DUE TO SUB-STANDARD SOIL CONDITIONS AND THE TOPOGRAPHIC CONFIGURATION OF THE SITE.	203,274
PARKING RAMP - 310 CARS @ 3,453/CAR	1,070,430
SITE WORK	85,000
SCOPE OF WORK INCLUDED UNDER SITE WORK	
GRADING:	
EXCAVATION	
COMPACTED BACKFILL	
ROADS AND WALKS:	
NEW PAVING	
CURB & GUTTER	
SIDE WALKS	
UTILITIES	
STORM SEWERS	
SANITARY SEWER	
WATER LINES	
MANHOLE & CATCH BASIN	
TRENCH EXCAVATION	
HEATING & COOLING PLANT	610,000
TOTAL	5,964,280
ESCALATION @ 7.5% APPROXIMATE ANNUAL RATE OF 10%. 7 1/2% FOR THE 9 MONTH PERIOD FROM JANUARY 15, 1974 TO OCTOBER 15, 1974.	447,321
TOTAL	6,411,601
CONTINGENCY @ 7% CONTINGENCY BREAKDOWN APPROXIMATELY 4% OF CONSTRUCTION COSTS FOR DESIGN CONTINGENCY APPROXIMATELY 3% OF CONSTRUCTION COSTS FOR POST-CONTRACT CONTINGENCY (I.E. CHANGE ORDERS, ETC)	451,864
TOTAL	6,863,465

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TOTAL CONSTRUCTION COSTS			6,863,465
GROUP II AND III EQUIPMENT COST CALCULATED AS 10% OF BUILDING COST ONLY. (I.E. 10% OF 3,995,576)	399,558		
TOTAL			7,263,023
ARCHITECTS FEE			
RAMP	1,070,430		
ESCALATION @ 7 1/2%	80,282		
	1,150,712		
CONTINGENCY @ 7%	81,098		
	1,231,810		
ARCHITECTS FEE @ 5%		61,591	
BUILDING			
ESCALATION @ 7 1/2%	4,893,850		
	367,039		
	5,260,889		
CONTINGENCY @ 7%	370,766		
	5,631,655		
ARCHITECTS FEE @ 7%		394,216	
TOTAL ARCHITECTS FEE			455,807
TOTAL NEW BUILDING COST			$7,718,830

AMOUNTS INCLUDED IN CONSTRUCTION COST ESTIMATE DATED JANUARY 14, 1974.

STRUCTURAL CAPACITY FOR SIX ADDITIONAL FLOORS OF APPROXIMATE SIZE: 100' X 250'

AREA INVOLVED:

4TH FLOOR	75' X 250' =	18,750 SQ.FT.
3RD FLOOR	100' X 250' =	25,000 SQ.FT.
2ND FLOOR	100' X 250' =	25,000 SQ.FT.
1ST FLOOR	100' X 250' =	25,000 SQ.FT.
SUB-TOTAL		93,750 SQ.FT.

CONNECTING LINK

5TH FLOOR	10' X 50'	=	500 SQ.FT.
4TH FLOOR	10' X 50'	=	500 SQ.FT.
3RD FLOOR	10' X 50'	=	500 SQ.FT.
2ND FLOOR	10' X 50'	=	500 SQ.FT.
1ST FLOOR	10' X 50'	=	500 SQ.FT.
	SUB-TOTAL		2,500 SQ.FT.
	TOTAL AREA		96,250 SQ.FT.

96,250 SQ.FT. X $1.50/SQ.FT. = $144,375.00

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ST. PAUL RAMSEY REMODELING

FIRST FLOOR - OUTPATIENT CLINICS

DENTISTRY	-	4800 SQ.FT.
ENT	-	2500
ORTHO	-	3240
WELFARE	-	1450
BUSINESS OFFICE	-	4240
E.R. ADMIN.	-	1100
E.R.	-	1120
		18,450

(18,450 SQ.FT.) X ($25/SQ.FT.) = 461,250

THIRD FLOOR - SURGERY

(8,724 SQ.FT.) ($40/SQ.FT.) = 348,960

FOURTH FLOOR - REMODELING OF TWO RADIALS FOR PEDIATRICS AND REHABILITATION 200,000

TOTAL REMODELING 1,010,210

ESCALATION @ 10% ANNUAL RATE
36 MONTHS - 30% 303,063

TOTAL 1,313,273

POST CONTRACT CONTINGENCY @ 3% (I.E. CHANGE ORDERS, ETC) 39,398

TOTAL 1,352,671

ARCHITECTS FEE @ 10% 135,267

TOTAL 1,487,938

GROUP II & III EQUIPMENT
@ 10% OF $810,210 81,021

TOTAL 1,568,959

89

ST. PAUL RAMSEY

NEW BUILDING COST CARRIED FORWARD		7,718,830
	TOTAL	9,287,789
SUB-SOIL INVESTIGATION AND SITE SURVEY FEES		6,000
	TOTAL ST. PAUL RAMSEY PROJECT COST	9,293,789

69

M.E.R.F.

	AREA	$/S.F.	TOTAL
FIRST LEVEL			
RESEARCH SPACE	2,672	62.00	165,664
EDUCATION FACILITIES	2,060	40.00	82,400
INSURANCE FACILITY	286	40.00	11,440
TOTAL 1ST FLOOR	5,018	51.71	259,504
FIFTH LEVEL			
LABS & RESEARCH	11,328	62.00	702,336
ADMINISTRATION	7,544	40.00	301,760
CIRCULATION & LUNCH ROOM	2,278	40.00	91,120
TOTAL 5TH FLOOR	21,150	51.78	1,095,216
TOTAL 1ST & 5TH	26,168	51.77	1,354,720
SPECIAL FOUNDATIONS (HOSP. BLDG.) 4% OF $271,032			10,841
PARKING RAMP 50 CARS @ 3453/CAR			172,650
TOTAL			1,538,211
ESCALATION @ 7.5%			115,365
TOTAL			1,653,576
CONTINGENCY @ 7%			116,007
TOTAL			1,769,583

GROUP II & III EQUIPMENT @ 10% OF 1,354,720		135,472
	TOTAL	1,905,055
ARCHITECTS FEES (SEE SCHEDULES)		119,898
	TOTAL M.E.R.F. PROJECT COST	2,024,953

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GILLETTE

FIRST LEVEL	AREA	$/S.F.	TOTAL
POOL	3,262	68.00	221,816
FOURTH LEVEL			
CLINICAL FACILITY	23,500	42.00	987,000
O.T.,P.T.,CAST RM., O & P LABS	25,668	55.00	1,411,740
TOTAL 4TH LEVEL	49,168	48.79	2,398,740
TOTAL 1ST & 4TH LEV	52,430	49.98	2,620,556
REMODELING			25,000
SPECIAL FOUNDATIONS (HOSP.BLDG.) 21% OF $271,032			56,916
PARKING RAMP 150 CARS @ 3,453			517,950
TOTAL PRESENT CONSTRUCTION COSTS			3,220,422
ESCALATION @ 7.5			241,531
TOTAL			3,461,953
CONTINGENCY @ 7%			243,699
TOTAL			3,705,652

GROUP II & III EQUIPMENT		325,000
	TOTAL	4,030,652
ARCHITECTS FEE (SEE SCHEDULE)		247,476
	TOTAL GILLETTE PROJECT COST	4,278,128

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ARCHITECTS FEE SCHEDULE

THE FOLLOWING FEES HAVE BEEN INCLUDED IN TOTAL PROJECT COSTS.

Architects/Engineers/Planners
One Appletree Square
Bloomington, Minnesota 55420
290-814 Tel. 612/853-2000

Elerbe

RAMSEY

Ramp	1,070,430	
Escal @ 7 1/2%	80,282	
	1,150,712	
Contin @ 7.0476%	81,098	
	1,231,810	
Architects Fee @ 5%		61,591
Building	4,893,850	
Escal @ 7 1/2%	367,039	
	5,260,889	
Contin @ 7.0476%	370,766	
	5,631,655	
Architects Fee @ 7%		394,216
	6,863,465	455,807

Offices in:
Anchorage, Alaska • Bloomington, Minnesota • Fairbanks, Alaska • Irvine, California • Minneapolis, Minnesota • New Orleans, Louisiana
Rochester, Minnesota • St. Paul, Minnesota • Washington, D.C.

Architects/Engineers/Planners
One Appletree Square
Bloomington, Minnesota 55420
290-814 Tel. 612/853-2000

Ellerbe

M.E.R.F.

Ramp	172,650	
Escal @ 7 1/2%	12,949	
	185,599	
Cont @ 7.01552%	13,021	
	198,620	
Architects Fee @ 5%		9,931
Building	1,365,561	
Escal @ 7 1/2%	102,417	
	1,467,978	
Cont @ 7.01552%	102,985	
	1,570,963	
Architects Fee @ 7%		109,967
	1,769,583	119,898

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Rochester, Minnesota • St. Paul, Minnesota • Washington, D.C.

Architects/Engineers/Planners
One Appletree Square
mington, Minnesota 55420
)-814 Tel. 612/853-2000

Elerbe®

GILLETTE

Ramp	517,950	
Escal @7 1/2%	38,846	
	556,796	
Contin@7.03935%	39,195	
	595,991	
Architects Fee @ 5%		29,800
Building	2,702,472	
Escal @7 1/2%	202,685	
	2,905,157	
Contin@7.03935%	204,504	
	3,109,661	
Architects Fee @ 7%		217,676
	3,705,652	247,476

ST. PAUL-RAMSEY HOSPITAL
ALLOCATION
OF
SQUARE FEET
BY
OUTPATIENT CLINICS

CLINIC	PRESENT SQUARE FOOTAGE	PROPOSED SQUARE FOOTAGE	
(New Building) Medicine Dermatology Neurology	6,300	6,500 (of 12,500 available clini space on second floor)	
(New Building) Pediatrics OB-GYN Surgery	5,200	8,200 (available clinic space on third floor)	
(Present Building) Orthopedics ENT Ophthalmology Dental	1,000 1,400 2,000 600	3,200 2,500 4,200 4,800	To occupy present clinic space
Urology	2,000	2,000	
TOTALS	18,500	31,400	

Overall increase of 12,900 square feet or 69.7%.

N.B. Square foot figures contain proportionate waiting and interior corridor space.

OUTPATIENT VISITS
1966 - 1973
By Major Medical Departments

CLINICS	1966	1967	1968	1969	1970	1971	1972	1973	Percent Increase(Decrease) 1966 - 1973
Medicine	14,560	15,111	14,876	15,081	16,939	15,277	17,337	22,064	51.5%
Pediatrics	8,206	9,189	11,049	9,482	10,031	11,260	10,120	10,143	23.6%
OB-GYN	7,738	9,545	11,174	9,142	10,955	11,979	12,065	13,748	77.6%
Dermatology	3,865	3,543	4,694	3,968	3,762	3,876	3,606	4,266	10.3%
Neurology	2,864	3,159	3,452	2,937	3,248	2,948	3,078	3,297	15.1%
Surgery	9,192	8,750	9,342	7,324	6,664	6,985	7,455	7,569	(17.7%)
SUBTOTAL	**46,425**	**49,297**	**54,587**	**47,934**	**51,599**	**52,325**	**53,661**	**61,087**	**31.5%**
ENT	3,132	3,103	3,345	3,542	3,767	4,136	4,824	5,242	67.3%
Ophthalmology	5,055	5,087	6,573	6,613	6,416	7,759	6,696	8,481	67.7%
Orthopedics	5,704	4,776	5,891	5,513	5,841	5,846	8,014	8,631	51.3%
Dental	664	688	768	762	1,142	1,123	1,437	2,357	254.9%
SUBTOTAL	14,555	13,654	16,577	16,430	17,166	18,864	20,971	24,711	69.7%
OTHER:									
Urology	2,539	3,890	3,356	3,025	3,096	2,883	5,196	4,971	95.7%
Physical Medicine and Rehabilitation	534	366	709	492	603	-	-	-	-
GRAND TOTAL:	64,053	67,207	75,229	67,881	72,464	74,072	79,829	90,769	41.7%

ST. PAUL-RAMSEY HOSPITAL
OUTPATIENT VISITS
1966 and 1973 Actuals
1976, 1980 and 1984 Projected at 6% Growth Per Annum

CLINICS IN NEW BUILDING	1966	1973	1976	1980	1984
Medicine	14,560	22,064	26,279	33,176	41,885
Pediatrics	8,206	10,143	12,080	15,250	19,253
OB-GYN	7,738	13,748	16,374	20,692	26,098
Dermatology	3,865	4,266	5,081	6,415	8,099
Neurology	2,864	3,297	3,927	4,958	6,259
Surgery	9, 192	7,569	9,015	11,381	14,368
SUBTOTAL	46,425	61,087	72,756	91,853	115,962
CLINICS IN EXISTING BUILDING					
ENT	3,132	5,242	6,243	7,882	9,951
Ophthalmoloyg	5,055	8,481	10,101	12,752	16,099
Orthopedics	5,704	8,631	10,280	12,978	16,384
Dental	664	2,357	2,807	3,544	4,474
Urology	2,539	4,971	5,920	7,474	9,436
Physical Medicine & Rehabilitation	534	------	------	------	------
SUBTOTAL	17,628	29,694	35,351	44,630	56,344
GRAND TOTAL	64,053	90,769	108,107	136,483	172,306
Square Feet Available	18,500	18,500	31,400	31,400	31,400
Visits/Sq.Ft./Year	3.5	4.9	3.4	4.3	5.5

ST. PAUL-RAMSEY HOSPITAL
EMERGENCY ROOM
SQUARE FOOTAGE

PRESENT SQUARE FOOTAGE	PROPOSED SQUARE FOOTAGE
9,100	12,500

Increase of 3,400 or 37.4%

EMERGENCY VISITS
1963 and 1973 ACTUALS
1980 and 1984 PROJECTED AT 5% PER ANNUM

	1966	1973	1976	1980	1984
	53,131	73,384	84,951	103,258	125,511

Increase of 29,874 visits by 1980 or 40.7%

Square Feet Available	9,100	9,100	12,500	12,500	12,500
Visits/Sq/Ft./Year	5.8	8.1	6.8	8.3	10.0

ST. PAUL-RAMSEY HOSPITAL

RATIONALE FOR PROPOSED CLINIC SPACE AND EMERGENCY SERVICE

1. The increase in outpatient visits is projected at 6% per year based on the experience of the last eight years.

2. In 1976, the year of occupancy for the proposed building, outpatient visits will have increased by 19% over 1973 actuals.

3. Projected outpatient visits for 1984 show that visits will have nearly doubled since 1973 (90% increase). The new building has been designed to accomodate these projections through the use of flexible, modular examination rooms which will maximize staff efficiency and minimize the length of time per patient visit.

4. The Outpatient Clinic space will be increased from 18,500 to 31,400 or 69.7%. Outpatient visits as projected will increase by the same percentage by 1983.

5. The increase in emergency service visits is projected at 5% per year based on the experience of the last eight years.

6. By 1980, the projected visits to the Emergency Service will equal the present number of visits per unit of space.

Prepared for Metro-Health Board, per their request with reference to the "Certificate of Need."
E.Ty.
02/13/74

BUDGETED HEALTH SERVICES
RAMSEY COUNTY
1974

SERVICES	COUNTY	TOTAL	PROGRAM	TOTAL
Community Mental Health	435,000		880,000	
Chemical Dependency Counselors	16,245		51,460	
Recreational Center for Inebriates	120,475	571,720	382,708	1,314,168
East Side Metro Day Activity	14,913		47,425	
Chemical Dependency Half-Way House (4)	91,054		569,549	
Selby Drop-In Center	24,198		77,442	
Drug Education for Youth	54,423		207,682	
Treatment Center - Shoreview	113,991		300,200	
Mentally Ill Half-Way House (2)	146,000		293,297	
American Indian Center	7,300		20,000	
Welfare Alcohol Program	47,500		190,000	
Urban League Day Care Center	67,932		167,000	
Child Abuse, Prevention & Treatment	29,206		146,029	
Occupational Training for Retarded	120,000		18,600	
Council for Parents of Retarded	19,070	627,587	22,110	2,059,334
County Nursing Service	901,712		901,712	
Neighborhood Clinics (6)	100,000		175,978	
St. Paul-Ramsey Hospital	1,619,836	2,621,548	1,619,836	2,597,526
Pollution Control - Air	40,000		40,000	
Pollution Control - Solid Waste	100,000	140,000	100,000	140,000
Mentally Ill - In State Institutions	20,000		20,000	
County Nursing Home	216,000		161,800	
Medical Assistance	6,598,000		31,550,000	
Medical General Assistance	2,735,000	9,569,000	2,800,000	34,531,800
Day Activity Centers (10)	219,242	13,529,855	1,257,978	40,742,828

This statement was read at County Board meeting on Monday Feb 11, 1974. S.J.K.

Delores J. Knaak

Ramsey County Commissioner - District No. 2

216 Court House
St. Paul, Minnesota 55102

POSITION STATEMENT: St. Paul-Ramsey-Gillette Hospital Authority-University of Minnesota Medical School-Ramsey Health Maintenance Organization-Minnesota State Prison Expansion

Dating back to early 1973, when the St. Paul-Ramsey-Gillette Hospital Authority-University of Minnesota Medical School-Ramsey Health Maintenance Organization-~~Minnesota~~ Stillwater State Prison expansion was being presented to the Ramsey County Board of Commissioners, I raised three types of questions:

MERF

1. First, are the combinations appropriate? For example, (a) What are the merits of taking crippled children and their long-suffering parents out of a park setting and placing them in a freeway enclosure? (b) How can law enforcement officials take prisoners up and down public elevators? (c) Many others.

2. Second, is there really a need for expansion? For example, (a) With bed-patient decline, could not emerging needs be accommodated mostly with remodeling rather than extensive new construction? (b) Are the greatly expanded administrative spaces really necessary? (c) Many others

3. Thirdly, given the mixture of multi-governmental and private interests represented in the conglomerate, how are the interests of the Ramsey County tax payers being protected?

These questions were not considered seriously at the time, and some were ridiculed by hospital staff at the time, but they were asked again by the legislative delegation, and are now being pursued in much greater detail by the study-review committee of the Metropolitan Health Board. For those of you on the County Board who have not attended the hearings of the Metro Health Board, transcripts are available, and they do contain highly significant data.

I am personally satisfied now that the questions of appropriateness and medical need are being thoroughly explored by the Metro Board, and I am willing to place considerable credence on their findings.

However, if the Metro Health Board reports favorably on the project, the problem of protecting the taxpayers of Ramsey County will probably remain. Unresolved problems include:

1. The City of St. Paul retains a 27½% interest in the current facilities, but as a municipality pays nothing for operating expenses. The new addition and remodeling will be difficult to separate from existing values, and will add to St. Paul's real estate value without additional investment on their part. To date they have refused to issue a quitclaim deed unless Ramsey assumes their past bonded indebtedness. (*3 To 5 millim additinal dollars)

2. The Ramsey County taxpayer is being asked to assume some highly significant fiscal risks. These are: (a) As a matter of public record the Gillette Hospital Authority has declared its intent to become a private agency and will then not have the full faith and credit of the State of Minnesota behind it. What if the new private agency cannot fund its share of construction? What if it cannot meet its operating expenses? The Ramsey County Boa rd and its taxpaying public will frankly be stuck with that share of space. (b) We are providing new space for the Ramsey HMO, a private agency, assuming that their rent will pay for the space. We don't know that will be true. The Twin Cities have gone from one to five HMO's in as many years, and no one knows if they will all survive. If the Ramsey unit does not survive, the Ramsey County taxpayers will have that non-paying space on their tax rolls. (c) MERF is a unique independent, medical education research foundation. However, their particular relationship to a public hospital has not, to my knowledge been tested by a court case, an attorney general's opinion, or an IRS ruling. If this structure should ever be successfully challenged, the Ramsey County taxpayers would again have the facility burden to bear. (d) The entire Ramsey County-St. Paul hospital complex is highly dependent on short-term

medical education contracts with the University of Minnesota. If these contracts were transferred to other metropolitan hospitals, these facilities would no longer receive outside compensation, and could become a burden on Ramsey County Taxpayers.

3. In view of the special risks described in statement 2, the governance of this complex structure is exceedingly important. The current governance is comprised of a 9-person appointed board, with Ramsey County Board members holding a minority position on the board. The 9-person board, known as the Hospital Commission meets monthly. This arrangement might be appropriate for a private, single purpose hospital, but I seriously question whether it is appropriate for the highly diverse conglomerate with which it must deal, or whether it can seriously protect the public taxpayer.

It is the question of appropriateness of governance to which this position statement is directed. It seems evident that well over 60% of space being constructed is for state and regional-oriented needs. The long-term assurances of continued payment for their share of the Ramsey-provided facilities by these outside beneficiaries is not well defined, and essentially minimal.

Therefore, I feel that regardless of the findings of need by the Metro Hospital Board, we should give serious consideration to inviting the University of Minnesota, who were just refused a $33M expansion on their site, to consider the acquisition of the St. Paul Ramsey facilities and its proposed expansion, with proper stipulations to assure that present and ascending levels of health and medical services to Ramsey County residents be continued.

St. Paul Pioneer Press
Metro Life
FEBRUARY 10, 1974 ☆

Decision Near On Hospital Expansion Plan

By Bob Goligoski
Staff Writer

Despite brickbats from Children's Hospital of St. Paul, a number of doctors and Ramsey County commissioners, the $14 million proposal to expand St. Paul Rom-

visits, they note, totalled 91,000 last year, up from the 79,829 of 1972.

Much of the information given to the review committee likely will be presented at the hearing.

Partially Scanned Material

Version 3
March 18, 2019

Key Tests Ahead On SPR Expansion

Continued From Page 1

cal layout and "costs too much money to run," according to its administrator, Jean Conklin.

Judging from reports submitted to the review group, there are elements of a struggle between SPR and Children's Hospital over which will be the dominant major medical center for children in the St. Paul area.

According to a Health Board official, Children's Hospital is offering Gillette the opportunity to merge with it.

Clifford Retherford of Minneapolis, chairman of the Gillette Hospital Authority, said in an interview that "we regard the objections of Children's

SYVERSON

There are indications that the SPR expansion plans will stir controversy among board members as to their advisability, need and scope.

The proposal likely will receive kinder treatment Monday from the county board. It approves the plan in concept but is

ate the state's share in a bill expected to win passage.

THE FOUNDATION is the billing unit for SPR doctors. Money collected is parceled out to physicians with some also being disbursed for educational and research activities.

Syverson stressed that no beds will be added at St. Paul-Ramsey under the project proposal.

In fact, it would result in the number of patient beds in the St. Paul area being reduced as Gillette will vacate its 72-bed facility and take over 60 beds now empty at SPR.

Gillette had a 70 per

Partially Scanned Material

Version 3
March 18, 2019

TELEPHONE REPORT

WHO: Donna Anderson, Hennepin County Health & Hospitals, Planning Office to Earl Marlow

WHEN: February 1, 1973, 3:30 p.m.

WHAT: Donna responded to an earlier request I had made for a copy of the "Hennepin County Comprehensive Plan".

She reports there is no such plan or single document of that kind.

The requirement to produce such a plan within six months, attached to the "Certificate of Need" for Hennepin County General, was issued in January 1973.

About March, they presented an interim document (a 3" looseleaf notebook) as evidence of the planning towards decentralized primary care facilities. Sub-parts were:

1. Demonstration grant to plan for decentralized primary facilities.

2. Development of the county's policy of purchasing needed services from private primary health care providers at the community level.

This document is not available for distribution, but it can be examined at the Metro-Council Library.

Following submission of this report, plus submission of certain specific additional or amplified data, the Metro-Health Board acknowledged "substantial compliance" with the requirement. That requirement was cleared some time in April or early May of 1973.

E. M.

Earl Marlow

EM/mcw

Researched and written by Earl Nyarlow.

Office of
ADMINISTRATOR
COUNTY OF RAMSEY

EUGENE F. MACAULAY
County Administrator

Room 945 Court House
St. Paul, Minnesota 55102
298-5591

January 31, 1974

Ms. Sally DeLancy, Chairman
Metropolitan Health Board
300 Metro Square Building
St. Paul, Minnesota 55101

REFERENCE: Application of Need for the Gillette-St. Paul Ramsey Project

Dear Ms. DeLancy:

On behalf of the County of Ramsey, I want to lend our full support to the application for a certificate of need for the proposed Gillette addition to St. Paul-Ramsey Hospital and Medical Center.

OFFICIAL COUNTY POSITION:

On April 2, 1973, the Ramsey County Board of Commissioners committed themselves to the proposal that Gillette Hospital facilities be merged with the St. Paul-Ramsey complex and further committed themselves to seek additional bonding authority with which to finance facilities expansion at St. Paul-Ramsey if and when it would become necessary. (See County Board Resolution #9-1676 attached.)

On succeeding dates, the Board took the following specific official actions to participate in and support this facilities merger proposal:

a. County Board Resolution #9-1914 dated 10/15/73
   - concurring with the action of the architectural consultant selection committee on the choice of Ellerbe Architects, Inc.

b. County Board Resolution #9-1997 dated 12/3/73
   - approving agreement as amended for consultation services in connection with planning of a merged facility.

c. County Board Resolution #9-2017 dated 12/10/73
   - appointing a member of the Board to serve on the Building Committee for the merging of facilities;
   - vesting that person with authority to request and receive certain information in the name of the Board.

d. County Board Resolution #9-2033A dated 12/17/73
   - amending the agreement for consultation services to provide for County Board review and approval as necessary for committment of funds.

e. County Board Resolution #9-2057 dated 12/28/73
- appointing a member of the Board to serve on the Building Committee for the merging of facilities.

f. County Board Resolution #9-2079 dated 1/14/74
- authorizes presentation of proposal to construct a Gillette addition at St. Paul-Ramsey to the Ramsey County delegation;
- authorizes Ellerbe Architects, Inc. to continue with planning of addition;
- directs the County Attorney to look into certain legal aspects of a merged facility;
- Conference Committee report on House File 2531, authorizing certain expenditures by Gillette Hospital Authority for planning.

ANALYSIS OF PROPOSAL:

That proposal takes a hard look at the realities of medical services demand upon the present separate facilities and projects those demands into the future to establish space requirements for a merged facility. Now, it's important that we keep in mind that we are talking about current demands for medical services from existing ongoing providers. From analysis of these current demands, we have decerned the trend and projected a solid need for the programs and space requirements of a merged facility.

In this process, Gillette Hospital Authority reexamined the original mission of the Gillette facility to provide long-term convalescent care of physically handicapped children and a physical plant designed to support this mission. From there they traced the evolutionary adaptation of the hospital as a primary service provider to the unique mission it now performs in providing comprehensive treatment of catastrophically handicapping disorders among children which are often of congenital origin. They found that the average length of stay was decreasing while at the same time therapy administered was more complicated and often of a multiple nature. Looking at the physical plant with today's and tomorrow's needs in mind, it is hopelessly inadequate.

Through the same process of reexamination of where it began, what its mission was, what its current mission is and where it can logically expect to be in the future, St. Paul-Ramsey finds its role as a primary health care provider holding steady but its committment to support delivery of secondary and tertiary care rapidly increasing.

From these studies the programming of a merged facility with the spacial design which this proposal envisions is solidly supported on: 1) demand for services; 2) increased capability to provide services; and 3) the economic delivery of those services.

DEMAND FOR SERVICES:

Analysis of the demand for services from both hospitals, by geographic area, demonstrates the complimentary nature of their respective service areas and

provides a major thrust for programming of a merged facility.

Patient origin studies show that 72% of all Gillette patients originated from outside the seven-county metropolitan area.

The largest percentage of out-state Gillette patients originate from the northeast, west and central regions of the state.

While at St. Paul-Ramsey, 88% of all out-patient and 84% of all emergency room visits were made by patients living in St. Paul and Ramsey County.

Nine St. Paul neighborhoods account for 71% of all out-patient and 67% of all emergency visits.

MEDICAL CAPABILITY:

With the added capability of Gillette and its fine staff, the proposed Gillette-St. Paul-Ramsey complex will provide for both a comprehensive primary, secondary and tertiary health care facility, staff and programs for children which serves the entire metropolitan area east.

New and innovative programs of pre-paid medical, dental and out-patient surgical services, plus a much needed expansion of the St. Paul-Ramsey Burn Unit will be possible.

More efficient and attractive space for cash paying and overhead cost absorbing public health corporations, such as the Ramsey Health Plan (an H.M.O.) and the St. Paul-Ramsey Medical Educational and Research Foundation (M.E.R.F.) will be provided. This will assure their continued use of facilities and their strong contribution to this medical complex.

ECONOMY:

From the viewpoint of economic delivery of services, the merged facility offers many opportunities for savings. Some examples are:

The elimination of 72 unneeded hospital beds (the Gillette complement).

The utilization of 60 unused beds at St. Paul-Ramsey (for the Gillette patient population).

Elimination of the need to duplicate facilities in 16 service departments.

A planned reduction of 72 staff positions formerly necessary to operate separate facilities that will not be required by a merged facility. This item alone is expected to reduce present operating costs by $175,000.00 each year.

CONCLUSION AND RECOMMENDATION:

The proposed merger of facilities of Gillette and St. Paul-Ramsey will better meet current and projected future demand for medical services from both agencies, will measurably increase their capability to provide needed services and make possible a lower unit cost of providing those services. Its accomplishment should be encouraged as an outstanding example of complimentary programming of the delivery of needed health care services in which a careful weighing of alternatives has been accomplished and a merged facility is clearly the most viable of alternatives.

We respectfully urge the Metropolitan Health Board to issue a certificate of need without extraneous conditions or requirements.

Respectfully submitted,

E. F. Macaulay

EUGENE F. MACAULAY
Ramsey County Administrator

EFM/mjw
Enclosure

COUNTY BOARD

File No. 2047

Resolution No. 9-1676

BOARD OF

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

April 2, 19 73

The attention of County Administrator Thomas J. Kelley; Ramsey County Hospital and Sanitarium Commission, c/o Chairman Ettel; Gillette Hospital-St.Paul-Ramsey, Att: Otto Jahnke, Administrator; Medical Education Research Foundation, St.Paul-Ramsey Hospital, c/o Chairman, Abramson
is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on April 2, 1973

By Commissioner Finley

RESOLVED That the Board of Ramsey County Commissioners is committed to the proposal that the Gillette Hospital be merged with the St.Paul-Ramsey Hospital complex, and Be It Further

RESOLVED That the necessary funding for the expansion shall be by the Medical Education Research Foundation if the Foundation can pay such funding without bonding and that the County will provide the land necessary for the merging and Be It Further

RESOLVED That if the aforesaid Foundation can not finance the expansion and bonding is necessary, the Board of Ramsey County Commissioners will seek legislation granting bonding authority to the extent of $7,000,000.

THOMAS J. KELLEY, County Administrator

By _____ Executive Secretary

Fri., Jan. 25, '74 ST. PAUL DISPATCH

LEGAL NOTICE

PUBLIC HEARING LEGAL NOTICE

The Metropolitan Health Board of the Metropolitan Council will hold a public hearing at 4:30 p.m. on Wednesday, February 13, 1974, in the Metropolitan Council Chambers, 300 Metro Square Building, Seventh and Robert Streets, St. Paul, Minnesota, to consider an application for a Certificate of Need from St. Paul-Ramsey Hospital and Medical Center and Gillette Childrens Hospital, University at Jackson, St. Paul, to plan and design a joint facility at an estimated cost of $13,788,107 ($3,770,507-Gillette; $10,018,600-Ramsey).

Further information may be obtained from the Metropolitan Health Board, 300 Metro Square Building, Seventh and Robert streets, St. Paul, Minnesota 55101, telephone: 227-9421, extension 368.

Sally deLancey, Chairman
Metropolitan Health Board
Press and Dispatch
Jan. 25, Feb. 2

No. 86

ST. PAUL-RAMSEY HOSPITAL AND GILLETTE HOSPITAL

PROPOSAL TO THE

METROPLITAN HEALTH BOARD

(Questions and Comments)

Members of the Metropolitan Health Board Study Subcommittee, I present this list of questions as a taxpayer, consumer and member of a group of concerned physicians of Ramsey County.

First, I would like generally to praise St, Paul-Ramsey Hospital for its excellent education program, its excellent burn unit and excellent emergency room services.

The dedicated physicians and staff spend many hours in service, research and teaching to help the St, Paul Community.

I am a staff member of this hopsital,

However, at this point I must depart and address my remarks to the administrative activities of the hospital.

The hospital is asking for a fourteen million dollar project, of which some will be funded by the State Legislature, some by the County and seven million dollars directly from the taxpayers of Ramsey County.

I, therefore, submit these questions and statements regarding:

A. The St, Paul-Ramsey Hospital-Gillette Hospital proposal and its inaccuracies and lack of completeness in some of the statements and proposals. This is based on the original proposal and not on the new modified information.

B. Questions regarding the health care consumers.

PART A.

QUESTIONS RELATED TO THE ST. PAUL-RAMSEY HOSPITAL AND GILLETTE HOSPITAL PROPOSAL TO THE METROPOLITAN HEALTH BOARD:

(Ramsey County Health Plan will be designated by the letters HMO)

(Medical Education and Research Fund will be designated by the letters MERF)

After reading the report to the Metropolitan Health Board I believe there are many areas which need further clarification. We should like to, through the following questions, ask you to clarify your positions in the many areas:

In the opening paragraph, you make a statement regarding a complete Children's Medical Hospital Complex--

Question? What is your definition of a complete Children's Health Center and Hospital?

Question? What is the actual inpatient census during the past year for pediatrics? What is the average length of stay of pediatric patients in the hospital? Please compare them with other hospitals. In the report, there is no mention of any of these statistics.

Our statistics show your hospital not to be the primary pediatric care unit of the city. Children's Hospital is the primary pediatric care unit of Ramsey County. This is particularly true in that all of the pediatricians actively support the Children's Hospital.

Question? What is your general inpatient census based on the last five years? Please state not only the occupancy rates based on the maximum number of beds in your hospital, but also the total number of inpatients seen per year over the past five years. Can you justify more space with these figures? Could the inpatient space available be used for many of your stated programs?

For example, Children's Hospital now uses former inpatient space for their Surgical Day Center.

Regarding your statements in the report on Page 5,, that you are the hospital of primary care for residents in much of the downtown areas--

Question? Why are you comparing statistics of individual hospital to your outpatient department when you should be comparing total outpatients seen by physicians in St. Paul areas outlined by you compared to the number seen in your outpatient department? For example, you list approximately an average of 75,000 or 80,000 adults and children seen in your outpatient department during the past five years. If one only takes three pediatric groups who are not seeing adults, the fifteen physicians see a total of almost 80,000 pediatric patients per year in their offices. This does not include hospital visits and does not include their procedures in emergency rooms in hospitals. I would like you to justify your reasoning that you are the one who gives majority primary care at St. Paul-Ramsey Hospital for the area stated.

On statistics based on your increase in outpatient flow and your increase in emergency flow, you have asked for an increase in space of many times that compared to the percentage increase in your statistics.

Question? How do you justify this on the basis of number recorded? Last year there were 91,000 visits to the outpatient department at St. Paul-Ramsey Hospital.

Question? How do you account for the increase of 79,000 to 91,000 visits compared to only an average increase of markedly less than that over the past several years? Would you please clarify this in terms of listing the types of categories of patients who are seen in the outpatient department? Does this include HMO and does this include simply laboratory visits such as, hemoglobins, chest x-rays, etc.

You have mentioned on Page 42, that the increase in outpatient visits to your emergency room and outpatient services is less than the national norm and yet you are asking for a dramatic increase in space.

Question? Could you justify this?

The Ramsey County Health Plan on Page 44. mentions that you expected to jump from 2,000 to 40,000 in a period of 10 years.

Question? This is speculation-can you give any justification for giving space to this type of institution which is not yet been proven and is still in the experimental stage all over the country?

Blue Cross and Blue Shield, who have recently been negotiating with you as an insurance company for your HMO have stated that their plan is experimental and if it is not profitable or loses money, will be dropped!

The next point of contention is on Page 71. which states that Children's Hospital could merge with St, Paul-Ramsey Hospital.. Could you explain the fact that Children's Hospital has said to you and the Metropolitan Health Board in a recent formal statement that they will not move with the St. Paul-Ramsey Hospital as part of a projectdeyelopment, but have elected to merge with Miller-St. Luke's Complex? Could you explain your justification for making a statement that includes the Children's Hospital?

REGARDING THE GILLETTE HOSPITAL

The experience with Gillette Hospital outpatient trends for the last five years were not included in this proposal.

Question? Would you please include them?

Also, the number of inpatient statistics for 1973 are not included in this report, either on inpatients or outpatients.

Question? Could you please include them in order to justify the amount of space required?

PART B.

SPECIFIC QUESTIONS RELATED TO CONSUMERS OF RAMSEY COUNTY:

If a 7 million dollar bond issue is being raised by the people of Ramsey County, it is important that these people obtain the facts related to many problems of finance in the St. Paul-Ramsey Hospital.

1. Is St. Paul-Ramsey a public hospital?

2. Is MERF a private corporation within St. Paul-Ramsey Hospital?

3. Is the HMO a private corporation?

Statement: If the HMO is a private corportion within your hospital, how do you justify the 7 million dollar bond issue to serve the use of a private practice HMO in the St. Paul-Ramsey Hospital?

4. The Ramsey County Health Plan has asked for approximately 6,000 new square feet.

Question? How many visits have there been to the Ramsey County Health Plan over the past year?

Statement: Your statistics are not available in this report.

5, What is the financial status of the Ramsey County Health Plan, who originally financed the Ramsey County Health Plan and if there is a loss sustained by the Ramsey County Health Plan at St. Paul-Ramsey Hospital, who pays for it?

It is my understanding that MERF and the hospital may take a loss under these circumstances.

Question? Is this true?

6. What is the relationship of MERF to the Ramsey County Health Plan?

What is the relationship of St. Paul-Ramsey Hospital to the Ramsey County Health Plan?

Regarding these questions, it is my understanding that a lesser amount of money is being charged to patients by MERF as a consultant for HMO patients. Also, in such areas as anesthesia, is a lesser amount being charged to HMO by the hospital? Also, insofar as beds, we would like to know what the room rates are for the HMO compared to room rates for ADC patients and regular patients. We would like to know the statistics of the per diem cost of patients in your hospital.

If there are lesser inpatient, outpatient and service charges to HMO patients than Welfare-ADC type patients and private patients, we feel that this is not proper. If this is true, ADC and private patients would be subsidizing the HMO.

7. How does the HMO pay St. Paul-Ramsey Hospital and who pays the deficit if they run at a deficit?

8. If St. Paul-Ramsey Hospital runs at a deficit due to decrease in charges through the HMO, even in part, who would then make up the deficit financing?

Is it not true that a general room rate increase would occur?

This would mean that both private patients and the County welfare patients would be paying for the private corporate finances of your HMO.

9. What is the relationship of the private physician to MERF and MERF to HMO and the HMO to the private physician?

It is my understanding that a private physician who is a member of St. Paul-Ramsey Hospital cannot bill a patient directly or cannot bill the HMO directly. MERF must do this and there have been physicians who have complained that MERF subsidizes the St. Paul-Ramsey physicians who in turn renders a service to the HMO patient. The private physician is not interested in subsidizing the HMO in this manner.

Have any private physicians refused to serve the HMO because of this?

10. On HMO patients, under the present situation, three types of physicians are being paid--the private physician, MERF and the primary HMO physician. The reason for that being is that MERF does the charging and does not pay the private referral physician his share of his charge to HMO for his services. Therefore, does part of the monies of the private referral go to both St. Paul-Ramsey physicians and HMO physicians? Is this not a form of fee splitting?

11. Why is there so much administrative space being allocated for MERF?

Are they going into the administrative business for the HMO and for the hospital? Why?

If MERF and the hospital do the administrative business for HMO, is it not true that both private patients and ADC patients indirectly subsidize the administrative business through MERF?

12. Regarding space requirements, the outpatient department wants 100% more space based on your figures for increased outpatient utilization; why?

The emergency room wants 50% more space. Based on your figures for increased utilization; why?

Ramsey County Health Plan wants 6,000 feet and the total outpatient would ask for 26,000 feet. Please justify this on the basis of your present patient flow or projected patient flow.

Medical records wants 50% more space. Why could you not utilize better systems rather than ask for more space?

Administration wants 50% more space. Does the number of patients justify this or is this related due to your Health Maintenance Organization? Should the public be asked to finance this?

13. Related to the HMO, could you please list the number of primary HMO physicians who you have hired and what is their background?

14. Do resident physicians do HMO work?

Is the teaching program tied in with the HMO?

It is my understanding that many patients are seen by residents rather than the MERF referral physician who has been contracted by the HMO. Please explain.

Should not the HMO then subsidize the educational program as do the ADC and private patients through MERF?

15. Who takes night call and emergency call for the HMO?

Do the primary physicians take call, partial call, or are the patients seen by the emergency room physician and house staff? (interns, residents and medical students)

If seen by the emergency room staff, are they properly compensated by HMO?

If so, is the compensation proportionate to that paid by MERF to the regular staff?

16. Have you asked permission for each private medical doctor to use their names as HMO consultants under MERF? To my knowledge you have not. This represents misrepresentation to the HMO patient and physicians.

17. HMO's are experimental and should be able to succeed under their own merit. Taxpayers and physicians do not question this. This is free enterprise. The question, again, is should the taxpayer have to subsidize his own medical care plus the HMO at St. Paul-Ramsey Hospital? Please justify.

18. It is my understanding that the nurses' training program is going to be phased out and the building next to St. Paul-Ramsey Hospital will be free over the next few years. Is this true?

Could you not use this space in addition to the space in your hospital which is not being utilized by inpatients for your purposes of expansion?

CONCLUSION:

1. In the interest of the taxpayer, consumer and deliverers of health care in this community, I have submitted a list of questions and statements which should be answered satisfactorily before any space or monies are allocated.

2. There are real questions regarding whether the Ramsey Health Plan (HMO) should be part of a public institution. Taxpayers should not have to subsidize this program.

3. There are also real questions regarding the need for the amount of space requested in areas other than the Gillette Hospital space.

4. The allocation of this space would mean a shift in terms of health care delivery in the Ramsey County area. St. Paul-Ramsey would be competing for more space and programs already established in the community. For example this would be of particular interest in the field of pediatrics where the major delivery of children's care in Ramsey County is the Childrens's Hospital. Other programs and hospitals in the city would also be affected.

5. I am also concerned that the Gillette project may be in jeopardy due to these added space proposals which may be unacceptable to the Committee.

I believe the majority of us agree that Gillette Hospital should stay in St. Paul.

Respectfully submitted,

Stanley A. Leonard, M.D.

Health Board
of the

METROPOLITAN COUNCIL
300 Metro Square Building, Saint Paul, MN

To: St. Paul-Ramsey - Gillettee Hospital Study Review Committee

From: Staff

Re: Issues in the St. Paul Ramsey - Gillette Certificate of Need Application

In review of the joint application from St. Paul-Ramsey Hospital and Gillette Hospital for a Certificate of Need, staff identified at least four major issues which need discussion and a decision. They are as follows:

1. The relocation of Gillette Hospital to the St. Paul-Ramsey site.

   The future location of Gillette Hospital has had considerable study over the past few years. In 1966 James H. Hamilton Associates recommended that the Gillette Hospital program be physically integrated with a Medical Center. The 1973 Legislature established an independent governing authority for Gillette and authorized a special committee to recommend a site for relocating Gillettee. As a result, St. Paul-Ramsey received the number one rank for Gillette affiliation. Legislation enabling such a move, contigent upon receipt of a Certificate of Need, was enacted.

   Nevertheless, the issue which the Study Committee must address is appropriate location and need for both general and specialized pediatric services in the metropolitan area and particularly in the St. Paul Area. St. Paul Children's Hospital has indicated its intent to relocate within 10 years to another site as part of the Associated Capital Hospitals.

   Should both developments be encouraged as somewhat independent developments which are needed in this area, or should another potential alternative be explored?

2. The need for the proposed ambulatory-expansion of St. Paul-Ramsey Hospital.

   The proposal indicates an overall expansion in space for specific programs at St. Paul-Ramsey of approximately 74%. The specifics of these expanded capacities are detailed on page 16

of the application. The Committee must reach a decision as to whether the proposed space is needed.

1 Consideration should be given to each program area to analyze the impact such an expansion may have on other similar services in the area; 2 whether the services proposed are needed at the St. Paul-Ramsey site; 3 whether existing space is presently available to house these programs without new construction; and the potential 4 impact such an expansion may have on medical and allied health professional education.

3. The Role of County Government for developing and implementing a comprehensive plan for delivering primary care services within the county.

The present draft of the M.D.G.-Health Chapter clearly identifies that it is the County's responsibility to develop and implement a comprehensive plan for delivering primary care services and that development of such a plan should be a joint responsibility of consumer, providers, planning agencies and the public sector. I a previous Certificate of Need Application from Hennepin County General Hospital, the Metropolitan Council modified the hospital's proposal by attaching the condition that the County agree to develop a plan for the provision of primary care on a decentralized basis, hold public hearings in the Community, and submit this plan to the Metropolitan Health Board within six months for approval. Similar questions were discussed ~~by~~ during the recent review of the B-C Extension request from the University Hospitals. Should a similar condition be placed on the St. Paul-Ramsey proposal?

4. The role of existing and potential resources on a neighborhood level for delivering of service and the training of health manpower.

Similar to the issues raised above, the review of the B-C application from University Hospitals raised concerns regarding the use of high volume service programs which presently exist as sites for clinical education of needed health manpower. The County Hospital has traditionally played a major role in these training programs. To what extent is the proposed program needed for medical education? Or should some of these programs be further decentralized to the neighborhood level.

MM:bp
1.23,74

County	Community
Ramsey	St. Paul/ ~~Northeast~~ Eastside

FACE TO FACE CRISIS CENTER, INC.
716 Mendota Avenue
St. Paul, Mn. 55106
772-2557 (crisis) (office) -> 772-2540
Kathy Kegan - Administrative Director
Dave Ecker - Program Director

#5

SERVICES	Days/Hours	Eligibility	Fees
* Counseling and referral: -Family, sex, emotional, and drug, legal Medical clinic: Venereal disease testing and treatment, pregnancy testing, contraceptive services, related counseling, abortion referral	Office hours: Mon.- Fri./ 9am - 5pm Counseling hours: Mon.- Thurs./ 9am - 11pm Friday/ 9am - ~~2~~ 3am (Sat.) Sat.& Sun./ 7pm - ~~2~~ 3am Clinic hours: Tues.& Thurs./ 6:30pm until all patients seen	None medical services only 21 and under except V.D.-all ages counseling -all ages	$1.00 donation requested

Average number of people served per month: ~~115~~ 600-700

Age range: Medical clinic 13 to ~~20~~ 21, counseling 9 to 60

Board of Directors: ~~15~~ 17 members with 25% under age 25

Chairperson: ~~James H. Templeton~~ Howard S. Kleyman

Funding sources: ~~Governor's Crime Commission,~~ National Free Clinic ~~Consortium~~ Council, private ~~donations~~ foundations, businesses, City of St. Paul, St. John's Hospital

Operating budget: ~~$30,000~~ $45,000

Geographical/Neighborhood served: East St. Paul predominantly - but also metro area

In operation since: 1972

Legal status: Non-profit corporation, tax exempt 501(c)(3), not a private foundation

Referrals To:	From:
St. Paul Bureau Planned Parenthood The Bridge Pharm House Family Service of St. Paul Women's Counseling Service Meadowbrook Women's Clinic Seton Residence	Youth Emergency Service ~~Pooncil Corner~~ other community agencies St. Paul Bureau Planned Parenthood St. Paul Schools

Staff: 3 full time and 2 part time paid staff
60 volunteers

Remarks:

County: Ramsey

Community: St. Paul/ Northwest

THE FAMILY TREE, INC.
1599 Selby
St. Paul, Mn. 55104
645-0478
~~Karla Ekdahl~~ - Director
Jane Berg

#6

SERVICES	Days/Hours	Eligibility	Fees
* Birth control services - Venereal disease diagnosis and treatment Pregnancy testing and counseling Related care and counseling Speakers bureau Teenage health counselors program	Office hours: ([illegible] M-Th) Mon.- Fri./ 9am - 5pm Clinic hours: Mon.& Tues./ 7pm - 9:30pm Wednesday/ 12:30pm-3pm Saturday/ 1pm - 3:30pm	None	$2.00 visiting fee to see doctor and cost of materials

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Average number of people served per month: 300 to 400

Age range: 14 to 57

Board of Directors: 20 members with 30% under age 25

Chairperson: ~~Jean Wolf~~ Ann Blonston

Funding sources: Private foundations: Ober Trust Fund, Bigelow Foundation, Medical Education and Research Foundation, Presbyterian Synod

Operating budget: $70,000 ($20,000 of which is cost recovery)

Geographical/Neighborhood served: No geographic limitations; serves mainly Macalester area

In operation since: 1972

Legal status: Non-profit corporation, tax exempt 501(c)(3), not a private foundation

Referrals To: St. Paul Bureau of Health
St. Paul-Ramsey Hospital
Planned Parenthood
Teenage Medical Service

From: Youth Emergency Service
Pooneil Corner
Helping Hand Health Center
Schools
St. Paul Bureau of Health

Staff:
3 full time and 2 part time staff
100 part time volunteers

Remarks: This clinic is also involved with group education (i.e. Parent Sex Education Program, Young Women's Consciousness Raising, etc.)

County: Ramsey

Community: St. Paul/ 7th Street

HELPING HAND HEALTH CENTER, INC.
499 West 7th Street
St. Paul, Mn.
224-7581
Mike Brabeck - Director
Pat Billstrom

#8

SERVICES
* General

- Family planning

Days/Hours
Phone hours:
Mon.& Fri./ 9am - 5pm
Tuesday/ 11am - 8pm
Wednesday/ 10am - 5pm
Thursday/ 11am - 10pm

Clinic hours:
Mon.& Fri./ 10am - 5pm
Tuesday/ Noon - 8pm
Thursday/ Noon-4pm, 6pm - 10pm

Tuesday + Thursday 9:00 AM to 10:00 P.M.
Wednesday 9:00 to 5:00
Mon + Fri 9:00 to 5:00
Tuesday + Thursday 9:00 to 1:00, 6:00 to 10:00
1st Wednesday of each month 1:00 - 3:30 Well-Child

Eligibility: Ramsey County resident

Fees: $1.00 - $12.00

Emergency:
Call St. Luke's Hospital

Average number of people served per month: 300

Age range: All ages

Board of Directors: 12 members with 8% under age 25

Chairperson: Vi Freshwater

Funding sources: Office of Economic Opportunity, Ramsey Action Programs, Hill Family Foundation

Operating budget: $61,000

Geographical/Neighborhood served: Ramsey County

In operation since: December 1971

Legal status: Non-profit corporation, tax exempt 501(c)(3), not a private foundation.

Referrals To: Maternal & Infant Care of Ramsey County Hospital
Ramsey County Mental Health
Westside Clinic
Family Tree

From: Self-referrals

Staff: Ramsey County Family Planning
Specialized physicians

6 full time paid staff
6 part time volunteers

5 full time paid staff
4 part time paid staff
6 volunteers

Remarks:

County	Community
Ramsey	St. Paul/ Summit-University

MODEL CITIES COMMUNITY HEALTH CENTER
(in the Martin Luther King Center)
270 North Kent
St. Paul, Mn. 55103
224-4601
Mrs. Timothy Van - Director

#10

SERVICES	Days/Hours	Eligibility	Fees
General medical care: Physical exams, immunizations, X-rays, treatment, lab tests, minor emergency treatment, pap tests, family planning, pediatric services	Mon./9:30am-11:30pm 1pm-5:30pm Tues./1pm-4pm 5:30pm-8:30pm Wed./9am-11:30am(Children's clinic) 8:30am-11:30am(Women's clinic) 5:30pm-8pm	Resident of St. Paul Model City	None
Dental clinic	M-T-Th-F ~~Thurs./8:30am-11:30am~~ 1pm-4pm	By appointment	
Eye clinic - exams, prescriptions, glasses	~~Friday~~ Wed.	By appointment	Cost of glasses
Pharmacy - prescriptions with information on drugs	Open during clinic hours		

Average number of people served per month: 1,000

Age range: All ages

Board of Directors: 11 members with 0% under age 25

Chairperson: Mrs. Harold Harris

Funding sources: Model Cities and Department of Community Services (St. Paul Division of Environmental Protection)

Operating budget: $380,000

Geographical/Neighborhood served: St. Paul Model Cities

In operation since: 1968

Legal status: A program of Department of Community Services - St. Paul Division of Environmental Protection.

Referrals To: Family Services of St. Paul
Ramsey County Welfare Department
Catholic Social Services
"606" Drop-In Center

From: Family Services of St. Paul
Ramsey County Welfare Department
Catholic Social Services
"606" Drop-In Center
Schools

Staff: Ramsey Welfare Services
Area Project + Referral Nurses →
18 full time and 2 part time paid staff
12 part time volunteers

Remarks: The general purposes of the Health Center are disease prevention and detection, medical treatment, health maintenance and health education. As of July 1, 1973, the dental and eye clinics will expand to full scale services.

County	Community
Ramsey	St. Paul/ Central

ST. PAUL-RAMSEY HOSPITAL CERVICAL CANCER PROJECT (PAP SMEAR CLINIC)
640 Jackson Street
St. Paul, Mn. 55101
222-1234
Dr. E.Y. Hakanson - Director

#16

SERVICES	Days/Hours	Eligibility	Fees
Free Pap smears G.C. smear free with any visit to hospital Family planning and abortion referral and counseling	Mon.- Fri./ 8am - 10:15am 12:30pm - 2pm Closed Wednesday afternoons	None	None

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Average number of people served per month: 1,400

Age range: 12 to 90

Board of Directors: Governing board of St. Paul-Ramsey Hospital and Medical Education and Research Foundation

Chairperson:

Funding sources: St. Paul Ramsey Hospital, Medical Education and Research Foundation, third party payments

Operating budget: $37,827

Geographical/Neighborhood served: Ramsey County

In operation since: 1966

Legal status: A program of St. Paul-Ramsey Hospital

Referrals To:

Not applicable

From: Planned Parenthood
Family Planning Clinic of St. Paul Bureau of Health
Family Tree

Staff: 1 full time and 6 part time paid staff

Remarks:

County: Ramsey

Community: St. Paul/ Riverview

WESTSIDE COMMUNITY HEALTH CENTER, INC.
(in the Neighborhood House)
179 East Robie
St. Paul, Mn. 55107
227-9291, Ext. 45
Dr. DeCubas - Director

#17

SERVICES	Days/Hours	Eligibility	Fees
* General medical services: Minimum routine lab tests, EKG machine, lead-poisoning, immunizations, cultures, family planning, well baby clinic, eye chart testing, school physicals	Mon.- Fri./ 8:30am-4pm Appointment only	None	Sliding fee schedule based on ability to pay

---

Average number of people served per month: ~~69 (150~~ 225 People families)

Age range: Infants to 90 over 25 (40 - 65)

Board of Directors: 10 members ~~with 20% under age 25~~

Chairperson: Not available

Funding sources: Bush Foundation, O.E.O., Medical Education and Research Foundation, fees, in-kind services from Ramsey Hospital, staff services from Bureau of Health + Ramsey Co. Nursing Service

Operating budget: $78,459

Geographical/Neighborhood served: Mainly west side but clients come from all over

In operation since: 1972

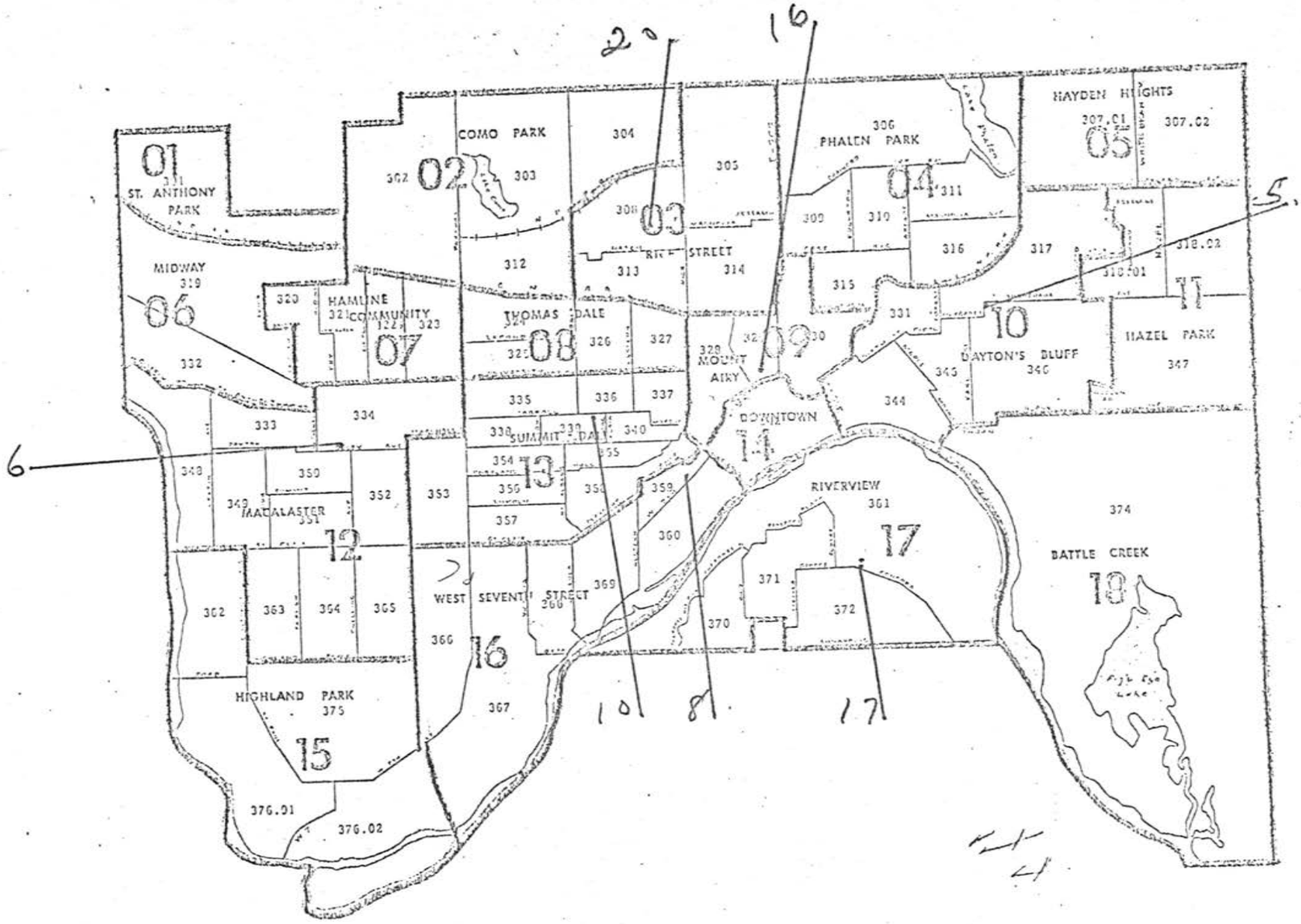
Legal status: ~~This is a program of Family Practice Department, St. Paul-Ramsey Hospital.~~ Private

Referrals To:
Riverview Hospital
Eastside Family Practice Clinic
St. Paul Ramsey Hospital
Bureau of Health

From:
St. Paul Ramsey Hospital
Family Nursing Service
Bureau of Health
Ramsey Co. Nursing Service

Staff:
4 full time paid staff
3 part time paid staff

Remarks:


01
ST. ANTHONY PARK
311
COMO PARK
02
303
304
305
306
PHALEN PARK
04
311
HAYDEN HEIGHTS
307.01
307.02
05
MIDWAY
319
06
HAMLINE COMMUNITY
07
RICE STREET
312
313
314
315
316
317
318.01
318.02
THOMAS DALE
08
326
327
MOUNT AIRY
09
DOWNTOWN
14
SUMMIT DA
340
10
DAYTON'S BLUFF
340
HAZEL PARK
347
11
332
333
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361
RIVERVIEW
17
MACALASTER
12
WEST SEVENTH STREET
362
363
364
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370
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372
374
BATTLE CREEK
18
HIGHLAND PARK
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376.02
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4
ST. PAUL

NOTE: If you have the Metropolitan Development Guide Notebook, please insert this proposed Development Guide Chapter after the tab indicating HEALTH.

METROPOLITAN DEVELOPMENT GUIDE

HEALTH

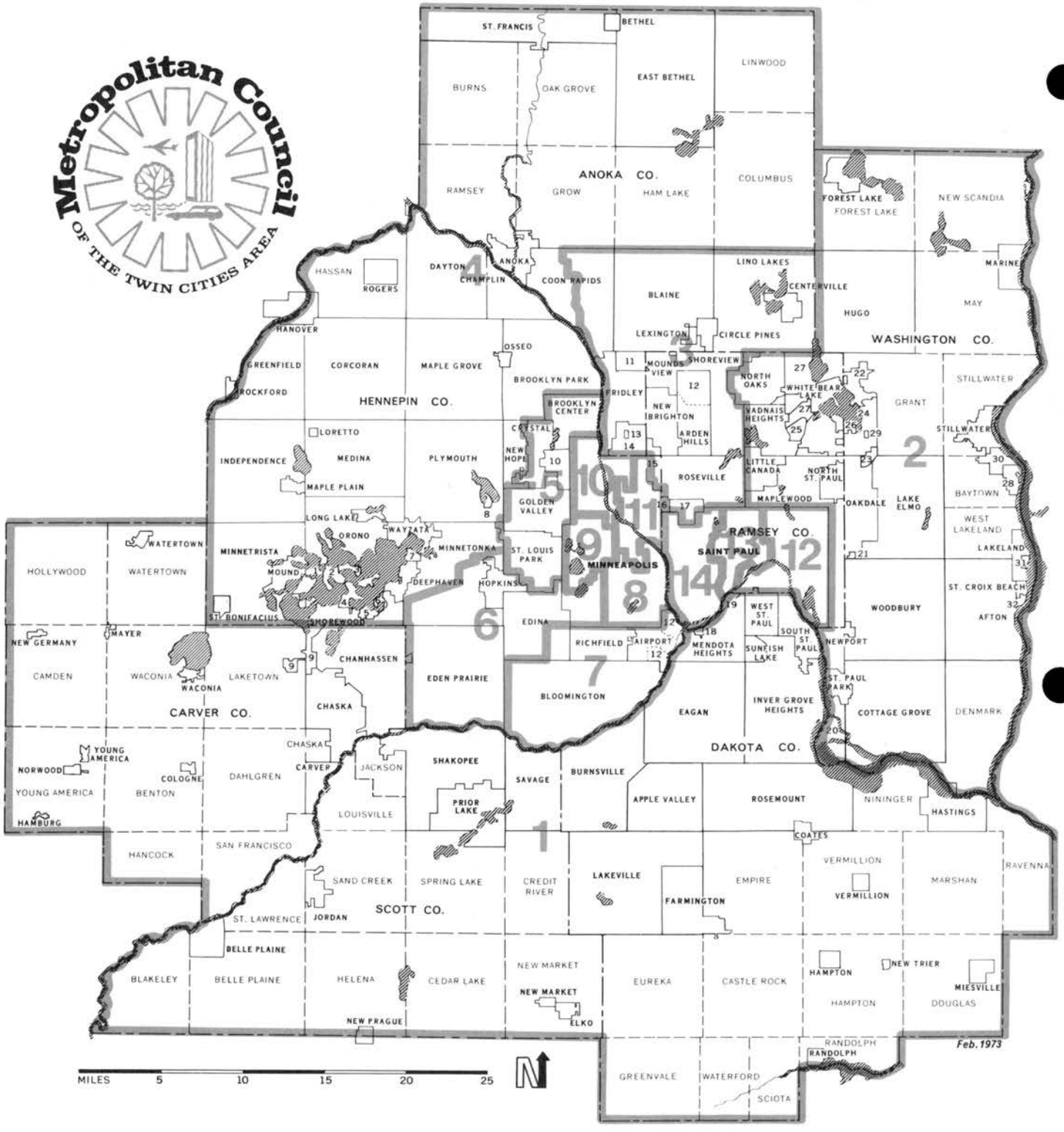
POLICY PLAN, PROGRAM

For Purposes of the Public Hearings

7:00 p.m., November 27, 1973
Heritage Hall, Minneapolis Public Library
300 Nicollet Mall
Minneapolis, Minnesota

and

7:00 p.m., November 29, 1973
300 Metro Square Building
St. Paul, Minnesota



TWIN CITIES METROPOLITAN AREA

The councilmen and their districts are as follows:

Chairman — John E. Boland, North St. Paul.

1. Paul A. Thuet, Jr., West St. Paul.
2. Stanley B. Kegler, Maplewood.
3. John Kozlak, St. Anthony.
4. Kingsley H. Murphy, Jr., Orono.
5. Alice Kreber, Crystal.
6. Dennis Dunne, Edina.
7. Robert L. Hoffman, Bloomington.
8. David L. Graven, Minneapolis.
9. E. Peter Gillette, Jr., Minneapolis.
10. James L. Dorr, Minneapolis.
11. Joan M. Campbell, Minneapolis.
12. The Rev. Norbert Johnson, St. Paul
13. Samuel A. Reed, St. Paul.
14. John J. Costello, St. Paul.

METROPOLITAN COUNCIL
300 Metro Square Building, Saint Paul, Minnesota 55101
227-9421

October 12, 1973

TO: Mayors, Town Board Chairmen, County Officials
Local Government Managers/Administrators/Clerks
Community, Civic, and Business Organizations
Interested Citizens, Media

SUBJECT: Public Hearings on Health Section of
Metropolitan Development Guide

The Metropolitan Council will hold two public hearings on the attached Health section of the Metropolitan Development Guide. Both of these hearings are open to the public and will be held as follows:

Tuesday, November 27, 1973
Heritage Hall
Minneapolis Public Library
300 Nicollet Mall
Minneapolis, Minnesota
7:00 P.M.

Thursday, November 29, 1973
Metropolitan Council Chambers
300 Metro Square Building
(Enter from Jackson Street)
St. Paul, Minnesota
7:00 P.M.

You are invited to attend these meetings and present your views on the proposed Health Guide for our Metropolitan Area to the Council.

The Metropolitan Council is considering this Guide under Section 6, Subdivision 5, of the Council law (Chapter 473B) under which the State Legislature has directed the Council

> "to prepare and adopt, after appropriate study and such public hearings as may be necessary, a comprehensive development guide for the metropolitan area. It shall consist of a compilation of policy statements, goals, standards, programs, and maps prescribing guides for an orderly and economic development, public and private, of the metropolitan area. The comprehensive development guide shall recognize and encompass physical, social, or economic needs of the metropolitan area and those future developments which will have an impact on the entire area including but not limited to such matters as land use, parks and open space needs, the necessity for and location of airports, highways, transit facilities, public hospitals, libraries, schools and other public buildings."

In addition to a copy of the proposed Health section of the Development Guide, I am including a brief outline of the procedures that will be followed at both public hearings. We anticipate that many people will want to participate in these hearings

and, therefore, ask you to follow these procedures so that everyone will have a fair opportunity to be heard. We encourage you to write or call the Council (227-9421, extension 221) and advise us in advance if you wish to speak. Those who register first will be scheduled to speak first. Registration will also be open at the beginning of the meeting at the entrance to the hearing room. If you are unable to attend the hearing, we encourage you to send your written comments addressed to the Council Chairman so that they can be entered into the record of the meeting.

A response from the citizenry of the Area based on a thorough consideration of the proposed Guide is important and will be of help to the Metropolitan Council. Therefore, I strongly urge you to read the attached document and provide us with your response. To aid the Council in analyzing responses, it would be helpful if you would refer to specific policies or portions of the plan, identifying the page number of the draft Guide to which your comments are related. In addition, it is helpful to Council members if you identify those policies you favor as well as those with which you may differ.

This proposed section of the Development Guide is the Metropolitan Area's first Health plan. In developing the plan, the Council has utilized many resources including the Metropolitan Health Board, committee hearings and discussions, reports and opinions from citizens and officials from throughout the Area. We invite you to add to these efforts by participating in this public hearing and providing us with your views and recommendations.

Additional copies of the proposed plan may be obtained from the Metropolitan Council's Public Information Office, 300 Metro Square Building, Seventh and Robert Streets, St. Paul, Minnesota 55101, telephone: 227-9421, extension 221.

Sincerely yours,

METROPOLITAN COUNCIL

John Boland

By
John E. Boland
Chairman

JEB:im

PUBLIC HEARINGS ON HEALTH SECTION
OF METROPOLITAN DEVELOPMENT GUIDE

Tuesday, November 27, 1973
Heritage Hall
Minneapolis Public Library
300 Nicollet Mall
Minneapolis, Minnesota
7:00 P.M.

Thursday, November 29, 1973
Metropolitan Council Chambers
300 Metro Square Building
(Enter from Jackson Street)
St. Paul, Minnesota
7:00 P.M.

PROCEDURES

The following procedures will be used to conduct the hearings to insure that each person has a fair opportunity to present his or her views:

1. Individuals will be asked to limit their remarks to five minutes. Representatives or groups will be asked to limit their remarks to ten minutes.

2. Groups or individuals that desire to make a presentation are asked to register by letter or phone before the meeting. To do so you may call the Council at 227-9421, extension 221. Those who register first will be scheduled to speak first. Registration for persons wishing to speak will also be open before and during the meeting at the entrance to the hearing room.

3. Questioning of speakers from the floor will be permitted only through approval from the chairman of the meeting.

4. Each speaker will be requested to state his or her name, address, and the group(s) he or she represents at the beginning of each presentation. The proceedings will be recorded by a court reporter. If possible, speakers are requested to provide a written copy of statements presented to the Council.

5. Speakers are requested to present only factual information and to avoid repetition of information previously entered into the record of the proceedings by others.

6. Individuals are requested to join with other individuals with similar viewpoints into groups. The names of individuals and/or groups being represented by a particular speaker will be entered into the record.

7. The hearing may be continued to another time and date if it is deemed necessary in order to properly hear all persons and groups.

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Preface

This comprehensive plan for health has been prepared under the authority of Chapter 896, 1967 Minnesota Session Laws, which directs the Metropolitan Council to "prepare and adopt...a comprehensive development guide for the metropolitan area" that "shall recognize and encompass physical, social, or economic needs of the metropolitan area and those future developments which will have an impact on the entire area...".

The Congress of the United States stated in the "Comprehensive Health Planning and Public Health Services Amendments of 1966" that access to acceptable, quality services in the pursuit of the highest level of health attainable is a right to be enjoyed by all persons. By further providing funding to develop comprehensive plans for "coordination of existing and planned health services" on a local, areawide basis, the principle of local determination was established. The effective agent for the accomplishment of the purposes of the Act is the areawide comprehensive health planning agency as defined in Section 314 (b) of the Act. Agencies thus funded are known as "314 (b)" agencies.

The Metropolitan Council is the designated 314 (b) agency for comprehensive health planning for the seven-county Metropolitan Area. The requirements for board composition are met through the appointment of the Metropolitan Health Board, the Council's operating arm for comprehensive health planning.

One of the requirements of 314 (b) agencies is to provide a written health plan. It is therefore also in response to federal requirements, as well as state, that this Health Guide has been prepared.

This Health Guide is to be used as a manual by the Metropolitan Council in its evaluation of Area health planning and development including applications for Certificate of Need and by decision makers in the public and private sectors whose actions shape the course of development in the Area.

The Metropolitan Council's Human Resources Committee and the Metropolitan Health Board met in joint sessions for several months during the spring and summer of 1973 to develop the Health Chapter. After determining the key issues, five informal public meetings were held in order to get as broad as possible a response to the issues from individuals and organizations. Much of the testimony from those meetings is reflected in the Health Chapter, and all the response was carefully considered.

The Chapter consists of two parts: an introduction and a policy plan, program. There is no separate section on implementation at this time, although one may be added at a future phase in the refinement of the Guide.

In addition, there is an Appendix containing Health Maintenance Guidelines and procedures for Certificate of Need applications.

PART I: INTRODUCTION

The Twin City Metropolitan Area comes off well in the provision of health services to the rest of the nation. People live longer, the infant mortality rate is less, there are more doctors, hospitals and other health resources, and the area enjoys a national reputation for excellence and progressiveness in the provision of health care.

However, a marked difference in health services is noted when the general population is compared with the poor and near-poor, racial minorities and people aged 65 and over. These groups suffer from more activity limiting chronic conditions, have more disability days, see physicians and dentists less often and have higher infant mortality (poor and black) and have shorter life expectancies.

Late in November of 1972, the Minneapolis Star's Metro-Poll asked a selected cross-section of residents of the Metropolitan Area what they thought about the adequacy of local health care. Seventy-two per cent of those responding said they thought it was adequate. Shown a list of nine health services, 55 per cent responded that one or more of the services were not available in their area and were needed.

Renters, persons in the 18-29 age group and union members were more inclined to think that additional local services are needed. People with family incomes of $15,000 or more generally felt that adequate health services are available.

Nearly 30 per cent of those polled felt that adequate services were not available.

For the year ending June 30, 1972, 7.6 per cent of the nation's Gross National Product was spent on health. The total expenditure of $83.4 billion was 10 per cent more than what was spent in 1971.

Despite the large (and growing) amount of money spent annually on traditional health care service, improvement of health has leveled off. Further expenditures alone will not solve the problems of health care. To significantly improve health, both manpower and facilities must be available and accessible in the right places. Segments of the health system must be better coordinated, with a concentrated emphasis on preventive health care. Only as health service delivery problems are solved can more care actually be obtained for the money spent.

The Health Chapter of the Metropolitan Development Guide seeks to define the health needs within the seven counties and to locate and allocate resources to meet those needs. Improving the working relationships among the diverse providers of health services will enhance the appropriateness and continuity of care. Unnecessary duplications can be identified and reduced or eliminated.

The concerns of the developmentally disabled, while not fully addressed in this Health Chapter, are currently being defined and will be included in future revisions of this document.

The policies included in the Guide, as diverse as they may appear, are consistent with three basic principles.

First, access to acceptable comprehensive health care services is a right enunciated in National Policy but not yet realized by every citizen.

Second, the right of the individual to freedom of choice in decisions concerning health matters must be preserved and supported. The individual must have free choice in seeking a source of health care. And the individual must have free choice in decisions regarding health matters and his own body when such choice does not imperil the health of the community.

Third, alternatives to the present care delivery system need to be developed which are supportive of the right of individual choice and consistent with present levels of knowledge of the system

Whatever the view, change is being envisioned and shaped, hopefully for the benefit of all people in the Metropolitan Area. The tools of change are Certificate of Need, both State and National, other review and comment responsibilities and the ability to persuade - the Legislature, other governmental units and the many parties of interest mentioned earlier.

PART II: POLICY PLAN, PROGRAM

AVAILABLITY AND ACCESSIBILITY OF HEALTH SERVICES

Health and health-related human services should be available and accessible to the whole metropolitan community with assurance of a continuum of preventive maintenance, curative and rehabilitative services.

The policies relating to accessibility deal with the definition of health service scarcity, reduction of barriers, better use of existing services and manpower, and the policy emphasis on prevention and maintenance services.

HEALTH SERVICE SCARCITY

A definitive basis is needed for allocating scarce resources to areas of need. Using available statistical indicators in varying combinations, some identification of areas which are medically underserved have been made. Six community areas within St. Paul have been identified as "Limited Health Service Areas" by the Human Resources Planning Council of St. Paul. See Figure 1.

The federally funded Children and Youth Program, using a different combination of weighted statistical indicators, ranked the census tracts of Minneapolis by magnitude of health problems. A map showing the ranking is displayed in Figure 2.

The South Hennepin Human Services Planning Board serving the suburbs of Richfield, Bloomington and Edina has identified mental health - related services as being scarce in those communities.

The Department of Health, Education and Welfare in recently issued guidelines defines the existence of health services scarcity as follows:

1) "When there is a quantitative lack of resources in a defined area and contiguous areas.
2) If resources are adequate, the services may still be scarce because they are inaccessible to the target population.
3) If resources and services are adequate and accessible, scarcity may still result from ineffective utilization of services"

A study will be needed to evaluate the usefulness of available statistical indicators and to identify geographic and/or demographic areas of health service scarcity throughout the Metropolitan Area.

POLICIES

1. HEALTH CARE SCARCITY AREAS FOR PRIMARY, ACUTE, AND LONG-TERM CARE SERVICES SHALL BE DEFINED AND GIVEN A PRIORITY TO BE USED AS A GUIDE FOR ALLOCATING HEALTH CARE RESOURCES OF SERVICES, MANPOWER AND FACILITIES TO AREAS OF GREATEST NEED.

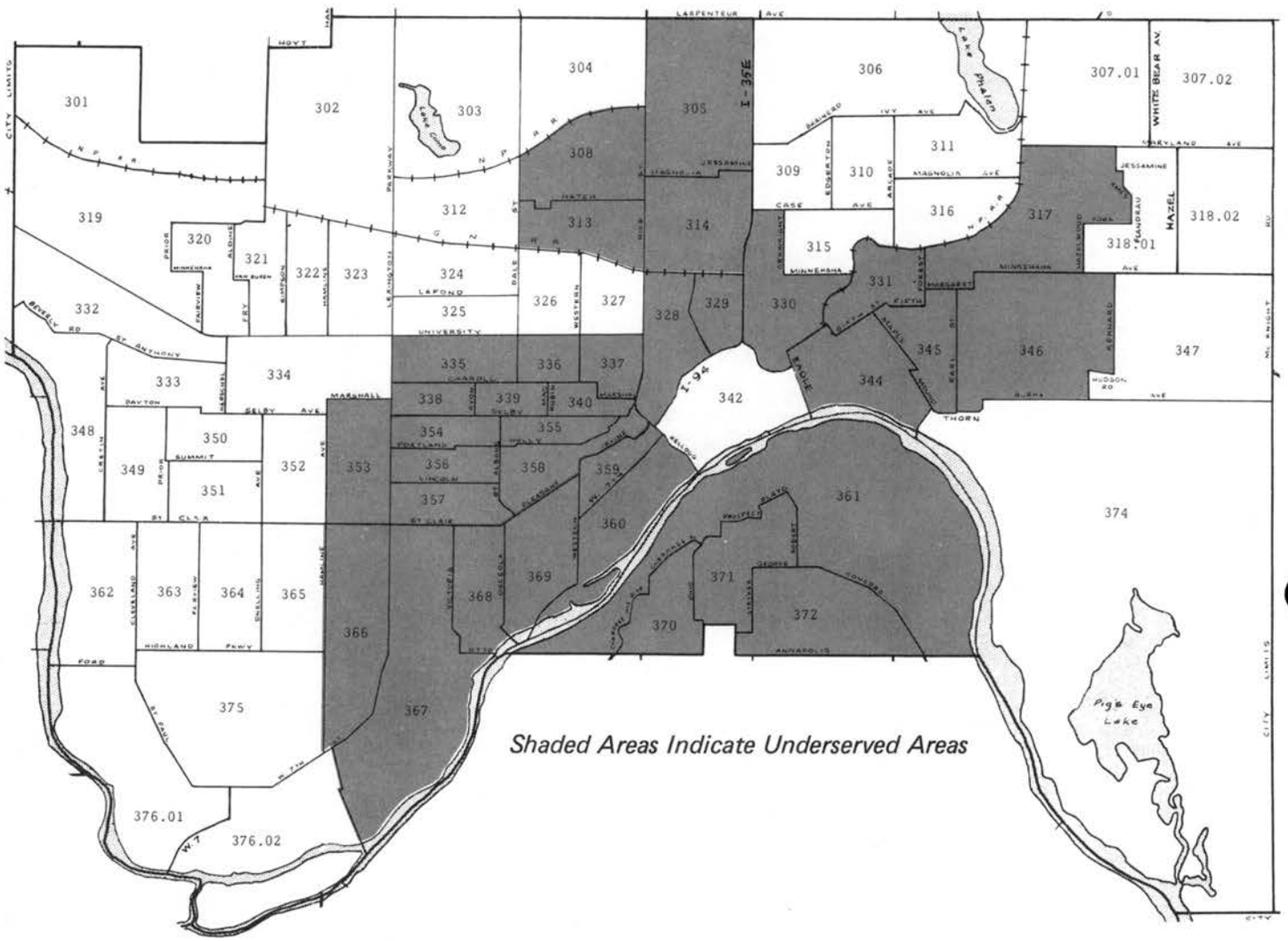


Figure 1. Limited Health Service Areas In St. Paul

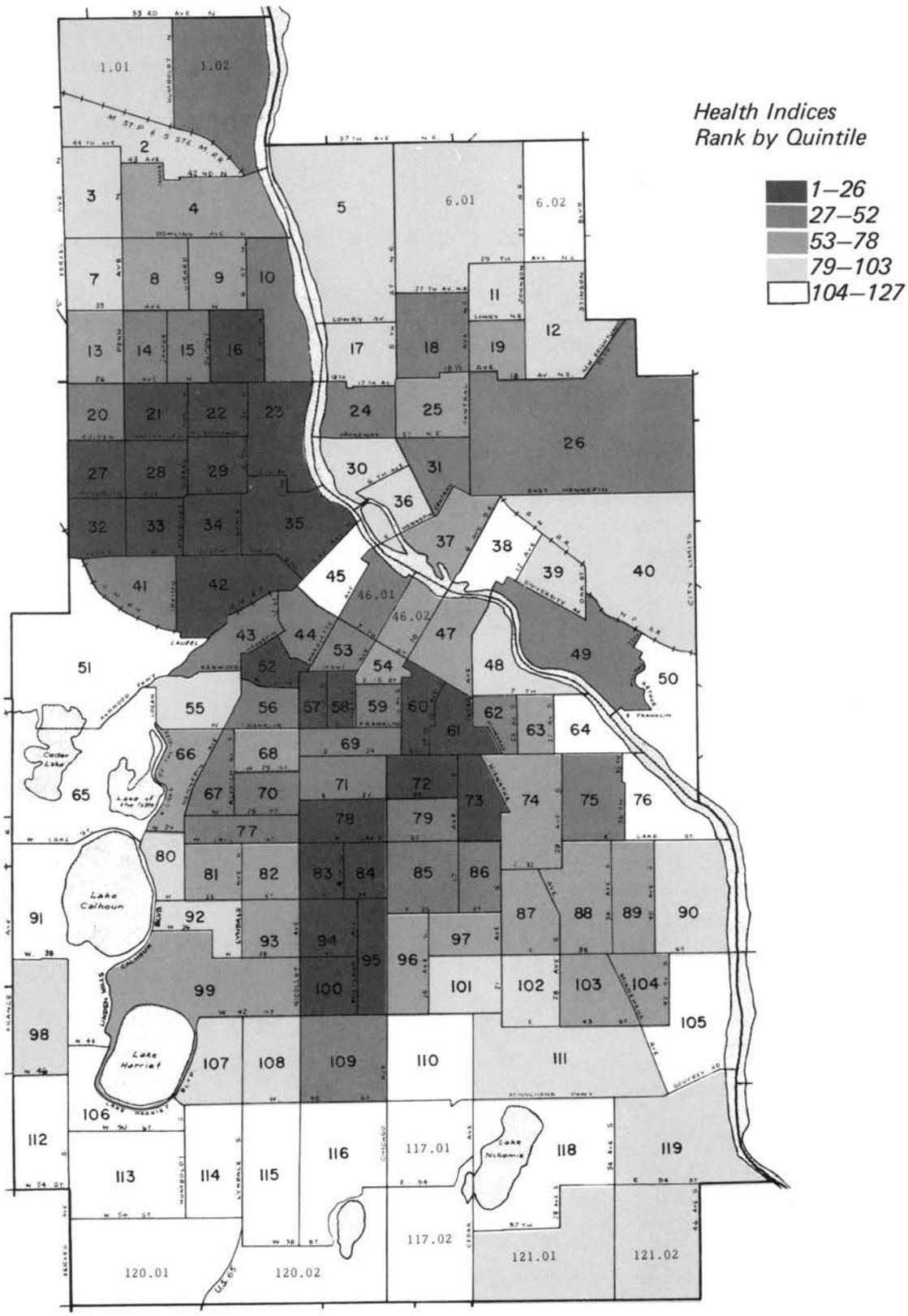


Figure 2. Magnitude Of Health Problems In Minneapolis By Census Tracts

As areas of health service scarcity are defined and identified, resources will need to be found to meet the scarcities. While the exact nature of the required services would have to await the completion of the study, some of the potential resources can be tentatively identified, but they are at best limited.

THE HOSPITAL AS A RESOURCE OF SERVICES

The hospital is an obvious resource. In aggregate it accounts for nearly 40 per cent of the nation's health bill. It has the ability to acquire financing, although it can't generate financing and must depend upon reimbursement for its services. It has expertise and a well-developed organizational structure. Most importantly, it has an organized medical staff. It is a reasonable expectation that the hospital should be prepared to include in its plans the provision of services to areas of scarcity. (See Policy Number 25).

THE NURSING HOME AS A RESOURCE OF SERVICES

The nursing home also has some potential for providing service to areas of scarcity that are within its competencies. Some nursing homes are already sharing their services with the community. Others could do much more, while some have all they can do to maintain their own programs. Wherever possible, nursing homes should actively seek cooperative arrangements, especially within their identified service area, to provide, share, or use services in a manner that will meet health service scarcities.

Facilities offering mental health services represent a broad spectrum of disciplines, conditions of need, approaches, techniques, organization, management, standards and quality. Mental health services are frequently developed in response to a singular need or age group and thus operate in isolation from other services. This deprives the patient of access to beneficial or supportive services. Throughout the Metropolitan Area, mental health-related services are among those most frequently mentioned as being unavailable or in short supply. Meeting the demand for what could be a widespread service scarcity will require, as a minimum, better use of existing resources. The expansion and development of mental health services should result in the creation of more multi purpose agencies which can effectively relate through consolidation and affiliation, to other health and social services in the community.

NEIGHBORHOOD HEALTH CENTERS

Neighborhood health centers sponsored by community organizations, local government, hospitals, special purpose organizations and others have developed in response to a variety of local needs. Centers such as the Martin Luther King Clinic in Saint Paul and the Pilot City Health Center and the Lutheran Deaconess Clinic in Minneapolis provide generalized medical services. Others such as Family Tree and the Face to Face Crisis Center in Saint Paul offer more specialized services, such as family planning, counseling, V.D. and drug services or services to certain age groups. The Community-University Health Care Center is an example of a center offering comprehensive health services to children and youth.

Currently neighborhood health centers in the Metropolitan Area number between twenty and thirty. A fairly comprehensive inventory is to be found in The Catalog , a publication by Enablers, Incorporated, which lists approximately 470 metropolitan agencies and operations offering services for the young.

Neighborhood health centers have frequently developed with extensive reliance on volunteer efforts and support. In some cases this has created difficulties in developing the solid organizational and financial base needed for long term operations. As providers of health services, both private and public, plan to meet identified health service scarcity, consideration should be given to supporting neighborhood health centers directly and through affiliation.

POLICIES

2. AS ADDITIONAL HEALTH CARE RESOURCES ARE DEVELOPED, THEY SHOULD FIRST BE ALLOCATED TO GEOGRAPHIC OR DEMOGRAPHIC AREAS OF DEFINED HEALTH SERVICE SCARCITY IN ORDER OF PRIORITY RANKING.

3. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS SHOULD MEET, TO SOME DEGREE, IDENTIFIED HIGH PRIORITY NEEDS IN HEALTH SERVICE SCARCITY AREAS IN ORDER TO RECEIVE A FAVORABLE RECOMMENDATION.

The study of health service scarcity could result in recommendations for changes in the way health services are delivered in the region. As "areas" are defined, the basis for not only the delivery of service but also the determination of financing could become geographically determined. Existing community organizations such as the Northeast Community Organization could become the focus for integrating health and other community services especially where boundaries coincide with geographic areas of health service scarcity.

Where established community organizations do not exist, the definition of areas of health service scarcity could be used to encourage the development of some kind of organization for the provision of health and other community services. Perhaps some "joint powers" arrangement similar to the hospital district as established under State law could be enacted to allow the development of funding of needed services. (See Policy No. 7).

Whatever alternatives exist or are suggested as a result of scarcity studies, it appears obvious that new resources can be generated only by government: municipal, county or State. Not only do the governmental units have taxing power, but they also are the only likely recipients of federal revenue sharing programs which can be used for health services.

THE COUNTY'S ROLE

The one unit of government large enough to economically coordinate service delivery, yet small enough to be responsive to the unique local differences within the region, is the county. By law, counties have responsibility for

certain "public health" functions. By practice, many counties have assumed wide responsibilities for provision of a variety of health services. The county appears to be the most logical body with accountability which could assume responsibility for planning of services to areas of scarcity.

It is assumed that the county would not attempt to plan service delivery on its own, but would enlist the aid of providers and citizens to assist it. The Hennepin County Health Coalition is an example of the type of organizational structure a county could use to involve consumers and providers along with government in a meaningful endeavor. The principle of consumer majority enunciated in the Comprehensive Health Planning Act should be observed, and the major focus of the county's planning efforts should be the delivery of services to areas of need determined the Health Scarcity Study. Plans thus formulated would be submitted to the Metropolitan Health Board for review.

The county under its plan, should purchase the services for which it has responsiblity whenever it can do so at a cost less than it can provide the service itself. Relieved of the day-to-day provision of service, the county can be free to set standards and evaluate outcomes.

POLICIES

4. COUNTY GOVERNMENTS SHOULD HAVE THE RESPONSIBILITY FOR DEVELOPING AND IMPLEMENTING A COMPREHENSIVE PLAN FOR DELIVERING PRIMARY CARE SERVICES WITHIN THEIR COUNTY TO IDENTIFIED AREAS OF HEALTH SCARCITY WHICH IS CONSISTENT WITH THE DEVELOPMENT GUIDE. THE PLAN WHEN COMPLETED, MUST BE SUBMITTED TO THE METROPOLITAN COUNCIL FOR REVIEW.

5. IN PLANNING FOR THE DELIVERY OF PRIMARY CARE SERVICES TO HEALTH SCARCITY AREAS WITHIN THEIR COUNTIES, COUNTY GOVERNMENTS SHOULD BE RESPONSIBILE FOR THE DEVELOPMENT AND SUPPORT OF NEIGHBORHOOD HEALTH CENTERS INCLUDING THE EXISTING CENTERS.

6. THE DEVELOPMENT OF PRIMARY CARE SERVICES SHOULD BE A JOINT RESPONSIBILITY OF CONSUMERS, PROVIDERS, PLANNING AGENCIES, AND THE PUBLIC SECTOR.

To be comprehensive, the plan devised by the county must include health education. The consumer, especially if he is poor, can probably be reached more effectively by his peers and neighbors through a community organization that does more than just provide health services. Such neighborhood health centers should have strong community ties through community control, consumer advocacy, or community review board.

POLICIES

7. ORGANIZATIONS WHICH REFLECT LOCAL OR NEIGHBORHOOD CUSTOMS, CULTURE AND CONCERNS SHOULD BE UTILIZED WHEN POSSIBLE FOR THE DELIVERY OF PRIMARY CARE AND HEALTH-CONSUMER EDUCATION.

REDUCTION OF BARRIERS TO HEALTH CARE

The care that most people seek most of the time is primary care and generally most people - whether they are affluent, poor, urban, suburban or rural - experience difficulties in securing adequate primary care.

Primary health care consists of 1) initial diagnosis, 2) basic treatment, 3) case management and referral, and 4) early detection of potential health problems. Often referred to as "entry care" or "maintenance care", primary health care includes those services needed for preventing illness and for health evaluation and management on a continuing basis.

PHYSICIANS SHORTAGE

Much of what doctors and other allied health professionals do should be considered primary care. The people who provide primary care are in short supply. For example, for over forty years the number of primary care physicians has remained static while the population has soared. This situation is far more damaging to the delivery of care than shortages in any single medical specialty.

While the total number of physicians has increased somewhat in relation to the population, the ratio of those providing primary care in the Metropolitan Region (i.e., family practitioners, pediatricians, internists, obstetricians, and gynecologists) continue to decrease dropping from 81/100,000 in 1950 to 52/100,000 in 1970.

Most problems for which care is sought require neither intensive nor highly specialized treatment. In "The Ecology of Medical Care", an article in November 2, 1961, edition of New England Journal of Medicine, it was reported that 750 out of 1,000 adults had one or more illnesses or injuries during a one month period, 250 consulted a physician, nine required admission to a hospital, five were referred to another physician and one to a university medical center. The study results would seem to support the preponderance of primary care, a substantial portion of which is probably delivered by someone other than a physician.

POLICIES

8. ALL PERSONS SHOULD HAVE A READILY ACCESSIBLE AND ACCEPTABLE SOURCE OF PREVENTION-ORIENTED PRIMARY CARE SERVICES IN THEIR NEIGHBORHOOD OR LOCAL COMMUNITY.

AVAILABILITY OF SERVICES

People may experience difficulties in obtaining care because they cannot get to a place where the services are available. Some can't pay for the service. Others don't know how to get to or use appropriate services. For good care to be useful, people will need help in overcoming the difficulties experienced in seeking care.

The geographic configuration of a neighborhood or local community may vary widely depending upon where in the region it is located. For a person with an automobile living in the outlying suburbs an accessible source of primary care could be a number of miles from his home as shown by the map on page 11, (Figure 3). For the person without an automobile and for whom even public transportation is not readily available, an accessible source should not be more than a few blocks from his home.

For persons with low incomes, diagnostic and non-emergency services should be available during hours that will not detract from their jobs. Health problems are often compounded or overlooked because services are not available during evening hours.

COST OF CARE

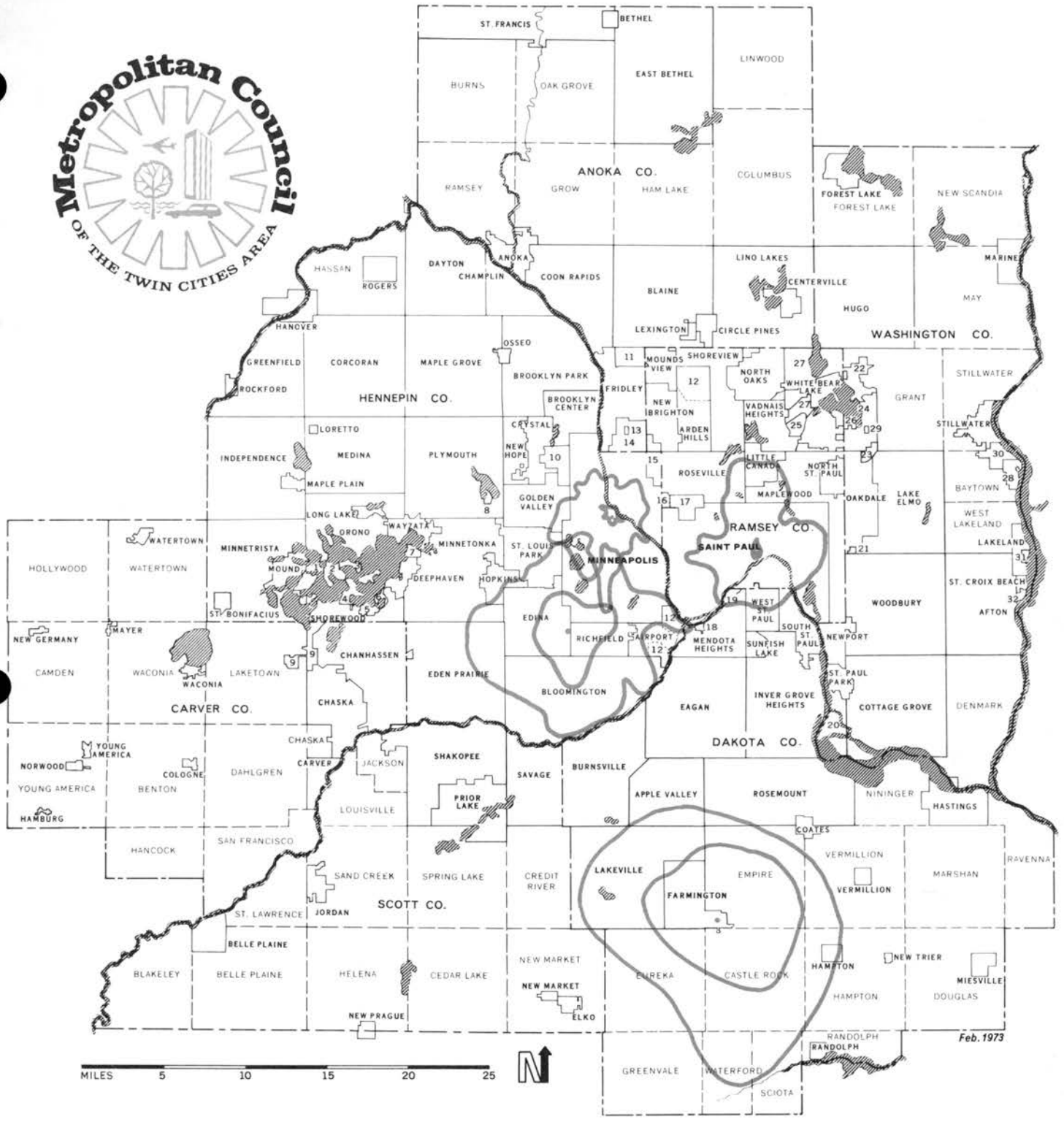
The cost of care can be a formidable barrier even for the relatively affluent. With increasing frequency large bills for health care are prominent in bankruptcy proceedings. The low-income family is pressed to meet daily needs, much less the cost of health care.

Because of the patient's financial limitations, he often uses health facilities on a crisis basis. He may go to a hospital emergency room for basic primary care. This may mean a complete lack of effective case management. The result may be extensive duplication of testing, confusion in diagnosis and treatment and lack of correction of non-emergency problems.

Many people do not have access to care because they do not know how to use the services - a difficulty often attributed to language or cultural differences. People are also intimidated by the impersonalized sophistication of most medical facilities. Special help, education and improved communication are among the possible remedies.

NEED FOR NON-MEDICAL SERVICES

Medical services alone may fall far short of meeting a person's needs for health care. The doctor's order if improperly carried out is ineffective. Perhaps what the person really needs is counseling or someone to listen to him and help him work through his problems. The whole person needs to be attended to in order to successfully deal with the cause of the physical symptoms. The facility to which a person comes for primary health care services should be able to supply a range of supportive services either directly or through arrangements with other suppliers.



TWIN CITIES METROPOLITAN AREA

1 SPRING PARK
2 ORONO
3 MINNETONKA BEACH
4 TONKA BAY
5 EXCELSIOR
6 GREENWOOD
7 WOODLAND
8 MEDICINE LAKE
9 VICTORIA
10 ROBBINSDALE
11 SPRING LAKE PARK
12 U. S. GOVT
13 HILLTOP
14 COLUMBIA HEIGHTS
15 ST. ANTHONY
16 LAUDERDALE
17 FALCON HEIGHTS
18 MENDOTA
19 LILYDALE
20 GREY CLOUD
21 LANDFALL
22 DELLWOOD
23 PINE SPRINGS
24 MAHTOMEDI
25 GEM LAKE
26 BIRCHWOOD
27 WHITE BEAR
28 BAYPORT
29 WILLERNIE
30 OAK PARK HEIGHTS
31 LAKELAND SHORES
32 ST. MARY'S POINT

ANOKA — County
GRANT — Township
OSSEO — Municipality

Figure 3. 10 And 15 Minute Auto Travel Time Rings From Selected Points

POLICIES

9. BARRIERS WHICH IMPEDE THE ACCESSIBILITY AND AVAILABLITY OF HEALTH SERVICES TO METROPOLITAN RESIDENTS SHOULD BE REDUCED TO THE LOWEST POSSIBLE LEVEL AT A COST WHICH THE COMMUNITY CAN AFFORD.

10. PRIMARY CARE SERVICES SHOULD BE EQUITABLY DISTRIBUTED AND KEPT IN BALANCE WITH DEMONSTRATED NEEDS.

11. PRIMARY CARE SERVICES SHOULD BE ORGANIZED AS A PART OF A BROAD BASED COMMUNITY RESOURCE.

ALTERNATIVE WAYS TO PROVIDE SERVICES

Where people because of location or circumstances cannot travel to or otherwise obtain services, services may have to be brought to them, either by a vehicle or by bi-directional cable television. Potential recipients of services delivered in this manner are the elderly or handicapped seeking to maintain a semblance of independent living, people living in isolated locations or conditions (both rural and inner city), and people who have had an emergency such as an accident or heart attack.

The mobile vehicle is useful for screening large numbers of people in order to detect early symptoms of illness or disease. Within the region mobile screening has been done for visual defects, diabetes, high blood pressure and heart disease, tuberculosis, hearing acuity and several other conditions. The technique is fairly simple. However, having identified a symptom needing treatment does not guarantee its treatment. To be effective, screening needs to be done in conjunction with a broader community health effort such as a health maintenance organization or other broad-based provider.

In New York City, the Lincoln Community Mental Health Center operates a Mobile Crisis Intervention and Suicidal Prevention Unit in the Bronx. Specially prepared teams take off on crisis missions when telephone requests for aid come in from citizens or agencies. Each team consists of a psychiatric nurse, two community mental health workers and a driver-attendent.

The United Presbyterian Church sponsors five mobile health education and early detection vehicles which operate in several communities in New Mexico, Colorado, Oregon, Idaho, upstate New York, Oklahoma, and Arkansas. A mobile health vehicle is in use in the Crookston, Minnesota, area operated by the Polk County Nursing Service.

One of the most innovative uses of mobile vehicles was developed by a California firm, Health Systems. The service, known as "Physicians on Call" (POC), draws on a changing pool of doctors, many of whom are interns from local hospitals. When the phone rings at the POC office, which is

open from 6 p.m. to 6 a.m. week nights and all weekend, the doctor on duty listens to the patient describe his complaint. He then decides whether the situation requires emergency transportation to the hospital by an ambulance, a house call, or perhaps just a prescription refill. If a house call is indicated, the POC physician sends a message by two-way radio to a colleague stationed in a roving van.

POLICIES

12. IN THE ABSENCE OF TRANSPORTATION OR OTHER ACCESS TO SERVICE ADEQUATE TO MEET IDENTIFIED HEALTH SCARCITY NEEDS, THE PROVISION OF PRIMARY CARE BY MOBILE MEANS OR BY USE OF A BI-DIRECTIONAL CABLE TELEVISION SHOULD BE EXPLORED AND IF FEASIBLE ENCOURAGED.

13. SELECTED PROCEDURES WITH KNOWN VALIDITY FOR SCREENING HEALTH-IMPAIRING CONDITIONS AMENABLE TO TREATMENT SHOULD BE AVAILABLE TO HIGH RISK POPULATIONS ON A MOBILE BASIS IF THE AVAILABILITY OF FIXED SITE FACILITIES IS NOT POSSIBLE OR PRACTICAL.

ACUTE CARE

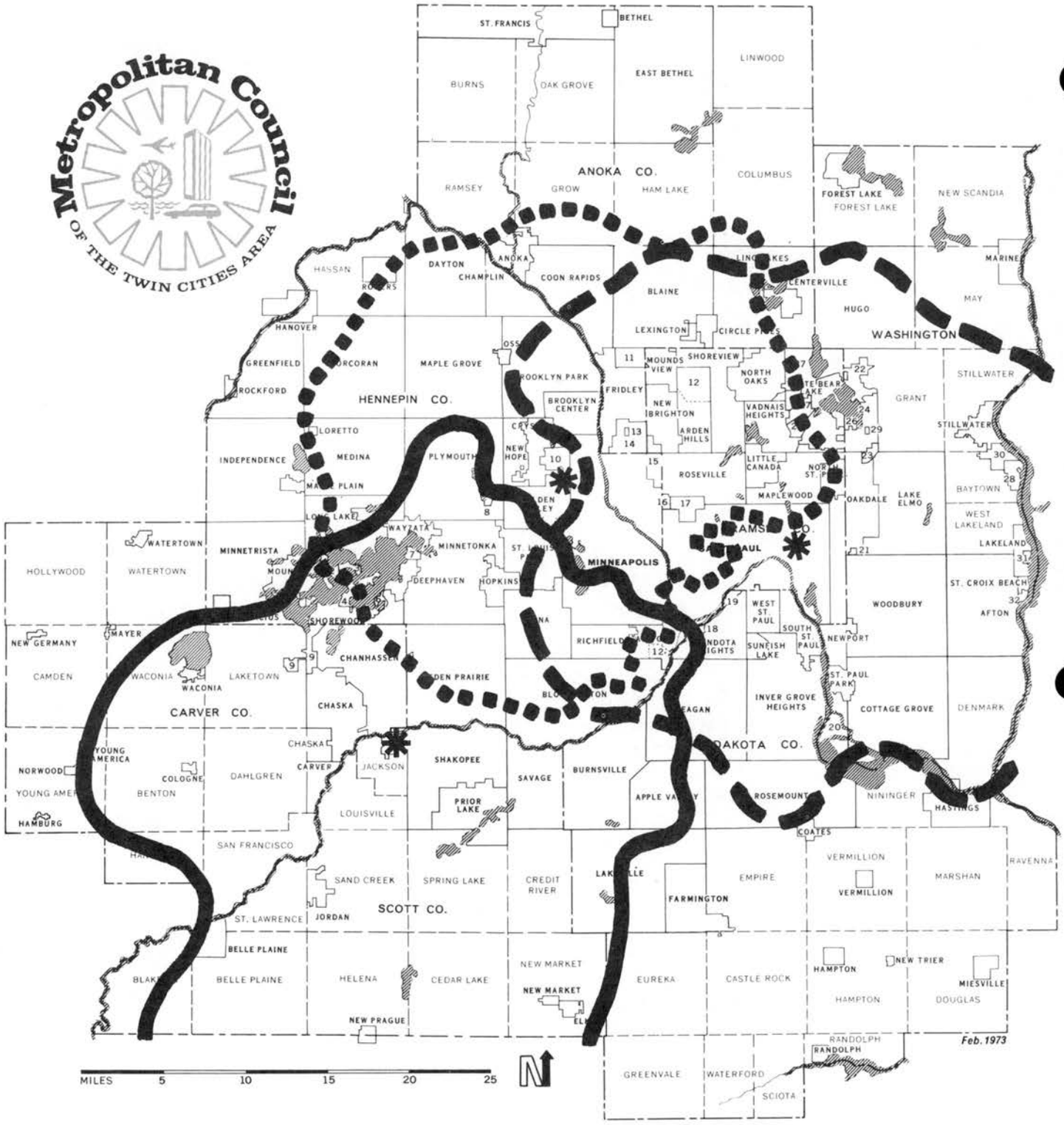
The Metropolitan Area is well supplied with general, acute hospitals. Based on current usage, hospital beds are projected to be in excess of demand by 239 beds in 1980. While the numbers of hospital beds are more than adequate, they need to be located convenient to people who use the hospital's services. Because, with the exception of emergencies, admission to the hospital is planned and scheduled including transportation to and from the hospital, convenience is often for family and friends who visit the patient. Judged by the distances people are willing to travel for normal daily activities, a maximum of 30 minutes travel time appears to be a reasonable measure of convenience. As indicated by the example on the map on page 14 (Figure 4), every person within the Metropolitan Region is within 30 minutes travel time of a hospital.

POLICIES

14. ACUTE CARE SERVICES MUST BE DISTRIBUTED TO SUPPORT AND PROMOTE HEALTH CARE WHICH IS CONVENIENT TO THE POPULATION BEING SERVED. EVERY RESIDENT MUST BE ABLE TO OBTAIN GENERAL SHORT-TERM ACUTE SERVICES WITHIN 30 MINUTES TRAVEL TIME.

EMERGENCY CARE

Most metropolitan residents are concerned that emergency services can be obtained quickly. The elements for a good system include quick access to a dispatch center, contact with an appropriate service, minimum response time by an emergency vehicle, in-route contact with the proper receiving station. A key element to a smooth functioning emergency system is a single access telephone number. The Metropolitan Council is conducting a feasibility study for the metropolitan-wide use of "911" as the emergency number.



TWIN CITIES METROPOLITAN AREA

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Figure 4. 30 Minute Auto Travel Time Rings From Selected Hospitals

The provision of emerging health care services should be planned from a metropolitan prospective and delivered through an organized hierarchy of emergency care providers. The Emergency Health Care Services Task Force of the Metropolitan Health Board and the Minnesota State Department of Health have recommended that a three-level system of emergency care facilities be organized for the Metropolitan Area. These are based primarily on progressive levels of manpower staffing in hospital emergency departments. Formal guidelines have been established by the Minnesota Department of Health by which the Metropolitan Health Board is required to evaluate the existing services in the Metropolitan Area and recommend the appropriate levels for specific emergency centers. The Metropolitan Health Board will make these recommendations in the next six months based on the guidelines established by the State Board of Health.

POLICIES

15. THE EMERGENCY HEALTH CARE SERVICE NEEDS OF THE METROPOLITAN AREA WILL BE ANALYZED AND RECOMMENDATIONS FOR APPROPRIATE DESIGNATION OF RESPONSIBILITY SHOULD BE MADE TO THE STATE BOARD OF HEALTH.

The emergency system could be used to help get information about health services. The Inland Counties Comprehensive Health Planning Council in San Bernadino, California, has developed a telephone access system which provides the community with instant access to a vast library of concise, accurate, physician-approved five-minute tape recordings on many health care topics. This is known as tel-med. It was developed by organized medicine in cooperation with public and private health care agencies. A similar system could be developed for the Metropolitan Area.

As a further service to consumers, the Metropolitan Health Board should publish on a periodic basis factual information about metropolitan health resources including nursing homes and how to use them.

POLICIES

16. EVERY RESIDENT SHOULD BE ABLE TO OBTAIN AMBULANCE ASSISTANCE FOR AN EMERGENCY WITHIN TEN MINUTES OF PLACING A CALL.

17. IN ADDITION TO THE "911" EMERGENCY TELEPHONE ACCESS SYSTEM, A 24-HOUR TELEPHONE HEALTH REFERRAL AND INFORMATION SYSTEM SHOULD BE DEVELOPED.

18. THE 24-HOUR REFERRAL AND INFORMATION SERVICE SHOULD INCLUDE A RESEARCH AND INVESTIGATIVE UNIT TO MONITOR METROPOLITAN HEALTH SERVICES, FOLLOW-UP COMPLAINTS AND REPORT FINDINGS AND RECOMMENDATIONS ANNUALLY TO THE METROPOLITAN HEALTH BOARD.

19. A CONSUMER's GUIDE TO METROPOLITAN AREA HEALTH RESOURCES, INCLUDING NURSING HOMES, SHOULD BE DEVELOPED AND PUBLISHED.

PREVENTIVE CARE

Available statistics, as inadequate as they may be, seem to indicate that the large expenditures over the past few years for traditional medical care has not improved health. The diseases from which many people die are more easily prevented than cured. Often all conventional medical care can do is prolong life. To significantly improve the state of health, disease must be prevented.

People generally buy only those medical services from which they might reasonably expect to receive a visible payoff. Economist Richard M. Bailey views demands for medical services according to the following order of urgency: 1) Demand arising from an emergency/serious, life-threatening situation, 2) demand for treatment of not so serious conditions, such as acute illness where life is not threatened, or a chronic illness where management of the problem is needed and 3) demand for medical services to detect developing medical problems.

Obviously, demand for life-saving services would be high, and the demand for the alteration of not so serious conditions or chronic conditions would be less (I can live with it, or I'll get over it). Because the benefits are not immediately obvious, the consumer makes what appears to be a rational decision not to purchase preventive services with the result that demand is low.

The present health care system in this Metropolitan Area generally responds well to the demand for emergency care and acute care. However, according to a recent study/report released by the Government Account Office (GAO) future demand for many "repair" and life-saving services in expensive acute care settings can be decreased by expanding the availability of preventive services. Too often minor health problems go unattended because services are not available, need for care is not obvious, or the effort required to obtain care is so large that people "muddle through" rather than seek services.

To promote preventive health care services, means will have to be found to enable existing providers to shift the emphasis to prevention. As new services develop, especially within an organized system such as a health meaintenance organization, the emphasis can more easily be built in.

POLICIES

20. IN PLANNING FOR THE DEVELOPMENT OF PRIMARY CARE SERVICES, THE EMPHASIS ON KEEPING PEOPLE WELL SHOULD BE GIVEN A HIGHER PRIORITY THAN THE EMPHASIS ON EPISODIC TREATMENT OF DISEASE.

Inpatient acute hospital care is the most expensive kind of health care. Its use should be limited to those who need it. Emphasis on inpatient care has resulted from many factors among which are specialization and the development of referral patterns among physicians who are organized as a hospital medical staff; advanced technology requiring expensive support facilities and equipment; and prepayment or insurance for hospital care which encourages hospital admissions.

Cost reimbursement financing has created excessive demand for acute inpatient services while depressing demand for less costly services which are not prepaid or insured. Patients requiring ambulatory care should not be treated as inpatients. National data for the most recent five-year period available (1964-1968) shows that: 1) for those under five, mortality rates were lower than in previous years, 2) for those between five and 14 years of age, there was not change, 3) for all age groups between 15 and 64, mortality rate rose, and 4) for those over 65, mortality rates were lower. Hence, improvement was registered only for the very young and the very old. This raises questions about the appropriateness and distribution of health resources and about the need for selectivity in making additional investments. Readily available sources of primary care services need to be developed in order to reduce the overuse of more costly and inconvenient alternatives, to organize the provision and use of preventive-oriented services such as health education and early detection, and to assure continuity of care.

POLICIES

21. PRIMARY CARE SERVICES SHOULD BE GIVEN A HIGHER PRIORITY FOR METROPOLITAN HEALTH PLANNING THAN FURTHER EXPANSION OF ACUTE, INPATIENT FACILITIES.

The community hospital is a basic resource accountable to the community which should be expected to provide not only basic acute services but also other health services which are unique to the community. However, this is not intended to imply that the hospital should necessarily deliver all needed community health services. The underlying principle for delivery of any needed health service is that it should be provided in the most efficient and effective manner consistent with high quality. The hospital must be able to compete both economically and qualitatively with high non-hospital services.

POLICIES

22. HOSPITALS SHALL BE ENCOURAGED TO DEVELOP NEEDED COMMUNITY HEALTH SERVICES, PROVIDED THEY CAN OPERATE ECONOMICALLY AND QUALITATIVELY COMPARED WITH HIGH QUALITY NON-HOSPITAL SPONSORED SERVICES.

Several hospitals, unites of government, and voluntary agencies have demonstrated a commitment to promote the development, expansion and upgrading of primary care services and can take pride in these efforts. In keeping with the priority for development of primary care services, hospitals should de-emphasize the further expansion of acute, inpatient services.

POLICIES

23. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS WHICH PROMOTE THE DEVELOPMENT, EXPANSION, OR UPGRADING OF PRIMARY CARE SERVICES SHALL HAVE A HIGHER PRIORITY THAN PROJECTS WHICH PROMOTE THE FURTHER DEVELOPMENT OR EXPANSION OF ACUTE, INPATIENT SERVICES.

BETTER USE OF EXISTING RESOURCES

The historical development of hospital services had until recently resulted in the concentration of hospital services in the central city where they were convenient to physician's office practice. Beginning in the late 1950's in Minneapolis, the relocation of one central city hospital, expansion of two existing suburban hospitals and construction of four new hospitals have provided needed hospital services for the suburban population.

As a result, the present hospitals are relatively well distributed throughout the Metropolitan Area. Nevertheless, specific populations have not benefited from the proximity of these hospitals (e.g. the aged, minorities, the poor).

HEALTH DELIVERY SERVICE AREAS

Under ideal conditions, all persons should have access to the health care facility of their choice, and all providers should be obligated to serve all patients who present themselves at their facilities. The current system of admission and financial reimbursement does not allow this to happen. The geographic area which a hospital serves, the scope of services provided, and the quality of care provided are directly related to the type and quality of the medical staff who choose to practice at that institution. Hospitals strive to attract physicians who in turn admit their patients to the institution. Therefore, the service area of the institution is effectively defined by the office practice of its medical staff.

Figures 5, 6 and 7 on the following pages illustrate by example, how service areas differ.

There is need to coordinate the delivery of health care services on a Metropolitan-wide basis so that population groups such as the aged, minorities, and poor are not left underserved and unserved. Each acute care provider should be responsible for making needed health care services available to residents of the communities contiguous to the institution. At the same time, physicians and patients should be permitted to exercise their choice of the type of care and institutions they prefer.

POLICIES

24. ACUTE CARE PROVIDERS SHOULD BE RESPONSIBLE FOR, BUT NOT LIMITED TO OFFERING SPECIFIC SERVICES TO SPECIFIC POPULATIONS.

25. COMMUNITY HOSPITALS SHOULD BE RESPONSIBLE FOR MAKING AVAILABLE A BASIC LEVEL OF HEALTH SERVICES TO DEFINED PRIMARY SERVICE AREAS AND/OR HEALTH SCARCITY AREAS.

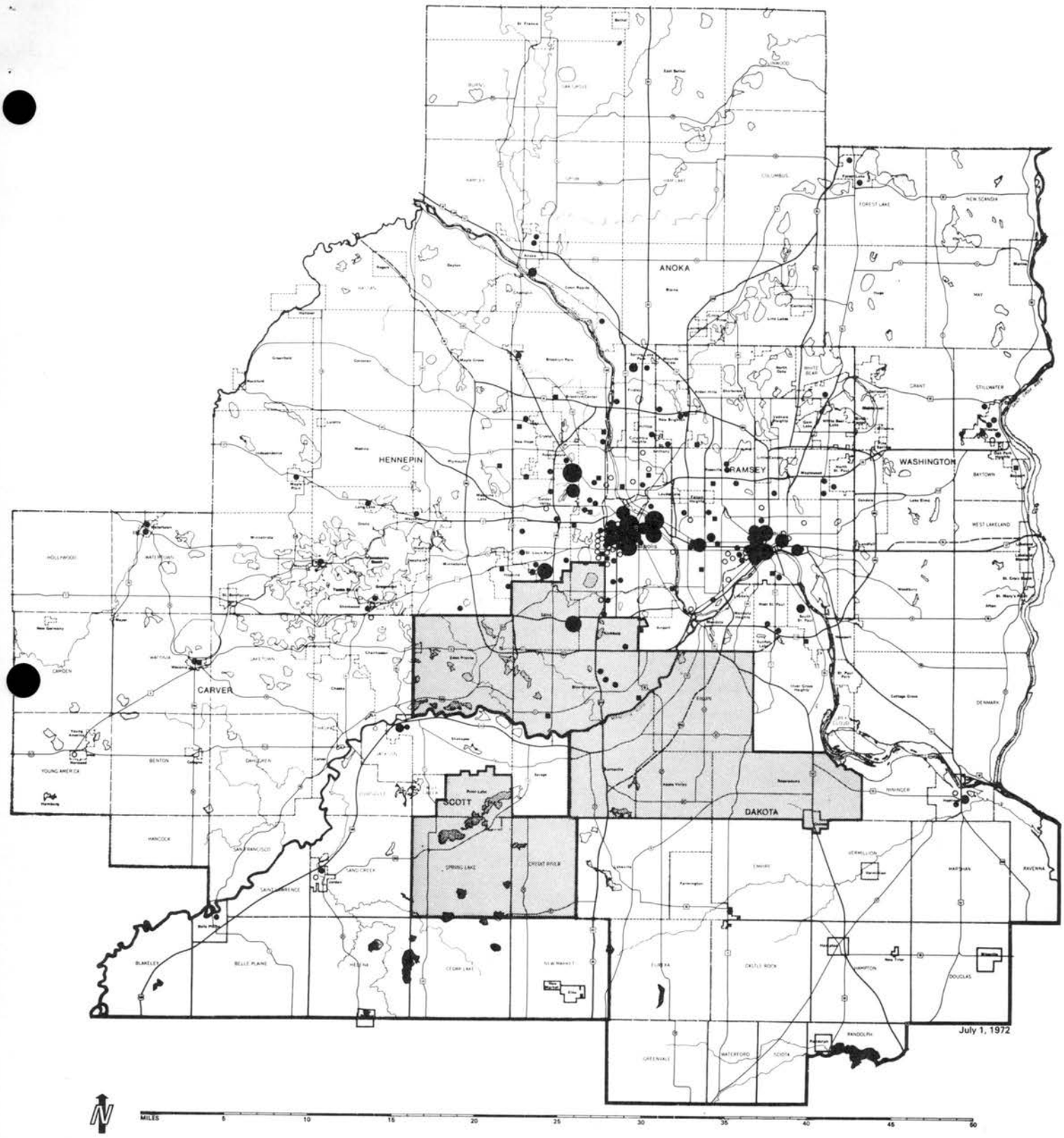
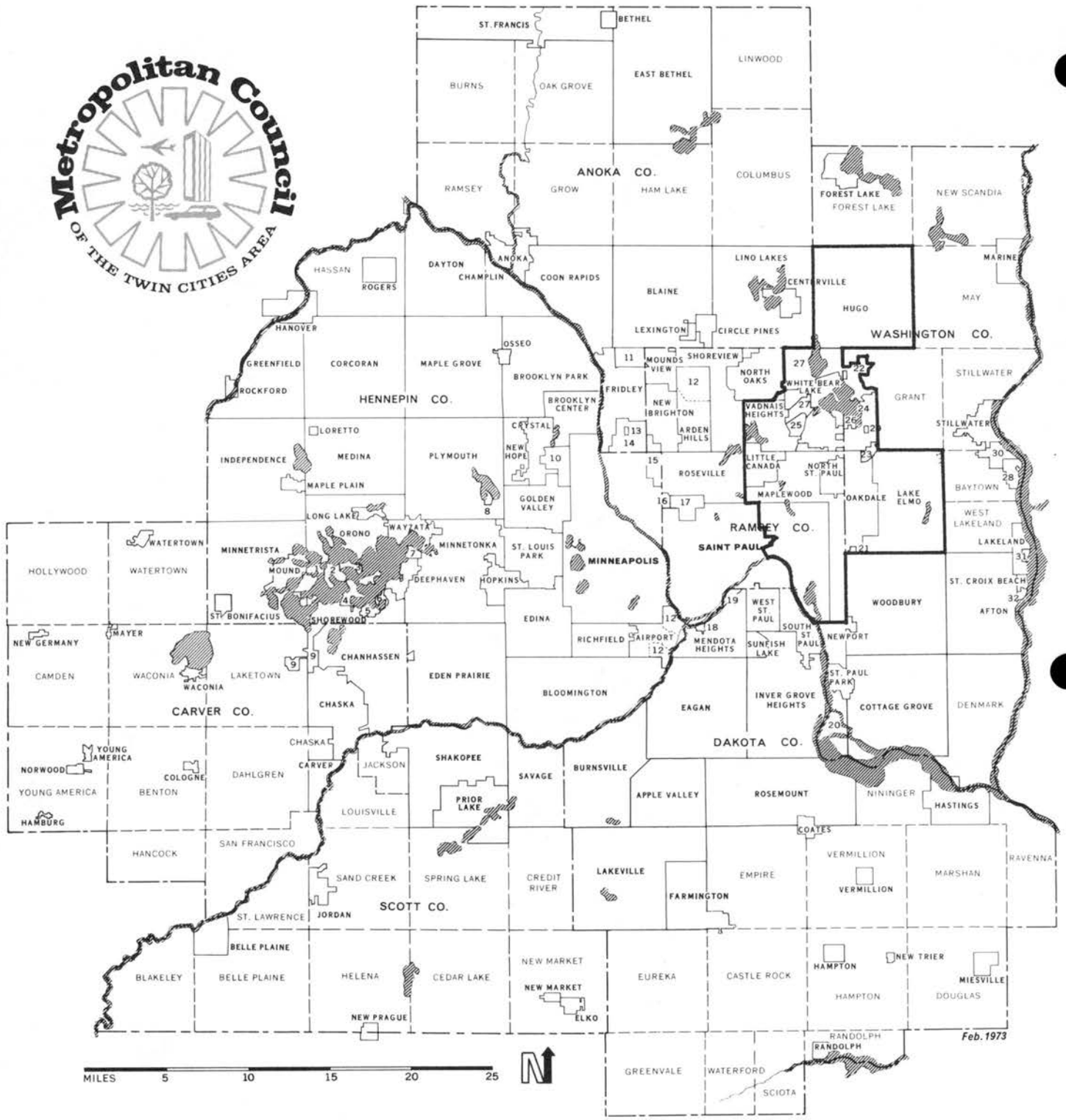


Figure 5. Service Area Of Fairview-Southdale Hospital



TWIN CITIES METROPOLITAN AREA

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31 LAKELAND SHORES
32 ST. MARY'S POINT

ANOKA — County
GRANT — Township
OSSEO — Municipality

Figure 6. Service Area Of St. John's Hospital

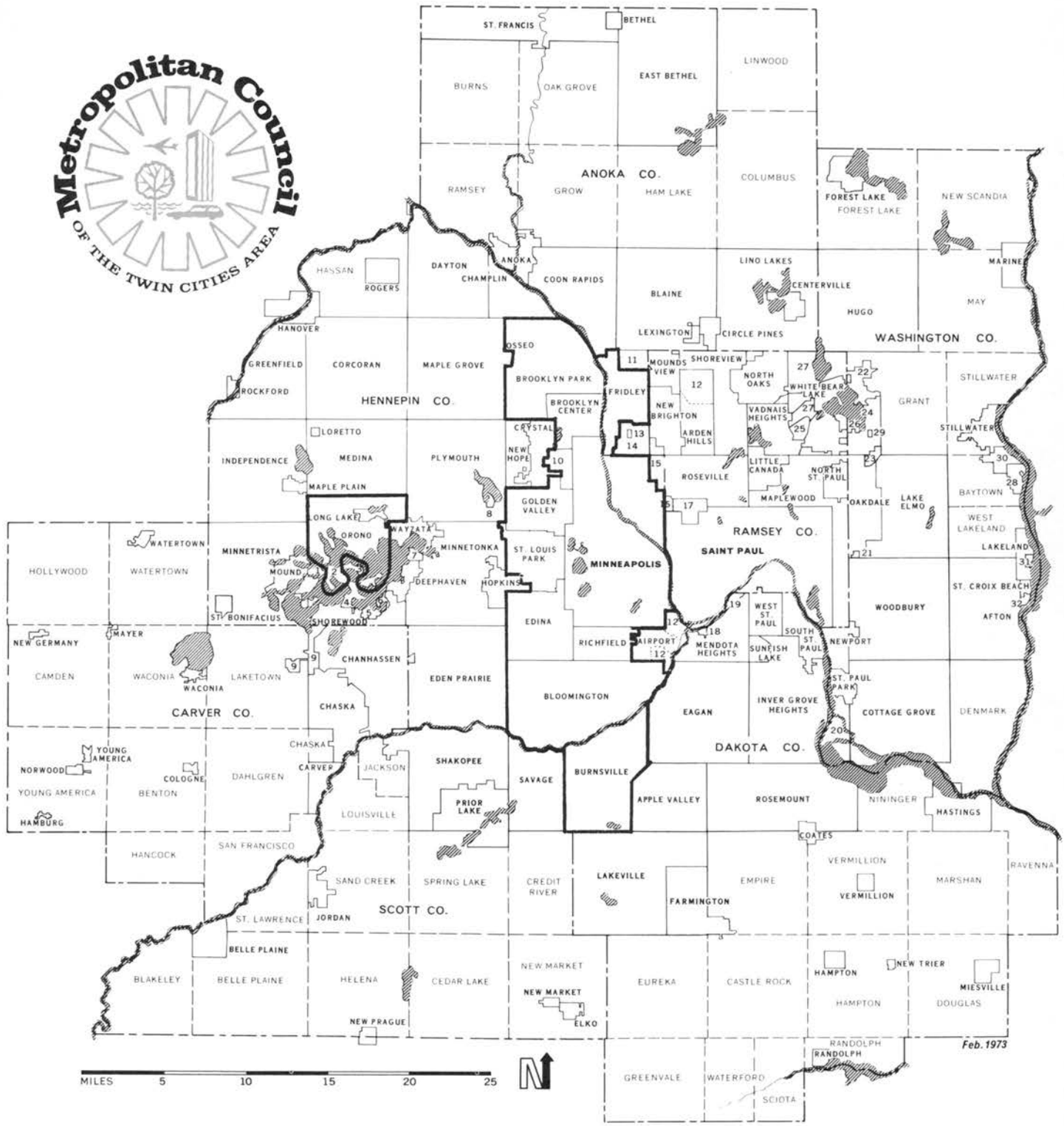

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Figure 7. Service Area Hennepin County General Hospital And Metropolitan Medical Center

COMMUNITY PARTICIPATION

To assure that the metropolitan health system is continuously responsive to the needs of area residents, community participation in the decision-making process is essential. The health system is large and complex, and active community participation at key decision-making proints insures that this system is guided by those it serves, rather than those who serve. Community participation should reflect the age, income, social, racial and sex characteristics of the population and geographic area served by the health care institution and sub-system.

If they have not already done so, hospitals should adopt organizational frameworks and operating procedures which will provide for community participation in decision-making.

POLICIES

26. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS SHOULD DEMONSTRATE ACTIVE COMMUNITY PARTICIPATION IN THE DECISION-MAKING PROCESS IN ORDER TO RECEIVE A FAVORABLE RECOMMENDATION.

DISTRIBUTION OF HEALTH SERVICES AND FACILITIES

The metropolitan health and health-related human services system should have a balanced distribution of services and facilities in accordance with the Area's needs.

SERVICE CAPACITY OF ACUTE CARE

The need for acute care services must be based on the demonstrated demand for services in an area and not the want or need of a specific facility or applicant. The need of the consumer must have preference over the want of the provider. These needs are community-wide in scope. Since the community pays for all available services regardless of whether they are used, the public must be protected against expenditures based on the needs of the individual institution when overall community needs can be met at lower costs. Blue Cross of Minnesota has released data on average daily charges for hospitals in the Metropolitan Area of approximately $103 a day. This is seven per cent over last year. Present trends indicate that this cost spiral is likely to continue.

There has been increasing awareness of the need to assure that programs meet the test of community evaluation. This concept has been made operational to the seven county Metropolitan Area through implementation of Comprehensive Health Planning, federal review and comment responsibilities over health grants awarded within the Metropolitan Area, State Certificate of Need legislation and the recently enacted Social Security Amendments of 1972. All of these legislative directives are intended to assure a balance between services and facilities provided and the demands of the Metropolitan Area. The Metropolitan Council supports this concept.

POLICIES

27. THE OVERALL SERVICE CAPACITY OF THE ACUTE CARE SERVICE SYSTEM SHOULD BE KEPT IN BALANCE WITH DEMONSTRATED NEEDS.

Patient origin data collected over the past ten years delineates two large medical market areas for the Metropolitan Area. One is concentrated in Minneapolis and includes most of Anoka, Carver, Hennepin, and Scott Counties. The other is concentrated in St. Paul and contains most of Dakota, Ramsey and Washington Counties. There is relatively little net migration (the difference between in-migration and out-migration from St. Paul to Minneapolis) of 62,985 medical-surgical, pediatric patient days of care out of a total of 2,689,875 days. As would be expected, the most overlap occurs on the suburban and rural fringes and to University Hospitals.

Future planning decisions will be based upon the total Metropolitan Area. While certain specific sub-regions of the area will be able to demonstrate demands for hospital services, the sum of needs of these sub-regions should not exceed the total demand in the total Metropolitan Area unless there are compelling reasons to the contrary. One such instance may be documented demand in a rural location with a well defined service area. However, in all such cases the applicant must convincingly demonstrate that the additional services would have very little negative impact on any other existing service in the Metropolitan Area.

For the purposes of this policy, service area shall be defined as the sum of all health planning neighborhoods where it can be documented that ten per cent or more of the medical-surgical patient days provided to residents of the area received these services at the specific institution under study.

POLICIES

28. THE NEED TO ADD OR REPLACE SERVICES AT ANY HOSPITAL SHALL BE BASED ON THE TOTAL NEEDS OF THE METROPOLITAN AREA, UNLESS THERE ARE COMPELLING REASONS TO THE CONTRARY.

NEW CONSTRUCTION

The Minnesota State Plan for Hospital Facilities indicate that once the non-conforming beds at Metropolitan Medical Center and Hennepin County General Hospital have been replaced by the new construction underway, existing hospital beds in this Metropolitan Area will conform to State Health Department and Federal construction standards. The Metropolitan Council recognizes that hospital facilities become obsolete rapidly due to technological and delivery system advances which change circumstances of quality patient care. Nevertheless, substantial capital investments have been made to develop and maintain the existing physical facilites. Wherever possible, the Metropolitan Area should benefit from using these facilities before new investments are made. Service needs caused by population growth, population shifts and new technology should be phased over time to permit utilization of existing capital investment for as long as possible.

POLICIES

29. SERVICE NEEDS OF THE HOSPITAL SERVICE SYSTEM SHALL BE MET BY MINIMUM CONSTRUCTION OF NEW AND MAXIMUM USE OF ACCEPTABLE SERVICES ALREADY AVAILABLE TO THE COMMUNITY IF SUCH SERVICES MEET OR COULD MEET CURRENT STANDARDS WITHOUT UNDUE EXPENDITURES FOR REMODELING.

Hospitals must be large if they are going to offer a broad range of services in an effective and economical manner. Current evidence and opinion suggest that minimum hospital size in a Metropolitan Area should be at least 200 beds and probably around 400 beds depending upon the range of services provided. Benefits of scale can be obtained through sharing and other cooperative efforts among hospitals such as is ocurring in "hospital complexes", satellite arrangements, mergers, and holding

companies. To achieve these benefits of scale the Metropolitan Council encourages needed expansion at existing hospitals and consolidation among hospitals, rather than add to the present number of hospitals. New hospitals should be built only if population concentration and medical practice in a defined area can support a large hospital providing a broad range of general acute services.

POLICIES

30. NO NEW HOSPITAL INSTITUTION SHALL BE ADDED TO THE SYSTEM UNTIL THE METROPOLITAN AREA AND THE DEFINED SERVICE AREA CAN DEMONSTRATE A DEMAND FOR AT LEAST 200 BEDS.

Current inpatient medical-surgical bed projects indicate a generally overbeded situtation in the Metropolitan Area until beyond the 1980-89's. Therefore, hospital facilities should be programed as conservatively as possible. Nevertheless, the present locations and service capacity may become inappropriate as new population concentrations develop and are served by growing numbers of medical personnel. Some redistribution should take place over time even though there is documented surplus capacity in existing hospitals. To this end the closing of some existing capacity in documented surplus areas with concurrent relocation to areas of documented need should be required.

POLICIES

31. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS FOR ADDITIONAL HOSPITAL SERVICES IN AN AREA OF DOCUMENTED NEED MUST BE ACCOMPANIED BY AT LEAST AN EQUAL REDUCTION IN SIMILAR HOSPITAL SERVICES IN AN AREA OF DOCUMENTED SURPLUS TO RECEIVE A FAVORABLE RECOMMENDATION.

HOSPITAL OCCUPANCY

At present, hospital capacity can best be defined in terms of inpatient bed capacity. This is the best single indicator for which statistics are available, even though hospitals have a variety of other programs such as outpatient, emergency, mental health and laboratory services which are not related directly to beds. Guildelines, criteria and utilization data in these latter areas are generally insufficient at this time for detailed delineation of overall community need. Future planning efforts will be directed to other measures of need as a means of de-emphasizing bed services and encouraging development of non-bed services.

Nevertheless, inpatient utilization and the costs associated with these services are quite well known. In patient hospital use rates by services are calculated each year, and are used to project future demand for services. The seven county Metropolitan Area is now served by a group of 37 general acute hospitals plus the Veterans Administration Hospital and two State mental hospitals. Excluding the mental hospitals, those hospitals provide almost 11,000 inpatient acute beds. In general, this inpatient hospital capacity is well distributed through the Metropolitan Area.

One of the difficulties in projecting demand for acute care services is the cyclical patterns of hospital usage which exists. Daily and seasonal variations in average daily census of medical-surgical patients for 1970 are shown in Figures 8 and 9.

The first four months of the year are by far the busiest with February peaking at 9.4 per cent above the overall yearly average. Day of the week cycles in hospital bed use are also evident. Monday through Thursday are busy while Friday through Saturday are slow. Therefore, this presents a difficult management problem in achieving minimum average costs considering the fixed costs of the hospital industry. Hospitals need some reserve capacity. Therefore, optimum average occupancy criteria have been established as follows:

1) An occupancy rate of 85 per cent for medical-surgical services is a generally acceptable criteria for projecting inpatient bed needs. A hospital operating at 85 per cent occupancy will experience some days each year when only emergency admissions are possible. In some cases higher occupancy goals should be considered realistic particularly for large hospitals or complexes where there is more flexibility in the use of available beds.

2) The occupancy goal for pediatric services is 80 per cent. While the same cyclical use pattern occurs, those units are usually much smaller than medical-surgical units and therefore are less flexible in usage of available beds.

3) A 90 per cent occupancy goal has been established for psychiatric services. While some variations in use patterns occur, they are much less pronounced. In addition, the psychiatry therapy program usually requires a longer average length of stay than the other short term services, permitting a higher average utilization rate.

In addition to the above criteria, several other statistical determinations will be taken into account when projecting inpatient hospital bed demand.

First, Metropolitan Council population forecasts projected at least seven years in advance will be used.

Second, present use rate based in patient days per 1,000 population will be defined and used. Included in the determination will be the net effect of in-migration and out-migration on hospital usage in the Metropolitan Area.

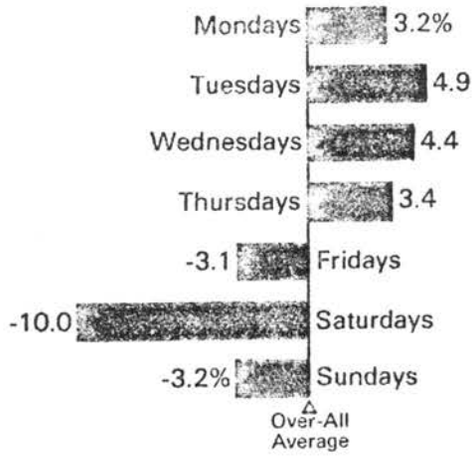

Figure 8. Daily Variation Of Inpatients, 1970

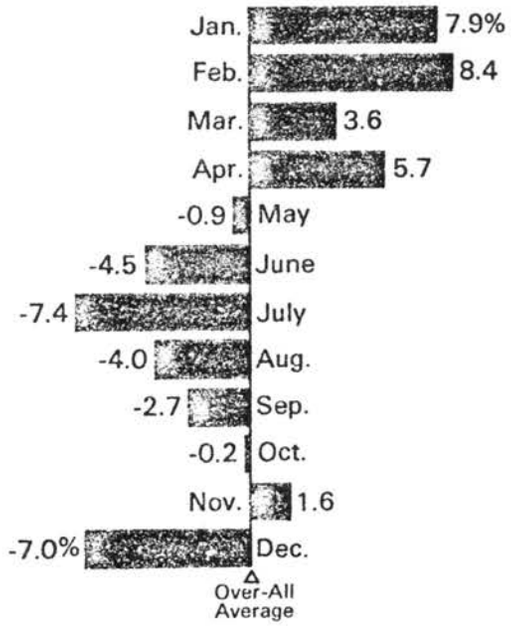

Figure 9. Seasonal Variation Of Inpatients, 1970

At the present time, this use rate will be considered constant when making projections. However, as accurate models are developed for predicting future use rate, the Metropolitan Council will use the estimated use rates (patient days per 1,000 population) in projecting future bed demand.

Third, the saturation rate of the defined Primary Service Area will be used to determine a more localized demand.

POLICIES

32. THE DEMAND FOR MEDICAL, SURGICAL, PEDIATRIC, OBSTETRIC AND PSYCHIATRIC INPATIENT BEDS SHALL BE CALCULATED ON THE BASIS OF 85 PER CENT MEDICAL-SURGICAL, 80 PER CENT PEDIATRIC AND OBSTETRIC, AND 90 PER CENT PSYCHIATRIC OCCUPANCY WHEN PROJECTED ON THE BASIS OF CURRENT UTILIZATION AND METROPOLITAN COUNCIL POPULATION PROJECTIONS.

Using the criteria as defined above, the projected bed demand for the total Metropolitan Area for medical surgical and pediatric beds in 1980 is as shown in Table 1. Note that the University and Veterans Administration Hospitals are considered regional rather than community hospitals, and therefore are not included.

TABLE 1

Community Hospitals' Bed Supply and Projected 1980 Demand for the Total Metropolitan Area

	Medical-Surgical	Pediatric
Projected 1980 Bed Demand	6,719	706
Beds Available January 1, 1973	6,606	1,006
Demand in Excess of 1973 Supply	113	(300)
Beds Under Construction	352	(4)
Demand in Excess of Supply after Construction	(239)	(296)
"Shelled" Bed Space (Unfinished Hospital space)	251	21

DESIGNATION OF HOSPITAL RESPONSIBILITIES AND FUNCTIONS

Hospital services have changed markedly from the day nursing care and simple diagnostic and therapeutic programs were provided to relatively few acutely ill patients. Today the technology of medicine requires a much broader range of services and increased personnel to provide for the many patients needing care ranging from minimal to intensive care. Facilities and equipment are growing more specialized and expensive. Qualified personnel are in short supply and expensive. Even if funds were available to cover the costs of facilities and equipment, the capacity to serve could be limited by the availability of personnel and the manner in which skills are deployed.

The above factors and many others strongly suggest that high volume is required to achieve economies of scale. Qualities of scale are even more important since only through daily practice can most health professionals maintain their proficiency. From this it follows that services which have high stand-by cost should be organized in strategically located hospitals rather than scattered among all hospitals in order to reduce costs, maintain quality, ensure efficient use of health manpower, and offer services in an effective manner.

POLICIES

33. ACUTE SERVICES WITH HIGH CAPITAL INVESTMENT REQUIRING HIGHLY SPECIALIZED OPERATING SKILLS WITH LOW PATIENT VOLUME SHOULD BE SHARED, CONSOLIDATED OR CONCENTRATED WHEREVER POSSIBLE IN ORDER TO DEVELOP A MORE EFFECTIVE OPERATING BASE AND SHOULD GENERALLY BE DEVELOPED IN MEDICAL CENTERS WITH THE DEMAND, RESOURCES AND CAPABILITY TO SERVE AS METROPOLITAN REFERRAL CENTERS FOR THESE SERVICES.

Hospitals in the Metropolitan Area are generally regarded as providing very high quality of care when compared to other areas of the nation. However, rapid advances in the health services require concentration and sharing of specialized services via large hospitals, medical centers, hospital complexes, satellite arrangements and mergers to reduce costs, maintain quality, and ensure efficient and effective delivery. From this, it then follows that the appropriate role of each Metropolitan Area hospital must be defined and specific hospitals designated as general community or referral hospitals for specific services. A major thrust of Metropolitan Health Board activities must be toward defining the area requirements, metropolitan demand by major service, medical staff availability and characteristics, and other factors which lead to specific designation of responsibilities. When appropriate studies have been completed and providers have had an opportunity to bid on the provision of specific health services these designations will be made.

POLICIES

34. FOLLOWING AN APPROPRIATE STUDY, EACH HOSPITAL WILL BE DESIGNATED AS A COMMUNITY OR REFERRAL HOSPITAL FOR SPECIFIC SERVICES BASED UPON FACTORS OF SERVICE AREA REQUIREMENTS, TOTAL METROPOLITAN DEMAND BY MAJOR SERVICE, MEDICAL STAFF AVAILABILITY AND CHARACTERISTICS, AND OTHER FACTORS AS APPROPRIATE.

That health scarcity should be defined and used as a guide to allocating resources has been established earlier in this Guide. Low-volume, high-cost services should be consolidated for more effective and efficient operation. While in most ways this Metropolitan Area is well ahead of most areas of the country in cooperative arrangements, it is felt that more refined controls will be needed on the future development of expensive services in both the hospital and long term care setting in order to direct resources into areas of greatest need. In a recent study the General Accounting Office (GAO) recommended that state and local agencies establish individual controls on specialized services and facilities to promote sharing and avoid costly duplication.

POLICIES

35. SPECIALIZED ACUTE AND REHABILITATIVE SERVICES SHOULD BE INDIVIDUALLY LICENSED IN RELATION TO IDENTIFIED NEEDS.

As previously discussed, inpatient hospital service needs will be generally programmed on the basis of total Metropolitan demand. Services which have high stand-by costs should be organized in strategically located hospitals in order to reduce costs, improve quality, and ensure efficient use of health manpower. This is particularly true in the downtown areas of Minneapolis and St. Paul where hospitals are relatively close together and service areas overlap. Pediatric and obstetric services, including intensive neonatal care are two of these services. In addition, with the declining birth rate and subsequent reduction in both the present and projected obstetric and pediatric demand, there must be a reduction in the number of these beds in the Metropolitan Area. Pediatric and obstetric units in the downtown areas which have low volumes should, over time, consolidate or phase out of existence.

Pediatric services should have a minimum of 1,500 admissions a year and obstetric services 1,500 births per year. Hospital services below these minimums should be consolidated or, over time, phased out of existence. However, due to the close working relationship and overlap of personnel functions, the pediatric and obstetric services should be closely related wherever feasible.

The Metropolitan Council is also concerned that uncoordinated development of inpatient pediatric services involving the University Hospitals, Minneapolis Children's Health Center, St. Paul Children's Hospital, Hennepin County General Hospital, Metropolitan Medical Center, Gillette State Hospital, and St. Paul-Ramsey Hospital could result in excess beds and unnecessary duplication of services. Such development could also impede progress toward better medical and allied health personnel education programs. The questions concerning community pediatric services and education should be raised anew so that they can at least be programmed by role and function to complement each other rather than be competitive.

POLICIES

36. PEDIATRIC AND OBSTETRIC BEDS SHALL BE PROGRAMMED ON THE BASIS OF TOTAL METROPOLITAN DEMAND. PEDIATRIC UNITS IN DOWNTOWN AREAS WHICH HAVE LESS THAN 1,500 ADMISSIONS A YEAR SHOULD, OVER TIME, CONSOLIDATE OR PHASE OUT OF EXISTENCE. OBSTETRIC UNITS IN THE DOWNTOWN AREA WHICH HAVE LESS THAN 1,500 DELIVERIES A YEAR SHOULD, OVER TIME, CONSOLIDATE OR PHASE OUT OF EXISTENCE. WHEREVER FEASIBLE, THE DEVELOPMENT OF OBSTETRIC SERVICES SHOULD BE RELATED TO THE DEVELOPMENT OF PEDIATRIC SERVICES.

Each hospital contains a large number of service functions such as radiology, laboratory, surgery, inhalation therapy and physical therapy, which are needed to support patient care. As such, the need for general non-specialized services at a single institution can be judged primarily on the need demonstrated by that institution. Only in the more specialized areas such as intensive, newborn care, radiation therapy, and open heart surgery and transplants does it become necessary to judge need on a regional basis.

Specific guidelines are needed to determine the appropriate requirements for general services at each institution, such as general radiology and general surgery capacity.

It is general practice to project need in community hospitals based on 250 days a year operation. In the case of general surgery, the projection is based on using each room for four-to-six cases per day depending upon the natures of the procedures and in radiology-fluoroscopy on 20 procedures a day. Such a base indicates operating the departments ten days less than five days a week for the year and approximately eight hours a day. There may be difficulties staffing these departments in a community hospital for greater periods than described above. However, patient costs are sometimes increased because services were not available when needed thereby increasing the average length of stay. The present cyclical pattern of hospital usage is both a cause and an effect of these arrangements. Therefore, an effort should be made to utilize existing resources at a higher level: 300 days a year, or twelve days less than six days a week per year.

POLICIES

37. THE NEED FOR GENERAL RADIOLOGY CAPACITY AND GENERAL SURGERY CAPACITY SHALL BE BASED ON THE DEMONSTRATED DEMAND AT EACH INSTITUTION RATHER THAN ON REGIONAL DEMAND FACTORS. CALCULATION OR CAPACITY IN RADIOLOGY SHALL BE BASED ON 300 DAYS A YEAR UTILITZATION AND 20 PROCEDURES A DAY PER ROOM. CALCULATION OF CAPACITY IN GENERAL SURGERY SHALL BE BASED ON 300 DAYS A YEAR UTILIZATION AND FOUR-TO-SIX PROCEDURES A DAY PER ROOM.

For similar reasons the need for general clinical laboratory services should be based on the demonstrated demand at each institution rather than on regional demand factors. A realistically attainable level of productivity is from 46 to 57 procedures per gross square foot. A median point in this range is about 51 annual procedures per gross square foot. While automation of many routine laboratory functions might presumably reduce the need for total space, hospital-clinical expansion may occur as greater emphasis is placed on an out-patient community screening and pre-admission testing. Whenever possible, automated processes should be shared among institutions.

POLICIES

38. THE NEED FOR GENERAL CLINICAL LABORATORY CAPACITY SHALL BE BASED ON THE DEMONSTRATED DEMAND AT EACH INSTITUTION RATHER THAN ON REGIONAL DEMAND FACTORS. CALCULATIONS OF NEEDED CAPACITY WILL BE BASED ON APPROXIMATELY 51 ANNUAL PROCEDURES PER SQUARE FOOT. WHEREVER POSSIBLE, AUTOMATED PROCESSES SHOULD BE SHARED AMONG INSTITUTIONS.

In many respects, the possible over-duplication of radiothereapy is less important as a contributor to hospital costs than are many less recognized and discussed "special procedures" services. However, given the natural tendency for physicians to orient to one hospital plus the nature of patient referral patterns it is almost impossible to achieve the highest level of efficiency at every hospital. Nevertheless, radiotherapy lends itself well to regionalization. Most patients are ambulatory and do not require that the primary or referring physician be present. Facilities and equipment are expensive and gain economies of scale from high volume.

Qualified radiotherapists are in short supply. The need to develop educational capabilities in conjunction with such services is almost mandatory. The patients can be treated with a team approach involving the primary physician, medical specialists, and specially trained paramedical personnel. The quality of the service is dependent upon volume of care to support the appropriate range of treatment alternatives and attract the needed specialty skills.

POLICIES

39. THE NEED FOR HIGH ENERGY RADIOTHERAPY SERVICES SHALL BE BASED ON THE TOTAL DEMONSTRATED DEMAND IN THE METROPOLITAN AREA. CALCULATIONS OF NEEDED CAPACITY WILL BE BASED ON A VOLUME OF AT LEAST 300 NEW CASES AND 8,000 TREATMENTS PER YEAR PER MACHINE.

Special procedures facilities and surgery facilities for diagnosis and treatement of caridac disease must be evaluated on a regional basis. The Inter-Society Commission for Heart Disease Resources has developed specific guidelines for medical facilities in the treatment and rehabilitation of

patients with cariovascular disease. The report of the Radiology Study Group of the Commission adopted the following standards regarding minimal and optimal caseload: "Three hundred cases per annum is recommended as the minimum number required to maintain the expertise of the professional teams engaged in these highly complicated procedures. There is also a compelling economic reason for high utilization since equipment costs are extraordinarily high and the life of the equipment short". Regarding facilities the Commission's Surgery Study Group found it difficult to define the optimal size of a cardiac surgical center. However, the Surgery Group does state: "We believe the smallest practical unit to qualify as a cardiac center should perform four to six cardic operations with extra-corporeal circulation weekly." In addition, both of the Study Groups have recognized the necessary physical interrelationship between diagnostic and surgical facilities. When diagnostic tests are conducted in a different location than where the surgery is performed, the diagnostic tests may have to be repeated.

The Surgery Study Group states, "Diagnosis and treatment are so closely related that facilities for both should be included in the same center to permit the closest possible liaison between all concerned professional and support personnel".

POLICIES

40. THE NEED FOR ADDITIONAL CARDIAC DIAGNOSTIC EQUIPMENT AND OPEN HEART SURGERY CAPACITY SHALL BE BASED ON: A) THE TOTAL DEMAND IN THE METROPOLITAN AREA: B) THE PERFORMANCE OF DIAGNOSIS AND SURGERY AT THE SAME LOCATION: C) THE PERFORMANCE OF A MINIMUM OF 300 CASES PER YEAR AT EACH DIAGNOSTIC UNIT AND D) THE PERFORMANCE OF A MINIMUM OF FOUR CASES ON THE HEART PUMP A WEEK BY EACH SURGERY UNIT. EXISTING UNITS WHICH DO NOT PERFORM THE MINIMUM LEVEL OF PROCEDURES A WEEK SHOULD, OVER TIME, PHASE OUT OF EXISTENCE.

SERVICE CAPACITY OF LONG TERM CARE

Long term health care is a system of services which extend over a person's lifetime or a significant portion of it. Such health care includes both medical and non-medical support services and is intended to reduce or retard the rate of total dependency of persons requiring such care. It emphsizes rehabilitation, and maintenance of a specific level of mental, physical and social functioning. For the most part, the people who need these services include the aged, developmentally disabled, mentally ill and chemically dependent persons, although significant numbers of other persons need long term rehabilitative services while convalescing from an acute illness.

As with acute care, the need for long term care services must be based on the demonstrated demand for services in an area and not on the preferences of a specific facility or providers of service.

Traditionally, long term health care services have been limited to custodial care and medically-oriented treatment and have only been available in nursing homes, boarding care homes, and state institutional settings. In the Metropolitan Area there are 186 nursing homes and boarding care homes representing 20,500 beds. In addition, there are two state mental hospitals, 16 community group homes for the mentally retarded and 16 general hospitals with inpatient services.

INAPPROPRIATE INSTITUTIONALIZATION

Until recently there have been few alternatives to institutionalization. This has led to inappropriate institutionalization of the aged, developmentally disabled, chemically dependent and mentally ill. The absence of alternatives forces doctors, social workers, families and friends to decide on institutionalization. Inappropriate institutionalization tends to bring on more rapid deterioration. The isolation from everyday living increases the emphsis on the residents' disabilities, diminishing whatever independence and human dignity they have when they enter. Their perception of themselves becomes one of helplessness, and soon they assume the roles of persons being told what to do and when to do it.

The "normalization principle" is one strategy for helping residents to develop their self-sufficiency and to retard the rate of deterioration. It is a principle which has been accepted internationally in providing long term care services for mentally retarded persons and has implications for the elderly and other disabled persons as well. This approach provides the elderly and disabled individuals with as normal a life style as possible. In most instances there should be integration and interaction with the mainstream of society.

To a large degree, society's attitude toward those who are dependent, disabled, mentally ill, or chemically dependent has been responsible for segregating these populations. The disabilities were thought to be irreversible. The last decade, however, has witnessed many studies and programs which have documented the inappropriateness of institutionalization and also demonstrated that the aged, disabled, mentally ill and chemically dependent can be helped to retard the rate of deterioration and, in many cases, to be rehabilitated.

A study based upon data from the Massachusetts Department of Public Health indicated that 40 per cent of the current institutionalized elderly would have benefited from other than the traditional nursing home or intermediate care home. The following Figure shows the estimated placement of the current institutionalized elderly based upon the Massachusetts data.

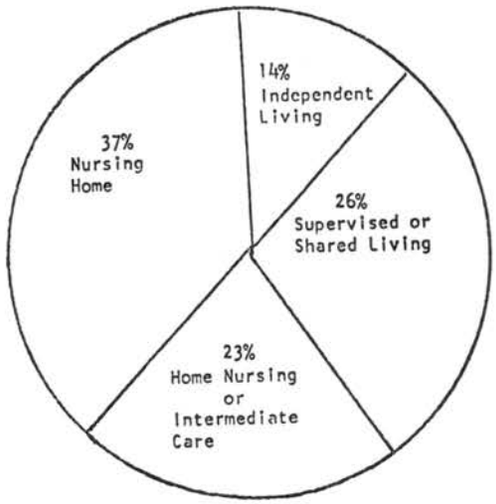

Figure 10. Approximate Placement of Institutionalized Elderly in Massachusetts

Long term health care services such as have been described above for the elderly may include personal care, home aide, meals-on-wheels, day activity, counseling, occupational and physical therapy, surrogate services, and appropriate levels of residential care. Also needed are homemaker-home health aide services which include personal care, meal planning and preparation, and day to day cleaning and upkeep; congregate meals in the community; home delivered meals; day activity. For the developmentally disabled these services may include infant-stimulation, vocational training, social-recreational activities, physical and speech therapy, counseling and a variety of residental arrangements. For the mentally ill and chemically dependent these services may include counseling, rehabilitation, psychological or psychiatric treatment, and half-way houses.

The answer to reducing total dependency and preventing inappropriate institutionalization lies in providing supportive services at the onset of the problem. Unfortunately, such services are not available to meet the needs of all aged or disabled residents in the Metropolitan Area. Lack of services or money force the aged, the disabled, the chemically dependent, the mentally ill and their families to turn to nursing homes or state institutions which are often more costly but not necessarily the most beneficial forms of service. Where services do exist there is little coordination between agencies to assure the individual that the services will be available on an orderly, continuous basis.

POLICIES

41. INTEGRATED SERVICE SYSTEMS WHICH EMPHASIZE PROVISION OF COMMUNITY ALTERNATIVES TO INSTITUTIONALIZATION WILL BE DEFINED AND DEVELOPED.

SUPPORTIVE SERVICES

The goal is to ensure that all persons in need of supportive services receive them without undue inconvenience and social trauma. Unfortunately, the current system of incentives and financial reimbursement does not encourage this. Within specified geographical areas, there should be a single organization accessible 24 hours a day, accountable and responsible for making available all supportive services needed by the disabled and the elderly, including those who are in public housing. To address this need the Metropolitan Health Board will develop studies which can serve as a basis in implementing a comprehensive system of long-term supportive services throughout the Metropolitan Area to reduce inappropriate institutionalization. These studies will include:

1. Identification of the geographic service areas for the Metropolitan Area so that long-term health services will be accessible to the elderly and disabled within each service area.

2. Listing of all necessary services which should be included in a comprehensive coordinated system of long-term health services for the aged, developmentally disabled, mentally ill and chemically dependent.

3. Determination of the basic core of long-term health services which should be available in each service area.

4. Identification of low-volume, long-term health services which could be shared by contiguous service areas.

The results of these studies should be used as a guide for the allocation of responsibility and resources.

Recognizing the vulnerability of people who need long term care, particularly the aged, to deceptive practices and misrepresentation, it is important that agencies providing in-home services be appropriately regulated.

POLICIES

42. AGENCIES PROVIDING HOMEMAKER-HOME HEALTH AIDE SERVICES MUST MEET STARDARDS OF APPROVAL OF A NATIONALLY RECOGNIZED STANDARD SETTING BODY SUCH AS THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AID SERVICES, CHILD WELFARE LEAGUE OF AMERICA, OR FAMILY SERVICE ASSOCIATION OF AMERICA.

43. WITHIN EACH DEFINED GEOGRAPHIC AREA, THERE SHOULD BE A SINGLE ORGANIZATION ACCESSIBLE 24 HOURS A DAY, AND ACCOUNTABLE AND RESPONSIBLE FOR MAKING AVAILABLE ALL THOSE SUPPORTIVE SERVICES NEEDED BY THE DISABLED AND THE ELDERLY, INCLUDING THOSE WHO ARE IN PUBLIC HOUSING.

Several agencies have demonstrated a commitment to promote the development, expansion and upgrading of care for the elderly, developmentally disabled, mentally ill and chemically dependent by promoting alternatives to institutionalization, implementing sharing arrangements, promoting outreach, and humanizing the care provided. These efforts will be promoted and encouraged.

POLICIES

44. PROJECTS REVIEWED UNDER THIS REFERRAL PROCESS WHICH PROMOTE ALTERNATIVES TO INSTITUTIONALIZATION AND BECOME PART OF AN INTEGRATED SYSTEM THROUGH SHARING ARRANGEMENTS OR OUTREACH SHALL BE GIVEN HIGH PRIORITY FOR DEVELOPMENT.

DEMONSTRATED DEMAND FOR SERVICES

As with the acute care, the need for long term care services must be based on the demand for services in the Metropolitan Area and not on the preferences or need of a specific facility or applicant. Each facility must plan or develop its program by evaluating its impact on other facilities within the Metropolitan Area. Facility planning and expansion must also consider the developing emphasis on long term care alternatives to institutionalization. Expansion of a facility cannot take place without examining its impact and effect on the people it will serve in terms of geographic and population needs and demand for services, quality of services and programs, availability and use of trained health manpower, and cost. Every long term care facility and program is directly accountable for these factors to the public and the community, which pays for these services largely with the public dollar. In 1972, approximately 65 per cent of all patients in nursing homes in Minnesota were receiving welfare reimbursement.

The Metropolitan Health Board has over the past two years analyzed data on the use of long term care facilities and services throughout the Metropolitan Area, particularly nursing homes. These studies indicate that there is considerable movement of residents within the Metropolitan Area to obtain needed long term care services. While the specific causes are unknown, this data does show that arbitrary usage of such boundaries as county or municipality to determine need is inappropriate. Although several large overlapping market areas do appear to exist, the general lack of definite service areas indicates that the Metropolitan Area should be considered in total unless there are very compelling reasons to the contrary.

One such instance may be a demand in a suburban or rural location with a well defined service area. However, in all such cases the applicant must convincingly show that the additional services would have very little negative impact on any other existing service in the Metropolitan Area. For the purposes of this policy, the service area shall be defined as the sum of all health planning neighborhoods in which it can be either documented or projected that 10 per cent or more of the persons receiving institutional long term care services obtained those services at the specific institution under study.

A second compelling reason to permit development of a long term care service in spite of a surplus in the total Metropolitan Area may be a specific project which significantly demonstrates a unique health care deisgn, programs, manpower use, services, community and patient outreach which will serve as a prototype service for improving the long term care delivery system. However, in all cases the applicant must convincingly show that the proposed project has never been attempted in this Metropolitan Area and will have minimal negative impact on any other high quality facility in this area.

A third compelling reason may be the evidence that an existing service of a similar nature will not exist by the time the project is completed or shortly thereafter. For the purposes of this policy, such evidence must include a certified statement by the owners of the existing long term care services which details the reason for the future closing of the service.

A fourth comeplling reason may be the need by a special constituency. Such documentation will indicate that 75 per cent or more of the residents are of a proven special group with unique health care needs or requirements, such as specific categories of the handicapped, mentally ill, mentally retarded and chemically dependent. In some very few instances, a religious group may meet this criteria because of a special health or dietary requirement due to religious orientation or belief (e.g. Christian Science).

A fifth compelling reason may be the need based on more than a local area's constituency or population. Eighty per cent or more of the residents in the institution under study should originate from throughout the total Metropolitan Area and/or from outside it, with no more than 5 per cent of the residents from any one health planning neighborhood.

In calculating metropolitan demand, the health planning neighborhoods as defined by the Metropolitan Health Board will serve as the geographic base to determine service area. The need for nursing homes, boarding care homes, and other residential facilities will be based on the following statistical determination: a) population changes and estimates projected annually to at least seven years, b) an occupancy rate factor of 95 per cent, c) utilization experience based on patient days per 1,000 population and for the defined service area, and d) the current and estimated saturation rate of the defined service area. At the present time the "use rate" will be considered constant when making projections. However, as accurate models are developed for predicting future "use rate", the Metropolitan Council will use the estimated "use rates" (in patient days per 1,000 population) when projecting future demand. The use of waiting lists only to justify need shall generally be considered as an unreliable indicator on which to base a decision.

In addition, for the purposes of this policy, the existence of unused, hospital-based, certified, extended-care beds shall be excluded when calculating community need for nursing home services. Present federal reimbursement criteria effectively eliminate the use of these facilities for all but a few specific individuals with well defined post-hospital medical needs.

Finally, beds approved for Certificate of Need by the Metropolitan Health Board but not constructed, as well as existing beds, will be considered when calculating bed demand.

POLICIES

45. THE NECESSITY TO ADD, REPLACE OR DEVELOP NEW LONG-TERM CARE FACILITIES AND SERVICES SHALL BE BASED ON THE TOTAL NEEDS OF THE METROPOLITAN AREA, UNLESS THERE ARE COMPELLING REASONS TO THE CONTRARY. SUCH COMPELLING REASONS MAY BE:

    1. A DOCUMENTED DEMAND IN A SUBURBAN OR RURAL LOCATION WITH A DEFINED SERVICE AREA.

    2. A PROJECT THAT SIGNIFICANTLY DEMONSTRATES UNIQUE HEALTH CARE DESIGN, PROGRAMS, MANPOWER USE, SERVICES, COMMUNITY AND PATIENT OUTREACH WHICH WILL SERVE AS A PROTOTYPE PROJECT TO DEMONSTRATE SIGNIFICANT IMPROVEMENT IN THE LONG TERM CARE DELIVERY SYSTEM.

    3. DOCUMENTED EVIDENCE THAT AN EXISTING SERVICE OF A SIMILAR NATURE WILL NOT EXIST BY THE TIME THE PROJECT IS COMPLETED OR SHORTLY THEREAFTER.

    4. THE DOCUMENTED NEED BY A SPECIAL CONSTITUENCY.

    5. THE DOCUMENTED NEED BASED ON MORE THAN A LOCAL AREA CONSTITUENCY OR POPULATION.

Using the criteria as defined above, the projected bed demand for nursing home beds in the Metropolitan Area in 1979 is as follows:

Table 2

Metropolitan Area

Projected Bed Demand 1979

	95% occupancy	90% occupancy
Projected bed demand	13,106	13,833
Available beds 4/25/73	14,556	14,556
Supply in excess of demand	1,450	723

At this time there is not enough substantial information to project the demand for long term care facilities and services for persons who are developmentally disabled, mentally ill or chemically dependent.

Current nursing home bed projections indicate a generally over-bedded situation in the Metropolitan area until beyond the mid 1980's. Therefore, nursing home failities should be programmed as conservatively as possible. Nevertheless, present locations and service capacity may become inappropriate as new population concentrations develop. Some redistribution should take place over time even though there is a documented surplus capacity in existing nursing homes. The closing of some existing beds in documented surplus areas with concurrent relocation to areas of documented need should be encouraged.

POLICIES

46. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS WHICH WILL REDISTRIBUTE INSTITUTIONAL LONG TERM CARE SERVICES TO AN AREA OF DOCUMENTED NEED BY AT LEAST AN EQUAL REDUCTION IN INSTITUTIONAL LONG TERM CARE SERVICES IN AN AREA OF DOCUMENTED SURPLUS, WILL BE GIVEN HIGH PRIORITY.

SIZE OF FACILITIES

There are presently almost 200 nursing homes and boarding care homes in the Metropolitan Area. Obviously, substantial capital investments have been made to develop and maintain these physical facilities. While a portion of the homes do not presently meet the new State and Federal critera, wherever

possible the Metropolitan Area should benefit from using existing facilities before investments are made in totally new facilities. In addition, consideration should be given to minimum capacities of long term care facilities to increase efficiency, economy and effectiveness of operation and care, while not losing the human touch.

Metropolitan Area nursing home facility administrators suggest minimum facility size should be in the 100-120 bed range. This appears to be the smallest size that present nursing homes find economically sound. The only Metropolitan Area counties in which the average size of homes is above 100 beds are Hennepin (107) and Ramsey (113). In all other counties the average size of the homes are below this minimum.

It should be noted, however, that this is specially related to the size of nursing home facilities. This minimum size does not apply to boarding care homes and/or residential facilities for the mentally ill, developmentally disabled, and chemically dependent. Introduction and implementation of the "normalization principle" as well as the Department of Health and Department of Welfare licensing may mandate much smaller unit sizes for provision of quality services for these types of homes. The size is more closely dependent upon the operating program for a specific type of disability.

Although the minimum operating size of the Area's nursing homes should be around 100 beds, there may be specific circumstances when smaller units may be possible or desirable. One such case might be a home in a rural location with a well defined service area. In some instances a combination of several levels of care may make a smaller unit economically and qualitatively feasible.

POLICIES

47. NEED FOR NURSING HOME AND BOARDING CARE HOME SERVICES SHALL BE MET BY A MINIMUM CONSTRUCTION OF NEW AND MAXIMUM USE OF ACCESSIBLE SERVICES ALREADY AVAILABLE TO THE COMMUNITY IF SUCH SERVICES MEET CURRENT STANDARDS OF CONSTRUCTION AND SERVICE QUALITY WITHOUT UNDUE EXPENDITURES FOR REMODELING. SUGGESTED MINIMUM CAPACITIES FOR NURSING HOMES ARE 100 BEDS UNLESS THERE ARE COMPELLING REASONS TO THE CONTRARY. SUCH COMPELLING REASONS MAY BE:

    1. A RURAL LOCATION WITH WELL DEFINED SERVICE AREA,

    2. A COMBINATION OF CARE LEVELS WHICH MADE A SMALLER UNIT ECONOMICALLY AND QUALITATIVELY FEASIBLE.

MEETING THE NEEDS OF LONG TERM CARE RESIDENTS

A variety of living arrangements must be made available to meet the changing needs of the elderly and others who need long term care services. There is a trend in long term care facilities for the elderly to include skilled and intermediate care, boarding care, and independent living within the same care complex or center. This enables the resident to easily move back and forth between care levels with minimal disruption. In addition, this concept should be expanded to include community outreach activities which will serve as alternatives to institutionalization and keep people independent as long as possible. Where it is not feasible or appropriate for the specific facility to provide a full range of supportive services (day care, mobile meals, senior citizens activity programs and community outreach activities), documented relationships of cooperative affiliations with other providers or a single coordinating organization in the community should be demonstrated. The program which is provided must de-emphsize the institutional aspects of care and enable the resident to live as independently as possible.

Long term care facilities planning additions and modifications which show these characteristics shall be given high priority for development.

POLICIES

48. REPLACEMENT, EXPANSION OR NEW DEVELOPMENT OF RESIDENTIAL FACILITIES SHOULD BE BASED ON: 1) CONTINUITY OF CARE AND SUPERVISION, 2) DOCUMENTATION OF EXISTING OR POSSIBLE COOPERATIVE AFFILIATIONS WITH OTHER PROVIDERS OF SUPPORTIVE SERVICES, 3) PROVISION OF A PROGRAM WHICH DE-EMPHSIZES THE INSTITUTIONAL ASPECTS OF CARE.

In locating long term care facilities the needs of individuals should receive high consideration, as many wish to remain in areas where they lived and have family and friends. This can reduce the trauma of institutionalization when necessary and reduce disorientation for the geriatric patient. Two considerations are particularly important. First, in order to become part of the continuum of care, long term care facilities will need to develop working relationships with hospitals and other health care groups and facilities. The resident must be kept within the health care mainstream so services are accessible with the least amount of difficulty. The multiplicity of medical and other supportive services are often confusing, and individuals find difficulty in making choices or knowing when and how to seek and find help.

Second, the resident needs to be close to transportation and normal community activities such as shopping. Isolation of the individual in long term care residential centers or care institutions without community contact increases physical, social and emotional deterioration. The facility should be located in an area where there is activity, and yet not be near heavy traffic or noise. Open space around the facility is

important for ambulatory residents. In addition, facilities should maintain contacts and coordinate with local neighborhood associations and planning groups.

POLICIES

49. LONG TERM CARE FACILITIES SHOULD NOT BE ISOLATED BUT SHOULD BE LOCATED TO SERVE APPROPRIATE POPULATION CENCENTRATION IN PROXIMITY TO OTHER URBAN SERVICES SUCH AS TRANSPORTATION, RECREATION AND SHOPPING. THE PROXIMITY TO AND POSSIBLE ENVIRONMENTAL EFFECTS OF FREEWAYS, PROVISION FOR BUFFER ZONES FROM TRAFFIC, INDUSTRIAL AND AIR TRAFFIC NOISE, PROVISION FOR OPEN SPACE ON THE FACILITIES SITE, AS WELL AS LOCAL PLANNING CONSIDERATION SHALL BE TAKEN IN ACCOUNT WHEN LOCATING LONG TERM CARE FACILITIES.

PAYING FOR HEALTH SERVICES

Cost containment or moderation, improved cost effectiveness, and ability to pay for all persons is a major objective of planning the organization and financing of health services.

ABILITY TO PAY

RISING HEALTH COSTS

The cost to society for providing health services is high - $83 billion for the nation in fiscal year 1972 or 7.6 per cent of the nation's Gross National Product. For the Metropolitan Area it has been estimated that total health costs may reach $700 million with projected health costs for the area exceeding $1 billion by the end of the decade. Until the last two years, the rise in medical care prices consistently led all other elements of the Consumer Price Index. While food and fuel prices now lead the lists of percentage increases over the past year, medical care cost increases are still high. Of the three major factors influencing the upward trend in health costs - inflation, increased use of services, and price increases - rising prices have accounted for nearly half of the increases. Medical Care prices in the Metropolitan Area have risen more rapidly than the nation as a whole over the past year. The Twin Cities experienced a 4.4 per cent upward change in the Medical Care Component of the Consumer Price Index contracted with a rate of 3.5 per cent for the nation.

The Medical Care cost price spiral has risen steadily since 1950, but even more sharply since 1966, the year in which Medicare and Medicaid were introduced. Personal health services cost the nation $12.1 billion in 1950. The comparable figure for 1970 was $67.2 billion, a more than five-fold increase.

The rise in health care costs has caused growing public alarm. Minnesota residents, in a health care opinion survey conducted in 1970 by Minnesota Blue Cross, Northland Regional Medical Program and Minnesota State Comprehensive Health Planning Agency, indicated that they found it "hard" to get health care because of costs. Given a choice of eight social priorities, nearly half of the Minnesotans interviewed rated the option "slow down the rise in medical costs" as their first and second choice for spending money to improve the State.

Many factors can be cited for this cost spiral, including the catch-up of health personnel in terms of salaries, the shorter average length of

stay which results in higher per diem charges, technical development in medicine, the influence of insurance coverage on admissions, the increase in physician's fees, the price and use of name-brand drugs, and the fragmentation of services. While over 85 per cent of Minnesota residents have hospital insurance, many contracts have significant exclusions or deductibles which result in substantial individual costs. While physician services in hospitals are relatively well covered by insurance, the same services done outside the hospitals are not covered. Most non-hospital health care items are poorly covered by insurance or any other third party agent. Even Medicare and Medicaid require substantial co-payment features that can be very hard on some individuals.

If health care is considered a right, then the public must be protected from cost barriers which deter them from seeking health care at a time when problems are minor and resultant costs lower. The postponement of medical assistance contributes to higher health costs for the community in that more intensive treatment, or a longer length of hospital stay, may be necessary to restore the person to good health. While convenient entitlement to health insurance may become a national right by act of Congress within the next few years the health system for the Metropolitan Area must be prepared to deal with the problems of cost and develop a management structure capable of channeling and allocating health monies, so that needed health care services are available regardless of ability to pay. Only then can health care be considered a right.

POLICIES

50. ALL METROPOLITAN AREA RESIDENTS SHOULD BE ABLE TO OBTAIN NEEDED HEALTH CARE SERVICES REGARDLESS OF ABILITY TO PAY.

FINANCING HEALTH DELIVERY SERVICES

The implications of the policy that all residents should be able to obtain needed health care services regardless of ability to pay are considerable. The case of patients who cannot pay in full should be spread across as large a base as is possible. The providers or the patients should not have to bear the sole responsibility of supporting those who cannot pay. Without appropriate and equitable subsidies, in the long run many providers will be forced out of business.

The Metropolitan Health Board should conduct a substantial study to define the costs and recommend appropriate mechanisms for financing the health delivery system. One way to finance health delivery might be a financial risk equalization pool in which payments could be deposited by providers, insurers, government and others - in accordance with an equitable formula - in a fund which could be used to subsidize the care of those unable to pay. Another might be the enactment of a state health services tax. Recommendations from this study should be transmitted to the Metropolitan Council and to the Minnesota Legislature for their respective consideration.

POLICIES

51. THE COST OF SUBSIDIZING THE CARE OF THOSE UNABLE TO PAY IN FULL SHOULD BE IDENTIFIED AND ALTERNATIVE LEGISLATIVE APPROACHES TO MEET THAT COST SHOULD BE DEVELOPED.

As health expenditures move toward eight per cent of G.N.P., concern for costs becomes a prominent influence on attempts to regulate the health care industry. Reimbursement policies can determine the level of the care a patient receives. Treatment tends to be provided at the level where reimbursement is available. Reimbursement should be geared to the most appropriate level at which a given service can be rendered. Often a service of equal quality which can be performed less expensively out of the hospital, would have to be performed in the hospital because reimbursement for such service is available only if performed there.

To achieve this goal, effective review of the specific service each patient received must be made at all levels of the health system. Mechanisms must be established and maintained to assure that, not only is the individual patient receiving proper services, but also in proper places.

Congress has recognized the need to evaluate the care provided by physicians and hospitals. The Social Security Amendments of 1972 provide for the development of Professional Standards Review Organizations throughout the nation. The purpose is to assure that services are medically necessary and provided in the most economical setting consistent with professional standards of acceptable quality. It is specifically stated that hospitalization should occur only when appropriate services cannot be delivered on an outpatient basis or more economically in an inpatient facility of a different type. Such emphasis could have substantial impact on the health costs in the Metropolitan Area. As an example, if the average length of stay for short term acute hospitalization in 1971 would have been reduced by one day, expenditures for hospital care in the Metropolitan Area would have been reduced by over $32 million per year.

Health care costs have risen significantly in spite of efforts to control them. The Metropolitan Health Board should study the feasibility and advisability of other ways to control costs. Questions to be explored may include: 1) the value of annual review of operating budgets of licensed health care facilities; 2) the value of prospective reimbursement; and 3) the value of capital budget review.

POLICIES

52. THE DEVELOPMENT AND IMPLEMENTATION OF PATIENT CARE REVIEW SYSTEMS WHICH ENSURE APPROPRIATE UTILIZATION OF SERVICES SHOULD BE ENCOURAGED.

The consumer is generally uninformed about the costs of the service he is receiving. With more information, the consumer is better able to choose where he obtains his care and evaluate the care once he has received it. Also, the planning agency is hard pressed to make much impact on rising costs in the absence of basic cost data. Because health care institutions are providing vital public services and are being financed largely by public funds, they should annually make available to the public detailed reports of their financial condition.

POLICIES

53. THE DEVELOPMENT OF A UNIFORM FINANCIAL DISCLOSURE ACT ON A STATE-WIDE BASIS FOR ALL HEALTH CARE INSTITUTIONS SHOULD BE ENCOURAGED.

To develop alternatives to institutionalization both in acute and long term health care services, there must be means to make these alternatives economically feasible. Major purchasers of service, both public and private, should be responsible for offering alternatives for their clients.

POLICIES

54. STATE AND FEDERAL AGENCIES, FOUNDATIONS, UNITS OF LOCAL GOVERNMENTS, AREA PROGRAMS AND OTHER PUBLIC AND PRIVATE AGENCIES SHOULD BE ENCOURAGED TO EXPAND ELIGIBILITY AND FUNDING FOR SERVICES WHICH PROVIDE ALTERNATIVES TO INSTITUTIONALIZATION.

In order for acceptable primary care services to be available, they must have adequate third party reimbursement.

POLICIES

55. FEDERAL, STATE AND OTHER THIRD PARTY AGENCIES SHOULD BE ENCOURAGED TO EXPAND COVERAGE TO INCLUDE HIGH QUALITY PRIMARY CARE SERVICES.

QUALITY OF HEALTH SERVICES

Quality Health and Health-related human services in all settings for all persons is a major objective of planning the organization and financing of health services.

In terms of high quality health services, generally accepted indicators show that the Metropolitan Area ranks well compared to the rest of the nation. People live longer, the infant mortality rate is lower, and there are more doctors, allied health professionals, hospitals and other health resources. The Area enjoys a national reputation of excellence and progressiveness in the provision of health care.

ASSURING CONTINUED QUALITY

Continuing efforts need to be devoted to assure that the care provided is the most appropriate consistent with cost and quality. Substantial beginnings have been made in monitoring certain types of care in hospital settings. The medical society-sponsored foundation based on peer review has been operating in this Area for several years. The recently enacted Social Security Amendments of 1972 require the formation of similar organizations throughout the country by 1974. These organizations are required to perform comparative evaluation of hospital and professional quality and costs, and have the power to deny federal reimbursement for costs which are considered unnecessary. These types of quality assurance mechanisms should be extended to all health care settings - offices, clinics, and others - for all types of health and health-related human services. The reviewing body should include physicians, other health professionals, and consumers. Third party payors should work with providers and consumers to define their role and participate in the process.

POLICIES

56. THE DEVELOPMENT OF ADDITIONAL WAYS TO ASSURE QUALITY CARE SHOULD BE ENCOURAGED.

The need to develop additional quality-assurance mechanisms for the long term health care system has stemmed from a basic dissatisfaction with the existing system. Reports of uneven quality are not uncommon in the long term health care industry. The importance of quality is a consideration in the Certificate of Need review process, particularly where there are multiple requests to provide similar services to the

same geographic area. However, to this date, it has not been possible for the Metropolitan Health Board to adequately describe or make quality determination on proposals it has received.

This has occurred for several reasons. First is the lack of consensus as to what criteria should be used to assess quality. Although there is agreement among professionals about the general characteristics of quality, there is little agreement about what specific criteria should be used to measure it. This controversy extends to not only WHAT to measure, but to HOW and WHO shall measure quality. This disagreement among those associated with long-term care has resulted in a reluctance on the part of agencies to impose criteria for quality.

Second, there has been a traditional low priority given to evaluating quality in terms of public policy. As services are licensed by the State, the public has assumed that the mere providing of services assures quality.

Third, there are certain legal restrictions. Limited data pertaining to quality does exist in the files of the State Department of Health, the State Department of Public Welfare, and the county welfare departments, but presently are unavailable for use by the Metropolitan Health Board.

In the absence of some other agreed upon standard, licensure is the only quality standard. That standard can be questioned because both state agencies are short of staff to periodically inspect and monitor the services.

There are counter forces, however, which may lead to changes in the attitude and policy. Industry is attentive to cost-benefits as they apply to human services. Governmental agencies are stressing accountability and demanding evidence of benefits in programs which they fund. As financing becomes tighter, quality becomes important. The consumer knows more about quality and says so.

The cumulative effect of these forces has directed more and more attention to the need to develop criteria to assess quality. More is being written about quality assessment. A magazine, Evaluation, devoted entirely to assessing human services systems, is now published in Minnesota.

Until recently, measuring quality meant preoccupation with the factors most easily quantified, such as those elements usually assessed in health, welfare, fire safety and building standards. Since very inadequate long term health care services are much in evidence, it would seem there is very little correlation between these standards and program effectiveness.

Recent studies have been directed toward assessing the program operation (how or why the process works or doesn't work), and the benefits to the consumer.

EVALUATING THE QUALITY OF ACUTE AND LONG TERM CARE

Evaluation systems are available which measure facility resources and program operation and provide fairly reliable indicators of quality at these levels. These include the Program Analysis of Service Systems; the accreditation instruments developed by the Joint Commission on the Accreditation of Hospitals; and the new licensing standards for nursing homes and supervised living facilities for the mentally retarded, physically handicapped, mentally ill and chemically dependent developed by the State Department of Health (facility resources) and State Department of Public Welfare (program).

In order to increase the reliability of such quality evaluations, it is good practice to utilize external review groups. Appropriate evaluation of quality then assumes that outside evaluators may use data provided by the service itself or may directly assess the resources, operation and outcome of a program as long as outside, objective criteria are used.

POLICIES

57. LONG TERM HEALTH CARE SERVICES SHOULD BE PERIODICALLY EVALUATED BY AN EXTERNAL REVIEW AGENCY.

58. IN REVIEWS UNDER THE REFERRAL PROCESS, CONSIDERATION SHALL BE GIVEN TO THE QUALITY OF OPERATION AND PROGRAM WITHIN THE FACILITY.

59. ACUTE CARE FACILITIES WHICH ARE ELIGIBLE FOR ACCREDITATION BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS MUST BE ACCREDITATED BY THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS (JCAH) TO RECEIVE A FAVORABLE RECOMMENDATION UNDER THE REFERRAL PROCESS.

60. PRIOR TO JANUARY 1, 1975, LONG TERM CARE FACILITIES WHICH ARE ELIGIBLE FOR ACCREDITATION BY THE JOINT COMMISSION ON ACCREDITATION MUST BE ACCREDITED OR APPROVED BY TWO OF THE FOLLOWING: 1) JCAH, 2) PEER REVIEW, 3) THE LICENSING AND CERTIFICATION PROGRAMS OF THE MINNESOTA STATE DEPARTMENT OF HEALTH IN ORDER TO RECEIVE A FAVORABLE COMMENT UNDER THE REFERRAL PROCESS.

61. APPLICATION FOR REVIEW UNDER THE REFERRAL PROCESS BY FACILITIES NOT ELIGIBLE FOR ACCREDITATION BY THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS MUST INCLUDE A RECENT EVALUATION BY ONE OF THE FOLLOWING: A PEER REVIEW, THE STATE DEPARTMENT OF HEALTH, THE STATE DEPARTMENT OF WELFARE, OR OTHER ACKNOWLEDGED EXTERNAL REVIEW AGENCY.

62. NO RECOMMENDATION WILL BE MADE FOR ISSUANCE OF A CERTIFICATE OF NEED FOR PROPOSALS SUBMITTED BY APPLICANTS, OR BY BOARDS OF DIRECTORS OF TRUSTEES OF FACILITIES WHO ARE CURRENTLY

INVOLVED IN RELOCATION OF LICENSURE PROCEEDINGS, UNLESS THE APPLICATION FOR CERTIFICATE OF NEED IS TO CORRECT A DEFECT IN SERVICE.

63. NO RECOMMENDATION WILL BE MADE FOR ISSUANCE OF A CERTIFICATE OF NEED FOR PROPOSALS SUBMITTED BY APPLICANTS, OR BY BOARDS OF DIRECTORS OR TRUSTEES OF FACILITIES WHO ARE CURRENTLY INVOLVED IN PROCEEDINGS WHICH MAY RESULT IN LOSS OF BED CERTIFICATION DUE TO SUBSTANDARD OPERATIONS OR SERVICES, UNLESS THE APPLICATION FOR CERTIFICATE OF NEED IS TO CORRECT A DEFECT IN SERVICE.

64. THE DEPARTMENT OF HEALTH AND DEPARTMENT OF WELFARE SHOULD BE SUPPORTED IN REQUESTS FOR ADEQUATE PERSONNEL TO MONITOR FACILITIES AND SERVICES FOR WHICH THEY HAVE LICENSING RESPONSIBILITY.

There are appropriate instruments and techniques to measure the quality of facility resources and program operation, although continuing improvement and refinement are desirable. However, more study and research are required to measure quality regarding results of a program and benefits to the consumer. The Minnesota Survey of Nursing Homes (Institute of Interdisciplinary Studies, 1969) states that the ultimate test of quality of care is what happens to the patient - the outcome.

More intensive effort should be encouraged and resources should be allocated to develop research designs which measure benefits or outcomes that are reliable and can be adapted to long term health care services for aging, developmentally disabled, mentally ill and chemically dependent persons.

POLICIES

65. THE DEVELOPMENT OF EVALUATION SYSTEMS TO ASSESS THE QUALITY OF LONG TERM HEALTH CARE SERVICES FOR THE AGING AND DISABLED IN THE METROPOLITAN AREA SHOULD BE ENCOURAGED.

Once uniform standards have been developed for program, staff qualifications, nomenclature, cost and evaluation, evaluation criteria can be developed so that both the cost effectiveness, number of people served, efficiency and the outcome of programs can be reviewed for each of the areas of mental health, mental retardation and inebriety.

There are two major evaluation components: output and outcome. Output is the number of people treated, the length of time treated or the number of times seen, and the number of different techniques used. Outcome refers to the success of treatment.

Presently in the field of both mental health and inebriety the problems

for measuring the degree of success of programs is complicated by the fact that the programs are subsidized by federal or foundation funding. The agency, organization or program must somehow explain what it is doing. Present evaluations are in terms of number of people seen, and length of time dealt with, but success of treatment is only alluded to.

Evaluation criteria should be developed for the purpose of sharing the impact of program on a given problem, the cost efficiency and effectiveness of programs, and the incorporation of date into an Area information system.

The present move from centralized to decentralized facilities appears to have merit in providing more normal living experiences, as does the drive to increase preventive and ambulatory care. Until the actual outcome can be displayed, however, these trends are arbitrary by nature.

POLICIES

66. CRITERIA FOR THE EVALUATION OF MENTAL HEALTH, MENTAL RETARDATION AND INEBRIETY SERVICES SHOULD BE DEVELOPED.

HEALTH SERVICES MANPOWER

The Metropolitan Health System should be adequately supplied with sufficient manpower appropriately trained and distributed to fulfill its goals.

UTILIZATION OF MANPOWER

Health manpower must be effectively utilized. The problem is not merely a shortage of physicians. There may be no shortage at all, but there is a shortage of particular types of physicians in particular communities. Some studies suggest that if most primary care were provided by multi-disciplinary teams staffed by physicians and nurses, there could actually be a surplus. There is an apparent concensus that, with the present maldistribution and inappropriate utilization of manpower, training larger numbers of physicians by itself will not alleviate problems with health care delivery.

In its report to the President in 1967, the National Advisory Commission on Health Manpower cited a crisis caused by manpower being channeled into "inefficient and inappropriate activities," making it hard for patients to get care.

Many of the physician's duties could be performed by an "allied" health professional. In fact, allied health professionals have been doing things for sometime now that only a physician used to do. For example, the public health nurse in her home visits has assessed the health status of pregnant women and new-born infants. She has given advice and information about health problems, referring patients to doctors on the basis of her professional judgment. The nurse may do more than just the duties delegated by a physician. The nurse practioner makes independent assessments of health status, decides who needs to see the doctor, and conducts physical examinations, prescribing and recommending treatment. They can help patients work through the emotional adjustment to illness.

The Loeb Center in New York runs an inpatient care facility under the direct supervision of professional nurses. Patients there are typically convalescent, chronic, or long-term. Physician care is available on a referral basis. Another example is the nurse clinic. These clinics have been operating in the Metropolitan Area for some time. They deal with such concerns as neo-infant care, management of care for individuals with chronic illness, and pre-natal care for mothers.

Allied health professionals are active in many other health areas. The

crucial issue is how independent of the physician they are in the performance of these duties. Physician control can mean anything from direct observation to a signature on an insurance claim form.

LEGISLATION

Public policy has placed limitations on what the allied health professional can do without some physician control. By law, what pharmacists and others can do is closely regulated since it touches what might be construed as the practice of medicine.

Legislation which would allow more independent status for allied health professionals should be recommended by the Metropolitan Council. This would require a definition of the proper balance between the responsibility of the allied health professional for his actions and the preservation of quality.

To prevent further fragmentation, the allied health professional should practice only where well defined relationships with physicians and others within the health system can be established. The Health Maintenance Organizations appear to have the potential for developing the broadest use of allied health professionals.

The 1973 legislature passed the Allied Health Manpower-Credentialing Bill giving the State Board of Health authority in reviewing, regulating, and establishing credentials for the various manpower categories. Roles of non-physicians should be carefully defined and educational programs should be modified to reflect changing roles. Legislation designed to reduce barriers which prevent utilization of each member of the health team at his optimal level of competence should be supported.

POLICIES

67. ALLIED HEALTH PROFESSIONALS SHOULD PROVIDE HEALTH CARE SERVICES WITHIN THEIR COMPETENCIES WITHOUT DIRECT PHYSICIAN SUPERVISION, PROVIDED THERE IS INTEGRATION AND CONTINUITY WITH OTHER HEALTH CARE SERVICES.

68. LEGAL RESTRAINTS TO EFFICIENT AND EFFECTIVE USE OF MANPOWER SHOULD BE RE-EVALUATED AND MODIFIED TO FACILITATE BETTER UTILIZATION OF THE TOTAL METROPOLITAN AREA HEALTH MANPOWER POOL.

Several states have passed legislation related to this problem; the state of Washington, for example, enacted into law amendments to their Nurse Practice Act which permits nearly full utilization of nurses. The legislation gives R.N.'s the right to perform such functions as the "observation, assessment, diagnosis, care or counsel, and health teaching of the ill, injured, or infirm" and the "maintenance of health and prevention of illness of others." It specifies that the nurses are "directly

accountable and responsible to the consumer for the quality of nursing care rendered." Both the Washington State Hospital Association and the Washington State Medical Association had opposed the bill. However, the hospital association withdrew its opposition after the legislation was amended to include the phrase, "provided, however, that nothing herein shall affect the authority of any hospital, hospital district, medical clinic or office, concerning its administration and supervision."

POLICIES

69. THE MINNESOTA LEGISLATURE SHOULD AMEND THE NURSE PRACTICE ACT EXPANDING THE PRACTICE OF NURSING TO PERMIT NURSES A MORE INDEPENDENT STATUS IN THE PROVISION OF PRIMARY CARE SERVICES.

EDUCATION

The personal nature of health care delivery requires that there be an adequate supply of health personnel, appropriately trained and distributed. Changes in consumer needs, patterns of medical practice, expansion of medical knowledge and population shifts must be accommodated.

A doctor is most likely to practice where he takes his specialty training. A similar pattern has been established for other health occupations. Particular attention should be devoted to where educational programs are located.

Education should be provided concurrent with and as a part of good service programs rather than duplicating programs to meet educational needs. The most expensive method of delivering service is in the educational setting. It would be even more expensive to construct service programs specifically for educational purposes. As a general rule, educational programs should be located where high volume quality service programs presently exist. However, this does not say that a certain care facility may not be needed at places like the University, but that greater attention be directed to using existing community resources on a decentralized basis to meet additional education needs.

POLICIES

70. EDUCATIONAL PROGRAMS FOR PHYSICIANS AND ALLIED HEALTH PERSONNEL SHOULD BE CONDUCTED IN EXISTING SERVICE PROGRAMS RATHER THAN DEVELOPING DUPLICATE SERVICE PROGRAMS OR REFERRING PATIENTS TO MEET THE NEEDS OF EDUCATION.

Existing facilities must be willing to participate in health manpower training programs. Responsibility, therefore, for health manpower development rests in large measure with facilities whose primary mission is health service. Some facilities presently make a major contribution

to the health manpower pool by operating or by participating in programs which train physicians and para-medical personnel for the community. Where high volume services exist, these services must be willing to participate in educating health manpower consistent with service capacity.

POLICIES

71. FACILITIES WITH HIGH VOLUME SERVICES SHOULD DEVELOP TRAINING PROGRAMS AS NEEDED CONSISTENT WITH SERVICE CAPACITY.

72. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS WHICH DUPLICATE SERVICES DUE PRIMARILY TO EDUCATIONAL FUNCTIONS WILL RECEIVE LOW PRIORITY.

PATIENT RIGHTS

The American Hospital Association adopted a statement of patient rights in 1972. Since that time, many of the same rights have been affirmed in law in the State of Minnesota. The basic premise behind such statements is that all activities within the hospital setting must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. While the role of patient in health manpower education is not specifically addressed, it is clear that the same general premise should apply. The patient has the right to consideration and respectful care. In addition, he has the right to be advised if he is expected to participate in clinical education programs and, in general, what this participation may entail. The patient should have the right to refuse to participate in such programs irrespective of financial classification.

POLICIES

73. PATIENT PARTICIPATION IN CLINICAL EDUCATION AND RESEARCH SHOULD BE WITH KNOWLEDGEABLE CONSENT IRRESPECTIVE OF FINANCIAL STATUS.

CONTINUING EDUCATION

Health services are rapidly changing. There is little question that the technological boom almost mandates a continuing education program so health professionals can become more aware of development within every field. Health professionals also need to understand the impact of technological developments in more than one highly specialized field so that allied health professionals and the specialists can continue to relate back to the whole person.

All persons in the health field should be required to continue their

education to maintain their certification and licensing. At the same time, these costs should be reimbursable.

POLICIES

74. CONTINUING EDUCATION AND UPGRADING OF SKILLS FOR ALL PERSONNEL SHOULD BE REQUIRED.

SUBSIDIZING EDUCATION

At present, those people who are ill pay for a large portion of health manpower education and training because patient charges subsidize educational programs. As a result, people who are well or who seldom use health facilities do not share in the expense of training and educating health manpower. Changes must be made so that the cost is spread more equitably among the residents of the entire population. Federal funds for training and education are dwindling so that the problem is becoming more critical. This trend increases the cost per person and, hence, the expense of the illness. With a broader base, the cost of manpower education and training could be shared without penalizing the patient. It would also allow more flexible, more effectively designed training programs.

The sharing of education and training costs among users and potential users of service allows more equitable distribution of costs and much more effectiveness and efficiency in the implementation of training programs. Alternatives to remove health manpower education and training costs from patient charges should be supported.

POLICIES

75. ALTERNATIVES TO REMOVE HEALTH MANPOWER EDUCATION AND TRAINING COSTS FROM PATIENT CHARGES SHOULD BE SUPPORTED.

HEALTH MAINTENANCE ORGANIZATIONS

The metropolitan health services system should be accessible, utilize health resources efficiently, and be structured to provide a continuum of comprehensive service.

Although the general quality of health care services in the seven-county Metropolitan Area is good, there is a need to further improve the delivery of these services. One of the proposed ways is through the Health Maintenance Organization concept. The Health Chapter, while emphasizing the Health Maintenance Organization, does not rule out other promising methods of delivering health care services.

The health care delivery system is a pluralistic system, composed of varieties of profit and non-profit organizations. Little study has been done to determine what effect the profit status of the organization has on the delivery of health services.

POLICIES

76. EARLY CONSIDERATION WILL BE GIVEN TO ANALYZING THE IMPLICATIONS OF PROFIT AND NON-PROFIT SPONSORSHIP FOR DELIVERY OF HEALTH SERVICES.

THE CONCEPT OF HEALTH MAINTENANCE ORGANIZATIONS

The Health Maintenance Organization (HMO) is based on a concept of total, comprehensive care delivered within an integrated organizational system. Full development of the concept should incorporate and satisfy each of the following elements:

1. Access to a range of health and health related services - comprehensive care.
2. Provision of services to areas of health service scarcity.
3. Better utilization of allied health personnel.
4. Emphasize prevention and education.
5. Provide primary care.
6. Could be developed to meet the county's responsibility either directly or through a purchase of service arrangement.
7. Could support neighborhood clinics to keep them viable.
8. Provision of mental health, mental retardation, and inebriety services.
9. Could be the financial mechanism for primary care delivery.
10. Quality could be monitored and evaluated.
11. Important resource for education through affiliation.
12. Can lower the cost of health care.

The Health Maintenance Organization is the embodiment of a strategy to reorganize the health service delivery system and to develop compatible financial incentives. The Medicare experience provided ample evidence of the folly of increasing the financial resources without modifying the delivery system.

The underlying idea of the Health Maintenance Organization is that more of the services that can improve health can be provided at lower cost. Studies of organizations similar to the Health Maintenance Organization appear to show that the increased use of comprehensive primary care services can decrease hospital utilization and lower the total cost of providing care.

Prepayment either by the enrollee or by some third party on his behalf introduces an element of financial stability to the system. The enrollee knows the full range of services he has contracted for in the event he should need them. The Health Maintenance Organization knows the revenue it has available to operate during the payment period. The fixed revenue provides an incentive to keep people well and to avoid overusing the more expensive, acute services. However, safeguards may be needed to prevent under-utilization of acute services.

The possibility of lower costs is leading large employers to consider contracting with Health Maintenance Organizations as an alternative to the usual health insurance plan.

POLICIES

77. HEALTH MAINTENANCE ORGANIZATIONS AS A DELIVERY SYSTEM SHOULD HAVE A HIGH PRIORITY FOR DEVELOPMENT AND EXPANSION.

EXISTING HEALTH MAINTENANCE ORGANIZATIONS

Five Health Maintenance Organizations are presently operating in the Metropolitan Area. Group Health Plan, Incorporated of Saint Paul, began operation in August, 1957. The major location is at 2500 Como Avenue, St. Paul, but there are also branches in downtown St. Paul, one in St. Louis Park and another planned in the southern suburbs. There are over 50,000 enrollees which include the city of St. Paul employees, State employees, University of Minnesota employees as well as other groups in St. Paul and Minneapolis. The service area includes a 25 mile radius of the main facility on Como Avenue which would encompass the entire Metropolitan Area.

The Medical Center Health Plan of St. Louis Park began operation in December, 1972, and is located at the St. Louis Park Medical Center in St. Louis Park. Enrollees are employee groups who negotiate directly with the Medical Center Health Plan. The service area is for the most part Hennepin County but also part of Carver, Anoka, and Ramsey counties.

The Nicollet Eitel Family Health Plan of Minneapolis was organized and developed in September of 1972 and is located at 2001 Blaisdell Avenue, Minneapolis. The enrollees are also employee groups who negotiate directly with the Plan. The service area includes a 15-mile radius of the facility.

The Ramsey Health Plan, Incorporated, began operation in 1972 and is located at the St. Paul-Ramsey County Hospital in the ambulatory care department. Enrollees are for the most part Ramsey County employees and their families. The service area is for the most part Ramsey County but also includes a 25 mile radius which is not strictly enforced. At present certain employee groups are the only ones that have been accepted into the Ramsey Health Plan.

The SHARE Plan of St. Paul began operation in October of 1972 and is located at Samaritan Hospital. Its enrollees are Burlington Northern employees plus their dependents and other railroad union members. The Plan is presently in negotiations for medicare and/or medicaid recipients. Present indications are the SHARE Plan will develop south and west of their existing location at Samaritan Hospital.

Twin City Health Care Development Corporation, which is sponsored by private industrial organizations in the Metropolitan Area, exemplifies further interest in the development of health maintenance organization. The major purpose of this organization is to educate and assist groups interested in developing HMO. Although Group Health of St. Paul was the only HMO operating in the 50's and 60's, the development of four more in 1972 shows further commitment in the Metropolitan Area to develop this alternative as a possible option to the traditional system.

The development of state legislation in 1973 for enabling and guiding the development of HMO's is further indication of the interest and

concern for the HMO concept and strategy is seen in the development of HMO by hospitals and by providers in the Metropolitan Area. Examples are the already mentioned St. Paul-Ramsey Health Plan, the Nicollet Eitel Plan, and the St. Louis Park Medical Center.

While support for the Health Maintenance Organizations is gaining momentum, it may be some time before this alternative will effectively compete with the traditional system. Governmental support is necessary if the Health Maintenance Organization is to realize its potential and achieve a level of effectiveness that will allow valid comparison with the existing system.

POLICIES

78. PROJECTS REVIEWED UNDER THE REFERRAL PROCESS WHICH ARE DEVELOPED AS A HEALTH MAINTENANCE ORGANIZATION OR IN CONJUNCTION WITH A HEALTH MAINTENANCE ORGANIZATION AND THAT MEET THE REQUIREMENTS OF THE HEALTH MAINTENANCE ORGANIZATION GUIDELINES SHOULD HAVE HIGHER PRIORITY THAN PROJECTS THAT DO NOT.

DEVELOPMENT OF HEALTH MAINTENANCE ORGANIZATIONS

The Metropolitan Health Board should prepare guidelines for the development of Health Maintenance Organizations which may come under its purview through Certificate of Need reviews, both State and Federal, or any other reviews under the referral process. The guidelines would be a useful standard for HMO development even where the review process is not mandatory. While the guidelines must be consistent with the 1973 Minnesota HMO Enabling Act and Regulations, they should go beyond to provide direction for future development.

POLICIES

79. GUIDELINES FOR EVALUATING THE VARIOUS FORMS OF HEALTH MAINTENANCE ORGANIZATIONS SHOULD BE DEVELOPED.

80. FOR SIMILAR HEALTH MAINTENANCE ORGANIZATION AND HEALTH MAINTENANCE ORGANIZATION RELATED PROJECTS REVIEWED UNDER THE REFERRAL PROCESS, THE PROJECT MOST CLOSELY MEETING THE REQUIREMENTS OF THE HEALTH MAINTENANCE ORGANIZATION GUIDELINES SHOULD HAVE PRIORITY.

The Health Maintenance Organization with its great potential to meet a variety of health needs is the preferred way to deal with health service scarcity. Whenever public funds are allocated for health-related services, support of Health Maintenance Organizations through subsidy or outright purchase of memberships for clients should be a considered option.

FUNDING

The State of Minnesota has made available limited funding for any non-profit organization wishing to start an HMO as long as the service area can be shown to be in a health service scarcity area. Federal legislation has been proposed to provide funds for HMO development. Additional funds to offset the substantial start-up and development costs will be required if all persons are to have ready access to a health maintenance organization.

Medicare and Medicaid patients now have the option to use health maintenance organizations of 30,000 enrollees and above. Section 226 of the Social Security Amendment 1972 (public law 92.603 H.R. 1, October 30, 1972) provides for reimbursement under medicare to health maintenance organizations. Beginning in July, 1973, two methods of reimbursement - incentive reimbursement and cost reimbursement-became available to qualified organizations providing comprehensive health services to Medicare patients. Both methods of reimbursement are on a predetermined, periodic rate.

POLICIES

81. FEDERAL AND STATE HEALTH SUBSIDY PROGRAMS SHOULD BE AMENDED TO MAKE THE BENEFICIARIES OF THESE PROGRAMS ELIGIBLE FOR MEMBERSHIP IN HEALTH MAINTENANCE ORGANIZATIONS.

82. FEDERAL AND STATE FINANCIAL AND TECHNICAL ASSISTANCE SHOULD BE MADE AVAILABLE IN ORDER TO ENCOURAGE THE PROMPT DEVELOPMENT OF COMPETITIVE HEALTH MAINTENANCE ORGANIZATIONS.

Some form of national health insurance will likely be enacted into law within the next few years. Congress should be encouraged to include health maintenance organizations as a crucial and integral part of any national health insurance measure.

POLICIES

83. PROPOSED NATIONAL HEALTH INSURANCE MEASURES SHOULD PROVIDE FOR THE PAYMENT OF MEMBERSHIP IN HMO AS AN ALTERNATIVE CHOICE.

APPENDIX

GUIDELINES TO HEALTH MAINTENANCE ORGANIZATIONS

The enclosed HMO guidelines have been developed for the Metropolitan Health Board. The Task Force involved providers, planners and health maintenance organizers as well as other interested organizations and some consumers. The purpose of the guidelines is to provide a standard for HMO development in the metropolitan area. While the guidelines are consistent with the 1973 Minnesota HMO legislation, they go beyond the minimum standards defined by statute to present a preferred direction for HMO development.

The Health Maintenance Organization (HMO) is an organized system of health care delivery that is responsible for:

a) the provision of comprehensive, continuous health care services to its enrollees* on a prepayment basis

b) the availability, accessibility and quality of the health care services provided or arranged for

c) having a reasonable procedure for:

   1) participation of enrollees in matters of policy decisions and operation

   2) monitoring of quality of health care services

   3) resolving complaints and grievances initiated by enrollees.

The HMO utilizes the manpower, facilities and equipment of the traditional fee for service approach to health care delivery. However the organizational emphasis and incentive structure are different.

*All asterisks refer to words defined in the definition section.

Ability to pay should not determine ability to participate in health maintenance. The financing of health care for the medically indigent or near poor is not a problem that can be solved individually by the HMO. It is a responsibility that must be recognized and resolved jointly by the public and private sector. The Metropolitan Health Board should proceed forthwith to organize a task force to address financing of adequate health care for all members of the community. As alternative methods of payment are developed, each HMO has responsibility to inform all potential and present enrollees who cannot pay the established rate, about payment alternatives.

The thrust of the HMO movement has been the inherent cost containment incentive. The objective of this set of guidelines is to encourage HMO development that will also reduce fragmentation, emphasize preventive and primary care, and ensure the appropriate utilization of health services and the efficient, effective utilization of health manpower.

These guidelines provide a frame of reference for planning and evaluating the development of health maintenance. The Metropolitan Health Board has responsibility for timely review and revision as required by growing understanding of the health care delivery system.

I. ORGANIZATION

A. Plurality of organizational structures for organizations for maintaining health should be encouraged. Regardless of organizational form, there must be appropriate consultation and input into the decision making process among participants, providers, and management. The continuance of a public policy which encourages pluralistic organizational arrangements will be dependent upon performance evaluation.

B. Health organizations known and/or defined as prepaid group practice,* or group practice* or health service plan corporation shall be in the eyes of the law and regulations, considered no differently than other HMO forms.**

C. Programs for record keeping, reporting, and evaluation should have similar terms to facilitate comparison. Standards developed for state law and regulation should encourage and allow organizations for maintaining health development.

D. The governing board* memberships shall be allocated in the proportion of at least but not limited to 40 per cent of the seats to enrollees who are non-providers. Each enrollee board member shall be elected by the enrollees after adequate disclosure to its membership. This representation is mandatory after the first year of operation.

E. Each organization for maintaining health must have a procedure to present grievances on an individual basis by enrollees or through their chosen representative. Each grievance procedure must provide for appeal to the governing board and/or for appeal to a state regulatory agency, or other recognized arbitration mechanism.

F. Any comprehensive health care plan offered to enrollees by the organization for maintaining health must be consistent with the minimum standards established by the state regulatory agency.

Encouragement of an increased spectrum of services beyond the minimum level should follow the guidelines given in the section of spectrum of services.

G. Each organization for maintaining health must offer its enrollees the opportunity to select a primary care server.

H. Each organization for maintaining health must offer its enrollees the opportunity to re-evaluate annually continued participation.

I. It is strongly recommended that each organization for maintaining health offer enrollment only to groups who make available one or more alternative choices among accessible health care services.

** Any of the aforementioned organizations wishing to be recognized as Health Maintenance as opposed to episodic care providers must follow the guidelines.

II. SPECTRUM OF SERVICES

A. An HMO shall provide as a minimum:

1) A written negotiated plan of care for each individual.

2) Continuity of care - preventive, diagnostic, therapeutic services resulting in corrective or ameliorative action.

B. The minimum level shall include the following specific service elements:

1) Physician and physician-supervised services consistent with A, 1 and 2 above. This will include emergent and urgent episodic medical care.

2) Inpatient acute care in the hospital and alternative in-patient facility services if they are less costly, of comparable quality, and consistent with A, 1 and 2 above.

3) Diagnostic/screening services with disclosure of detected problems and referral to sources of care:

a. Mental health, mental retardation, developmental disabilities for dysfunctional behavior and inebriety.

b. Dental, vision and hearing.

C. Beyond the minimum level the different levels shall include various combinations of services with intent to gradate as follows:

1) Assuring that therapeutic services for B, 3a and b above are arranged and integrated into A, 1.

2) Services of B, 3a and b provided by the HMO either by in-house staff or contractual arrangement.

3) Extension of services for B, 1, 2, and 3 above to include services beyond medical and hospital including all health and health related human services.

III. FINANCE

A. Funding

1) Health scarcity areas will receive priority of funds.

2) Applicants for proposed HMO funds shall present in their proposal evidence of potential cost effectiveness.

3) Funding recommendations which appropriately fall within

the eges of the Board/Metropolitan Council will come about only after adequate public notice for reviewing application and including contacting major newspapers, public hearing and reasonable opportunity for public presentations. Such hearings shall be at a time and place convenient for public attendance. Applications supporting documents and any records (written or taped) shall be held as a matter of public record. This process applies equally for inviting applications for review and final award of funds.

4) Minimum published standards for planning and development monies must be established to evaluate applications. (Recommendation: Guidelines must be developed for make-up of the members of the hearing committee to avoid conflict of interest and to assure impartiality.)

5) Incentives should be developed to bring non-public funds into the funding process.

6) The Metropolitan Health Board/Metropolitan Council shall encourage the development of HMO's and shall establish a policy of encouraging a variety of financial models of organization.

7) Foundations and similar sources of funds are encouraged to use these guidelines in utilizing their funds and encouraging HMO development.

B. Finance

1) HMO's must provide evidence that they can meet their contractual obligation to their enrollees.

2) HMO's must provide annually full disclosure of balance sheet, operating income and expenses and proposed plans for management of surpluses and deficits to the State Board of Health and a summary of same to the enrollees.

C. Payment to Servers*

1) Alternatives for HMO to contract with servers shall be encouraged.

D. Health Maintenance Performance

HMO's shall be encouraged to develop and employ incentive mechanisms to improve the health maintenance performance of servers and enrollees.

The Metropolitan Health Board shall annually publish a consumers directory of HMO's which shall include a description of each HMO with a summary of performance evaluation data.

IV. EVALUATION

A. Each HMO shall develop an administrative data base summarized on a fixed time period interval (such as quarterly) including input* and output* measures for utilization and delivery performance, outcome measures* for effectiveness of care and measures indicating quality of services.

1) Administrative statistics shall be based on person-years* for all utilization and cost data for all input and output measures which must include enrollment acceptance and rejection as well as termination by reason.

2) Outcome measures* shall be based on a personally negotiated plan of care and aggregated* within the HMO by whatever variables are unique to that HMO.

3) Indicators of quality shall be based on several measures including technical performance, practice audits* and maxims of care.*

B. All HMO's shall be compared on performance measures derived from the three sets of measures indicated above and all such comparisons shall be adjusted for attributes and characteristics identifying the specific HMO per se as well as its enrollees. All enrollees shall receive a summary of the HMO evaluation report annually.

DEFINITIONS

1. Aggregated - grouped, clustered, pooled.

2. Comprehensive Health Maintenance Services - complete, continuous health care services for maintaining the person's physical, mental and social well being.

3. Enrollee - an individual who has entered into a contractural agreement or on whose behalf a contractural agreement has been entered into with a formal organization for the provision of health care services.

4. Governing Board - the policy establishing body that ultimately is responsible and accountable for the activities and future direction of an organization.

5. Group Practice - the formal organization of three or more health care providers, either full time or part time, to provide health care through the joint use of equipment, personnel and facilities.

6. Health - a condition of complete physical, mental and social well being; not simply the absence of disease or infirmity.

7. Input - services provided to the enrollee including tests, drugs, hospitalization (etc.).

8. Maxims of Care - the definition of practice patterns determining methods of choice, the criteria used to determine whether or not services should be provided, and if provided, to whom, for what time periods, and for what intended outcomes. These would generate norms of care.

9. Medical Group Practice - a subset of health group practice by three or more physicians, either full time or part time, who are formally organized to provide medical care through joint use of equipment, personnel and facilities.

10. Outcome measures - the social, psychological, physical health status of the enrollees, which results after receiving inputs (services, etc.).

11. Output - the number of tests performed, people seen, procedures done, prescriptions made, i.e. quantity of various kinds of activities.

12. Person years - the full time person equivalents (calculated number of years of all enrollees in an HMO) equivalent equal:

$$\frac{\text{Number of people X length of time (in days)}}{365}$$

for any given time period.

13. Practice audits - medical and other professional reviews of the care delivered based on both health records and outcomes which review method of choice, and actual service provided (inputs rendered), across all enrollees or specific subsets of enrollees and groups of/or specific servers. These would generate practice pattern profiles.

14. Prepaid Medical Group Practice - a medical care delivery system which accepts responsibility for ensuring the availability and delivery of a defined set of medical services to a defined subscriber population. It combines a financing mechanism (prepayment) with a particular mode of delivery (medical group practice) by means of an administrative organization.

15. Preventive Medicine - taking measures for anticipation, prevention, detection and early treatment of disease.

16. Provider or Server (can be used interchangeably) - the individual(s) or organization(s) delivering or supplying health care services.

17. Rating Base -

    A. Community rating - a system under which rates are determined on a per person or per organization basis. The rate can be different for size of family; however, basic rates are equivalent for each enrollee, i.e. we all pay for what the entire enrollee population uses in services.

    B. Experience rating - (entire enrollee membership) - involves charging various groups of members different rates for same basic services (per capita). Groups of people with high usage will be charged more, i.e. each organization or group pays in relation to what services it uses.

PROCEDURES FOR APPLYING FOR CERTIFICATE OF NEED

The following procedures are given to aid in the handling of all proposals under the Regulations for Certification of Need Act (Chapter 628 of Minnesota Statutes, 1971). These steps should provide the applicant an understanding as to the procedures involved in the processing of the Statement of Notification of Intent and Proposal for Certification of Need.

Phase I - Notification of Intent

Step 1 The Applicant submits a Notification of Intent for construction or modification of a health care facility required under the Act in writing to the Metropolitan Council/Health Board.

Step 2 The Referral Section of the Metropolitan Council notifies the State Board of Health and the State Comprehensive Health Planning Agency. A copy of the Notification of Intent is forwarded to the Metropolitan Health Board Staff, who in turn presents the Notice of Intent to the Five-Man Committee of the Metropolitan Health Board. TIME - 2 DAYS

Step 3 The applicant may request a written determination from the State Board of Health as to whether the project is subject to Certificate of Need. Whenever the applicant's Notice of Intent is unclear or in question, the Health Board may request a determination from the State Board of Health whether a Certificate of Need is required. TIME - 8 DAYS

Step 4 The applicant will be notified by the State Board of Health after a determination for a Certificate of Need Proposal is made, not later than thirty (30) days after the request was submitted to the Metropolitan Council. If a proposal is not needed, the applicant can proceed without a review. A review of the proposal by the Metropolitan Health Board will be required when the State Board of Health determines that the applicant's Statement of Intent falls within Certificate of Need legislation. TIME - 20 DAYS

Step 5 Once a determination is made, the applicant must submit in writing to the Metropolitan Council, ten (10) copies of the Certificate of Need Proposal (Proceeds to Phase II - Non-specified time period).

Phase II - Certificate of Need Proposal

Step 6 The Referral Section of the Metropolitan Council refers the proposal immediately to the Metropolitan Health Board staff who will determine whether the proposal is acceptable in content for review.

A. If the proposal is not acceptable, the Council will return it to the applicant for additional information or modification, or TIME - 10 DAYS

B. If the application is acceptable, the Council will acknowledge receipt to the applicant, and

C. The Council will also submit the application to the State Health Board and State Comprehensive Health Planning Agency. TIME - 10 DAYS

D. The referral section forwards the file of the acceptable application to the Metropolitan Health Board staff who in turn presents the proposal to the five-man Health Board Committee.

In the case where there is an unacceptable application, the Metropolitan Health Board staff will work with the applicant to obtain the additional information necessary for acceptance of the application.

Step 7 Upon acceptance of the applicant's proposal, the five-man Health Board Committee will determine the review mechanism.

A. Staff Review

B. Health Board Review

C. Study Committee/Advisory Committee Review

TIME (approximately) - 60 DAYS

Step 8 Prior to any public hearing, the Health Board will hold the necessary study review procedures through the use of Study Committees and Advisory Committees which will study, review and comment on the proposals. Applicants will be informed as to the process involved in review of their applications.

Step 9 The Metropolitan Council provides a notice of a public hearing in a legal newspaper of general circulation for two (2) successive weeks, the last notice to appear at least ten (10) days prior to the hearing date.

Step 10 The Public Hearing allows both the proponents and the opponents along with any interested parties to be heard and/or present written evidence regarding a proposal for Certificate of Need.

Phase III - Recommendation for Certificate of Need

Step 11 Upon recommendation from the Health Board for approval or denial of the Certificate of Need proposal, the Metropolitan Council, acting through the Referral Section, will prepare the Recommendation Report utilizing the Health Board recommendations and taking into consideration a comprehensive input from other Council staff.

The Council's recommendations including Health Board recommendations are transmitted to the State Board of Health with a copy to the State Planning Agency. These recommendations will be set forth in detail for either the issuance or denial of a Certificate of Need.

Step 12 Within sixty (60) days of receiving the recommendations from the Metropolitan Council, the State Board of Health must issue the Certificate of Need, reject it, or refer the application back to the Metropolitan Council for further consideration.

Such an issuance of the Certification will expire within one year if construction or modification is not begun. It will then be necessary for the applicant to re-apply through the procedures as outlined above.

ST. PAUL-RAMSEY HOSPITAL
ST. PAUL, MINNESOTA 55101

January 23, 1974

Ms. Sally deLancy, Chairwoman
Metropolitan Health Board
300 Metro Square Building
Saint Paul, Minnesota 55101

Dear Ms. deLancy:

The Ramsey County Hospital and Sanitarium Commission, along with the Administrative and Medical Staffs of Saint Paul-Ramsey Hospital and Medical Center have long shared with the Metropolitan Health Board concern in facilitating the provision of health care services in neighborhoods throughout the city and county where a need has been demonstrated and interest expressed in such development. Saint Paul-Ramsey has maintained a supportive-type role to foster the development of such services on a neighborhood basis where both control and direction is provided for by the community in which the program is located.

The hospital staff has put together a summary of such outreach activities undertaken in recent years in which the staff has provided support in planning, coordinating and offering services. The summary which is attached, begins by describing in some detail the thrust of the Department of Family Practice, the philosophy espoused by the staff of the department and some of the objectives it hopes to achieve. Doctor Hunt, Chairman of the Department, identifies the ways in which he sees both the neighborhood clinics and the central facility interfacing to provide the ~~optional~~ optimum level of care to the communities they serve.

In conclusion, we might mention that the administrative section of the hospital provides consultative services in Pharmacy and Dietetics to a number of community agencies and the Ramsey County Nursing Home. They have assisted the Housing and Redevelopment Authority in designing a clinic to be incorporated in the newly constructed senior citizen's highrise apartment on Edgerton and Jecks; and in assisting the Saint Paul Bureau of Health, the City of Saint Paul and the County of Ramsey with various facets of the health care delivery system.

We trust this information will be of further assistance to the Metropolitan Health Board in evaluating our Certificate of Need Proposal.

Yours sincerely,

LaVand Syverson
LaVand Syverson
Executive Director

Frank W Quattlebaum
Frank W. Quattlebaum, M.D.
Acting Medical Director

LMS:jra
Attachment

January 22, 1974

OUTREACH ACTIVITY OF THE STAFF OF SAINT PAUL-RAMSEY HOSPITAL

DEPARTMENT OF FAMILY PRACTICE:

The main health care thrust of the Department of Family Practice at Saint Paul-Ramsey Hospital is given within a milieu of concern for the needs of society oriented toward the community and the medically disadvantaged. The department relies on a solid background of secondary and tertiary care at Saint Paul-Ramsey Hospital.

The department's main facility is a model neighborhood health center comprising 10,000 square feet located on the lower East side of Saint Paul in Target Area "C". Comprehensive health services are provided to the residents in this area utilizing modern x-ray and laboratory equipment as well as specialty consultation from Saint Paul-Ramsey. In addition, the department is responsible for the care of patients in a satellite clinic in the Neighborhood House on the West side of Saint Paul. This is located in Target Area "B" and serves a mixed lower socioeconomic population. This facility utilizes Spanish-speaking community health workers, nurses and physicians as well as a system of 24-hour coverage for emergencies and off-hour care. The department is also responsible for the ambulatory health care of approximately 1,500 prisoners per year in the Ramsey County Workhouse and approximately 9,000 per year in the Ramsey County Jail. Satellite clinics have been developed for this purpose and care is delivered in the prison environment where health personnel can better understand the needs of the inmates. One of the physcians in the Department of Family Practice spends almost full time im the Stillwater prison caring for approximately 700 inmates. Plans are being finalized for a senior citizen's clinic which will be developed in a High Rise Project several blocks from the model clinic. Negotiations are also underway to provide medical consultation to the Martin Luther King Center in the Selby-Dale area.

The department is active in teaching medical students in Phases A, B and D, developing ambulatory care record systems, researching health care delivery needs, working closely with community representatives to assure a cooperative approach towards health care and educating allied medical personnel.

Possibly the greatest contribution of this department will be its graduates. Many of these physicians are socially motivated. They will now be able to carry out their inclinations from a background of excellent teaching which can only be provided by an institution geared towards educational pursuits such as Saint Paul-Ramsey. In addition, they will benefit from the Family Practice Department's emphasis on social medicine given in the patient's own environment.

In order for this department to continue the above orientation, it is necessary to have clinic space at Saint Paul-Ramsey. This would enhance specialty consultation by making it possible for our physicians to communicate directly with the referral specialist and to see patients together when possible, thereby saving time and avoiding the confusion that is often associated with patient referrals. This would also permit our department to coordinate care for those patients suffering from multiple diseases requiring the services of several types of specialists. Furthermore, it would allow us to deliver primary care in a personal manner to those patients who live in the area, such as residents of Mt.Airy, and those patients who find it convenient to take the bus to Saint Paul-Ramsey.

Another important advantage is that it would now be possible for the Family Practice Department to accept referrals from other specialists. Frequently patients will have a problem requiring specialty care at Saint Paul-Ramsey but also have many additional afflictions that require services of a family physician. (An example of this type of situation would be an elderly patient with prostatic hypertrophy, rheumatoid arthritis, hypertension and reactive depression. The urologist treating the prostatic hypertrophy could now elect to refer this patient to Family Practice for treatment of the other problems and coordination of other specialty care if indicated.)

Community outreach efforts such as those described above cannot retain their vitality without secure back-up facilities. In fact, they could become a hazard to a patient rather than an asset. If solid liaisons with experienced physicians are not developed diseases may be missed, communications between other specialists are often hampered and follow-up is impaired, especially when the patient has complex problems. Comprehensive primary health care cannot be practiced in isolation from secondary and tertiary sources.

This new outpatient facility would provide those of us in the Saint Paul area an unique opportunity to merge all aspects of the health care system from primary ambulatory care to the highly specialized tertiary care found solely at Saint Paul-Ramsey Hospital. It would now be possible to coordinate health care in a way which would provide leadership for this area of the country. In any event, it would allow the Family Practice Department to have the opportunity to continue to make in-roads into the health care of the medically disadvantaged that are not possible at the present time.

DEPARTMENT OF AMBULATORY CARE:

1. Saint Paul Fire Department Paramedics and Firemen-initial training and continuous inservice.
2. Divine Redeemer Emergency Medical Technicians-teaching.
3. 916 VoTech-Emergency Nurse Course-curriculum and teaching.
4. 916 VoTech-Emergency Medical Technicians-teaching.
5. 3M Company-consulting, medical products.
6. MRFAA Advisor (Medical Rescue & First Aid Association)-North Memorial Hospital Emergency First Aid Seminar-Advisory Board and lecturer (annually).
7. Medical Instructor and advisor to the P.R.I.M. (Professional Rescue Instructors of the State of Minnesota).
8. Advisor to the Division of Emergency Medical Services, State of Minnesota Health Department.
9. Ongoing teaching and information programs to various civic and private organizaitons (P.T.A.'s, teachers associations, schools, nursing students throughout the states of Minnesota and Western Wisconsin, nurses associations, volunteer rescue and ambulance peronnel in these areas, etc.)
10. Advanced Emergency Aid Seminar (rescue personnel, nurses, etc.).
11. Saint Paul Fire and Police Departments-instruction in first aid to recruits.
12. Clinics at Saint Paul Bureau of Health.
13. Advisor-Saint Paul Chapter of American Red Cross Disaster Committee.
14. Provide manpower for onsite medical coverage at Minnesota State Fair.
15. Nursing Home and Board and Care Home examinations and visits.
16. Medical Advisor and teacher to Midwest Ski Patrol Association.
17. Community service projects involving examinations for voluntary organizations such as camp physicals for the Boy Scouts, etc.

DEPARTMENT OF ANESTHESIOLOGY:

1. Gillette Children's Hospital-Saint Paul.
2. Lakeview Memorial Hospital-Stillwater.
3. District Memorial Hospital-Forest Lake.
4. Rice Memorial Hospital-Willmar.
5. School of Nurse/Anesthetists-Saint Paul.

DEPARTMENT OF DENTISTRY:

1. Activity confined at present time to inhospital, however, the department is involved in ongoing planning regarding dental services at the Family Practice East Side Clinic. Such service will be staffed by SPRH.
2. Ongoing planning regarding dental coverage for members of the Ramsey Health Plan.

DEPARTMENT OF DERMATOLOGY:

1. Consultative services at SPRH.
2. Large, crowded outpatient service at SPRH.

DEPARTMENT OF MEDICINE:

The department in conjunction with an increased thrust toward primary care with its patients plans to develop various screening and therapeutic clinics for specific disease states, such as asthma, as well as an extensive program in patient education in terms of prevention and ongoing care. In addition:

1. Cardiology-The Mobile Coronary Care Unit is essentially a program of the Department of Medicine. It requires extensive training of firemen and the monitoring of the Fireman Emergency Rescue Units. This also requires facilities for special ECG, echocardiogram studies, phonocardiogram studies in a centralized location.
2. Endocrinology-Central facility necessary to have large enough case numbers of diabetic patients to efficiently operate a comprehensive diabetic clinic (presently being done).
3. General Medicine-A hypertension clinic is now being formed and community screening of blood pressure will be developed. Those patients with high blood pressure will be referred to their community physician or to SPRH (their choice).
4. Pulmonary Disease-Plan to enter shortly into more comprehensive program of care and education for patients with chronic obstructive lung disease. This program would include complete pulmonary function evaluation, physical rehabilitation, inhalation therapy and an educational program utilizing physicians and nurse clinicians. Such a program entails a "center" concept. The instrumentation involved in pulmonary function, physical medicine and rehabilitation, inhalation therapy, are costly, sophisticated and best utilized at a central location. Also need access to sputum cytology, sputum culture techniques and special x-ray techniques.
5. The department also provides consultation to the Lake Owasso Home and Family Tree, Inc.

DEPARTMENT OF NEUROLOGY:

The department is engaged in a number of average activities, limited more by nature of the practice or the specialty of neurology, than by our desires to provide service where it is needed. At present we serve as the neurology consultant to the Gillette Children's Hospital on a weekly basis and provide neurological service to the Stillwater State Prison. We have made visits throughout the state as part of the rural physician's program and also as consultants and lecturers for the Developmental Disability Program and the Comprehensive Seizure Center.

Since the average patient does not consult a neurologist until after he has been seen by his family physician, we see most of our patients on referral and usually require sophisticated diagnostic facilities to properly render service. We must have immediate access to electroencephalographs, brain scan devices, special x-ray tecnhiques, specialized blood determinations, visual field equipment, and consultant neuro-psychology specialists. For this reason, most of our activity must be performed in an outpatient setting adjacent to the main hospital where these expensive resources exist if we are to avoid unnecessary duplication of expense and personnel. At present, although most of these facilities are available to us, they are inconveniently located for our patients, many of whom have difficulty in walking and we look forward to moving into a new facility where we can relieve many of these problems for our patients and where it will be more convenient for them.

DEPARTMENT OF NEUROSURGERY:

1. Currently participating in a weekly outpatient neurosurgery clinic at Saint Cloud and the development of a Spinal Cord Injury Care Center at SPRH.
2. Gillette Children's Hospital.

DEPARTMENT OF OB/GYN:

1. Maternal-Infant Care Projects at Riverview Clinic Neighborhood House, Mechanic Arts High School Clinic, Bureau of Health Clinic, Prenatal and Special Family Planning, Prenatal-Martin Luther King Center.
2. Mechanic Arts High School Comprehensive Medical Clinic.
3. Pap Smear Project-offers free Pap smears to patients in a special clinic in the hospital as well as administering and coordinating Pap smears for various out-of-hospital clinics such as the Bureau of Health, Planned Parenthood and Family Tree.
4. Responsible for staffing certain of the family planning clinics at the Bureau of Health as well as at the Martin Luther King Center, Neighborhood House and East Side clinics.
5. Supply consultation, staffing, supervision and general medical direction to the Family Tree Clinic.
6. Have established a Perinatal Center which is open to all physicians for their high risk obstetrics and pediatric patients.
7. Have a special Adolescent clinic in the evening at SPRH.
8. Colposcopy clinic for referral of patients with suspicious Pap smears. No room for this clinic in present Outpatient Department. This is the only Colposcopy clinic in the East Metropolitan area.
9. Ongoing planning for care of women inmates at Shakopee Correctional Institution.

DEPARTMENT OF OPHTHALMOLOGY:

1. Target Area Clinic located at Martin Luther King Center. Department staff conduct ophthalmology clinic every Wednesday, year-round from 2-5 p.m. Purpose of the clinic is to provide medical eye care for individuals in the Target Area. This clinic has been in existence for five years.
2. Glaucoma Screening Clinics-scheduled on a regular basis with staffing provided by the department.
3. Stillwater Prison-patients are seen on a regular basis once a week with medical eye care provided by departmental staff.

DEPARTMENT OF ORTHOPEDICS:

At the present time because of space limitation in the outpatient area, the fracture clinic meets three half-days a week (should be daily). Outreach facilities are limited because of the need for x-ray control of fractures and x-ray evaluation of orthopedic patients, and the requirement of plaster services make it more practical for the patient to come here, however, our current facilities are overcrowded and average seventy patients per half-day session and five examining rooms which creates patient delays and more hurried contact that is far from ideal. We would like to be open on a regular daily basis in order to serve the other outreach clinics for fracture and orthopedic needs. We have currently the medical manpower to do this but not the space to accomplish it. The department does provide consultation to the Gillette Children's Hospital and the Stillwater Prison.

DEPARTMENT OF OTOLARYNGOLOGY:

1. Outpatient and inpatient services (including minor surgery) at Stillwater Prison.
2. Specialty education regarding Paramedical Emergency School.
3. ENT consultation at Gillette Children's Hospital.

DEPARTMENT OF PATHOLOGY:

1. Cervical cancer screening program. The department performs over 18,000 cancer screening examinations on gynecologic (Pap-Smears) and other cytologic material on outpatients and patients seen by the following agencies: Outpatient Department-SPRH, Family Planning Clinics-SPRH, VD Clinic-SPRH, Cancer Screening Clinic-SPRH, Saint Paul Bureau of Health, Family Planning (Planned Parenthood), Family Tree, Family Practice Clinic, West Side Clinic. Over 10% of these show results requiring medical follow-up.
2. Specialty Consultation. The department provides regular laboratory consultation and supervision for: Family Practice Clinic, West Side Clinic. Occasionally members of the department are involved in consultation at several smaller hospitals in Minnesota and Western Wisconsin (Amery).

Specialized Services

The department is the largest and the only complete clinical laboratory in the East Metropolitan area and among others offers the following specialized services to community hospitals and physicians:

1. Special Chemistry: a) Examination of fetal-placental function (Estriol) and fetal maturity (L & S ratio), offered 7 days a week as emergency procedure, b) Toxicology screening and quantitative blood level determinations of drugs, anticonvulsants, digoxin, etc. (also offered on an emergency basis), and c) Advanced endocrinology procedures.
2. Bacteriology Services: a) Venereal disease screening program (in contract with State Health Department), over 35,000 cultures per year with 2-8% positive results. Also outreach clinics throughout the city such as Family Practice, Family Tree, West Side Clknic, and b) Tuberculosis mycobacteriology and fungus bacteriology. The department serves as mycobacteriology laboratory for the Tuberculosis Section (County Sanitarium) of Saint Paul-Ramsey Hospital and for send-in material from the community.
3. Ultrastructural Examinations: The department has the only electron microscope in the East Metropolitan area available for studies of surgical material.

DEPARTMENT OF PEDIATRICS:

The Department of Pediatrics has a long and documented community affiliation. Our department believes that existence as a part of a community medical center offers the opportunity and responsibility to work with other health care agencies in the discovery of child health problems. Conjointly solutions of these needs is thus possible. In 1963 a full time director of the department was appointed. An early pressing need was for diagnostic facilities for mentally retarded and neurologically handicapped children. To meet this need, a clinical facility for the community was established with the aid of a USPHS grant. This clinic, which is now known as the Child Development Center, serves the entire eastern metropolitan region. It provides services to all regional school districts, area physicians, Ramsey and other County Welfare Departments and other children's agencies. As an outgrowth of this service, it became clear that a long term placement facility for retarded children was needed in the area. Our department has provided pediatric consultants and primary care for children at Welcome Home which was founded to meet that need.

1. In 1964 the first children's seizure clinic for the community was established at Ancker Hospital. Today a full time pediatric-neurologist is available and utilized as a consultant by schools, area physicians and other hospitals including Gillette Children's Hospital.
2. The Maternal and Infant Care program, begun in 1966, involves clinics in two high priority urban areas of Saint Paul. It has been staffed in part by members of our department continuously since inception.
3. Service on community boards by members of our department is recognized as a responsibility. During the last decade our staff has provided such services to, among others, Family Nursing Service, Ramsey County Welfare Department, Saint Paul Public Schools, Saint Paul Association for Retarded Citizens, Saint Paul Health and Welfare Planning Council. Professional outreach has also been provided for various day care centers, community health clinics, and Head Start programs.
4. In 1969 in response to community requests led by Judge Archie Gingold, the Department of Pediatrics helped to organize a community Child Abuse Team. Interaction with the Sex and Homicide Division of the Saint Paul Bureau of Police, Family Nursing Service, Ramsey County Welfare Department, Division of Child Protective Services, children's associations has resulted in a unique nationally and internationally recognized service. This represents yet another facet of our outreach programs.

5. More recently the Departments of Obstetrics and Pediatrics have combined some staff functions to develop a high risk Perinatal Center. Our Experience in the Maternal and Infant Care project provided much valuable information and certainly the incentive for this development. It, like the Child Development Center and the Child Abuse Team, represents the only facility of a comparable nature in the community.
6. Professional education has always been a significant part of our program. We have participated with the School of Public Health, Division of Nursing, University of Minnesota, in developing a training program for Pediatric Nurse Associates. This course, now in its third year, is an important concept in improving primary health care delivery for children. Additionally, medical students, interns, residents and postgraduate fellows have been trained in our department.
7. Our staff has also developed educational programs for other health personnel, presented at the Nolte Continuation Center, University of Minnesota. Two of these were focused on mental retardation services for children and child abuse management. Other numerous educational programs for various community agencies have been provided.

DEPARTMENT OF PHYSICAL MEDICINE:

That Physical Medicine is a highly specialized, highly centralized, hospital-type of service is well documented by the fact that very little of this kind of service is provided in even the larger group practices in the Twin City area much less in a private practitioner's office. In order to provide adequate service, specialized personnel training in Physical, Occupational and Speech Therapy are necessary. A great deal of equipment and space is also required. The SPRH department occupies perhaps more floor space than any other department except for Pathology and Radiology. In addition to space requirements, since the team approach is utilized extensively, all involved personnel must be available in the immediate treatment area. Physical Medicine and Rehabilitation is a service which, though always individualized, must be highly centralized and can be provided only in a facility with close medical supervision and the availability of all appropriate allied personnel.

DEPARTMENT OF PSYCHIATRY:

The department provides the medical-psychiatric services to the Saint Paul Drug Rehabilitation Center, Inc., a non-profit organization devoted to the diagnosis, treatment and rehabilitation of those addicted to narcotics. This treatment modality is wholly outpatient oriented and has been operational since 1970. The current year calls for the establishment of a day care center with the goal of caring for "drug free" clients, studying the effectiveness of a long-acting narcotic substitute under the sponsorship of SAODAP (Special Action Office for Drug Abuse Prevention) and developing the Center as an educational area for undergraduate and postgraduate education with the University of Minnesota.

Through the department's autonomous planning and through its alliance with the Saint Paul Ramsey Mental Health Center, the medical staff provides primary, advisory and consultative services to many community agencies such as the:

Ramsey County Welfare Department
Probate Court
Juvenile Court
Wilder Child Guidance and Development Clinic
Hoikka House
Public Health Nursing
Catholic Guild Hall
Greenbrier Home
Retreat House
Activity and Day Treatment Units of the Mental Health Center
Ramsey County Workhouse
Detoxification Center
Center for Behavior Modification

The departmental staff resources is directed to planning and development of community resources that will ultimately provide a continuum of care service to the mentally ill. The staff is actively involved in a Task Force for After Care Services. A three-year federally funded study devotes itself to the acute and longterm management of the chronic mentally ill with treatment emphasis in extramural services. As members of the academic faculty at the University, the staff actively participates in the educational process directed to the Rural Physicians Associate Program.

DEPARTMENT OF SURGERY:

The department is primarily an inpatient operation. It provides special services to the community that are not available in other hospitals in the east metropolitan area.

1. Surgical care for injury victims is provided on a twenty-four hour basis seven days a week by a specialized multiple discipline trauma service.
2. There is also a Burn Unit at the hospital which provides care for burn victims from Ramsey County, all of Minnesota, western Wisconsin and the Dakotas.
3. In addition, the department provides general surgical care for patients from the east metropolitan area.

In order to provide preoperative evaluation and ongoing postoperative care for these inpatient services, a modern outpatient facility is necessary. It is planned in the future to reduce hospital costs by providing for surgical services on an outpatient basis. An outpatient building with facilities for a Surgicenter will facilitate that transition and allow for economy in many surgical procedures.

DEPARTMENT OF RADIOLOGY:

Because of the equipment involved, the department is necessarily confined a great deal to activities within the hospital including diagnostic and therapeutic consultation, radio-isotope, vascular x-ray and deep therapy. We do provide radiologic services to the following:

1. Ramsey Health Plan
2. Family Practice East Side Clinic
3. Stillwater Prison
4. Ramsey County Workhouse (will be putting a machine there shortly so inmates will not have to come here - we will go there)
5. Gillette Children's Hospital
6. Annual chest x-ray services to the Ramsey County Home
7. Victory Memorial Hospital in Stanley, Wisconsin

Special Activities:
Doctor Bjornson is Co-Director (active administrative director role) of the Health Professionals Drug Abuse Project for Minnesota, North and South Dakota, Western Wisconsin and Northern Iowa which is funded by the National Institute for Mental Health. He also conducts a fortnightly forum on chemical drug dependency for the community education and information.

DEPARTMENT OF UROLOGY:

1. Gillette Children's Hospital-currently conducts the urological evaluation of the children at this hospital. Children needing sophisticated urological,radiological and other investigations are referred into SPRH
2. Kidney Dialysis-consultations given to hospitals in the Saint Paul area on patients requiring dialysis. When need for dialysis arises, these patients are transferred to SPRH for treatment.
3. Stillwater Prison-Department staff will be actively involved in this program with a regular specialist clinic at the prison.
4. Family Practice East Side Clinic-Negotiations are being carried out to have a urology session on a regular basis at this clinic to evaluate patients referred by the clinic for urology problems. Further evaluation tests and procedures will be carried out at SPRH if indicated.
5. Spinal Cord Injury Unit-Treatment center is to be at SPRH with services extended to other Saint Paul hospitals and outstate. This outreach will take the form of consultations for acute cases as we hope to establish a first class method of managing the acutely injured spinal cord patient. If necessary, the patients will be referred to SPRH for evaluation or management depending on their condition.

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1/22/74

CONCERNED AGENCIES:

1. Saint Paul Fire and Police Departments
2. Family Practice East Side Clinic
3. Neighborhood House West Side Clinic (Family Practice, Ob/Gyn)
4. Martin Luther King Center (Family Practice, Ob/Gyn, Ophthalmology)
5. Mechanic Arts High School Comprehensive Medical Clinic
6. Saint Paul Bureau of Health
7. Family Tree, Inc.
8. Planned Parenthood (Ob/Gyn, Pathology)
9. Welcome Home (Peds)
10. Community Mental Health Center
11. Saint Paul Drug Rehabilitation Center
12. Hoikka House
13. Catholic Guild Hall
14. Ramsey County Welfare Department
15. Probate Court
16. Juvenile Court
17. Wilder Child Guidance and Development Clinic
18. Greenbrier Home
19. Retreat House
20. Ramsey County Workhouse
21. Detoxification Center
22. Center for Behavior Modification
23. Health Care Teams to Nursing Homes
24. Family Nursing Service
25. Public Health Nursing
26. Ramsey Health Plan
27. University of Minnesota (Burn Unit, Spinal Cord Center, Kidney Dialysis)
28. Boys Totem Town
29. Lino Lakes Correction Center
30. Shoreview Treatment Center
31. Ramsey County Home
32. Hospital Administration (Meals on Wheels, Stillwater Prison, Emergency Hot Meals for Local Disasters, etc.)
33. Lake Owasso Home
34. Minnesota State Fair
35. 916 VoTech School
36. Ramsey County Welfare Board
37. Stillwater Prison
38. Gillette Children's Hospital
39. Saint Paul Association for Retarded Citizens
40. Saint Paul Health and Welfare Planning Council

jra
1/22/74

ST. PAUL-RAMSEY HOSPITAL
ANALYSIS OF BED COMPLEMENT

(In Response to Question of Hospital Advisory Committee)

1. Capacity Number of Beds: 574

In 1973, Saint Paul-Ramsey Hospital was licensed for 574 beds and 26 bassinets, the capacity number of beds provided for at the time of construction.

2. Beds Set Up and Staffed - January 1974: 473

2.1 Fifth Bed Removed

Several years ago, the fifth bed was removed from the multi-bedded rooms, thus reducing the bed complement to 515. The rooms were first designed to accommodate four beds, than prior to the hospital opening, those rooms were modified to accept five beds when it became apparent that the new hospital could not accommodate all of old Ancker's patients.

2.2 One 30-Bed Unit Closed

The decline of the inpatient census over the past several years, coupled with the increased demands for space resulted in a decision to convert one unit to temporarily house Medical Social Service and the Welfare Intake Unit. This radial will be occupied by Gillette when it moves.

2.3 Eight Beds on Medicine Closed

Eight beds on a Medical Nursing Unit are temporarily closed. It will be opened when the 15-bed maximum security unit is opened.

2.4 Four Other Beds Closed

Rooms contianing four beds have been converted to offices. When the new building is complete, offices will be relocated and rooms restored to bed use.

3. Bed Complement When Gillette is Relocated at Saint Paul-Ramsey Hospital

3.1 Saint Paul-Ramsey Hospital		
Burn Unit	20	
Maximum Security	15	
All Other Beds	420	
Total Saint Paul-Ramsey Beds		455
3.2 Gillette Beds		60
Total Bed Complement		515

4. Occupancy Rate:

4.1 Year	Total No. Patient Days	Average Daily Census	Beds in Service	% Occupancy
1973	117,421	322	474	68%
1974	125,000 (Budgeted)	342	473	72%

4.2 When 60 of the 515 total beds are assigned to Gillette, the occupancy rate for 1973 and 1974 respectively based on 455 Saint Paul-Ramsey beds would be 71% and 75%.

4.3 In 1973 a total of 12,091 days of care (exclusive of new born) were rendered to children at Saint Paul-Ramsey Hospital. Based on fifty-one beds assigned for children, a 65% occupancy was maintained.

The average daily census was 24 for Medical-Surgical Pediatrics and 9 for Child Psychiatry.

ST. PAUL-RAMSEY HOSPITAL
and
MEDICAL CENTER
ST. PAUL, MINNESOTA 55101

Gillette
Children's Hospital

December 10, 1973

Ms. Sally deLancy, Chairwoman
Metropolitan Health Board
300 Metro Square Building
Saint Paul, Minnesota 55101

Dear Ms. deLancy:

It is with pleasure that we come to the Metropolitan Health Board with a joint proposal to bring together the strength of two outstanding hospital programs in one hospital facility, to the benefit of the patients they serve and taxpayers of the State of Minnesota and of Ramsey County.

Many services of the two hospitals would be shared under this proposal. Seventy-two beds, Gillette's present complement, will be eliminated because Saint Paul-Ramsey's surplus of beds can meet Gillette's bed requirements. The proposal will result in a reduction of 82 staff positions at Gillette and a net savings of $175,000 per year. With merging of the Gillette and Saint Paul-Ramsey Hospital programs the East Metropolitan area would have a complete children's health center and hospital complex.

Other facets of the proposal will make it possible for Saint Paul-Ramsey Hospital to better serve its outpatient clients, who reside in the Saint Paul neighborhoods with the greatest health care needs. The Saint Paul-Ramsey proposal includes space for new or expanded programs in prepaid health care, dentistry and outpatient surgery.

Because both the Gillette and Saint Paul-Ramsey Hospital proposals will require action by the Legislation, your early action on the proposal is respectfully requested.

Respectfully yours,

Michael F. Ettel

Michael F. Ettel, Chairman
Ramsey County Hospital
and
Sanitarium Commission

Clifford Retherford

Clifford Retherford, Chairman
Gillette Hospital Authority

bw

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REVISED PAGES

TO THE

APPLICATION FOR A CERTIFICATE OF NEED

FOR

GILLETTE CHILDREN'S HOSPITAL
ST. PAUL-RAMSEY HOSPITAL

Pages: 1,2,5,15,16,18,19,21,23,24,41,42,43,45,47

January 23, 1974

GILLETTE

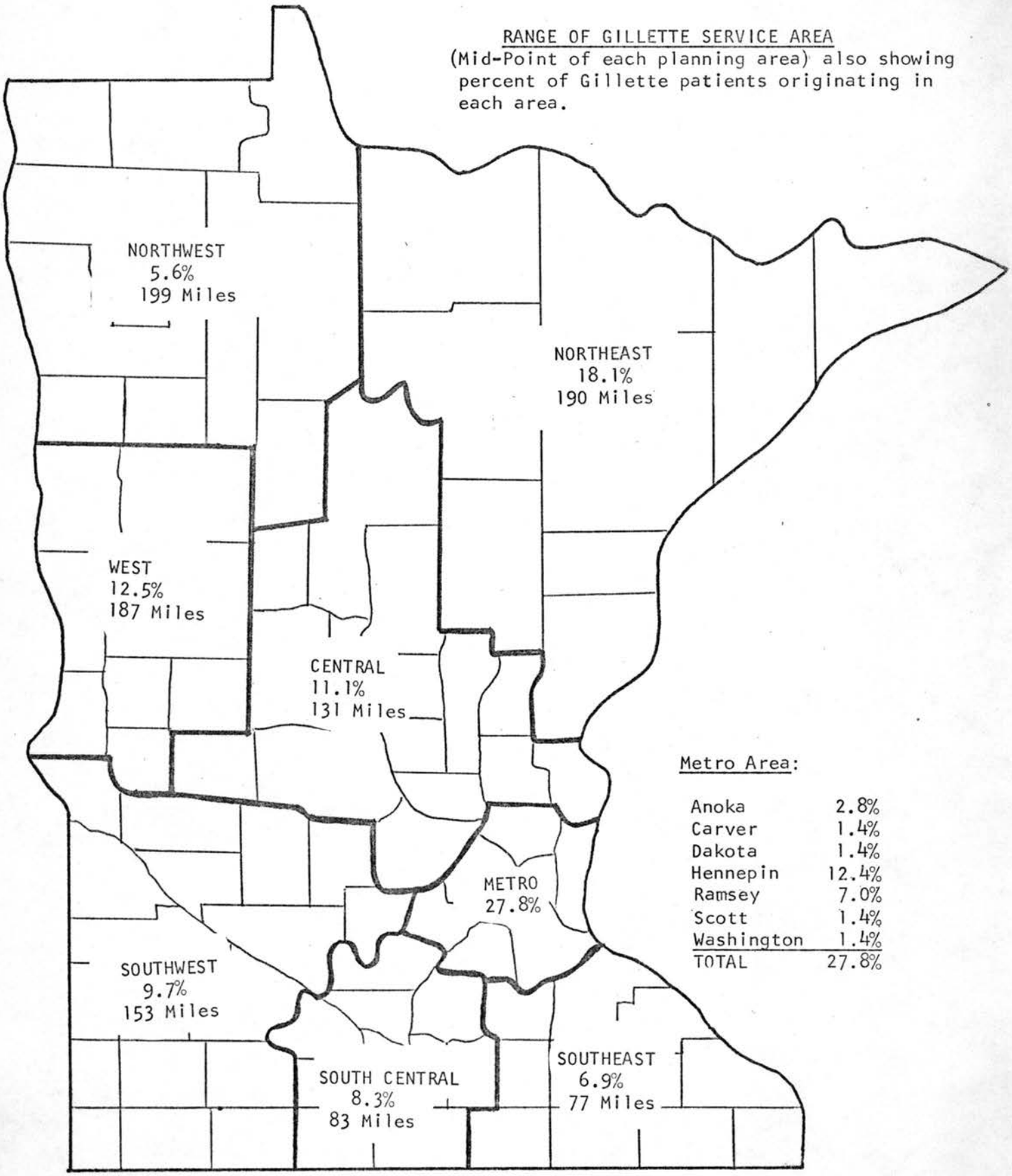
The unique program of the Gillette Hospital serves the entire state and accepts patients from out of the state. Seventy-two percent of Gillette's patients originate from outside the Twin-Cities Metropolitan area. Table I shows the percentage of Gillette patients originating in each of the states planning regions. The counties in each of these regions is shown on the map on page 2. The entire state is considered to be the primary service area. These figures are compiled from Gillette Hospital admission records. The population of the states regions, by the age groups Gillette serves, are shown in Table VI, page 10

TABLE I

PERCENTAGE OF GILLETTE PATIENTS FROM MINNESOTA REGIONS
WITH
DISTANCE FROM GILLETTE TO CENTER OF REGIONS

REGION	PERCENTAGE OF PATIENTS	DISTANCE FROM REGION
Northwest	5.6%	299 Miles
Northeast	18.1%	190 Miles
West	12.8%	187 Miles
Central	11.1%	131 Miles
Southwest	9.7%	153 Miles
South Central	8.3%	83 Miles
Southeast	6.9%	77 Miles
TOTAL	72.2%	
Metropolitan Area:		
Anoka	2.8%	22 Miles
Carver	1.4%	38 Miles
Dakota	1.4%	22 Miles
Hennepin	12.4%	23 Miles
Ramsey	7.0%	15 Miles
Scott	1.4%	30 Miles
Washington	1.4%	10 Miles
TOTAL METROPOLITAN	27.8%	

RANGE OF GILLETTE SERVICE AREA
(Mid-Point of each planning area) also showing percent of Gillette patients originating in each area.



Metro Area:

Anoka	2.8%
Carver	1.4%
Dakota	1.4%
Hennepin	12.4%
Ramsey	7.0%
Scott	1.4%
Washington	1.4%
TOTAL	27.8%

ST. PAUL-RAMSEY

To define the service area of the outpatient and emergency departments of St. Paul-Ramsey Hospital, a patient origin study was conducted during a 9 day period in September, 1973. A special clerk recorded the addresses of all patients receiving services in either of these departments during the study period. These addresses were coded in accordance with the same system used by the state-wide patient origin studies of hospital in-patients, familiar to Minnesota hospitals.

TABLE II

PERCENTAGE OF OUT-PATIENT AND EMERGENCY PATIENTS
FROM
ST. PAUL, RAMSEY COUNTY, AND ELSEWHERE

	Out-Patient (N=3,343)	Emergency (N=1,709)
St. Paul	75.5%	70.9%
Ramsey County Suburbs	12.6%	13.2%
Minneapolis	0.6%	1.9%
Hennepin County Suburbs	0.6%	1.4%
Other Metro Counties	5.8%	6.0%
Other Minnesota Counties	0.9%	2.1%
Other States	1.1%	1.7%
Unidentified	2.6%	2.6%

Table II shows a great similarity in the percentage of patients from the various areas to both the outpatient and emergency departments. St. Paul and Ramsey County accounted for 88% of all outpatient department visits and 84% of emergency department visits.

The St. Paul census tracts were grouped by neighborhoods for purposes of analysis, and the neighborhoods ranked according to the number of patients going to Ramsey. There were twenty defined neighborhoods. Separate rankings were made for the two departments. For both departments, the first four neighborhoods were identical: Summit-University, North Rice, Dayton's Bluff and Dale-Thomas. These neighborhoods were the source of 42.4% of outpatient department visits and 40.3% of emergency visits. Nine neighborhoods were among the first ten neighborhoods on each list, although not in identical order. These nine neighborhoods accounted for 70.8% of outpatient department patients, and 67.2% of emergency patients. (See Table III for Outpatient Visits; Table IV for Emergency Visits.)

In the above analysis St. Paul-Ramsey views the neighborhoods in terms of the numbers of patients "sent" to the hospital. A more important analysis to the metropolitan health board would look at the hospitals in St. Paul from the neighborhood's point of view and ask at what hospitals do the persons from the neighborhood seeks care? Ideally, this could be determined in the same manner as the statewide origin studies of inpatients; that is, by conducting a study that would include all patients of all hospitals during a given time period. Since this was impossible another approach was made.

The number of patient visits from each neighborhood during the nine day study was multiplied by a factor to get an estimated annual number of ~~patient of~~ patients. This annual estimate was divided by the population in thousands to get the estimated annual number of visits per thousand population from each neighborhood. This procedure was followed for both the outpatient and emergency departments. The neighborhoods were again ranked by visits per thousand; this was done for both outpatient and emergency departments.

The first four neighborhoods on the ranking per thousand visits were the same for both departments, in almost identical order. Three of the four were different neighborhoods than in the previous ranking (by number of patients) due to great population differences. Eight neighborhoods were among the first ten on both the outpatient department and emergency department rankings of visits per thousand.

From studying the rankings of the neighborhoods for the outpatient and emergency departments, both in terms of visits to the departments and visits per thousand population, some general conclusions can be drawn.

First, essentially the same neighborhoods show up in the top ten or twelve on all rankings. Second, the visits per thousand population rankings would indicate that St. Paul-Ramsey is the predominate source of medical care for the majority of persons residing in the Downtown, Mt. Airy, Summit-University, and Inner-West Seventh neighborhoods, and for a somewhat lesser majority in Dale-Thomas, Dayton's Bluff and North-Rice neighborhoods.

In addition, St. Paul-Ramsey is probably the predominant source of medical care for persons residing in the Riverview, Phalen-Mounds, and Outer-West Seventh neighborhoods.

Each of the two rankings (by numbers "sent" to St. Paul-Ramsey and by visits per thousand per year) produced a pattern of order that was similar for both the outpatient and emergency departments. This similarity of ranking for the two departments was greatest at the top of the ladder, and less at the bottom of the ladder; that is, less where St. Paul-Ramsey was less important. There were two major differences in this pattern. Crocus Hill, which has the highest average family income of all St. Paul neighborhoods, ranked 11th on visits per thousand per year, but fifth in Emergency Room visits per thousand. Were it not for this exception, the rank order of outpatient and emergency visits for the first seven neighborhoods would be identical. It is also interesting that Highland Park, the fourth highest neighborhood in average family income, ranked 19th in the outpatient visits per thousand, but 10th in emergency visits per thousand. A possible conclusion for these two exceptions to the pattern is that these two high-income, high education neighborhoods would not normally use the traditional "low income" hospital when given a choice. However, in emergency situations, they go to what is known to be St.Paul's "best" emergency hospital.

On the basis of the above, the primary service area is defined as the first ten neighborhoods on the list of outpatient visits per thousand (Table V); that is: Downtown, Mt.Airy, Summit-University, Inner West Seventh, Dale-Thomas, Dayton's Bluff, North Rice, Riverview, Phalen-Mounds, and Outer West Seventh. A map of the area is shown on page 9.

The secondary service area is defined as the remainder of St.Paul and Ramsey County. The population of both areas is shown in Table VIII.

The information for this section was obtained from a special patient origin study, and the U.S. census. The neighborhoods in St. Paul were delineated in a study, "General and Community Socio-Economic Profiles - St. Paul, Minnesota, January 1, 1973, prepared by Dianne Reyer, Community Health & Welfare Planning Council.

TABLE III

ST. PAUL NEIGHBORHOODS RANKED BY
OF
NUMBER OF PATIENTS SEEKING SERVICE
IN
ST. PAUL-RAMSEY HOSPITAL OUT-PATIENT DEPARTMENT
IN A NINE DAY STUDY (N=2524).

RANK		NEIGHBORHOOD	TOTAL VISITS		PERCENT OF VISITS	
1	*	Summit-University	428		17.0	
2	*	North Rice	255	1069	10.1	42.4%
3	*	Dayton's Bluff	203		8.0	
4	*	Dale & Thomas	183		7.8	
5	*	Riverview	171		6.8	
6	*	Payne-Phalen	166		6.6	
7	*	Phalen-Mounds	150		6.0	
8	*	Mount Airy	135		5.3	
9		Outer West Seventh	100		4.0	
10	*	Hazel Park	96		3.8	
11		Macalester Groveland	84		3.3	
12		Highland Park	84		3.3	
13		Crocus Hill	83		3.3	
14		Inner West Seventh	76		3.0	
15		Downtown	75		3.0	
16		Merriam Park	67		2.7	
17		North Midway	67		2.7	
18		Battle Creek	47		1.9	
19		North Como	43		1.7	
20		St. Anthony	11		0.4	

*These neighborhoods accounted for 70.8% of all visits to the outpatient department. They are also in top ten for emergency department. (See Table IV)

TABLE IV

ST. PAUL NEIGHBORHOODS RANKED IN ORDER
OF
PERCENTAGE OF ST. PAUL PATIENTS SEEKING SERVICE
IN
ST. PAUL-RAMSEY EMERGENCY DEPARTMENT
IN A NINE DAY STUDY (N=1,207)

RANK		NEIGHBORHOOD	TOTAL VISITS		PERCENT OF VISITS	
1	*	Summit-University	197		16.3	
2	*	North Rice	114	487	9.4	40.3%
3	*	Dayton's Bluff	96		8.0	
4	*	Dale Thomas	80		6.6	
5	*	Hazel Park	74		6.1	
6	*	Payne-Phalen	67		5.6	
7	*	Mt. Airy	64		5.3	
8		Crocus Hill	64		5.3	
9	*	Phalen-Mounds	60		5.0	
10	*	Riverview	60		5.0	
11	*	Outer West Seventh	52		4.3	
12		Merriam Park	41		3.4	
13		Highland Park	41		3.4	
14		Macalester-Groveland	38		3.1	
15		North-Midway	36		3.0	
16		Inner West Seventh	33		2.7	
17		North Como	30		2.5	
18		Downtown	28		2.3	
19		Battle Creek	23		1.9	
20		St.Anthony	9		0.7	

*These neighborhoods accounted for 67.2% of emergency department visits. They are also the top ten neighborhoods for the out-patient department. (See Table III)

TABLE V

ST. PAUL NEIGHBORHOODS RANKED IN ORDER
OF ANNUAL VISITS PER THOUSAND
TO
ST. PAUL-RAMSEY HOSPITAL OUTPATIENT AND EMERGENCY DEPARTMENTS

	OUTPATIENT (N=2,524)		EMERGENCY (N=1,207)	
Rank	Neighborhood	Visits/M	Neighborhood	Visits/M
1	Downtown	981	Mt.Airy	620
2	Mt. Airy	914	Downtown	524
3	Summit-University	590	Summit-University	389
4	Inner West Seventh	531	Inner West Seventh	330
5	Dale-Thomas	381	Crocus Hill	271
6	Dayton's Bluff	364	Dale-Thomas	246
7	North Rice	321	Dayton's Bluff	238
8	Riverview	281	North Rice	205
9	Phalen-Mounds	275	Outer West Seventh	189
10	Outer West Seventh	254	Highland Park	173
11	Crocus Hill	246	Battle Creek	165
12	Battle Creek	236	Phalen-Mounds	157
13	Merriam Park	198	Riverview	141
14	Payne-Phalen	196	Payne-Phalen	113
15	North-Midway	121	Hazel Park	96
16	Macalester-Grove.	94	North Midway	93
17	Hazel Park	87	North Como	69
18	North Como	69	Macalester-Groveland	61
19	Highland Park	62	St. Anthony	60
20	St. Anthony	51	Merriam Park	43

Chart II - Primary Service Areas of St. Paul-Ramsey Outpatient and Emergency Departments

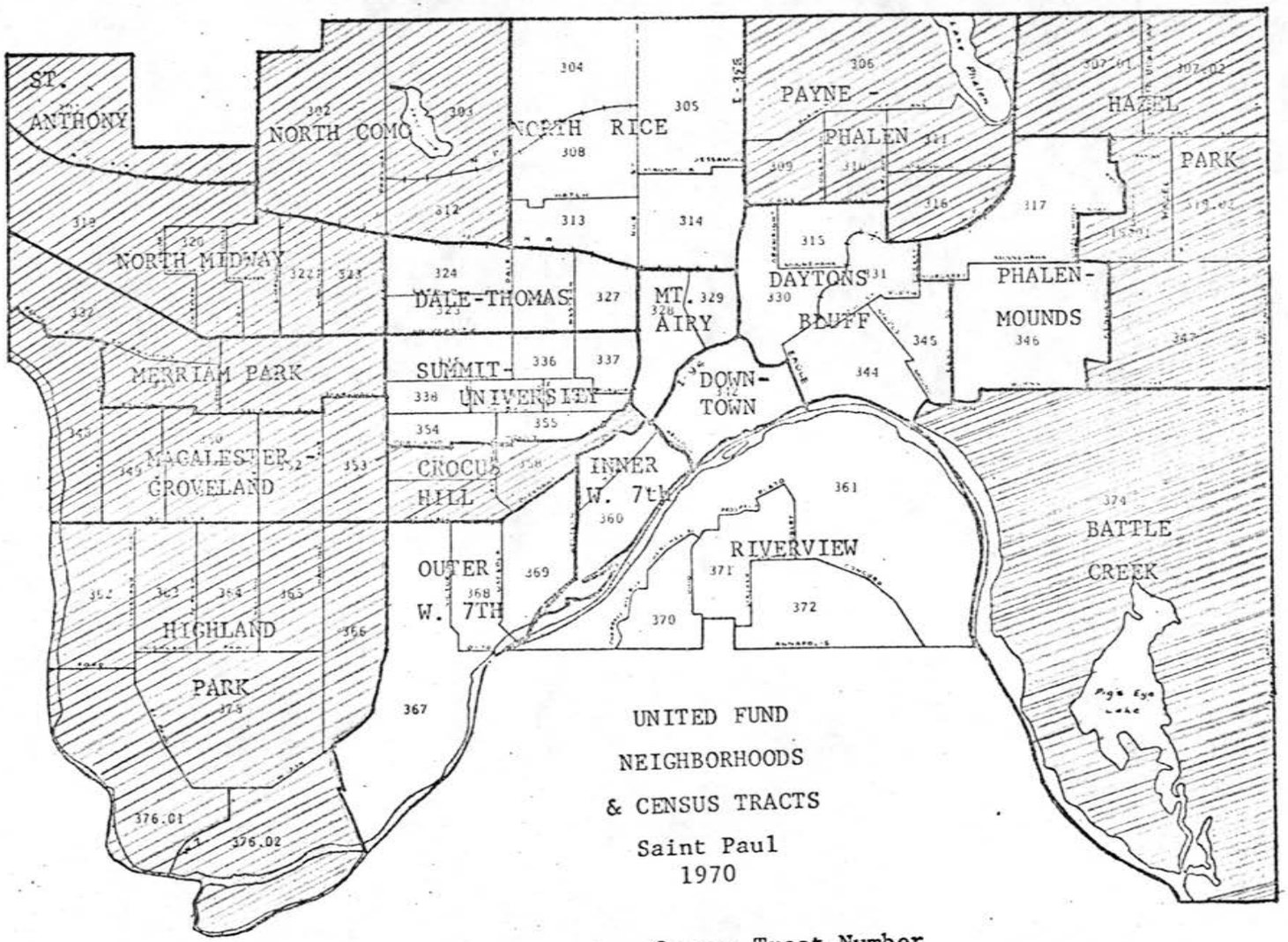


TABLE VI

POPULATION BY REGION (1960,1970 and Projected 1980) AND BY AGE GROUP SERVED BY GILLETTE HOSPITAL

Region	Total	Years 00-04	Years 05-09	Years 10-14	Years 15-21
Northwest					
1960	64,239	17,138	17,257	16,112	13,732
1970	60,793	11,609	15,462	16,543	17,179
1980	50,643	11,523	11,094	10,990	17,031
Northeast					
1960	148,995	42,449	40,720	35,614	30,212
1970	139,893	26,389	34,844	39,011	39,654
1980	114,612	27,292	25,591	24,328	37,401
West					
1960	71,353	19,723	19,357	17,142	15,131
1970	71,637	13,103	17,237	19,323	21,631
1980	60,190	14,451	12,980	12,593	20,166
Central					
1960	135.817	37,638	36,300	32,936	28,943
1970	156,037	31,970	40,292	41,704	42,071
1980	118,481	34,352	32,892	34,569	51,020
Southwest					
1960	130,550	36,309	36,150	32,422	25,669
1970	121,181	23,624	30,494	34,042	33,021
1980	95,278	21,162	20,499	22,217	32,400
South Central					
1960	86,966	24,701	22,791	20,226	19,248
1970	88,886	17,164	21,525	23,313	26,884
1980	77,836	19,504	17,323	16,222	24,787
Southeast					
1960	150,504	42,654	39,616	35,177	33,057
1970	159,050	32,388	40,397	41,916	44,349
1980	147,206	35,204	33,136	31,942	46,924
Metropolitan					
1960	623,368	195,393	168,559	135,079	124,337
1970	783,757	175,524	202,384	199,169	206,680
1980	839,032	222,994	192,871	177,187	245,980
Metropolitan Region by County					
Anoka					
1960	42,371	15,606	12,264	8,401	6,100
1970	76,845	18,737	22,446	19,990	15,672
1980	96,910	23,505	19,672	22,506	31,227
Carver					
1960	9,051	2,694	2,540	2,132	1,685
1970	12,448	2,737	3,430	3,350	2,931
1980	13,543	2,892	2,735	3,315	4,601

Table VI (continued)

Region	Total	Years 00-04	Years 05-09	Years 10-14	Years 15-21
Dakota					
1960	35,684	11,808	9,869	7,921	6,086
1970	65,785	15,978	18,941	17,149	13,717
1980	90,056	19,956	17,781	22,645	29,674
Hennepin					
1960	330,391	101,036	88,719	71,531	69,105
1970	378,759	81,804	93,273	95,339	108,339
1980	385,674	111,075	94,661	74,403	105,530
Ramsey					
1960	172,347	53,121	45,923	37,613	35,690
1970	194,544	43,564	48,138	48,413	54,429
1980	185,536	50,918	43,630	38,481	52,507
Scott					
1960	10,006	3,217	2,756	2,240	1,793
1970	15,403	3,587	4,375	4,084	3,357
1980	16,952	3,581	3,137	4,254	5,980
Washington					
1960	23,528	7,911	8,488	5,241	3,888
1970	39,977	9,117	11,781	10,844	8,235
1980	47,832	9,558	8,764	12,183	17,327

SOURCE: Minnesota Population: Trend, Estimates, Projections, Minnesota Department of Health March, 1972.

Section Two: POPULATION OF SERVICE AREA

TABLE VII

TOTAL POPULATION SERVED BY GILLETTE HOSPITAL
(0-21 years of age)

Region	Population 1960	Population 1970	Projected Population 1980
Northwest	64,239	60,793	50,643
Northeast	148,994	139,898	114,612
West	71,352	71,637	60,190
Central	135,816	156,037	152,833
Southwest	130,549	121,181	96,278
South Central	86,965	88,886	77,836
Southeast	150,504	159,050	147,206
Metropolitan	623,368	783,757	839,032
State Population Totals	1,411,791	1,581,239	1,538,630

Source: "Minnesota Popluation, Trends, Estimates, Projections," Minnesota Department Health, March 1972

TABLE VIII

POPULATION OF PRIMARY AND SECONDARY SERVICE AREAS
OF
ST. PAUL-RAMSEY OUT-PATIENT AND EMERGENCY DEPARTMENTS

AREA	1970	1960	% Change	% City Population
Primary Service Area				
1. Downtown	2,166	1,521	42.4	.69
2. Mt. Airy	4,186	3.900.	7.3	1.35
3. Summit-University	20,547	26,428	-22.3	6.63
4. Inner-West Seventh	4,056	5,658	-28.3	1.31
5. Dale-Thomas	13,620	15,120	-10.0	4.39
6. Dayton's Bluff	15,820	16,987	- 6.8	5.1
7. North Rice	22,540	19,248	17.1	7.27
8. Riverview	17,239	17,763	- 2.9	5.56
9. Phalen-Mounds	15,456	13,062	18.3	4.98
10. Outer West Seventh	11,150	12,993	-14.2	3.59
TOTAL PRIMARY SERVICE AREA	126,780	132,680	- 4.4%	40.89%
Secondary Service Area				
Balance of St. Paul	183,200	180,731	1.4	59.10%
Ramsey County Exclusive of St. Paul	166,275	109,113	52.3	-
TOTAL SERVICE AREA (RAMSEY COUNTY)	476,255	422.525	12.7	-

The Metropolitan Council population forecasts shows a slight increase in St. Paul's population by 1980 (less than one percent), and an increase in Ramsey County population of 8.6% by 1980. Forecasts are not available for neighborhoods.

GILLETTE

The following institutions offer many services somewhat comparable to those of Gillette:

Mayo Clinic, Rochester
University of Minnesota, Minneapolis
Kenny Rehabilitation Institute, Minneapolis
Shriner's Hospital, Minneapolis

None of the above, however, offers a range of services as complete as Gillette.

ST. PAUL-RAMSEY

All St. Paul hospitals offer emergency services and an increasing amount of out-patient work is done in hospital emergency rooms in St. Paul as across the nation. However, emergency and out-patient activity at St. Paul-Ramsey is many times that of any other St. Paul hospital and, in fact, equals that of the five or six next ranking hospitals in these services. St. Paul hospitals are listed in section six with their emergency and out-patient activity as reported to the Minnesota Department of Health.

GILLETTE AND RAMSEY

Project Proposal

The proposal is to build a four-story structure North of, and connected to the existing hospital building, plus a new fourth and fifth floor over the existing three story building. The second floor, which would be on a grade level, would be partially open, forming a traffic tunnel entrance. A five story parking ramp would be constructed directly West of the building described above.

The major purposes of the new building are 1 to accomodate the non-bed services of Gillette Hospital, 2 allow for expansion of existing St. Paul-Ramsey outpatient services; 3 permit inauguration of a new outpatient surgical service and 4 a new general dentistry program; 5 expand the Ramsey Health Plan; 6 permit modification of the burn unit; 7 and house research and administration facilities of the St.Paul-Ramsey Medical Education and Research Foundation (MERF).

The existing St. Paul-Ramsey building (opened in 1965) will be modified to permit expansion of various clinical and administrative services.

St. Paul-Ramsey programs would occupy the first three floors. Gillette Hospital would occupy the new fourth floor which would connect to existing nursing unit towers. This new Gillette building will contain those Gillette services which, for the most part, will not be shared with St. Paul-Ramsey. (Another group of services will be shared). Gillette Hospital beds will consist of two existing St. Paul-Ramsey circle units on the fourth floor connected to the new construction.

A smaller fifth floor will be built over the existing building, and will house additional research facilities and the administrative offices of M.E.R.F., the St. Paul-Ramsey Hospital Medical Education and Research Foundation.

The new Gillette space (which includes first floor swimming pool in addition to the fourth floor) total 52,430 gross and 34,400 net square feet. New St. Paul-Ramsey space totals 98,048 gross and 65,600 net square feet. MERF totals 26,168 gross square feet.

The St. Paul-Ramsey programs that will be expanded are listed on the following page with existing and proposed net square feet.

TABLE IX

SPACE ALLOCATION FOR SPRH PROGRAMS IN SQUARE FEET

	PROPOSED A		B	C	
Activity Description	Present Space in Existing Facility	Space Maintained in E. F.*	Remodeled Space in E. F. *	Space In New Facility	Total of (A,B & C) Space
Outpatient	18,500	6,400	10,600	18,850	35,850
Emergency	9,100	9,900	2,200	-	12,100
Business Office	1,800	-	4,200	950	5,150
Welfare Intake	1,000	-	1,450		1,450
Ramsey Health Plan	1,100	-	-	6,000	6,000
Laboratory	13,000	13,000	-	1,300	14,300
Radiology	18,800	18,800	-	1,650	20,450
Medical Records	6,600	-	-	12,700	12,700
Pharmacy	3,200	3,200 -	-	900	4,100
Social Service	3,500	500	-	3,000	3,500
Volunteers	400	200	-	500	700
Personnel (Locker Space In New Bldg.)				2,400	2,400
Telephone	1,000		-	1,000	1,000
Research	13,800	13,800	-	14,000	27,800
MERF Admin.	500	-	-	7,800	7,800
Office Relocation (displacement)	3,000	-	-	4,000	4,000
Clinic Admin.	300	-	-	400	400
T O T A L	95,600	65,800	18,450	75,450	159,700

* - Existing Facility

GILLETTE AND RAMSEY

Bed Decrease

The proposal does not require addition of beds. In fact, the total number of beds in St.Paul will be reduced by seventy-two, by closing the existing Gillette Hospital, and the number of general beds (St. Paul-Ramsey) will be reduced 60 beds by the dedication of these beds to Gillette Hospital. In addition, the remainder of the nursing unit containing the burn program will be converted to its use, including some non-bed services, resulting in the additional reduction of perhaps eight beds.

GILLETTE

Proposed Services

Gillette and St. Paul-Ramsey will share a number of services, thus precluding the necessity of entirely replacing Gillette, and continuing the present duplication. The following services of Ramsey will be shared by Gillette:

1. Dietary
2. Housekeeping
3. Laboratory
4. Plan Operations and Maintenance
5. Special X-ray procedures
6. Purchasing and stock inventory
7. Business Office and Collections
8. Central Supply
9. Pharmacy
10. Heat
11. Laundry and Linen Inventory
12. Personnel Facilities
13. Anesthesiology Coverage
14. Operating Rooms

The following services will be part of the total Gillette Program, some of which may be shared in part with Ramsey. Each service is being studied in detail to determine the extent to which this is possible.

1. Outpatient Service and Inpatient Services
2. Diagnostic X-ray (limited sources)
3. Medical Records
4. Medical Photography
5. Prsothetic and Orthotic Laboratory
6. Physical Therapy (Some modalities may be shared)
7. Occupational Therapy
8. Speech and Hearing
9. Educational Program for Patients
10. Cast Room
11. Administration
12. Medical Educational Program
13. Pool Therapy
14. Dentistry
15. Psychological Services
16. Social Service

RAMSEY

Proposed Services

The outpatient clinics provided by St. Paul-Ramsey on a weekly basis include:

DENTISTRY
- Oral Surgery

DERMATOLOGY

MEDICINE
- Adult Allergy
- Cardiac
- Chest (medical)
- Chest (TB)
- Gastro Enterology
- General Medicine
- Hematology
- Hypertension
- Infectious Disease
- Lipid
- Med. Endocrine
- Metabolism
- Renal
- Rheumatology
- S.L.I.M. (obesity)

NEUROLGOY
- General Neurology

OB-GYN
- Family Planning
- Gynecology
- Gyn. Oncology
- Post Partum
- Prenatal
- Prenatal (MIC)
- Special OB

OPHTHALMOLOGY
- Angiography
- Clinical Pathology
- Corneal & Contact Lens
- Glaucoma
- Motility & Special
- Neuro. Ophthalmology
- Peds. Ophthalmology

ORTHOPEDIC
- Fracture
- Orthopedics

OTOLARYNGOLOGY
- Audiology
- General ENT

PEDIATRIC
- Allergy
- Cardiac
- Chest
- Child Development Ctr.
- General Pediatrics
- High Risk Infant
- Metabolism
- Neurology
- Peds. Problem
- Peds. Urology
- Renal
- Well Child

PHYSICAL MEDICINE
- Physical Medicine

SURGERY
- Chest, Peds., Vasc.
- General Surgery
- Hands & Trauma
- Plastic, Burns
- Proctology
- Neurosurgery

UROLOGY
- General Urology
- Vasectomy

The Ramsey Health Plan will occupy approximately 6,000 square feet of space in the outpatient service area, which space will be expandable, Ramsey Health Plan space is rented from the Hospital.

The outpatient services areas will be constructed in such a way as to permit maximum flexibility with respect to usage by various clinic services and/or the Ramsey Health Plan. From a central reception area patients will be referred to small clinic units, each staffed by full time nursing personnel permanently assigned to encourage continuity of relationships between staff and patients. Clinic services requiring special construction or equipment will be combined when possible to maximize the number of units available for general use. The purpose of the small units is to create the warm intimate environment, as opposed to the cold mass production

environment of county hospitals of bygone days. Small units will also maximize the capability of use by different clinic services large and small.

The outpatient surgical center will consist of reception and waiting areas, and related supply and staff areas. This program will be located adjacent to the in-patient surgery to facilitate sharing of staff and facilities.

The burn unit, on the fifth floor, will be expanded to occupy an entire circle, plus adjacent service core areas. This uncommon, but important program is regional in scope. The nearest similar units are in Denver, Iowa City, Milwaukee, and Chicago. The present 28 bed area will be reduced to 20 beds.

The outpatient area will provide for a new section for general dentistry, an addition to the existing oral surgery program. General dental services are being sought by Ramsey Health Plan members. In addition, there is some indication that the neighborhoods St. Paul-Ramsey serves as the Primary Physician also lack private connections with dental practitioners.

The maximum security emergency unit will be within the emergency department, but physically separated from it by a maximum security parameter. This area will include treatment facilities for three patients and a separate security (sallyport) automobile entrance. Patients who are in the custody of the Ramsey County Sheriff or the State Department of Corrections will be treated in this unit.

The large number of medical students and house staff assigned to St. Paul-Ramsey requires approximately two times the space required by a private clinic to see the same number of patients.

GILLETTE

New Positions

The number of staff positions of Gillette Hospital will be reduced by 82 because of the proposal. This is a net figure after the addition of $17\frac{1}{2}$ new positions in departments presently understaffed. These positions are listed below:

Social Service	2	Clinical	1
Photography	3	Medical Director	1
Physical Therapy and Pool	1	Orthotic & Prosthetic Lab	3
Occupational Therapy	$\frac{1}{2}$	Surgery	2
Speech and Hearing	$\frac{1}{2}$	Secretary for Medical Director	1
Medical Records	$2\frac{1}{2}$		

The total proposal, on the basis of space alone, will require approximately 23 housekeeping employees and 2 supervisors, plus 6 trades and maintenance employees.

GILLETTE (continued)

The outpatient and emergency expansion may require a few nursing department personnel, depending on new clinic schedules made possible by additional space. Essentially, however, the additional space for these two departments will simply relieve pressure from the existing staff, both medical and hospital, which could servce more patients if additional space was available.

The outpatient surgical program amy or may not require some new staff depending upon scheduling revisions. As the patient load increases, however, staff will necessarily be added in those areas affected.

Any additional Ramsey Health Plan employees will be employed by the Plan rather than the hospital.

RAMSEY

New Positions

New staff positions necessitated by this project will be building maintenance and nursing personnel. The number of additional staff required has not yet been determined, but will come out of a thorough study of the outpatient department now in progress by a special committee. However, there will be no immediate expansion of the medical staff. The present staff, both full-time medical and interns and residents, could serve more patients if space were available. There is no indication that recruitment of these personnel would be a problem.

GILLETTE

Capital Expenditures

Land Costs	-
Construction Costs	3,220,000
Fixtures & Furnishings	-
Equipment	325,000
Architects Fees & Contingent	225,407
Total Expenditures	3,770,507

RAMSEY

Capital Expenditures

Land Costs	-0-
New Construction Costs	6,863,465.
Remodeling	1,300,662.
Equipment, Fixtures & Furnishings	480,579.
Architects Fees	585,873.
Total Expenditures	9,230,579.

RAMSEY

Operating Costs of Out-Patient & Emergency Departments

	1974 Budget	1973 Projected
OUTPATIENT		
Salaries	496,914	428,754
Other Expense	97,785	98,215
Total Expense	594,699	526,969
EMERGENCY		
Salaries	665,432	556,140
Other Expense	114,329	132,790
Total Expense	779,761	688,930

GILLETTE

TABLE X

Gillette Occupancy Rates for Months in 1972

	72 Beds (Existing)	60 Beds (Proposed)
January	57%	80%
February	64%	76%
March	58%	70%
April	60%	71%
May	60%	71%
June	56%	66%
July	65%	78%
August	58%	70%
September	51%	61%
October	65%	78%
November	51%	61%
December	33%	40%
YEARLY RATE	58%	69%

Gillette Occupancy Rates for Past Six Years

1968	55% (bed complement 156, change July to 146)
1969	55% (bed conplement 146, change July to 129)
1970	48% (bed complement 129)
1971	63% (bed complement 110)
1972	70% (bed complement 72)
1973	58% (bed complement 72)

Six Year average occupancy: 58.2%

Total patients admitted in 1972 were 993 and 996 in 1973.
Gillette outpatient visits are 25,000 annually.

TABLE XI

UTILIZATION OF ST. PAUL-RAMSEY
OUTPATIENT AND EMERGENCY DEPARTMENTS

TIME PERIOD	OUTPATIENT DEPARTMENT Number Visits	OUTPATIENT DEPARTMENT Change From Previous Year	EMERGENCY DEPARTMENT Number Visits	EMERGENCY DEPARTMENT Change From Previous Years
1968	75,229	11.9%	64,213	17.4%
1969	67,881	(9.8%)	69,020	7.6%
1970	72,464	6.8%	68,690	(0.4%)
1971	74,072	2.2%	63,451	8.2%
1972	79,829	7.8%	67,014	5.6%
1973	90,754	14.0%	73,384	9.5%
SEPTEMBER 1972	6,431		5,998	
OCTOBER "	7,186		5,860	
NOVEMBER "	6,958		5,424	
DECEMBER "	6,039		5,376	
JANUARY 1973	7,284		6,356	
FEBRUARY "	7,097		5,380	
MARCH "	7,991		5,691	
APRIL "	7,181		5,580	
MAY "	7,784		6,470	
JUNE "	7,644		6,537	
JULY "	7,728		6,748	
AUGUST "	8,617		6,676	
SEPTEMBER "	7,085		6,581	

TABLE XII

GILLETTE RATE AND COST PROJECTS FOR BOTH SITES

	Ramsey Estimated	Gillette Projected
Total Annual Patients Days	19,118	19,118
Cost Per Day per Patient	113.42	123.03
Average Rate per Day Charged	124.76	135.33
Rate per Welfare Patient (Not Including New Building Depreciation)	118.49	128.06
Percentage of Welfare Patients in Facility	37%	37%
Percentage of Private Pay Patients in Facility	1.2%	1.2%

GILLETTE

The following pages summarize the cost projections developed by Gillette Hospital to determine the effect on costs of a move to the Ramsey site. Table XII shows that the cost per patients day would be $9.61 per day less at Ramsey then at the present site. Part of the reason for this is the staff reduction that would be possible because of the more efficient nursing units at Ramsey.

Table XIII compares actual costs of Gillette Hospital for the year ending June 30, 1972 with projected costs at both the existing and Ramsey sites. The projected increase is great, but less at the Ramsey site. Table XIV shows the results of twenty actual surgical cases whose charges were calculated with both existing Ramsey rates and an assumed 4% increase in Gillette rates. Again, the patient's cost was almost 10% less with the Ramsey rates.

Table XV was prepared to determine the cost of the move to the Department of Public Welfare, the purchaser of approximately 35% of Gillettes services. The savings at the Ramsey site was about $65,000. The cost of care to Medicaid, and the percentage of Medicaid patients from each of the state's regions is shown in Table XVI. Medicaid paid $359,227 the year ending June, 1972.

The four subsequent pages show cost comparisons in greater detail, depreciation and revenue comparisons, projected department costs at St. Paul-Ramsey, and comparative costs of Gillette's charging departments, at the two sites.

RAMSEY

The expanded St. Paul-Ramsey facilities are expected to have little effect, if any, on charges for services. In fact, some of the shared services could result in volumes of activity that reduce unit costs, thus slowing the rate of increase of health costs

TABLE XIII

COMPARISON OF ACTUAL AND PROJECTED COSTS (GILLETTE)

Gillette Children's Hospital: Actual and Projected Costs:

	Actual Costs 1971-72	Projected Costs 1973-74 Present Gillette Site	Projected Costs 1973-74 Ramsey Site
Total Expenses	$2,293,051.59	$2,824,569.00	$2,649,434.00
Less			
Education for Patients	128,587.81	216,401.00	131,511.00
Outpatient	160,013.34	236,963.00	286,314.00
Bequest, Educ. & Res.	52,359.29	19.076.00	15,236.00
Revenue From Ramsey*	0	0	48,000.00
Total Deductions	340,960.44	472,440.00	481,061.00
Net Inpatient Costs	1,952,091.15	2,352,129.00	2,168,373.00
Patient Days	19,118	19,118	19,118
Cost per Patient Day	102.11	123.03	113.42

TABLE XIV

COMPARATIVE CHARGES OF TWENTY RECENT SURGICAL CASES
AT
GILLETTE CHILDREN'S & ST. PAUL-RAMSEY

Name	Number of Days Hospitalization	Financial Cagegory	Gillette Crgs. with 4% increase	Chrg St. Paul Ramsey with 1/73 increase	Difference in Charges
Michelle M	135	2	13,363.00	12,040.50	1,327.50
Mark W	15	3	2,151.00	2,014.00	143.00
Betty W	6	3	904.00	839.00	65.00
Daniel S	11	3-4	1,407.50	1,295.50	112.00
Kathleen T.	10	3	1,225.00	1,120.00	105.00
Eva W	22	1	2,111.00	1,865.50	245.50
Joseph B	12	3	2,078.00	1,976.50	101.50
Clinton B	9	3	1,305.50	1,226.50	79.00
Patricia C.	13	3	2,306.00	2,160.00	146.00
Lynn D	5	2	740.50	684.50	56.00
[illegible]blin C.	8	2	1.465.95	1.397.75	68.00
Denise E	15	2	2,188.00	2,075.00	113.00
Annette R.	10	3	1,408.75	1,277.75	131.00
Christian P.	13	1	2,566.00	2,440.00	126.00
Brian S.	16	4	1,897.50	1,713.00	184.50
Michelle M	64	3	7,172.00	6,412.50	759.50
Monica D.	226	2	29,207.37	26,783.15	2,434.22
Danny S	14	2	1,295.00	1,142.00	153.00
Becky L.	193	2-5	23,000.07	21,056.20	1,943.87
Sue Ann O.	22	2	2,200.00	1,964.00	236.00
Totals	277		100,002.94	91,483.35	8,519.59
Per Diema			114.05	104.31	

*These figures include building, equipment depreciation and lease costs.

TABLE XV

COST OF PATIENT CARE GIVEN BY GILLETTE CHILDREN'S HOSPITAL UNDER MEDICAID

(Title XIX)

For Fiscal Year 1971-72

Region	Cost of Care	Percentage of Total Medicaid Patients from each Region
Northwest	$28.355.00	8%
Northeast	44.577.00	12%
West	32,308.00	9%
Central	57,910.00	16%
Southwest	23.613.00	7%
South Central	36,586.00	10%
Southeast	3.309.00	1%
Metropolitan		
Anoka	13.785.00	4%
Carver	0	0
Dakota	0	0
Hennepin	71.378.00	19%
Ramsey	38.530.00	11%
Scott	5,500.00	2%
Washington	3.376.00	1%
Metropolitan Total	1.132.569.00	37%
Totals	359.227.00	100%

TABLE XVI

COMPARISONS OF COST TO DEPT. OF PUBLIC WELFARE
FOR
PATIENTS AT GILLETTE

	Projected 4% Inc. + Deprec. Gillette	Ramsey Site
Total Expenditures	2,824,569	2,649,434
Less School Costs	148,032	112,057
Medical Education and Research	19,076	15,236
Chargeable Expenses	2,657,461	2,522,141
Patients Receipts	1,794,522	1,672,851
Receipts from Ramsey	-	48,000
Cost to Dept.of Public Welfare		
Category II - Dept of Public Welfare assumes total cost	525,608	491,591
Category III- Dept of Public Welfare assumes deficit covering patients with partial insurance coverage	469,862	439,453
Total Cost to Dept of Public Welfare	995,470	931,044
Discount to Dept. of Public Welfare	53,491	46,796
Total	2,843,483	2,698,691
Reserve for Contingencies	186,022	176,550

Cost Comparisons

	Proposed Costs at St. Paul Ramsey		Present Costs at Gillette Childrens		Differences in Costs	
					Decrease	Increase
Salaries and Fringe Benefits:	1,819,555		2,343,479			
(Using Gillette's present salaries plus 4%)						
Using Ramsey's present salaries						
Totals		1,819,555*		2,343,479	523,924	
Shared Costs with St. Paul Ramsey:			(Not including Salaries)			
Housekeeping	14,907		293			14,614
Plant Operation and Maintenance	131,922		43,318			88,604
Dietary	108,431		36,937			71,494
Pharmacy	60,365		47,429			12,936
Laboratory	65,862		7,467			58,395
X-Ray	26,751		2,090			24,661
Post-operative Recovery Room	12,081		-0-			12,081
Laundry	31,613	Includes the linen inventory	23,245	Costs at Hastings. No inventory		8,368
Medical Supplies	81,070		85,228		4,158	
Non-medical Supplies	31,869		49,504	Includes the linen inventory	17,635	
Totals		421,871		295,511	21,793	351,153
Nurse Costs:						
Nursing Circles	30,552		-0-			30,552
Surgery	19,642		-0-			19,642
Totals		50,194		-0-		50,194
Non-Shared Costs at St. Paul Ramsey:						
Fees and In-Service Education	15,988		24,185		8,197	
Communications	9,781		13,510		3,729	
Depreciation of Buildings	84,353		125,000		40,647	
Depreciation of Equipment	42,500		20,000			22,500
Service Contracts for Equipment	2,192		2,884		692	
Totals		154,814		185,579	53,265	22,500
Grand Totals		2,649,434		2,824,569	598,982	423,847
				- 2,649,434	- 423,847	
Net Savings at St. Paul Ramsey				175,135	175,135	

*This total includes all salaries presently paid by contracts: Medical Education and Research Funds; Title I, federal funds; and federal funds from Crippled Childrens Services for 5 employees in Soc. Ser.

Possible Services Gillette May Wish to Purchase at St. Paul Ramsey Site:

Blue Cross Accounting	19,709	
Liability Insurance	15,600	
Total		35,309

Depreciation and Revenue Comparisons

	Costs at St. Paul Ramsey	Cost at Gillette if State Accounting Allowed	Differences in Costs	
			Decrease	Increase
New Costs at St Paul Ramsey:				
Depreciation:				
New Building	8122500	—o—		8122500
Parking Ramp	312800	—o—		312800
Present Building	1~~28~~	12500000*	12500000	
Equipment (New)	3250000	—o—		3250000
Equipment (Old)	1000000	2000000	1000000	
Total Depreciation	12685300	14500000	13500000	11685300
		- 12685300	-11685300	
Net Savings		*1814700	*1814700	

*Based on a conservative evaluation of our presents buildings of *5,000,000.00

Possible Areas for Revenue from St. Paul Ramsey: Estimates:

Orthotic and Prosthetic Laboratory	1700000
Photography Department	2100000
Swimming Pool	1000000
Total	4800000

Projected Department Costs at St. Paul Ramsey Hospital

Department	Costs at St. Paul Ramsey	Present Costs at Gillette Children's	Differences in Cost — Decrease	Differences in Cost — Increase
Shared Costs:				
Dietary	1084310	1409228	324918	
Housekeeping	749070	1604471	855401	
Plant Operation & Maintenance	1319220	1920875	601655	
Central Supply	—0—	1298000	1298000	
Surgery & Post-operative Rec. Rm.	1533795	1208476		325319
Anesthesia	709475	746296	36821	
Pharmacy	603650	714365	110715	
X-Ray	726151	964830		238679
Laboratory	658620	627067 *1		31553
Laundry	316130 Includes linen inventory	252450		63320
Total Shared Costs	7701208	9079403		
Non-Shared Costs:				
Medical Records	784869	450968		333901
Photography	603693	247205		356488
Cast Room	249688	207032		42656
Physical Therapy & Pool	1460676	1194749		265927
Occupational Therapy	309976	262595		47381
Speech Therapy	282278	180900		101378
Dental	201486	182701		18785
Orthotics & Prosthetic Laboratory	2315436	1619190		696246
Out-patient Department	952140	862547		89593
Education - school for patients	1120568 Includes Title I Money	1480320	359752	
In-patient Care	7735301	9130665	1395304	
Administrative - General	1625139	2481567 *2	856427	
Social Service	999461	675000 *3		324539
Medical Education & Research	152360	190768 *3	38408	
Total Non-Shared Costs	18993152	19166281	4707136	2957786
			-2957786	
Grand Totals	2649434	2822569		
		-2649434		
Net decrease in Costs of Care at St. Paul Ramsey		173135	173135	

*Presently done at Hastings State Hospital - State assumes cost - No linen inventory included.

*2 Paid with Federal Funds by Crippled Children Services.

*3 Paid from Medical Education and Research Account.

This statement is calculated with Gillette's present salaries plus a 4% increase and on Ramsey's present salaries (increased January, 1973)

Comparative Costs of Charging Departments

Department	St. Paul Ramsey Site	Present Gillette Site	Differences in Costs — Decrease	Differences in Costs — Increase	Revenue estimated from Ramsey
Cast Room	30201	25654		5047	
Surgery	169817	156476		26299	
Post-operative Recovery Rm.	12958				
Anesthesia	76124	94293	18169		
Pharmacy	64770	84380	19610		
X-Ray	81160	59251		21909	
Photography	70088	32254		37834	21000
Laboratory	70660	73108	2448		
Physical Therapy + Pool	185272	153269		32003	10000
Occupational Therapy	39200	36749		2451	
Speech Therapy	32941	21631		11310	
Orthotic + Prosthetic Lab.	270277	194387		75890	17000
Out-patient Dept.	286314	236963		49351	
In-patient Care	1112405	1420677	308272		
Totals	2502687	2589092	348499	262094	48000
Non-Chargeable to Patient					
Education (School)	131511	216401	84890		
Medical Educa. + Research	15236	19076	3840		
Totals	146747	235479	88730		
Grand Totals	2649434	2824569	437229		
		- 2649434	- 262094		
Net Savings		175135	175135		48000
Revenue		+ 48000			
Total Savings		223135			

This statement is calculated at the Gillette Site with Gillette's present salaries plus 4% ; at the Ramsey Site with Ramsey's present salaries (increase January, 1973).

Possible Services Gillette May Wish to Purchase at St. Paul Ramsey Site:

Blue Cross Accounting	19709
Liability Insurance	15600
Total	35309

ST. PAUL-RAMSEY

Service Area Overlap

The recent patient origin study conducted by St. Paul-Ramsey to define its service area for the emergency and outpatient departments (see section 1), together with the high volume of activity in these two departments, established this institution as the leading provider of the services to persons residing in the primary service area defined; and, in addition, the dominant provider of these services in the county. This is not to say overlap of the service area does not exist. The service area overlap of the emergency and outpatient services of St. Paul hospitals has never been studied, but is presumed to be considerable, with some increased utilization from the neighborhoods nearest each hospital. The actual extent of overlap, however, can be determined only with concurrent patient origin studies.

Occupancy Rates

The emergency and outpatient activity of St. Paul hospitals is compared below by listing figures reported to the Minnesota Department of Health for the year ending September 30, 1972. In fairness to all hospitals listed, including St. Paul-Ramsey, the Health Board should know that the definitions of units of service is not precise; for example is an emergency visit one patient receiving several services, or does each service department report its own procedures as one visit? Thus, reporting differences for these items may be great, and they can be considered rough comparisons only.

TABLE

EMERGENCY, OUTPATIENT, AND RELATED UTILIZATION
OF
ST. PAUL HOSPITALS, YEAR END 9-30-72

Hospitals	Emergency Visits	Clinic Visits (1)	Other Visits (2)	Home Care Visits	Total
St. Paul-Ramsey	57,104	73,772	6,347		137,223
Bethesda	11,765	13,817			25,582
Children's	10,270	7,858			18,128
Gillette		24,100			24,100
Midway	9,868		13,637		23,505
Miller	3,168	6,480	7,241		16,889
Mounds Park	8,171		10,739		18,910
NPBA(Samaritan)	2,122	18,396			20,518
Riverview	2,419		5,542		7,943
St. Johns	16,661		9,331	4,810	30,802
St. Joseph	9,185		20,166		29,351
St. Lukes	4,817		3,315		8,132

Effects on Others

(C) It is difficult to predict the probably effect of this project on the utilization of the other hospitals in St. Paul. The only certainty is that the pressures placed upon the Emergency Department of St. Paul-Ramsey Hospital are becoming dangerously unbearable, and the waiting lists for outpatient services are growing longer. It is not known whether the increased demand for services at St. Paul-Ramsey results from an increasing population, increased utilization of health services among regular Ramsey patients, unavailability of required services at other St. Paul hospitals, or all three of these. The applicant has no information which would predict a decline in the utilization of the services of other hospitals.

GILLETTE

Service Area Overlap

(A) As indicated in section 1, the service area of the Gillette hospital is the entire state. While on the surface, this would appear to be an overlap in service areas, one could also argue there is no overlap because the services are not comparable. For exampel, uncomplicated diagnosis such as club feet, or dislocated hips are usually treated in local institutions throughout the state. But if a local physician encounters numerous complications the patient is usually referred to Gillette because of Gillette's unique capability to deal with multiply handicapped patients.

Occupancy

(B) No attempt was made to obtain occupancy rates of the institutions mentioned in section three of this form because gross occupancy rates would not be comparable nor meaningful. This is because Gillette's unique characteristic is its' service to children with multiple handicaps whose care demands an approach not found elsewhere.

Effect on Others

(C) Movement of the Gillette programs to the Ramsey location should not effect the occupancy rates of other institutions, nor should it effect the existing relationships between Gillette and the other institutions. Presently, and for highly individuals reasons, patient referrals are made between Gillette, The Mayo Clinic, The University of Minnesota Hospitals, and Shriner's Hospital.

GILLETTE

Historical Perspective

Gillette was originally built for long term convalescent care of physically handicapped children. The building was specifically designed for such care and the grounds have elaborate play areas. Presently, the building proves inefficient for acute care and one playground is seldom used because the children are confied to bed. Originally, patients were children having poliomyelitis, tubercular bone disease or congenital handicaps. Today, children having poliomyelitis are seldom seen because of the vaccine now being used and tubercular spines are not seen because of advancements in Public Health programs. The children with congenital defects are more complicated and multiple in nature becuase the mortality rate of infants has declined. Today, surgical intervention is being used more frequently and at a younger age; the average length of stay has been drastically reduced, therapies have increased, and as much care as possible is given on an outpatient basis.

The unique characteristic of Gillette is the concentration and coordination of special medical and non-medical skills which makes possible the treatment of catastrophically handicapping disorders.

The equipment and personnel concentrated in this specialized setting is very expensive and requires the volume of Gillette Hospital to maintain the lowest possible unit cost. Personnel are not now used as efficiently in the present building as they could be in the St. Paul-Ramsey building. (This was covered in section four).

Service

Gillette now has about 2,500 children from throught the state under its care. (Seventy-two percent of Gillette's patients come from outside the metroplitan area). Table XVII shows new admissions, re-admissions and total patients under Gillette's care during the last fiscal year.

The last column, showing the total number of patients under care, includes both in and outpatients. The total patients under care (about 2,500) compared with the amount of outpatient visits and admissions (over 25,000) shows that each patient has many contacts per year with Gillette, only a small percentage of which are inpatients. Gillette is successful in practicing the often preached and now popular goal of getting patients out of bed and out of the hospital as soon as possible. This fact is further emphasized by Table XVIII which traces, since 1954, the decrease in the average daily census, the decrease in average length of stay, and the equally dramatic increase in total patients. Gillette's annual outpatient visits of 25,000 ranks with hospitals with many times the size of Gillette.

One of the reasons for the demand for Gillette's services is that many babies with congenital anomiles that formerly died now survive. The number of these children born in Minnesota, by region, in a given year is shown in Table XIX.

The increase in surgery, laboratory and x-ray services performed over the past 20 years is shown on tables XXI and XXII. These increases reflect the increased patients mentioned above. The kinds of services rendered to patients in the most frequently seen diagnostic categories is shown on Table XX. This illustrates the great variety of services used by most patients. The manner in which these services are coordinated by the staff for each patient's needs is Gillette's unique contribution to care of the multiply handicapped.

Gillette

Another very important function of Gillette is education of physicians in Orthopedic Surgery, and other related specialities; nurses, therapists, special education teachers, orthotists, prosthetists and all others. The facilities for practical education in Children's Orthopedic in our State and the United States are limited for the above mentioned professionals. The study done by James A. Hamilton Associates, Inc. indicated 70% of the practicing Orthopedic Surgeons in the State of Minnesota have received all or a majority of their pediatric orthopedic training at Gillette.

Research

A third function of Gillette is clinical research. Pioneering operative techniques, techniques in patient management that smooth the course to help in reducing the child's length of hospital stay, are examples. This kind of research has been going on at Gillette ever since it began, but the development of the Research and Educational Fund, some five years ago, has made a tremendous improvment of our research capabilities and production. For example; Dr. J.H. Moe procured at Gillette Hospital the concept of treating scoliosis (curvature of the spine) by ambulation rather than bedrest. Prior to this effort it was routine throughout the country to treat patients with scoliosis for six months in bed, absolutely never getting them up at all. It is now routine that such patients get up after only eight days in bed following their operative procedures. Then they go home after about fourteen days and they are ambulatory the remainder of their care. This is financially beneficial to the parents, psychologically beneficial to the patients and their families and stimulates a faster healing of the fusion site. This is a classic example of clinical research that has direct patient benefit. This technique of early ambulation is known through out the country as the "Moe Gillette Technique" of early ambulation of scoliosis patients.

Plan Development

Gillette's present planning began in 1966 when the legislature approved retaining a consulting firm to make recommendations regarding Gillette's future. A summary of the recommendations of James A Hamilton Associates follow:

1. That a centralized program of referral care for children with orthopaedic handicapping conditions be continued in the future as a Gillette Hospital program

2. That this program be made available to all children requiring this kind of care, regardless of the ability of the family to pay the costs.

3. That the Gillette Hospital program by physically integrated with a medical center.

4. That the Minnesota Depatment of Public Welfare transfer responsibility for operating a Gillette Hospital program to a medical center governing authority.

5. That the planning for the immediate future is based on either of two bed sizes - 100 beds or 60 beds: that the role in outpatient care should have increasing emphasis: that ambulatory and day care programs for handicapped children be considered that medical education and other paramedical education be continued to train health personnel and to enhance the quality of service: and that an expanded research role be effected.

B Proposed Course of Action for Consideration by the Department of Public Welfare

1. Initiate discussions with officials of selected Medical Centers.
2. Develop proposals for legislative and/or regulation change.
3. Change the system of Medical Staff reimbursement.

C. The Development of Gillette Hospitalon a New Site:

1. Criteria for selecting site.
2. Sites proposed for consideration
3. Physical development on a site.

D. Maintenance and Utilization of the Present Hospital Buidlings

1. Estimated capital expenditures assuming a move within five years ($432,000.00).
2. Estimated capital expenditures assuming a move is delayed to ten years ($750,000.00).

A number of the consultants recommendations have been carried out, and others are in the process of being implemented.

The 1973 legislature established an independent governing authority for Gillette, and authorized a special committee to recommend a site for relocating Gillette. This committee met for a year, defining criteria and investigating a number of Medical Centers. St. Paul-Ramsey received the number one rank for Gillette affiliation.

Relocation of Gillette with St. Paul-Ramsey would allow Gillette to:

1. Have the multiple services patients need for complete care, through sharing of services and immediate consultation. Many of these services are being purchased now with the patient being transported to them. Services to be shared are listed in section four.
2. Benefit from efficiences in the use of personnel because of an improved work flow.
3. Reduce expenditures by at least $175,000.00 per year.
4. Reduce further the average length of stay.
5. Make available to a greater number of professionals Gillette's clinical teaching facilities.

Gillette Summary

Gillette Hospital is a concentration of specialized medical and paramedical services expertly coordinated to treat each multipli-handicapped child as a whole being according to his individual needs. At present, children requiring certain sub-specialty services receive these services at other institutions, usually on an outpatient basis. St. Paul-Ramsey has the complete spectrum of pediatric sub-specialty clinics plus well-child and high risk infant clinics, all in the department of pediatrics. The burn unit and poison control center services are often utilized by children. There is a child-psychiatry service and a child abuse team. The Child Development Center is a specialized program in diagnosing mental retardation problems. The Ophthalmology Department has a pediatric clinic. The OB-GYN Department has pre-natal, post-partum, and family planning clinics.

ST. PAUL-RAMSEY

Traditional Role of Governmental Hospital

Historically, City and/or County owned hospitals have been large teaching institutions charged with the responsibility of providing care for indigent persons in the geographic area of the governmental body. No one who could afford a private physician and a private hospital would seek care in a city or county hospital. This role of the city/county hospital was changed suddenly and dramatically with the passage of Medicare and the sleeping giant passed with it, Medicaid. Both Medicare and Medicaid paid for health services for persons for whom such care was previously either unavailable, or available only through an uncoordinated hodge-podge of governmental programs, most of the control for which rested in state and county governments. The new Medicare/Medicaid programs created not only federal money but federal regulations, such as the requirement that the program recipient be permitted a free choice of vendor. This requirement eliminated the historical necessity of so called "welfare patients" obtaining medical care in an institution operated by the governmental unit paying for this care, and placed city and county hospitals in competition with other hospitals. The fears of many observers that city and county hospitals would disappear, and with them the teaching programs that trained most of the medical interns and residents in the nation, failed to materialize. There are many reasons for this, most of which are not within the scope of this application. Among the reasons, however, were the national trend towards increased utilization of hospital outpatient and emergency departments, and the fact that the governmental institutions had far more experience and capacity to provide these kinds of services.

Trends in Outpatient Services

That this experience and capacity is acknowledged by the public is supported by the record. For example, according to the latest American Hospital Association's Guide to the Health Care Field, the increase in outpatient visits in state and local governmental short term general and other hospitals was 16.1% from 1971 to 1972; while non-government not-for-profit hospitals showed an increase of the same item for the same year only 8.7%. A recent issue of Hospitals reported findings from the National Hospital Panel Survey (882 hospitals selected from a universe of 5,859 hospitals) that the average annual increase in outpatient visits was 10.3% since 1969.

While St. Paul-Ramsey;s outpatient utilization has not increased as dramatically as the national statistics the increase is none-the-less impressive. (Perhaps the gap between need and services is not as great in St. Paul-Ramsey's service area -- Minnesota has been ranked number one in health care by a prominent research organization).

The utilization of the outpatient department has increased at a rate of about 6% per year since 1968. Follwing an 11.9% increase in visits in 1968 there was a decline of almost 10% in 1969 followed by a steady increase each year since that date. In 1973 the total number of outpatient visits was 90,754, an increase in activity of 14%

The emergency department has experienced a steady increase in demand for services which from 1968 through 1972 averaginb about 7½% per year. The number of visits to the emergency department in 1973 was 73,384 resulting in an increase of 9.5%.

Factors Contributing to Space Needs

The increased patient load has not been simply an increase in demand for existing services. Since the hospital opened in 1965 the outpatient department has added numerous clinics for the various medical subspecialties until today more than 50 subspecialty clinics are held each week. (See section Four, page 18 for listing). This increase in services through the years has required an increase in full-time medical staff from 14 in 1966 to 72 at the present. In 1966 the medical staff was a basically volunteer staff whose major professional interests, and offices,were elsewhere. The number of medical interns and residents affiliated with Ramsey has increased from 40 in 1966 to 135 in 1973. There are 70 medical clerks at present, only 10 in 1966. The total medical compliment of staff, residents, and interns would be sufficient to see more patients, and at a faster rate, if sufficient space were available.

Because this size staff was not planned for, offices have been carved out of departments throughout the hospital, rooms have bee subdivided in some areas to contain two or three times the people for which they were designed Conference rooms, corridors, elevator shafts, and storage areas have disappeared in the process.

Perhaps the newest and most exciting program in terms of potential is the Ramsey Health Plan the only prepaid health plan (or as they are now called, Health Maintenance Organizations) inthe nation which exist in the confines of a county teaching hospital. This program in its first year became viable without any outside grants and is furnishing excellent medical care to 2,000 people. The present enrollment is three times greater than was anticipated by this date, which confirms the interest and need for this type of medical care in St.Paul. The original group of county employees has now been expanded to include some municipalities in the area. It appears that in a short time the plan could grow far beyond the physical capacity of the building. As with so many other services the Ramsey Health Plan was carved out of an area dedicated to another use, thus adding to the physical pressures placed on the entire facility. The groups of employees now discussing Ramsey Health Plan membership are comprised of individuals not now receiving health care at St. Paul-Ramsey. In addition to these groups, plans are underway to include in the Ramsey Health Plan, Medicare and Medicaid recipients living in the primary service area, large numbers of whom are now receiving all of their care at Ramsey. The physical limitations of the building are hampering planning efforts and without an expansion program will stifle the great potential of this new program.

As was explained in section four, certain space in the new building would be dedicated to the Ramsey Health Plan. In addition, the outpatient department design will permit outpatient units to be used by either

specialty clinics (as we now know them), the primary care clinic, being planned for, or the Ramsey Health Plan. Such a building plan is essential to the future of the prepayment (HMO) concept, which is showing great promise as the health care model of the future, and which is being encouraged by federal and other incentives. While some critics consider planning for these programs a little more than speculation, existing HMO's are growing rapidly. The enrollment in the Ramsey Health Plan is expected to grow to 20,000 in five years and perhaps, 40,000 in ten years.

The primary medical care of the Ramsey Health Plan is being provided by physicians attached to the department of Ambulatory Care, which also serves the emergency department, and the "walk-in clinic" section of the emergency department, a service which provides primary care on a 24-hour basis. Future plans include primary care Clinics staffed by the Department of Family Practice. Need for primary care clinics exists now regardless of the payment mechanism. The facilities are required by the number of patients and must be adaptable for use by more than one organizational framework for providing this care.

Some persons and groups in the Ramsey Health Plan and elsewhere are interested in organizing a prepaid dental care plan. The base for a dental plan now exists at St. Paul-Ramsey with the present programs for dentistry and oral surgery.

The department of surgery is interested in the development of an outpatient surgery program patterned after the free standing outpatient surgical facilities being developed in some areas, notably Phoenix, Arizona. Such facilities are designed to provide quality surgical care to patients whose operations are too difficult or dangerous to perform in a physicians office, but not of such consequence as to require hospitalization. The inclusion of such a program of St.Paul-Ramsey will permit integration of the Gillette Hospitals' surgical program in St. Paul-Ramsey without the construction of additional operating rooms.

The community mental health center of Ramsey County maintains offices both in downtown St. Paul and at St. Paul-Ramsey Hospital. Because of the space shortage the mental health area has been shared with another department. The mental health program would like this space returned to its use. Additional space will also be required by the implementation of a new program of cooperation between the community mental health center and the hospital's department of Psychiatry. While planning in the program area is not complete there exists hope for a break-through from the traditional stand-off between the mental health programs of psychiatrists and those of psychologists.

A final new program being developed at Ramsey for which space is needed is a maximum security emergency area. The need for this service was first introduced in 1970 by the Ramsey County Sheriff's office, which accompanies a number of its clients to the hospital emergency room before

detention in the county jail. A new contract between the State of Minnesota Department of Corrections and St. Paul-Ramsey for care of inpatients from Stillwater State Prison and St. Cloud Reformitory, as well as outpatient services to be performed at St. Paul-Ramsey Hospital, gives impetus to the need for such a facility. The maximum security unit would consist of three examining rooms with related services, accessible from a separate drive-in security (sally port) entrance. Emergency and/or outpatient procedures that could be performed by personnel and equipment transported to this unit would be performed here, thus minimizing the exposure of security prisoners to the remainder of the hospital.

The proposed program will also make additional space available for expansion of the social service department and a number of administrative offices --- Admitting, Insurance, Credit and Collections, Data Processing, Accounting, Purchasing, Personnel and General Administration. Most of these services will be expanded in the areas vacated by services relocated in the new structure. Many of these services were non-existent when the hospital opened, or were performed by County offices.

In 1966 the number of employees in the above mentioned departments plus the emergency and outpatient departments totaled 109 while in 1973 the average number has been 277, or an increase of 68%. Needless to say, this increase in staff has created some extremely difficult conditions.

The primary service area of the outpatient and emergency departments of St. Paul-Ramsey Hospital has been defined as the first ten of the twenty St. Paul neighborhoods listed in the first column of Table V, Section One (page 8). Regardless of which neighborhoods are included in the primary service area, the importance of St.Paul-Ramsey Hospital to the health care needs of the citizens of St. Paul and Ramsey County is clear on a number of grounds. These include: The character of the population in the primary service area; The volume of outpatient and emergency services rendered; the wide range of specialty clinics offered; the institution's teaching program; and the special programs available required of a county teaching hospital.

The neighborhoods comprising the St.Paul-Ramsey primary service area are, with one or two exceptions, the most disadvantaged neighborhoods in St. Paul. For example, nine of the ten neighborhoods in the primary service area rank the lowest in terms of monthly contract rents. Eight of the ten neighborhoods are the lowest when ranked in terms of medium housing values.

Because medical problems are closely correlated to income level, a comparison of incomes in the St. Paul-Ramsey (outpatient and emergency) primary service area to those of other neighborhoods maybe most significant. Table XXIII on page shows, for example, that the average incomes of all but one neighborhood in the primary service area are below the St. Paul average family income. The second column in the same table shows that all but one of the ten neighborhoods in the primary service area is in the bottom ten, (or bottom half) of neighborhoods ranked in order of family incomes. The primary service

area neighborhoods also are those with the greatest percentage of income below poverty level. In fact, eight of the ten neighborhoods are listed among the ten St. Paul neighborhoods with the largest percentage of incomes below poverty level. The ten primary service area neighborhoods also contain eight of the top ten St. Paul neighborhoods ranked in terms of incomes from social security. All but one of the primary service neighborhoods is among the top ten neighborhoods ranked by percentage of income from public assistance.

Without belaboring the disadvantaged status of neighborhoods in the primary service area, it can be said that these neighborhoods are among those with the lowest median level of education, the highest birth rate, the greatest amount of illegitimacy, and the highest crude death rates for all St. Paul neighborhoods. The point of this discussion of population characteristics of the primary service area neighborhoods is that these are the neighborhoo St. Paul-Ramsey traditionally has served, and that continue to look to St. Paul-Ramsey as their major source of medical care. As a result they must weigh heavily in St. Paul-Ramsey's long range planning.

As a final note to this discussion of neighborhoods, it should be known that St.Paul-Ramsey has proven its interest in serving neighborhoods by extending services beyond its walls. Several neighborhood programs are served by St. Paul-Ramsey, either through sponsorship or working agreements. These are the Family Practice Clinic on the East Side of St. Paul; clinic services in the Ramsey County Workhouse and County Jail; Family Tree, Inc., which provides medical care; V.D., and birth control information in the Selby-Snelling neighborhood; and a methadone treatment program. In addition, maternal and infant care clinics, and eye screening clinics are held by St. Paul-Ramsey at the Martin Luther King Clinic in the Selby-Dale neighborhood. Finally, medical services are provided through St. Paul-Ramsey to many nursing home patients in the county.

TABLE XVII

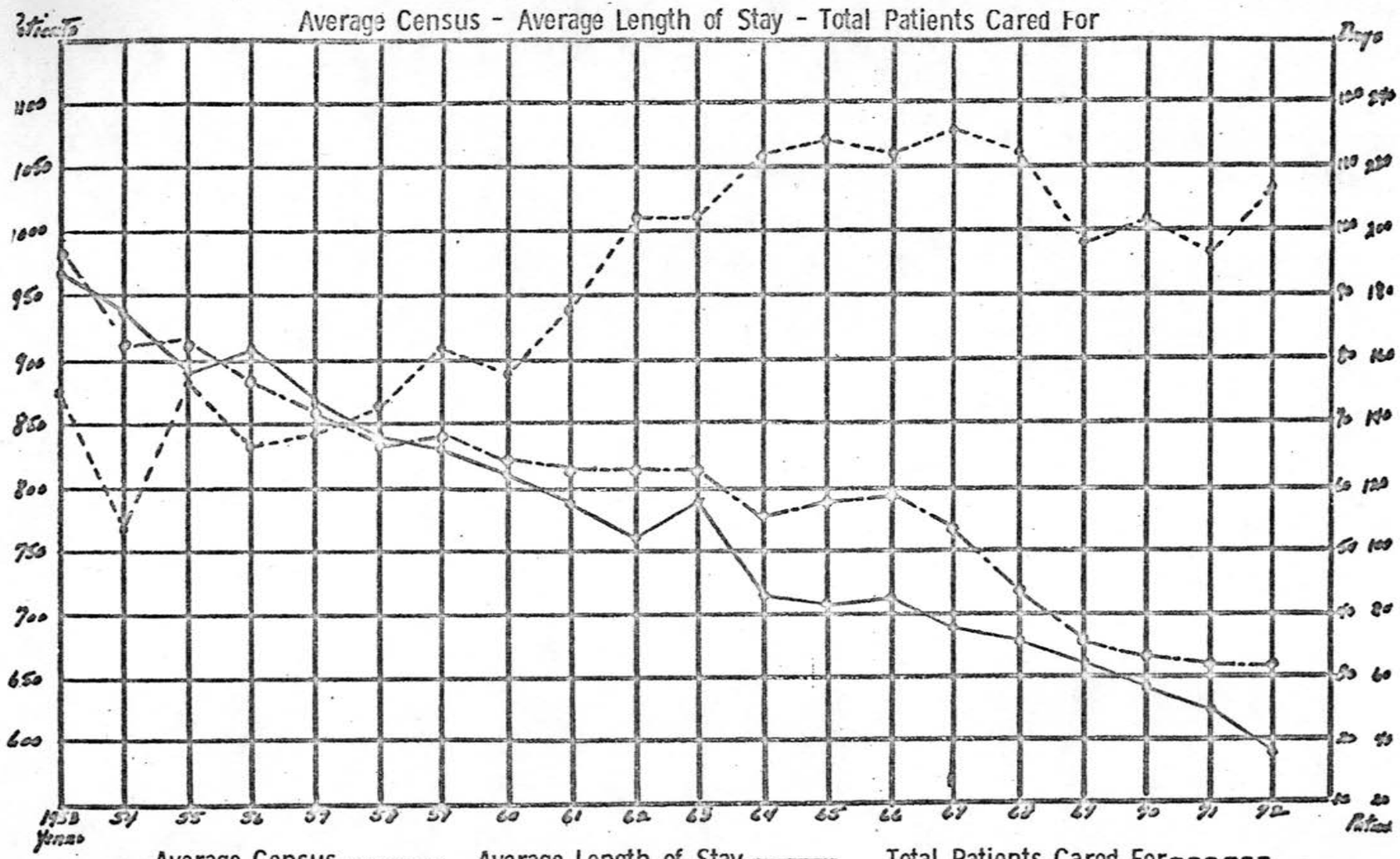
GILLETTE CHILDREN'S HOSPITAL

Patients Given Hospital Care During the Fiscal Year 1971-72

Region	New Admissions	Readmissions	Patients Under Care (in and out patients)
Northwest	37	58	140
Northeast	118	188	452
West	82	130	312
Central	72	115	277
Southwest	63	100	243
South Central	54	86	208
Southeast	45	71	173
Metropolitan	182	288	695
Totals	653	1,036	2500

GILLETTE CENSUS, LENGTH OF STAY, AND TOTAL PATIENTS COMPARED FOR 20, YEARS

TABLE XVIII



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Part A: Congential Anomalies in Minnesota by Region

TABLE XIX

Region	Live Births	Per Cent of Congenital Anomalies	Number of Congenital Anomalies
Northwest	2,439	1.6%	39
Northeast	5,256	1.3%	68
West	2,728	1.6%	44
Central	6,349	1.4%	89
Southwest	4,259	1.5%	64
South Central	3,355	1.1%	37
Southeast	6,165	1.5%	92
Metropolitan	31,947	1.3%	420
Anoka Co.	3,353	1%	34
Carver Co.	531	1.3%	7
Dakota Co.	2,709	.9%	24
Hennepin Co.	15,038	1.4%	211
Ramsey Co.	8,099	1.4%	113
Scott Co.	627	1.1%	7
Washington Co.	1,590	1.5%	24
State Total	62,497	1.4%	875

Section Seven: NEED FOR PROJECT DEVELOPMENT

Table XX

Gillette Services Used By Various Diagnostic Categories

Services Offered Our Patients

Diagnosis	Percentage	Orthopaedics	Pediatrics	Neuro-Surgery	Neurology	Urology	Plastic Surgeon	Physical Therapy	Occupational Therapy	Speech & Hearing	Orthopedic Appliances	Specialized Nursing	Dentistry	X-Ray	Laboratory	Photography	Special Tests	School Evaluation Psychological Testing
Scoliosis	30%	x	x	?		x		x			x	x	x	x	x	x	x	x
Cerebral Palsy	18%	x	x		x			x	x	x	x	x	x	x	x	x	x	x
Hip Cases	11%	x	x					x			x	x	x	x	x	x		
Foot Cases	8%	x	x					x			x	x	x	x	x	x		
Myelomeningocele	11%	x	x	x	?	x		x	x	x	x	x	x	x	x	x	x	x
Traumatic Accident Cases	1%	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x
Amputees	4%	x	x					x	x		x	x	x	x	x	x		x
Growth and Development	4%	x	x		x			x	x	x	x	x	x	x	x	x	x	x
Plastic Surgery	2%		x				x					x	x	x	x	x		
Other Diagnosis	11%	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x

TABLE XXI

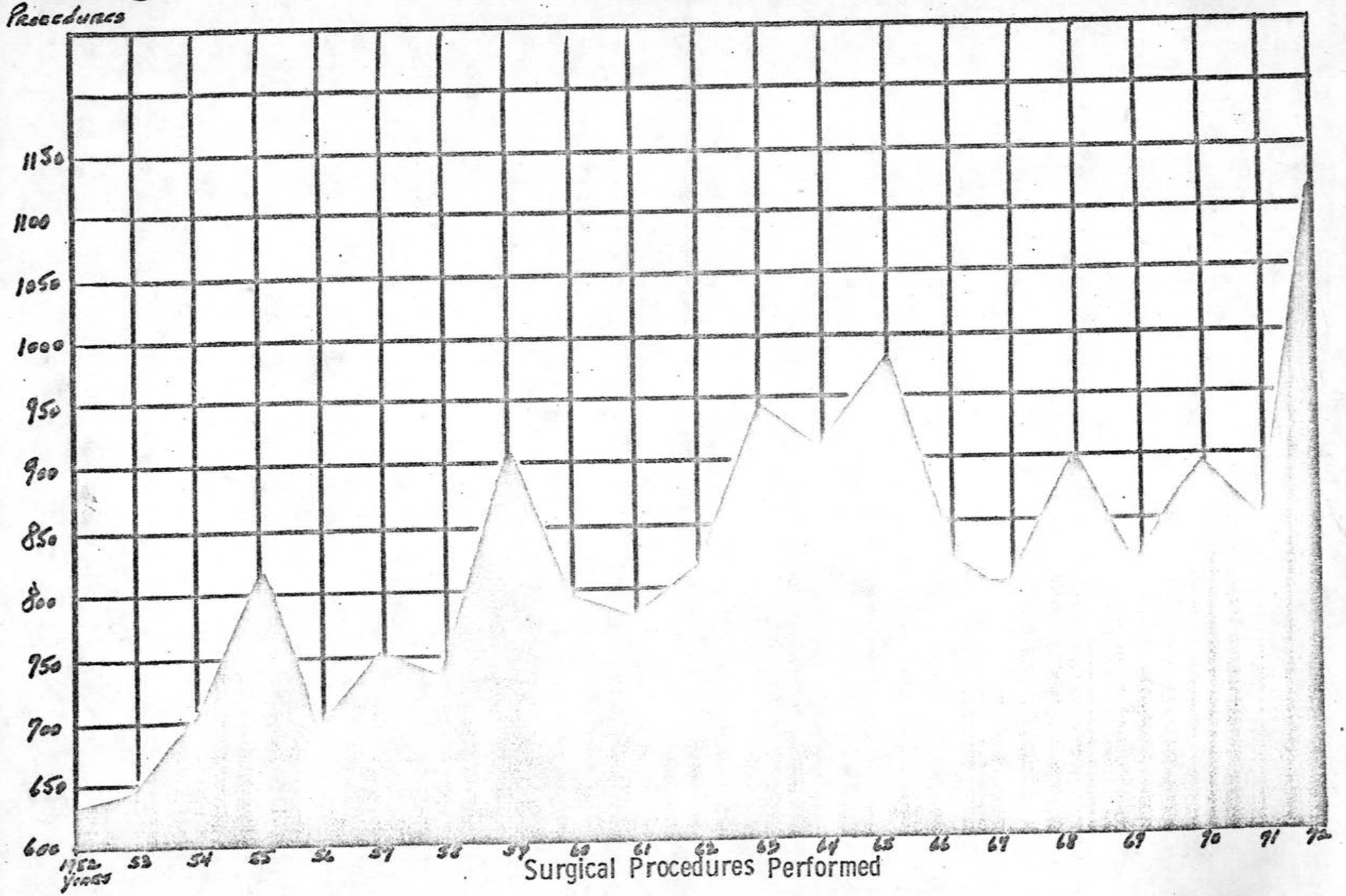
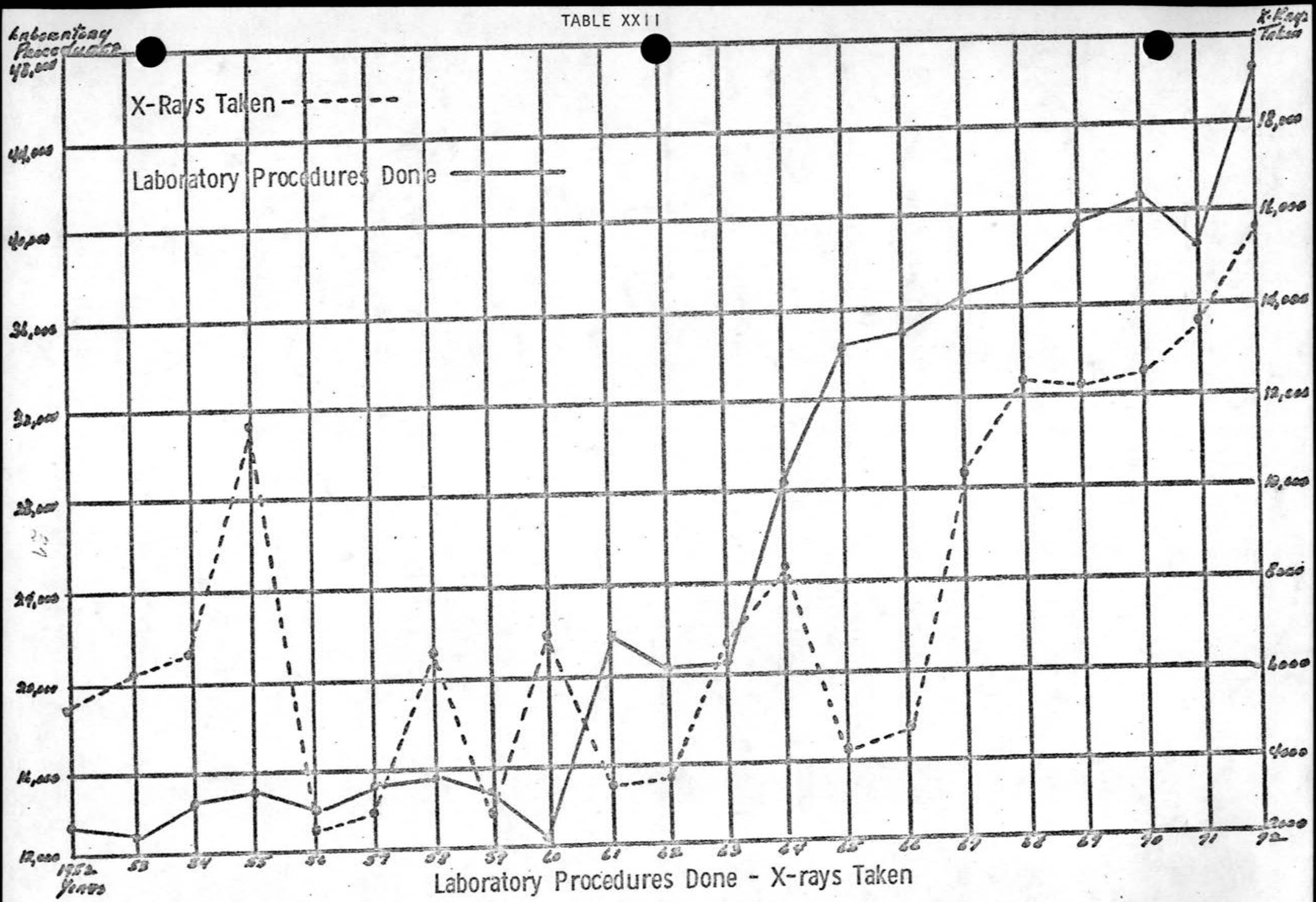

Procedures
1150
1100
1050
1000
950
900
850
800
750
700
650
600
1952 years
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
Surgical Procedures Performed

TABLE XXII



Laboratory Procedures Done - X-rays Taken

INCOME CHARACTERISTICS OF NEIGHBORHOODS IN PRIMARY SERVICE AREA, ST. PAUL OUTPATIENT AND EMERGENCY DEPARTMENTS

	Average Family Income	Rank By Family Income	% Incomes Below Poverty Level	Rank of % Incomes Below Poverty Level	% Incomes From Social Security	Rank by % Incomes From Social Security	& Incomes From Public Assistance	Rank By % Incomes From Public Assistance
1. Downtown	9,250	17	3.2%	16	24.0%	1	5.0	7
2. Mt. Airy	6,921	20	45.3	1	16.0	11	14.7	1
3. Summit University	7,720	19	18.8	2	19.8	3	9.7	2
4. Inner West Seventh	8,624	18	14.1	4	19.1	6	4.6	8
5. Dale Thomas	9.939	13	9.8	6	20.7	2	5.5	5
6. Dayton's Bluff	9,629	16	12.0	5	18.7	7	6.2	4
7. North Rice	9,784	15	14.3	3	16.0	12	6.5	3
8. Riverview	9,853	14	8.7	8	19.4	5	4.4	9
9. Phalen Mounds	11,413	9	8.9	7	16.1	9	5.1	6
10. Outer West Seventh	10,489	11	6.4	12	19.8	4	3.2	11
St. Paul	11,263	-	7.6	-	15.1	-	3.5	-

Compiled from Table IX, p. 23, "General and Community Socio-Economic Profiles, St. Paul, Minnesota", Community Health & Welfare Council, January, 1973.

Section Eight: ESTABLISHED PLANNING PRIORITIES

The Health Policy section of the Metropolitan Development Guide, now in draft form, purposes a number of policies relating to availability and accessibility of health services. The first of these speaks of health care in scarcity areas.

The primary service area of the emergency and outpatient departments of St. Paul-Ramsey as defined by a special study, is almost exactly the same as the areas of limited health service in St. Paul. (The would be exactly the same except for the fact that different neighborhood definitions wer used.) The major beneficiaries of the St. Paul-Ramsey proposed are the persons living in these scarity areas. The St. Paul-Ramsey proposal is also consistent with MDG policy proposals relating to HMO development and training programs.

The Gillette-St. Paul-Ramsey affiliation is consistent with MDG policy proposals relating to hospital occupancy, and minimum construction of new and maximum use of available services.

This proposal is consistent with other MDG policy proposals such as the encouragement of health services located in neighborhoods. These and other MDG policy proposals could be implemented by St. Paul-Ramsey if further research and planning proves them desireable.

GILLETTE

The cost of Gillette position of this proposal will be sought from the Legislature.

The cost of depreciation per patient day (40 years) would be $5.15, which is 4.5% of the cost per patient day.

ST. PAUL-RAMSEY

The St. Paul-Ramsey Medical and Educational Research Foundation (M.E.R.F) has pledged two million dollars to the project. Seven million will be sought from Ramsey County and the balance, approximately one million, from the Legislature.

There will be no cost to the patient for indebtedness. St. Paul-Ramsey's changes do not include interest and depreciation, except for medicare and medicaid cases, which reimburse for these costs.

Section Ten: COMMENCEMENT AND COMPLETION DATES

If the Legislature will pass acts necessary to the project in January or February, the architect's estimate construction could begin in October of November, with completion 18 months later.

A bill for an act

relating to public buildings and public lands of the state of Minnesota; authorizing the acquisition and betterment of public land and buildings and other public improvements of a capital nature; the acquisition by gift, purchase, or condemnation of certain real property therefor, etc.

CONFERENCE COMMITTEE REPORT ON H. F. NO. 2531 May 19, 1973

Honorable Martin O. Sabo, Speaker of the House of Representatives

Honorable Alec G. Olson, President of the Senate

We, the undersigned conferees on the part of the House and the Senate, upon the disagreeing votes as to H. F. No. 2531, report that we have agreed upon the items in dispute and recommend as follows:

(2) At Gillette State Hospital

For designing, rehabilitation and constructing $ 170,000

Provided that no more than $170,000 may be expended for architectural planning of a project of which the state share shall not exceed $3,530,000, however, these funds shall not be expended unless Ramsey county or an agency thereof provides its share.

Provided further that these funds shall not be available unless separate legislation is enacted by the legislature which authorizes a Gillette Authority.

House Conferees:

FRED C. NORTON — NEIL S. HAUGERUD — HOWARD E. SMITH

DONALD B. SAMUELSON — DELBERT F. ANDERSON

Senate Conferees:

NORBERT ARNOLD — EDWARD G. NOVAK — JOHN L. OLSON

RICHARD W. FITZSIMONS — JACK T. DAVIES

RATING OF EACH HOSPITAL SITE PRESENTED

Priority List	Weight of Each	CRITERIA USED	Childrens Hospital of Mpls		St. Paul Ramsey		Children Hospital of St. Paul		Hennepin County General		U of M Hospital		Fairview Hospital	
1	5	Pediatric Expertise (Children's Medical Care)	5	25	3	15	5	25	3	15	5	25	2	10
2	5	Medical Education	2	10	4	20	3	15	4	20	5	25	2	10
3	5	Excellent Outpatient Facilities	3	15	4	20	5	25	4	20	5	25	3	15
4	5	Concise Internal Arrangements for Available Bed Facilities	0	0	5	25	0	0	0	0	0	0	5	25
5	5	Operating Costs												
6	5	Impact on Hospital Community - Bed Space	0	0	5	25	0	0	0	0	0	0	4	20
7	4	Concise Internal Arrangements - Architectural Barriers	2	8	5	20	3	12	3	12	3	12	3	12
8	4	Access from Street for Handicapped	5	20	5	20	5	20	5	20	5	20	5	20
9	4	Location - Physical Accessibility from Highway	3	12	5	20	3	12	3	12	2	8	5	20
10	4	Parking Facilities	2	8	4	16	3	12	2	8	1	4	3	12
11	3	Concise Internal Arrangements - Non-Shared Facilities	3	9	3	9	3	9	3	9	3	9	5	15
12	3	Degree of Integration - Program	2	6	3	9	5	15	2	6	4	12	2	6
13	3	Capital Cost												
14	2	Concise Internal Arrangements - Shared Facilities	1	2	4	8	5	10	3	6	5	10	2	4
15	2	Medical Staff Acceptance	1	2	3	6	5	10	2	4	0	0	4	8
16	2	Total Staff Acceptance	2	4	4	8	5	10	1	2	0	0	3	6
17	1	Compatability	3	3	3	3	5	5	2	2	1	1	5	5
18	1	Location - Public Transportation	1	1	2	2	1	1	2	2	3	3	1	1
19	1	Location - Motel and Eating Facilities	1	1	3	3	1	1	3	3	3	3	2	2
20	1	Location - Ground Facilities	0	0	0	0	0	0	0	0	0	0	4	4
21	1	Political Consideration	1	1	5	5	4	4	1	1	1	1	3	3
22	1	Use of Facilities Abandoned	3	3	3	3	0	0	3	3	1	1	3	3
Total	67			130		237		186		145		159		201

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

File No. 204?

Resolution No. 9-2079

January 14 19 74

The attention of County Attorney; County Administrator;
St. Paul Ramsey Hospital & Sanitarium Commission;
Gillette Hospital Authority; Ellerbe Company;
is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on January 14, 1974

By Commissioner Finley

RESOLVED By the Board of Ramsey County Commissioners that Ellerbe Architects Incorporated, the St. Paul Ramsey Hospital Staff, the Ramsey County Hospital & Sanitarium Commission, and others interested in the project, are hereby authorized to present to the Ramsey County Delegation the concept of the St. Paul Ramsey Hospital-Gillette Hospital Addition presented to this meeting of the County Board, and Be It Further

RESOLVED That Ellerbe Architects, Incorporated are hereby authorized to proceed under the terms and conditions of their contract with the Ramsey County Hospital & Sanitarium Commission, and County of Ramsey, and the Gillette Hospital Authority for preparing plans for the joint hospital facility and parking ramp, and Be It Further

RESOLVED That the Board of Ramsey County Commissioners be furnished with a complete financial breakdown showing the estimated cost of constructing the proposed St. Paul Ramsey - Gillette Hospital Addition, and the allocation of costs between the County of Ramsey, the Gillette Hospital Authority, Medical Education & Reaearch Foundation, and Be It Further

RESOLVED that Edward E. Cleary, Assistant County Attorney is requested to prepare and present to the County Board within two weeks, a clarification of what has to be done from the legal standpoint to amend the present law, so as to permit construction of the proposed addition as planned.

EUGENE F. MACAULAY County Administrator

By_____ Executive Secretary

OFFICE OF COUNTY ADMINISTRATOR RAMSEY COUNTY, MINNESOTA

ST. PAUL, MINNESOTA JANUARY 14, 1974

The Board of Ramsey County Commissioners met in adjourned regular session at 10:00 a.m. on the above date with the following members present: Carlson, Danna, De Courcy, Finley, Knaak, Salverda, Cohen - 7. Absent: None.

Also present was Thomas Quayle, Assistant County Attorney.

Chairman Cohen presided. (2155)

MINUTES

Commissioner De Courcy moved, seconded by Commissioner Salverda, that the reading thereof be dispensed with and that the minutes of the regular meeting of January 7, 1974 and of the annual meeting of January 8, 1974, be approved as submitted. Roll Call: Ayes - 7. Nays - None. (2155)

ST. PAUL-RAMSEY-GILLETTE HOSPITAL

Doctor Weir of the St. Paul-Ramsey Medical Staff was present. He informed the Board that members of the Ramsey County Hospital and Sanitarium Commission, representatives of the Medical Staff, Administrative Staff, and Ellerbe Architects, Inc., were present. He introduced Mr. Welsh of Ellerbe Architects who presented slides showing preliminary plans for the St. Paul-Ramsey-Gillette Hospital Addition.

There was some discussion. Mr. Edward E. Cleary, Assistant County Attorney, who was present, pointed out that there are legal problems with the present law and that the City of St. Paul is a part owner of St. Paul-Ramsey Hospital and has outstanding bonds for the City's share of the original construction. He suggested slight changes in the law and that, possibly, the City could quitclaim to the County its rights in the hospital, subject to the rights of the City bond holders.

There was further discussion. Commissioners De Courcy and Knaak expressed concern about the unknown costs such as possible extras to the construction contract, cost of furnishing and equipment and the allocation of such additional costs. Several persons spoke, including Dr. Gumnit of the Medical Education Research Foundation and Mr. Michael Ettel, Chairman of the Hospital and Sanitarium Commission.

Dr. Weir suggested that the County Board approve the preliminary plans and authorize the Architect to proceed under the contract and that the Board also authorize an appearance of representatives of the County Board and the Commissions and the staff to meet with the County Legislative Delegations meeting this evening and present the plans and proposals for funding.

January 14, 1974 - Continued.

Commissioner De Courcy moved, seconded by Commissioner Knaak, that consideration of the matter be laid over for two weeks until figures are obtained showing complete costs and complete break-down of the allocation thereof. Roll Call: Ayes - De Courcy, Knaak - 2. Nays - Carlson, Danna, Finley, Salverda, Cohen - 5.

Commissioner Finley introduced the following resolution and moved its adoption, seconded by Commissioner Danna. Roll Call: Ayes - Carlson, Danna, Finley, Salverda, Cohen - 5. Abstaining: De Courcy, Knaak - 2. (2047) (9-2079)

RESOLVED By the Board of Ramsey County Commissioners that Ellerbe Architects Incorporated, the St. Paul Ramsey Hospital Staff, the Ramsey County Hospital & Sanitarium Commission, and others interested in the project, are hereby authorized to present to the Ramsey County Delegation the concept of the St. Paul Ramsey Hospital-Gillette Hospital Addition presented to this meeting of the County Board, and Be It Further

RESOLVED That Ellerbe Architects, Incorporated are hereby authorized to proceed under the terms and conditions of their contract with the Ramsey County Hospital & Sanitarium Commission, and County of Ramsey, and the Gillette Hospital Authority for preparing plans for the joint hospital facility and parking ramp, and Be It Further

RESOLVED That the Board of Ramsey County Commissioners be furnished with a complete financial breakdown showing the estimated cost of constructing the proposed St. Paul Ramsey - Gillette Hospital Addition, and the allocation of costs between the County of Ramsey, the Gillette Hospital Authority, Medical Education & Research Foundation, and Be It Further

RESOLVED that Edward E. Cleary, Assistant County Attorney is requested to prepare and present to the County Board within two weeks, a clarification of what has to be done from the legal standpoint to amend the present law, so as to permit construction of the proposed addition as planned.

DDH480

ABATEMENTS

Commissioner De Courcy moved, seconded by Commissioner Carlson, that in view of the applicant Raymond R. Bossard failing to be present and support the application No. 86829 seeking reduction in the 1972 valuation of property at 1549 Chelsea Street, St. Paul, that said application be rejected in accordance with the recommendation of the County Assessor. Roll Call: Ayes - 7. Nays - None. (2155)

At this time, Chairman Cohen was excused. Vice-Chairman Finley took over as presiding officer. (2155)

Commissioner De Courcy moved, seconded by Commissioner Danna, that the following applications be approved in accordance with the recommendations of the Department of Property Taxation. Roll Call: Ayes - 6. Nays - None. (2155)

nber pplicant District	Assd. Year	Value Change From:	To:	Market Value From:	To:	Original Tax	Reduction in Tax	Adjusted Tax
REDUCTION IN VALUE - PRIOR YEARS								
8[illegible]2 Ferdinand A. Bucher Maplewood	1972	6020	1720	14000	4000	616.06	440.04	176.02
85200 Harold J. Holly	1971	770	320	3080	1280	178.38	104.24	74.14
St. Paul	1972	3800	1720	9500	4300	423.02	231.54	191.48

BOARD OF

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

File No. 2047

Resolution No. 9-2057

December 28, 19 73

The attention of County Commissioner Mrs. Donald M. De Courcy; St. Paul Ramsey Hospital & Sanitarium Comm; County Administrator; Gillette Hospital Authority; County Attorney, Gary Davis

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on December 28, 1973

By Commissioner Finley

RESOLVED That County Commissioner Mrs. Donald M. De Courcy be and she hereby is appointed to represent the Board of Ramsey County Commissioners on the Building Committee of the St. Paul-Ramsey Hospital and Sanitarium Commission - Gillette Hospital Authority Addition.

EUGENE F. MACAULAY County Administrator

By_____ Executive Secretary

STATE OF MINNESOTA

Resolution No. 9-20337

December 17 19 73

The attention of County Attorney, Gary A. Davis; County Administrator; St. Paul Ramsey Hospital & Sanitarium Commission; Gillette Hospital Authority; Ellerbe Company;

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on December 17, 1973

By Commissioner Knaak

RESOLVED By the Board of Ramsey County Commissioners that the agreement between the County of Ramsey, the St. Paul Ramsey Hospital & Sanitarium Commission; the Gillette Hospital Authority, and Elêerbe Company Architects for architectural services in connection with the St. Paul Ramsey Gillette Hospital Addition, be amended to provide as follows:

There shall be no committment of funds for physical improvements to the St. Paul Ramsey Hospital without approval by the Board of Ramsey County Commissioners.

EUGENE F. MACAULAY County Administrator

By_____ Executive Secretary

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

File No. 2047

Resolution No. 9-2017

December 10 19 73

The attention of Delores Knaak, County Commissioner;
St. Paul Ramsey Hospital & Sanitarium Comm; County Administrator;
Gillette Hospital Authority; County Attorney, Gary Davis;

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on December 10, 1973

By Commissioner Finley

RESOLVED That County Commissioner Delores Knaak be, and she hereby is appointed to represent the Board of Ramsey County Commissioners on the Building Committee of the St. Paul Ramsey Hospital & Sanitarium Commission, Gillette Hospital Authority Addition, and Be It Further

RESOLVED That Commissioner Knaak is authorized on behalf of the Board of County Commissioners to request adequate budget account ability from the aforesaid commission and authority, and that the County Administrator is directed to extend to Commissioner Knaak every cooperation in obtaining the information needed as a representative of the Board of County Commissioners.

EUGENE F. MACAULAY County Administrator

By_____ Executive Secretary

BOARD OF

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

File No. 2047

Resolution No. 9-1997

December 3 19 73

The attention of County Attorney, Gary A.Davis; R.C.Hospital & Sanitarium Commission; Elderbe Architects; Gillete Foundations; Co. Administrator, Mr. Peters;

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on December 3, 1973

By Commissioner De Courcy

WHEREAS The Board of Ramsey County Commissioners on November 19, 1973 (Resolution 9-1973, File 2047) approved a proppsed agreement between the Ramsey County Hospital & Sanitarium Commission and the County of Ramsey, the Gillette Hospital Authority, Ellerbe Architects, Inc., providing that the said Ellerbe Architects, Inc. furnish certain professional services in connection with the erection of a joint hospital facility and parking ramp adjacent to, and connected to the St. Paul Ramsey Hospital & Medical Center, and the remodelling of certain portions of the St. Paul Ramsey Hospital & Medical Center with certain amendments, and

WHEREAS The County Attorney has negotiated with the other parties to the agreement for their approval of the agreement and the form approved by the County Board of Commissioners, and

WHEREAS The County Attorney has reported acceptance of the proposed agreement by the other parties thereto, with certain minor changes, Now, Therefore Be It

RESOLVED That the Board of Ramsey County Commissioners hereby approves the aforesaid agreement as amended and authorizes the Chairman of the Board of County Commissioners and the County Administrator to execute said agreement on behalf of the County of Ramsey.

EUGENE F. MACAULAY County Administrator

By_____ Executive Secretary

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

Resolution No. 9-1914

October 15, 19 73

The attention of St. Paul-Ramsey Hospital and Sanatarium Commission; Director, St. Paul-Ramsey Hospital; Gillette Children's Hospital Administrator

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on October 15, 1973

By Commissioner Finley

RESOLVED That the Board of Ramsey County Commissioners hereby concurs with the action of the St. Paul-Ramsey-Gillette State Hospital Architect Selection Committee and approves the selection of Ellerbe Architects, Inc. as the architect for the St. Paul-Ramsey-Gillette State Hospital addition subject to approval by the Board of County Commissioners of an agreement between the County of Ramsey and Ellerbe Architects, Inc.

EUGENE F. MACAULAY, County Administrator

By _____ Executive Secretary

COUNTY BOARD

BOARD OF

RAMSEY COUNTY COMMISSIONERS

STATE OF MINNESOTA

File No. 2047

Resolution No. 9-1676

April 2, 1973

The attention of County Administrator Thomas J. Kelley; Ramsey County Hospital and Sanitarium Commission, c/o Chairman Ettel; Gillette Hospital-St.Paul-Ramsey, Att: Otto Jahnke, Administrator; Medical Education Research Foundation, St.Paul-Ramsey Hospital, c/o Chairman, Abramson

is respectfully called to the following Resolution of the Board of County Commissioners of Ramsey County, Minnesota, adopted at the meeting held on April 2, 1973

By Commissioner Finley

RESOLVED That the Board of Ramsey County Commissioners is committed to the proposal that the Gillette Hospital be merged with the St.Paul-Ramsey Hospital complex, and Be It Further

RESOLVED That the necessary funding for the expansion shall be by the Medical Education Research Foundation if the Foundation can pay such funding without bonding and that the County will provide the land necessary for the merging and Be It Further

RESOLVED That if the aforesaid Foundation can not finance the expansion and bonding is necessary, the Board of Ramsey County Commissioners will seek legislation granting bonding authority to the extent of $7,000,000.

THOMAS J. KELLEY, County Administrator

By _____ Executive Secretary

S.F.No. 56

CHAPTER No. 540

AN ACT

relating to welfare; establishing and empowering a Gillette hospital authority for the purpose of operating a children's hospital in conjunction with Ramsey county hospital; appropriating funds; amending Minnesota Statutes 1971, Sections 246.01; 256.01, Subdivision 2; repealing Minnesota Statutes 1971, Section 246.02, Subdivision 3; and Chapter 250.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [GILLETTE HOSPITAL AUTHORITY.] Subdivision 1. There is hereby established as a public corporation in the executive branch of state government and a political subdivision of the state, a Gillette hospital authority. The purpose of the authority shall be to govern the operation of Gillette children's hospital in conjunction with the Ramsey county hospital in such manner as to obtain a maximum of efficiency and economy in the performance of and training in medical and surgical care of crippled children.

Subd. 2. The Gillette hospital authority shall be governed by a board of directors consisting of seven members, not more than three of whom shall be residents of Ramsey county. One member shall be the commissioner of public welfare or designee of the commissioner. Six members, at least half of whom shall be consumers as defined in Minnesota Statutes, Section 145.72, shall be appointed by the governor with the advice and consent of the senate, for terms of six years and until their successors are appointed and qualified; provided, however, that initial appointments shall be made so that the terms of two members expire on

December 31, 1974, two on December 31, 1976, and two on December 31, 1978.

Subd. 3. Members of the board shall serve without compensation, but shall be entitled to reimbursement for actual and necessary expenses. The board shall organize by electing a chairman and such other officers as may be required. In addition the board may employ an administrator and such other professional, technical, and clerical personnel as may be required. All employees of the Gillette Children's Hospital who are in the classified service of the state on the effective date of this act shall be continued as employees of the authority without loss of status, seniority, or benefits. The departments of administration and civil service shall endeavor to assist in the transfer elsewhere within state service of any classified employee who desires such assistance. Classified personnel may, with their individual approval and the approval of the authority, enter the unclassified service. All other employees of the authority shall be in the unclassified service. The authority may prescribe all terms and conditions of employment of unclassified employees, including but not limited to the fixing of classification and compensation, without regard to the provisions of Minnesota Statutes, Chapter 15A. Full time employees of the authority shall be members of the Minnesota state retirement system, to which the authority shall make employer's contributions.

The authority may contract for the services of individuals who perform medical, technical, or other

services of a professional nature, and may contract for the purchase of necessary supplies, services, and equipment. Except as it determines, the authority shall not be subject to the provisions of Minnesota Statutes, Chapter 16, concerning personnel, budgeting, payroll, or the purchase of goods or services. Any department of state government is authorized, within the limits of its functions and appropriations, to assist the authority upon request.

Subd. 4. The authority, acting through its board of directors, may contract with the governing body or officials of the Ramsey county hospital and of any other hospital or institution, for the joint maintenance and operation of the Gillette children's hospital in conjunction with existing or contemplated facilities at the Ramsey county hospital. Contracts may include agreements for the joint employment and utilization of personnel, the joint purchase of supplies and equipment, and joint construction, acquisition, or leasing of space for offices, outpatient facilities, operating rooms, and other medical facilities for use in training in the care and treatment of crippled and handicapped children, the operation of a brace shop, and the conduct of patient education programs. No contract shall however, provide for the expenditure of funds for additional patient bed capacity. The authority shall be subject to the certificate of need act provided in Minnesota Statutes, Sections 145.71 to 145.83. In any case wherein a certificate of need is required, the authority shall, at the time of application, notify the house committee on

appropriations and the senate finance committee, whose opinion shall be advisory only.

Subd. 5. In the exercise of the powers granted pursuant to this act the authority shall have the power to accept gifts and grants, to sue and be sued, and to establish a schedule of charges for medical, hospital, and rehabilitative services furnished. All funds received by the authority from any source are hereby annually appropriated to the authority, which shall be responsible for their management and control. Annual audited financial statements shall be submitted to the legislature through the department of public welfare and a biennial report shall be submitted to the legislature by the authority not later than November 15 of each even-numbered year.

Subd. 6. The Gillette children's hospital shall seek reimbursement for costs of care and treatment provided, from parents to the extent of their ability to pay, from insurance policies covering care and treatment, and from other sources, including any federally financed medical aids for which the child is eligible. To the extent of appropriations available therefor, the department of public welfare shall continue to provide financial assistance to the authority to pay for costs of care otherwise unmet which are beyond the ability of parents to provide. Children from other states who can benefit from the services of the hospital may be accepted upon the referral of a medical doctor. Reimbursement for full costs for care provided non-resident patients shall be obtained from parents, from

insurance policies covering care and treatment, or from any sources other than the state of Minnesota which may be available to the child and his family.

Sec. 2. This act is effective upon passage and approval. Any unexpended balance in the Gillette State Hospital medical education and research account, in the appropriation made by Laws 1971, Chapter 964, Section 2, Subdivision 15, and in legislative appropriations to the Gillette children's hospital are hereby reappropriated to the authority created by this act.

Sec. 3. Minnesota Statutes 1971, Section 246.01, is amended to read:

246.01 [POWERS AND DUTIES.] The commissioner of public welfare is hereby specifically constituted the guardian of both the estate and person of all feeble-minded or epileptic persons, the guardianship of whom has heretofore been vested in the state board of control or in the director of social welfare whether by operation of law or by an order of court without any further act or proceeding, and all the powers and duties vested in or imposed upon the state board of control or the director of social welfare, with reference to mental testing of persons mentally deficient or epileptic, and with reference to the institutions of the state of Minnesota except correctional institutions administered and managed by the commissioner of corrections, are hereby transferred to, vested in, and imposed upon the commissioner of public welfare, and in relation thereto he is hereby charged with and shall have the exclusive power of

Alec G. Olson
President of the Senate.

Martin O. Sabo
Speaker of the House of Representatives.

Passed the Senate this 17th day of May in the year of Our Lord one thousand nine hundred and seventy-three.

Patrick E. Flahaven
Secretary of the Senate.

Passed the House of Representatives this 17th day of May in the year of Our Lord one thousand nine hundred and seventy-three.

Edward A. Burdick
Chief Clerk, House of Representatives.

Approved May 23, 1973

Wendell R. Anderson
Governor of the State of Minnesota.

Filed May 23, 1973

Arlen I. Erdahl
Secretary of State.