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GOVERNMENT AND GOVERNANCE FOR ST. PAUL–RAMSEY MEDICAL CENTER IN THE 1980'S

The Present

Book I. Current Assessments: Outside Forces, Current Role, and Performance

The Future

Book II. New Directions for Strategic Planning, Organization, and Governance

Lewin & Associates
Lucy Johns
Wood, Lucksinger & Epstein

January 1985

Lewin and Associates incorporated

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The Present

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CHAPTER ONE

ENVIRONMENTAL FACTORS IMPORTANT FOR STRATEGIC PLANNING AND IMPLICATIONS FOR ST. PAUL-RAMSEY MEDICAL CENTER

Amidst the welter of data currently available descriptive of St. Paul-Ramsey Medical Center's (SPRMC) environment, one unmistakable fact stands out: the instability of almost every number and trend. Viewed positively, the current and foreseeable future environment in which SPRMC will provide services is extremely dynamic. The first -- and never finished -- task of a strategic planning process is therefore to cull the data for patterns and significance so as to reduce uncertainty and minimize surprises.

This chapter describes a set of figures and trends selected for their current and potential importance to SPRMC in shaping its role and programs over the next five years. The subject areas include the following:

1. population;
2. acute health care resources and utilization;
3. hospital market shares;
4. hospital prices and expenses;
5. private third-party payment;
6. government payment.

Data are presented when available for two distinct geographic areas:

1. Twin Cities Metropolitan Area ("Metro Area");
2. "Service areas" defined for SPRMC.

The Metro Area includes the counties of: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. Metro Area data are useful for situating SPRMC within its urban environment. The Metro Area is also a familiar boundary for health planning, reflected in long-standing routines for collection and analysis of health care statistics.

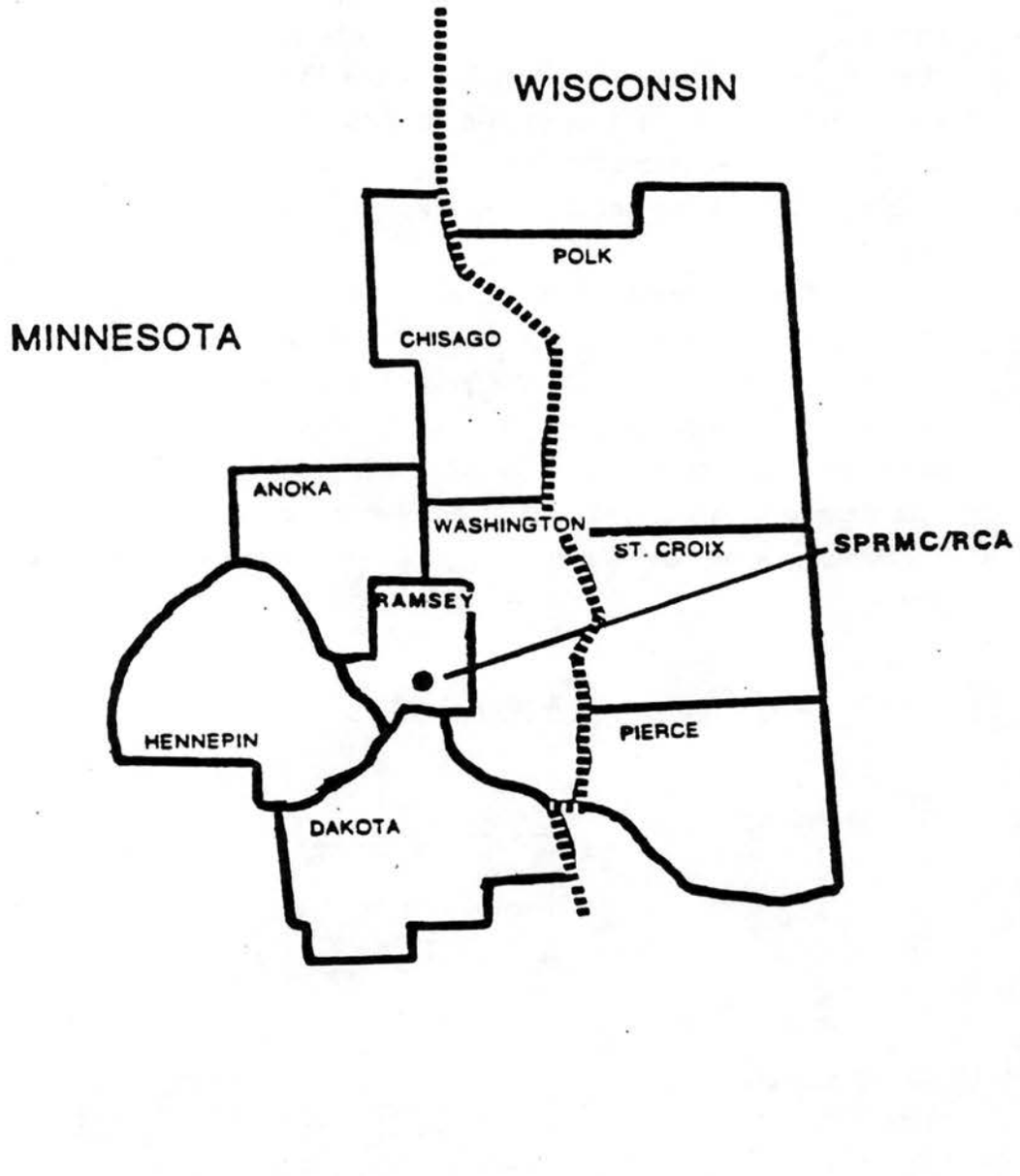
SPRMC's service areas are geographic areas of particular importance for this hospital. They are the places from which SPRMC draws its patients and within which there is competition that could change the flow of patients to SPRMC. Service area boundaries are arbitrarily defined by a hospital to reflect specific planning or marketing needs, and will change over time.

Service areas for SPRMC have been proposed in hospital planning documents and in the Kearney studies prepared for Ramsey Clinic Associates (RCA).[1/] The areas are derived in different ways and overlap but are not identical. For purposes of this Strategic Plan, Lewin and Associates and its independent consultants have utilized the SPRMC service areas as defined in the Kearney study and shown in Figure 1-1. These service areas are:

Primary:	Ramsey County	
Secondary:	Minnesota	Wisconsin
	Washington County	Polk County
	Dakota County	St. Croix County
	Hennepin County	Pierce County
	Anoka County	
	Chisago County	
Third-tier:	Minnesota	Wisconsin
	Isanti County	Barron County
	Goodhue County	Dunn County
	Sherburne County	Burnett County
	Pine County	Pepin County

Figure 1-1

SPRMC Primary and Secondary
Service Areas



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Our reason for adopting the Kearney service areas is that both population and comparative hospital data are readily available by county but less so by census tract. (By contrast, the population base for the primary service area defined in SPRMC documents includes some census tracts in Ramsey and some in Washington Counties.) The Kearney service areas are well suited to long-range planning and for describing and projecting environmental trends. Conversely, the SPRMC service areas familiar from hospital studies are ideal for detailed, short-term marketing plans.

POPULATION

Important population data are shown in Figure 1-2. In essence, the population in SPRMC's primary service area of Ramsey County is leveling off at about 450,000 people, and is aging. Population in surrounding counties is both growing and aging.

ACUTE HEALTH CARE RESOURCES AND UTILIZATION

Acute health care resources include hospitals; physicians; selected, specialized medical services; and selected ancillary services. Current supply and use of these resources are described below.

Hospitals

As is well known, Minneapolis-St. Paul is abundantly supplied with hospitals, use of which has been declining for several years. Hospital resources and their use in the Metro Area and in Ramsey County in 1983 are shown in Table 1-1. Concerning the Metro Area, the Metropolitan Council has commented that:[2/]

Figure 1-2

Key Population Trends
SPRMC Service Areas
1970-1990

Data Set	Key Facts and Trends (most numbers rounded)	Consultant Comments
Primary Service Area: Ramsey County	1. St. Paul City population declined 1970-80 by about 40,000 persons (-12.8%). Total population 1980 = 270,230. 2. Other Ramsey County population increased 1970-80 by about 23,000 persons (14%). Total Other County population 1980 = 189,554. 3. Total Ramsey County population therefore declined by about 16,500 people 1970-80 (-3.5%). 4. Virtually no change is projected for the total Ramsey County population in this decade (-.1% decline, 500 people).	Historically, SPRMC derives 75% of its admissions from Ramsey County (62% from St. Paul). No projections are available for St. Paul City only.
Secondary Service Area: Minnesota Washington Dakota Hennepin Anoka Chisago Wisconsin Polk St. Croix Pierce	5. Only Hennepin County population declined 1970-80 by about 20,000 people (-1.9%). Total population 1980 = 953,537. 6. All other counties increased by 21-47% in 1970-1980. Greatest growth in persons was a 54,500 increase in Dakota, while greatest % increase was in Chisago (47%, 8,000 people). 7. Total population for these counties increased 1970-80 to 1,709,757 (9.4%). 8. An increase of 8.4% is projected for these counties in 1980-90. Every county will grow. Greatest growth projected to occur in Anoka (33,000 increase), Washington (29,000 increase), Dakota (29,000 increase), and Hennepin (12,000 increase).	Historically, SPRMC derives 18% of its admissions from the Secondary Area counties.
Third-Tier Service Area: 4 counties in Minnesota 4 counties in Wisconsin	9. Population increased 23% 1970-80, for a total in 1980 of 204,989. 10. Population is projected to increase 1980-90 by 24% (49,000 people).	Historically, SPRMC derives 5% of its admissions from this area.

Figure 1-2 (continued)

Data Set	Key Facts and Trends	Consultant Comments
Geographic Detail	11. Within Ramsey County, St. Paul fell from 65% of the population in 1970 to 59% of the population in 1980. 12. Three communities, Roseville, Maplewood, and New Brighton, now each contain over 5% of the county's population (7.8%, 5.9%, 5.1%).	No projections to 1990 are available.
Age Detail	13. Median age for Ramsey County is 29. 14. Children (0-14 years) as a proportion of total population declined in Ramsey County and most of the secondary counties 1970-80. In Ramsey, the number of children declined 13% to become 21% of the total; in the secondary area, the number of children declined 19% to become 22% of the total. 15. Old people 65 as a proportion of total population increased in all service areas 1970-80. 16. In Ramsey, the number of elderly increased by nearly 5,000 (10%) to become 11.6% of the total population. In the secondary area, the number increased by 25,000 (20%) to become 9.4% of the total. In the third-tier, the increase was 4,500 people (20%), to become nearly 14% of the total. 17. The number of children in Ramsey is projected to decline 1980-90 (-.7%), and to increase in all the other service area counties except Anoka (5% in secondary, 20% in third-tier). 18. The number of elderly is projected to increase in every county in the service area 1980-90: by 12% in Ramsey, 18% in Secondary, 11% in third-tier. 19. The number of elderly in Anoka, Dakota and Washington is projected to increase over 40% 1980-90 (65%, 50%, 44%, respectively).	Pediatric admissions historically account for 8% of SPRMC total. Elderly admissions are increasing steadily as a % of total SPRMC medicine-surgery admissions. The increases are as follows: 1978 1983 Medicine (% total) 39% 45% Surgery (% total) 17% 21%

Source: Kearney, Progress Report, September 26, 1984, "Planning Data Base," pp. 8, 11, 13.

Table 1-1

Hospital Supply and Utilization
Twin Cities Metro Area and Ramsey County
1983

Area/Resource	Number	% Change 1982-83	Area/Resource	Number	% Change 1982-83
Metro Area			Ramsey County		
hospitals	34	--	hospitals	10	--
patient days	2,148,569	-8.6%	patient days	567,382	-9.6
admissions	313,998	-3.6	admissions	82,307	-5.3
licensed beds	10,442	.16	licensed beds	2,955	--
staffed beds	9,032	-2.6	staffed beds	2,322	-6.0
average census	5,886	-8.6	average census	1,554	-9.6
ave. stay (days)	6.8	-5.6	ave. stay (days)	7.1	-1.7
occupancy (lic.)	56.0%	-8.6	occupancy (lic.)	52.6%	-9.6
occupancy (st.)	65.0%	-6.0	occupancy (st.)	66.9%	-3.9
pt. days/1,000	881	-10.0	pt. days/1000	1,234 1/	-9.6

Note:

1. Determination of this use rate theoretically requires a statistic for Ramsey County residents' patient days adjusted for both in- and out-migration. This statistic is not available. Patient days reported by Ramsey County hospitals for 1983, unadjusted and therefore including non-Ramsey County in-migration (which includes Wisconsin) for hospital care, is used to derive this rate. (1983 Ramsey County population interpolated by Lewin and Associates from 1980 projections in Kearney, p. 8.)

Sources:

Metro Area: Metropolitan Health Planning Board, "Hospital Acute Care Use in the Twin Cities Metropolitan Area," Data-Log, No. 18-84-071, May 1984.

Ramsey County: Kearney, Progress Report, September 26, 1984, "Planning Data Base," pp. 15, 17, 19, 29. Ramsey County statistics not found in Kearney are calculated by Lewin and Associates from hospital-specific data in the above study.

- 43 percent of licensed beds were empty on an average day in 1983;

- at the regional standard of 80 percent occupancy for acute care, there were 3,084 excess beds in 1983 (1,674 based on staffed beds);

- "We are rapidly approaching a point where half of all the bed capacity in the system is unused at any given...time."

Comparable statements apply to Ramsey County:

- 47 percent of licensed beds were empty on an average day in 1983;

- at the regional standard of 80 percent occupancy for acute care, there were 1,013 excess beds in 1983 (379 based on staffed beds);

- over half of the licensed bed capacity in Ramsey County was unused at any given time in 1983.

Pictured in terms of numbers of hospitals, at an average bed capacity of 295 (the current licensed average for Ramsey County), there are 3.4 too many hospitals in the County. At least two hospitals are known to be responding to this situation, one by consolidating some services with a hospital in St. Paul, the other by relocating within the County to be closer to suburban users.

Not only are Ramsey County hospital beds typically unused at an efficient level, the rate of use as measured by patient days per 1,000 is rather high compared to the Metro Area rate,[3/] as follows:

	% greater than 1983 Metro rate
1983 Ramsey County patient days per 1,000 (unadjusted)	40%
1983 Ramsey County patient days per 1,000 (adjusted for 16% in-migration)[4/]	19
1983 Ramsey County patient days per 1,000 (adjusted for 20% in-migration)[5/]	13

This suggests that Ramsey County hospitals may not yet have felt as much impact from HMO and other utilization controls as other hospitals in the Metro Area. Consequently, further and major declines may be anticipated.

Looking at hospital capacity and use in SPRMC's secondary and third-tier service areas, supply has remained steady and use is declining almost everywhere, as shown in Table 1-2. The major population increases in these areas over the last decade have not apparently overcome contrary forces holding hospital use in check.

Physicians

From 1970 through 1981, physician supply increased substantially in Ramsey County and in all but one of the surrounding secondary and third-tier counties. As shown in Table 1-3, nine counties, including Ramsey and Hennepin, experienced physician manpower increases at rates exceeding population increases (as shown by rising physician:population ratios).

Unfortunately, no data are available concerning utilization of physician services in Minnesota or in Minnesota

Table 1-2

Hospital Supply and Utilization Trends
Secondary and Third-Tier Service Areas[1]
1979-1983

Supply, Utilization Indicator	Service Area Trends	
	Secondary Area[2]	Third-Tier Area[3]
Hospitals	No change	No change
Licensed beds	No change except for slight increase in Hennepin County (140 beds)	No change except for very slight decrease in Barron County, Wisc. (4 beds)
Admissions	Steadily down, every county	Steadily down, five counties; no change, one county (Dunn, Wisc.); increase, one county (Pine, Minn.)
Patient days	Steadily down, all except St. Croix, Wisc., which fluctuates.	Steadily down, four counties; no change, one county (Dunn, Wisc.); increase in 1983, two countiees (Burnett, Wisc.; Pine, Minn.).
Occupancy	Steadily down, all except St. Croix, Wisc., which fluctuates.	Generally down, but fluctuates at some very small hospitals.

Notes: 1. As defined by the Kearney, Progress Report, September 26, 1984.

2. Washington, Dakota, Hennepin, Anoka, Chisago in Minnesota; Polk, St. Croix, Pierce in Wisconsin.

3. 4 in Minnesota; 4 in Wisconsin.

Source: Kearney, Progress Report, September 26, 1984, pp. 20, 22.

Table 1-3

Physician Supply
Ramsey County
Selected Secondary and Third-Tier Counties[1/]
1970-1982

Location	Number of Physicians			Physician to Population Ratio		% Increase by Specialty 1970-1981			
	1970	1981	% Increase	1970	1981[2/]	GP	Medical	Surgical	Other
Ramsey	513	822	60%	1:683	1.427	28%	89%	42%	98%
Washington	22	68	209	1:3190	1:1689	88	N/A	600	200
Dakota	39	84	115	1:2912	1:2098	64	N/A	100	150
Hennepin	1210	1889	56	1:543	1:357	15	102	36	78
Anoka	30	101	236	1:3963	1:1037	79	N/A	200	567
St. Croix	17	25	47	1:2021	1:1639	36	0	200	0
Barron	23	39	70	1:1476	1:980	37	N/A	300	100
Isanti	9	18	100	1:1476	1:1980	60	N/A	150	0
Goodhue	25	34	36	1:1337	1:1056	38	50	33	0
Total, all service areas	1956	3153	61%	1:762	1:537	28%	108%	44%	88%

Notes: 1. Increase of >5 physicians over the period.

2. Population estimated by Kearney (Table 44).

Source: Kearney, Progress Report, September 26, 1984, "Planning Data Base," p. 58.

counties. It can be inferred, however, that local physician activity is down, since this is true nationwide and in the north central U.S., as shown in Figure 1-3.

Selected Specialized Medical Services

Specialized medical services are usually expensive, frequently both life-saving and risky for the patient, and often in over-supply in urban areas. Over-supply means inefficient levels of use at some or all hospitals, the possibility of "unnecessary" use, and the potential for sub-optimal outcomes due to inadequate volume.

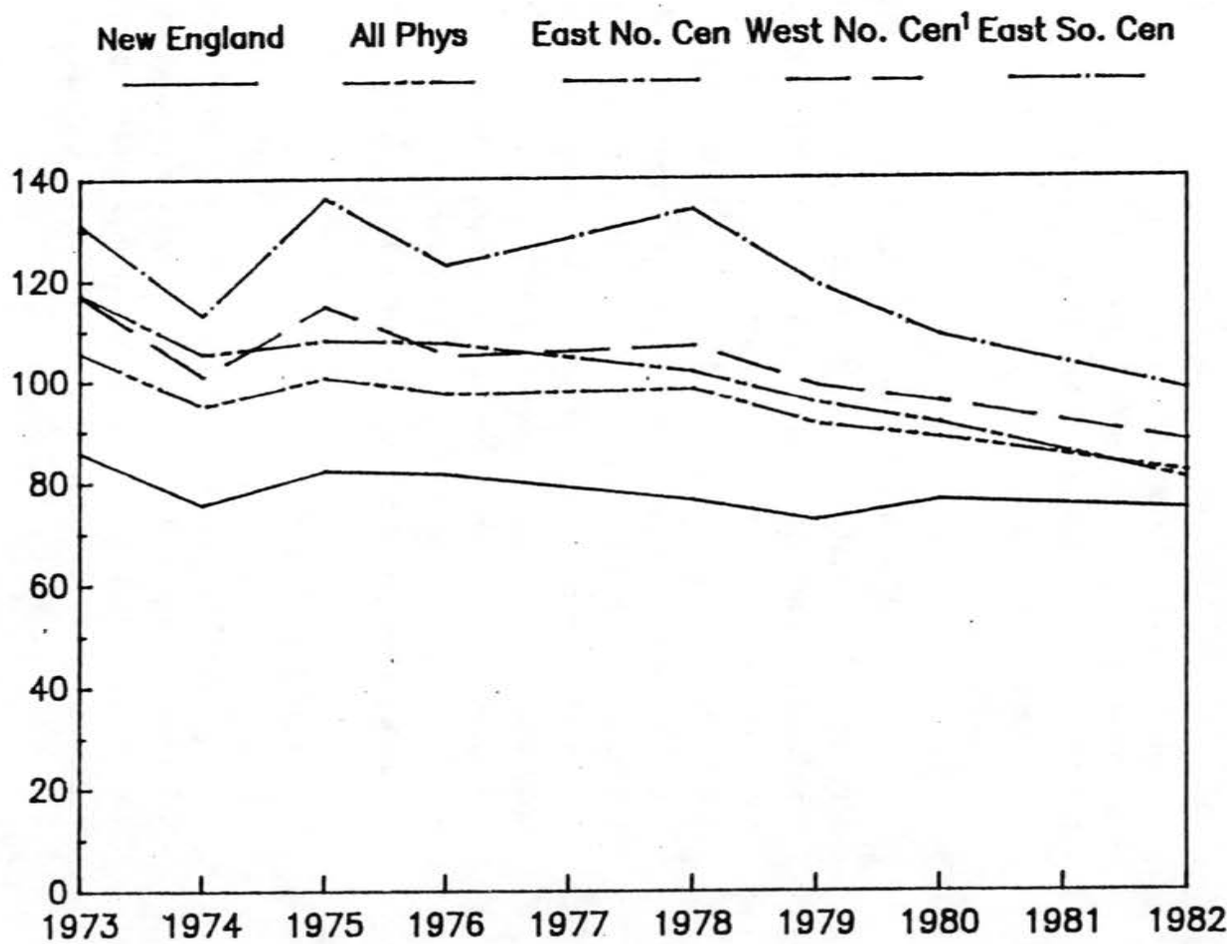
Available data indicate that certain specialized medical services are plentiful in the Metro Area, but that de facto "regionalization" has occurred and is increasing for many, as shown in Table 1-4. For every service shown in the table, from two to seven hospitals supplied at least 50 percent of all services used in 1983. These hospitals were termed "dominant" by the Metro Health Council. SPRMC, it may be noted, supplies seven of the ten services inventoried in Table 1-4, but is "dominant" in only one: pediatrics. However, SPRMC is dominant in burn treatment, traumas and emergency services, categories which were not inventoried, and certain of the inventoried specialties may be necessary backups to these stronger suits.

Selected Ancillary Services

Availability of ancillary services' supply and utilization data is spotty. A major reason is that presence and use of such services in physician offices (office buildings) are not currently reportable. Data available for Ramsey County are shown in Table 1-5 and document that:

Figure 1–3

AVERAGE VISITS PER WEEK SELECTED AREAS OF U.S., 1973–82



Visits per Week	1973	1982
New England	85.9	74.6
All Physicians	105.8	81.8
East North Central	117.4	80.4
West North Central	117.1	87.9
East South Central	131.2	98.0
Mountain	109.6	78.7
Pacific	98.3	78.7
Middle Atlantic	84.2	73.7
South Atlantic	117.7	83.2
West South Central	116.8	90.5

1. Includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North & South Dakota

Source: "Socioeconomic Characteristics of Medical Practice 1983," AMA

Table 1-4

Trends in Specialized Services
Twin Cities Metropolitan Area
1979-83

Specialty Service	# hospitals 1983	% change in # of procedures/days 1979-83	Metro market share: # hospitals "dominant" 1/ 1983	Metro market share: % of procedures 1979	Metro market share: % of procedures 1983	Leading hospital	SPRMC Position: provides	SPRMC Position: in dominant group	SPRMC Position: E. Metro market share: change in
Cardiac									
open heart	10	58 %	4	70 %	76 %	Abbott-NW	yes	no	up 1/3 10/
cath	10	48	5	65	73	Abbott-NW	yes	no	down 1/2
open heart (peds)	3	52.5	2	84	98	UM	no	no	na
cath (peds)	5	-39.5	2	86	99	UM	no	no	na
Radiation Therapy (megavoltage)	16	1.4 3/	6	88	89	St. Joseph's	no 7/	no	na
CT Scanning	19 2/	82 4/	5	49	48	Abbott-NW	yes	no	down 1/2
NICU	6	16 5/	3	66	70	UM	yes 8/	no	down 1/10
NICU transfers	6	33	3	na	99	Minn. Children's	yes	no	NR 11/
Obstetrics	29	15 6/	7	48.5	56	Fairview	yes	no	up 2/5 12/
Pediatrics	22	-22 5/	4	52	69	Minn. Children's	yes	yes 9/	up 4/5

Notes:
1. Term used by Metropolitan Health Planning Board.
2. CT also available at four clinics, for which no data are reported.
3. Actual cases decreased over the period, but procedures ("treatments") per case have increased. The Metro Area case decrease may be due to decline in out-of-area referrals.
4. Procedures measured in HECTS (Head Equivalent CT Scans).
5. Measured in days.
6. Measured in births.
7. Service closed 1981.
8. SPRMC NICU ADC is lowest in the Metro Area (11) and occupancy is second lowest (73%).
9. SPRMC combined with Gillette Children's for this service.
10. SPRMC adult open-heart surgeries 1983 = 168. "Dominant" hospitals do over 250/year.
11. NR = not reported.
12. SPRMC live births 1983 = 1,227. "Dominant" hospitals have over 2000/year.

Source: Metropolitan Health Planning Board, "Specialty Services Utilization Trends," draft, October, 1984.

Table 1-5

Use Rates per 100 Admissions
Selected Specialized Ancillary Procedures
Ramsey County Hospitals[1]
1983

Hospital	Rate per 100 Admissions				
	Dx Ultra-Sound	CT Body Scans	Cardiac Caths	ER Visits	Surgeries[3]
SPRMC	25	21	1.2	434	37
United[2]	52	na[5]	3.9	123	35
St. Joseph's	14	15	1.6	--	40
St. John's	22	12[6]	--	139	62
Bethesda-Lutheran	15	.5	--	198	62
Midway	21	27	--	--	56
Children's	--[4]	--	--	--	30
Gillette	--	--	--	--	60

Notes:
1. Excludes Mounds Park and Samaritan, for which admission data are unavailable.
2. Admission data for 1983 unavailable. Admissions in 1982 = 16,114. Therefore 16,000 admissions are assumed here for creating the rates.
3. Inpatient only.
4. Service not available.
5. Performed off-site in medical office building and not reported.
6. Includes head scans on inpatients.

Source: Kearney, Progress Report, 1984, "Planning Data Base," pp. 16, 39.

- CT scans are done at (or by arrangement, near) every hospital;
- diagnostic ultrasound is done at (or by arrangement near) every hospital;
- inpatient dialysis is done at two hospitals (SPRMC, St. Joseph's);
- outpatient dialysis is done at only one hospital (SPRMC);
- 28 percent of all Ramsey County hospital surgery is done on an outpatient basis;
- there are five emergency rooms in the County;
- cardiac catheterizations and open heart surgery are done at three hospitals (SPRMC, United, St. Joseph's);
- use of these services varies widely by hospital.

HOSPITAL MARKET SHARES

The advent of a more competitive marketplace for hospital care has created a great interest in market share data. While such data are now widely available, SPRMC was one of only two acute hospitals in the Metro Area that did not participate in the ongoing, comprehensive market share surveys prepared by the Council of Community Hospitals until 1984-85.[6/]

SPRMC market share data and analyses prepared by SPRMC staff and by Kearney enable us to present some salient points

about market shares in Ramsey County and in the Metro Area, as shown in Figure 1-4. All available data indicate that SPRMC is maintaining its market share while overall hospital use is shrinking. The data further show that the three large, government, teaching hospitals in the Twin Cities -- SPRMC, Hennepin and University of Minnesota -- are all holding their market positions despite higher prices.

Market share data for some counties in SPRMC's secondary service area are shown in Figure 1-5. It can be seen that several Ramsey County hospitals draw patients from outside the County, and that SPRMC has the highest share only for Polk County, Wisconsin.

HOSPITAL EXPENSES AND PRICES

Comparative data on hospital expenses (costs) and prices (charges) is of great interest in a competitive environment, and is discussed in more detail in Chapter Three. Average expenses per patient day and discharge in the Metro Area rose steadily until 1983. However, rates of increase between 1982 and 1984 have been projected to be about 50 percent less than those experienced in the 1979-1982 period for both indicators. Expenses at the three government teaching hospitals, Hennepin County Medical Center, the University of Minnesota, and SPRMC are considerably higher than Area averages, but have also risen at lower rates over the period. This could indicate a "catch-up effect" at Metro Area community hospitals, expanding their scope of services and/or a change in patient mix at these hospitals, requiring more expensive care. The rapid deceleration in the rate of increase in hospital costs and charges in the Metro area in 1983-84 may in part be due competition for patients and HMO contracts may be beginning to have an effect in the Metro Area.

Figure 1-4

Key Market Share Facts and Trends
Ramsey County and Metro Area
1982, 1983

Data Set	Key Facts and Trends	Consultant Comments
Hospital Market Share (measured by admissions) Ramsey County Detail	1. Five hospitals in Ramsey County have increased their market shares in the last 5 years, despite an overall drop of 11% in county-wide admissions. These hospitals are: SPRMC United St. Joseph's Children's Gillette	These are SPRMC's local competitors. SPRMC's Ramsey County market share (admissions) increased from 15% to 18% from 1978. The yearly rate of increase exceeded that of any other hospital, i.e., SPRMC increased its share faster than any of the other four hospitals.
	2. Six Ramsey County hospitals each had over 10% of Ramsey County admissions in 1982. These were: United (20%) SPRMC (18%) St. Joseph's (13.5%) St. John's (13%) Bethesda-Lutheran (11%) Midway (11%)	
	3. Highest Ramsey County market share is currently (1982) held by United, at 20%.	
	4. Minnesota hospitals outside Ramsey County attracted 23% of Ramsey County residents' admissions in 1981.[1]	Total Ramsey County residents' admissions for any year are unknown, as are total inflows of residents of other counties. If these were known, one could say: there are x thousand patient days leaving the county; this is a market potential for someone, etc.
Metro Area Detail	5. Only 7 of 14 large (over 10,000 admissions) Metro Area hospitals increased their Metro Area market shares in 1983 compared to 1982, despite an overall drop of 3.6% in total admissions. These hospitals are: Abbott-Northwestern Methodist University of Minnesota Fairview-Southdale SPRMC Fairview Mercy	There are 34 hospitals in the Metro Area. The increases were all very small, less than one percentage point in every case.

Figure 1-4 (continued)

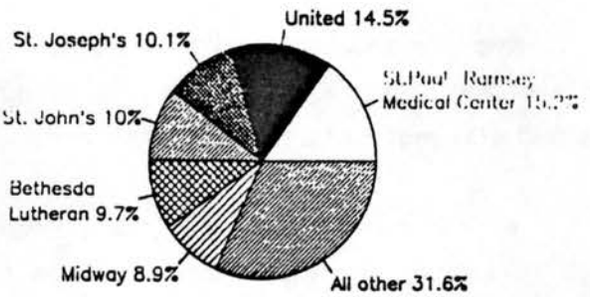
Data Set	Key Facts and Trends	Consultant Comments
Metro Area Detail (continued)	6. These 14 largest hospitals are gaining on the 20 smaller ones, increasing their collective market share from 70.5% to 72% in 1983.	
	7. Looking at absolute number of admissions, only 3 large Metro Area hospitals increased theirs in 1983: Abbott-Northwestern (+161) Methodist (+817) Fairview (+1912)	Absolute number of admissions is another indicator of market drawing power, along with market share percentages. "How many are lost" at one hospital compared to others is therefore a number of interest.
	8. 11 large Metro Area hospitals lost admissions in 1983, but only two lost fewer admissions than SPRMC: Fairview-Southdale (-82) Univ. of Minnesota (-154) SPRMC (-249)	SPRMC lost admissions at a lower rate 1982-83 (-1.3%) than either the Metro Area (-3.6%), Hennepin (-4.9%), or any of its Ramsey County competitors. University of Minnesota's rate was even lower than SPRMC's (-.8%).
	9. The three big Metro Area teaching hospitals each maintained or increased market share 1982-1983, and each maintained its overall ranking in the Metro Area: U. of Minn. 6.2% 4 Hennepin 4.9% 8 SPRMC 4.6% 9 (Market Share 1983; Rank 1982 and 1983)	These three hospitals constitute a "peer group" for SPRMC for comparison purposes.

1/ Data for out-migration do not include out-of-state hospitalizations of Minnesota residents. In addition, no conclusion can be made regarding in-migration, since available data do not show discharges of out-of-state residents or Minnesota residents of counties outside the Metropolitan Area.

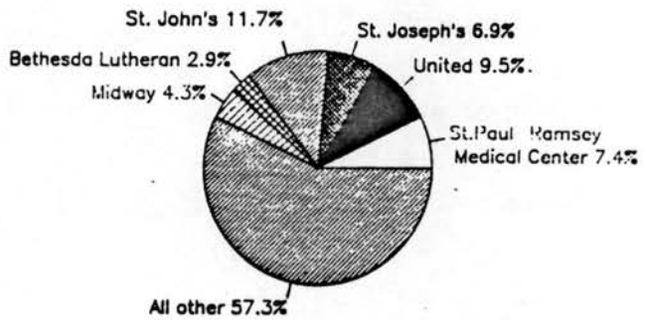
Source: Kearney, pp. 16, 35. Metropolitan Council and Metropolitan Health Planning Board, "Hospital Acute Care Use in the Twin Cities Metropolitan Area, 1982 and 1983," Data-Log, n.d., Tables 1, 4 and 9.

Figure 1-5

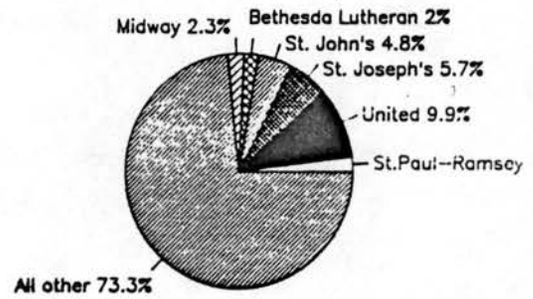
RAMSEY COUNTY MARKET SHARE BY PERCENT DISCHARGES:
RAMSEY COUNTY HOSPITALS AND SPRMC, APRIL 1981



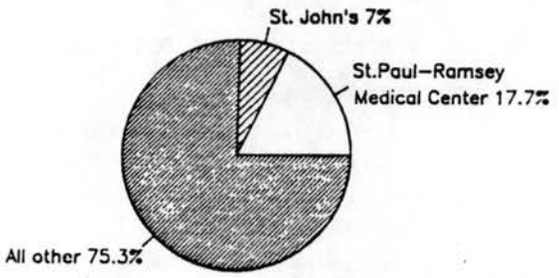
WASHINGTON COUNTY MARKET SHARE BY PERCENT DISCHARGES:
RAMSEY COUNTY HOSPITALS AND SPRMC, APRIL 1981



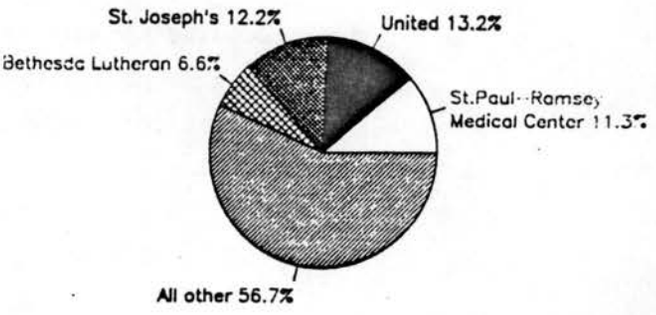
DAKOTA COUNTY MARKET SHARE BY PERCENT DISCHARGES:
RAMSEY COUNTY HOSPITALS AND SPRMC, APRIL 1981



POLK COUNTY, WISCONSIN, MARKET SHARE BY PERCENT DISCHARGES:
RAMSEY COUNTY HOSPITALS AND SPRMC, APRIL 1981



ST. CROIX COUNTY, WISCONSIN, MARKET SHARE BY PERCENT DISCHARGES:
RAMSEY COUNTY HOSPITALS AND SPRMC, APRIL 1981



Source: 1981 COCH Patient Origin Study as reported in
Kearney Progress Report, Sept. 26, 1984
Planning Data Base, page 35.

PRIVATE THIRD-PARTY PAYMENT

Two prominent trends in this area of the health care field are possibly the most important of all environmental factors for SPRMC strategic planning. These are:

- the substitution of fixed, negotiated, contractual rates for traditional charges for inpatient care; and

- the introduction of stringent inpatient utilization review procedures, including prior review of elective admissions and concurrent review of all admissions, based on length-of-stay norms.

Together, these two trends, independent of any others, portend both reduced revenue from private patients and the virtual disappearance of "charge shifting"[7] to cover uncollectible accounts.

These private reimbursement trends are familiar in the Metro Area from the growth of HMOs, the initiation of PPOs, and the introduction of the "AWARE" program by Blue Cross/Blue Shield. The Twin Cities, in fact, have achieved a national reputation for aggressive movement away from traditional physician and hospital payment mechanisms and towards HMOs and preferred provider organizations (PPOs).[8]

A total of 710,176 people are now reportedly enrolled in six non-profit HMOs, and one informed observer predicts this figure will double in five years.[9] If the yearly rate of membership increase from 1979-1984 were to be maintained (18%/year compounded[10]) for the next five years, 1,624,900 HMO enrollees would be the result. That both current HMO penetration and future

prospects are central for hospital strategic planning would seem to be self-evident.

Several recent local studies have attempted to document the impact of HMO growth on Metro Area hospitals. Salient findings are summarized in Figure 1-6. The accumulated evidence indicates that HMO patients use fewer resources than insured patients, and also use specialty services differently from insured patients, (not to mention government patients).

To the extent that SPRMC has yet to feel the full impact of a significant growth in HMO enrollment, current admission and length-of-stay patterns and departmental activity levels could undergo additional changes. It has been alleged to the consultants that HMO penetration in St. Paul lags well behind that in Minneapolis. During 1983, HMO patients accounted for only 5 to 6 percent of SPRMC's patient population, lower, we believe, than other hospitals in the Metro Area. If a significant proportion of SPRMC admissions from St. Paul are insured patients, then it is probably inescapable that either SPRMC will lose insured patients as HMO penetration picks up in St. Paul, or that it may retain these patients but only by contracting for them with one or more HMOs. Either way, additional loss of patient days and differential pressure on major inpatient services can be expected.

In addition to HMOs, PPOs negotiate discounts on daily hospital rates, and Blue Cross/Blue Shield pays on a prospective price basis. These trends, combined with the change in government reimbursement, have resulted in some 70 percent of SPRMC's patient population being covered by prospectively paid rates. Given this situation, SPRMC's 20 percent decline in length of stay in 1983-84 is significant, but we expect there may be more tightening to come in both average length of stay and admissions per 1000.

Figure 1-6

Research Findings from Recent HMO Studies
and Implications for Planning
1984

HMO Research Findings	Implications for Planning
1. Both group and IPA HMO lengths of stay were 1.5-2.2 days shorter in 1982 than self-pay, commercial insurance, and BC patients, and 2.7 days shorter than the Metro average.1/	1. An increase in Metro Area HMO patients means fewer hospital resources will be required areawide.
2. Group HMO patients had shorter average lengths-of-stay in 1982 for 5 of 7 DRGs than all other categories of payer except "self-pay," with age, sex and "severity" controlled.2/	2. HMOs appear to need fewer hospital resources independent of the characteristics of their enrolled populations. It has been speculated that HMO populations are younger, healthier, etc. To the extent such factors can be accounted for, there is still a residual effect from the "HMO itself": this type of organization uses hospitals less.
3. Total HMO admissions are distributed among 13 "service groups" very differently from admissions of commercially-insured and BC/BS patients. In particular, the proportion of HMO admissions is relatively low in general medicine, ophthalmology, orthopedics, oncology, cardiology, chemical dependency, and psych., and relatively high in gyn, ob, newborn, peds. and ENT. These differences are not due to age differences between HMO and insured populations.3/	3. HMOs use several hospital services much less intensively than typical insured populations. An increase in HMO patients could thus have uneven impact on a hospital, some departments feeling more "loss of business" than others.
4. In 1982, the top 15 DRGs (admissions) in the Twin Cities accounted for only 33.4% of total admissions, but 52.1% total HMO admissions.4/	4. This is further evidence that HMOs buy a characteristic "product mix" of services from hospitals, a mix not necessarily identical with the mix available.
5. HMO admissions increased 1980-82 from 0 (i.e., not classified) to 10.3% of Metro Area total admissions, while the combined percentage for commercial insurance and BC/BS decreased from 52:7% to 43.4% of total admissions.5/	5. HMOs are not only different, they are growing, and they are growing at the expense of the traditionally insured population.

Sources:
1. D. Aquilina and A. N. Johnson, "Payer Utilization Profiles: Admissions and Length of Stay," Council of Community Hospitals (COCH), November 1983, p. 7.
2. B. E. Dowd, A. N. Johnson and R. A. Madson, "The Relationship of Third-party Insurance Coverage to Inpatient Length-of-Stay in Twin Cities Hospitals," COCH, February, 1984, p. 15.
3. D. Aquilina and A. N. Johnson, op. cit., pp. 15, 25.
4. D. Aquilina and A. N. Johnson, "Do HMO's and Other Buyers Purchase Similar Hospital 'Products'?," COCH, May, 1984, p. 6.
5. D. Aquilina and A. N. Johnson, "Payer Utilization Profiles...," p. 10.

GOVERNMENT PAYMENT TRENDS

Payment for inpatient care by Medicare on a case-based (DRG) basis has already had a measurable impact on all participating hospitals. Medicare average length of stay is down over one day per stay and there has been no increase in the number of admissions, according to national data. Payment growth has been limited to the growth in the hospital market basket portion of the consumer price index and federal budget projections indicate a possible freeze in DRG payments. Further, 1985 will see the advent of extensive contracting for Medicare patients on the "95% capitation rule;" i.e., qualified HMOs will be able to draw patients away from the fee-for-service Medicare program by offering increased Medicare benefits.

Similarly, Medicaid payments will become increasingly inadequate as capitation contracting spreads and as federal matching funds are constrained.

SUMMARY

The implications of environmental trends for SPRMC may be summarized as follows:

- There is not a single trend which, by itself, implies a strong or healthy future for SPRMC.
- SPRMC's vulnerability to changes in private, third-party payment patterns has been delayed by uneven HMO growth in the Metro Area, St. Paul being comparatively "underdeveloped" in this respect.

- SPRMC has thus far maintained its flow of admissions, and thereby its market share, as competition has heated up in the Metro Area and especially in St. Paul.

- The market for inpatient services will continue to contract, and maintaining present market share is problematic unless SPRMC can gain a share of the prepaid care market.

- Trends in demography and hospital use indicate that one or two hospitals may not survive through the 1980s.

- Medicare and Medicaid patients will move into organized health systems.

- Fewer hospitals will be able to accept unfinanced patients in the Twin Cities.

Notes -- Chapter One

1. St. Paul-Ramsey Medical Center, "Patient Origin Analysis Update," November 1983; Kearney, Progress Report, September 26, 1984, "Planning Data Base," pp. 1-8. (Hereafter: Kearney)

2. Metropolitan Council and Health Planning Board, "Hospital Acute Care Use in the Twin Cities Metropolitan Area," Data-Log, No. 18-84-071, May 1984, pp. 3-4.

3. While other data sources may vary, the consultants chose to use data from the most authoritative local source. The numbers used in these calculations are from the Metropolitan Health Planning Board for this analysis.

4. Patient days per thousand for 1983 for Ramsey County, adjusted for assumed 16% in-migration, were 1050. In 1983, 14.9% of SPRMC patient days were from non-Metro Area admissions (SPRMC, "Patient Origin Analysis Update," November 1983, p. 16). Assume another 1% for non-Metro admissions to other Ramsey County hospitals.

5. If one assumes 20% total non-Metro in-migration, the patient days/1000 in 1983 were 988.

6. Council on Community Hospitals, "Market Share Analysis Report," quarterly.

7. The traditional practice of shifting unreimbursed costs incurred by government and non-paying patients to the charges paid by insurers.

8. J. K. Iglehart, "The Twin Cities Medical Marketplace," The New England Journal of Medicine, 311: 343-348, August 2, 1984.

9. Ibid, p. 343.

10. R. Feldman, et al., "The Competitive Impact of HMOs on Hospital Finances: An Explanatory Study," COCH, n.d., Table 1. The rate of growth is derived from enrollment data for 1979 in this table and the 710,000 current enrollment figure cited by Iglehart.

CHAPTER TWO

ORGANIZATIONAL FRAMEWORK AT SPRMC: MISSION, GOVERNANCE AND RELATIONSHIPS TO EXTERNAL ORGANIZATIONS

The "organizational framework" at SPRMC encompasses three elements:

- mission;
- governance structure; and
- relationship to external organizations.

This framework at a public hospital affiliated with a university medical school is always complex. Hospitals are never simple to understand or easy to run, but public hospitals often appear byzantine. This chapter describes SPRMC's current mission, governance, and external relationships as the consultants understand them. It concludes with our assessment of the hospital's ability to respond to environmental pressures within the current framework.

MISSION

> **Mission,** n. 2. The business with which an agent, envoy, etc. is charged.
> (The American College Dictionary, New York: Random House)

In common parlance, "mission" responds to the question: "Why are we here?"

The mission of SPRMC is stated in statutes enacted since 1969 by the Legislature of the State of Minnesota. The original statement is as follows:

"The (Ramsey County Hospital and Sanitarium) Commission shall take all measures necessary and proper to provide hospital and medical services for the indigent, and contagiously ill, catastrophically injured, and city and county prisoners, and may take all measures necessary and proper to maintain the hospital as a research and teaching institution."[11]

Notice:

- The Commission shall provide services to the indigent, contagiously ill, and catastrophically injured ...;
- The Commission may provide for teaching and research.

In 1982, the mission statement was amended, as follows:

"The (St. Paul-Ramsey Medical Center) commission shall provide hospital and medical services for the indigent of Ramsey County, the contagiously ill, and catastrophically injured and city and county prisoners, and maintain the hospital as a research and teaching institution. It may provide hospital and medical services for the general public."[12]

Notice:

- The Commission shall provide services to the indigent of Ramsey County and (shall) maintain the teaching and research functions;
- The Commission may provide services for the general public of any unspecified area, i.e., not limited to Ramsey County.

This 1982 statement supplies the hospital's current mission, its reason for being.

In practice, this mission statement requires that SPRMC serve Ramsey County patients unable to pay and ineligible for any government reimbursement program, but not non-county indigent persons. It underlies development of the Trauma Center, and it explains the presence of the teaching program. The mission can also justify the existence of virtually any service provided to anybody at SPRMC as the exercise of the discretionary authority to serve "the general public."

It may be stressed that it is the hospital's governing commission, not the Ramsey County Board of Commissioners, that has the statutory mandate to provide care to Ramsey County indigents. In a memo prepared by the County Attorney's Office in 1983, the legal background concerning the County Commissioners' responsibilities was researched at length.[13] It appears that:

- The authority of Minnesota counties to provide for "hospitalization" of the indigent residents of the County is discretionary;[14]

- A 1968 court case stated that, while such authority is discretionary, "It has long been the unequivocal policy of our state that any person living in Minnesota and in need..., who...is unable to earn a livelihood, shall be cared for at public expense."[15]

- Ramsey County is authorized to provide funding for operations and construction (see section 2, below) at SPRMC, and is the only entity so authorized.[16]

Therefore the memo states that:

- "...the discretionary language which gives the County authority to provide funds should be construed to achieve a mandatory result;"[17/]

- "In the sense that, if supplemental assistance is to be provided to the medically indigent, it must be done by the county, (therefore) the county does have a responsibility to the medically indigent."[18/]

In sum, the Hospital Commission's mission is clear; the County Commissioners' charge less so.

GOVERNANCE

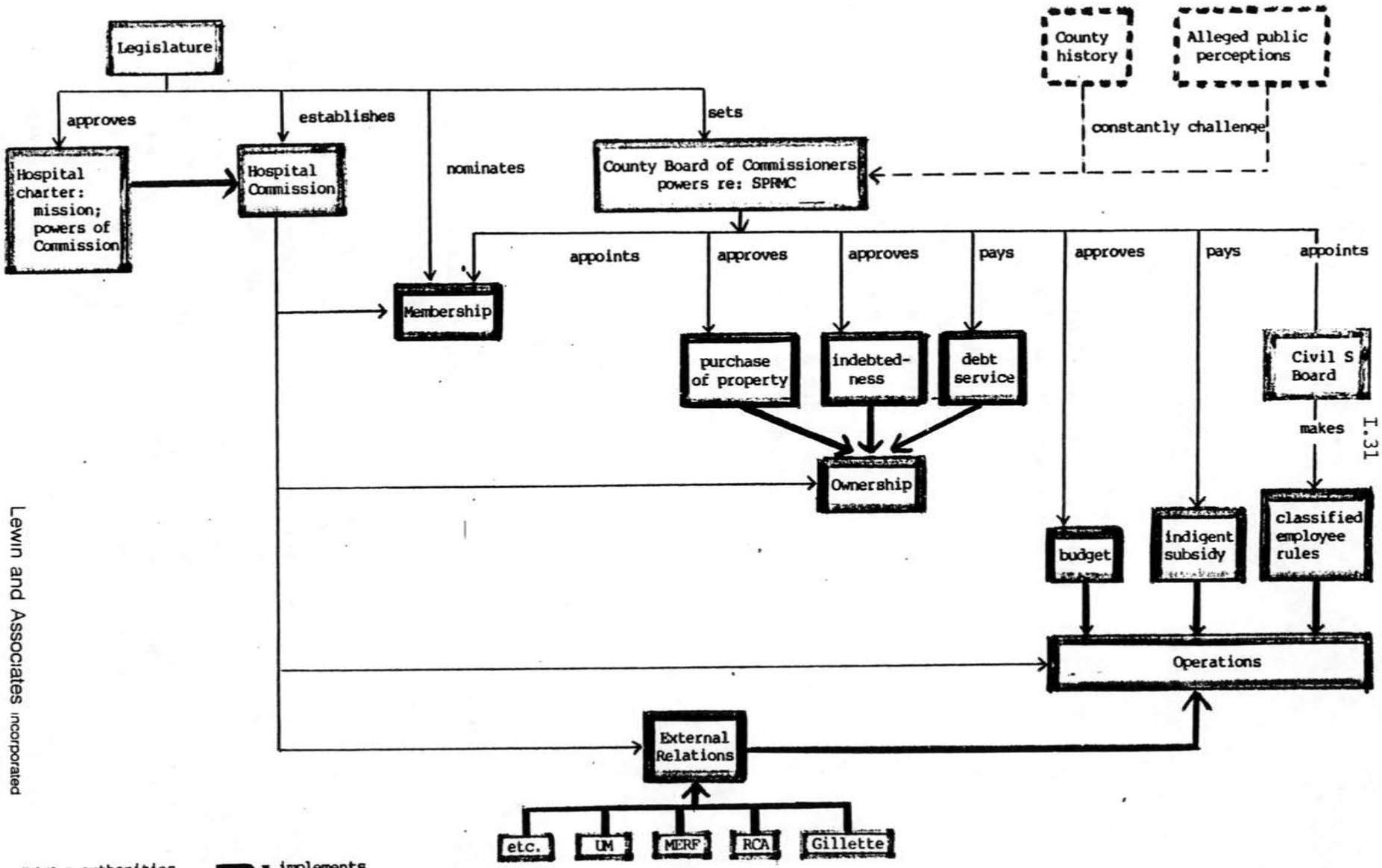
> **Governance**, n. 1. government; exercise of authority; control. 2. method or system of government or management.
> (The American College Dictionary, New York: Random House, 1955)

Governance, a fundamental feature of any hospital, responds to the question: "Who's in charge here?"

The legal structure of governance at SPRMC is shown in Figure 2-1. The Legislature of the State of Minnesota is the ultimate governing authority of SPRMC, since both the composition of the hospital's governing board and the guiding philosophy ("mission") of the institution derive from state statutes, and cannot be changed without enabling legislation. The state's interest extends even further: 9 out of 15 appointments to the governing board must come from persons nominated by Ramsey County

Figure 2-1

Who's In Charge Here: Current Governance
of St. Paul Ramsey Medical Center



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legislators. Having reserved for itself some fundamental governance elements at SPRMC, the state then delegates a mix of governance and management responsibilities to two penultimate authorities, the St. Paul-Ramsey Medical Center Commission ("Hospital Commission"), created by statute and designated as the hospital's official governing board, and the Ramsey County Board of Commissioners. The key obligations of these two governing bodies are as follows:

	County Board	Hospital Commission
MANDATORY	• appoints 15 Hospital Commission members, 9 from the list of nominees, 4 County Commissioners, and 2 at large	• nominates 2 at-large members of the Commission (since 1983) and elects its own officers
	• approves SPRMC budget; approves purchase of property by the Hospital Commission	• has all power necessary or convenient for "the operation, administration, management and control" of SPRMC[19]
	• approves any line of credit sought by the Hospital Commission	• may own property in its own name
PERMITTED	• may issue revenue bonds to finance SPRMC facility construction, and pay for same by an ad valorum property tax	
	• may annually levy a tax "for operation and maintenance" of SPRMC[20]	
	• may provide funds "pursuant to requests" from SPRMC for operations[21]	

Although the Hospital Commission's grant of authority from the state is very broad, the Commission and SPRMC are statutorily bound to adhere to a number of state requirements:

- Commission meetings are open, with a few stipulated exceptions;
- Commission funds are public funds, to be maintained in a public depository, which is regulated by law;
- Public purchasing laws apply to the Commission and SPRMC;
- Contracts must provide for access to the contractor's books, records, etc.;
- Data are subject to the state's Data Practices Act;
- SPRMC, as a "political subdivision of the state,"[22/] is exempt from state real estate taxes, subject to tort liability limits ($200,000 per person; $600,000 per occurrence), and bound by the Charitable Hospitals Act, which prohibits strikes.

The Hospital Commission is also required by statute to subject all but eight of its employees to Ramsey County's civil service commission and procedures, and to use the Ramsey County Attorney as legal counsel.

The total governance structure of SPRMC is clearly rife with checks and balances that must be meshed by a high degree of trust and cooperation among the parties. Absent such attitudes, the potential for mutual interference, even harassment, is high.

RELATED ORGANIZATIONS

Shown at the bottom of Figure 2-1 is a cluster of entities having no governing authority over SPRMC, but which nevertheless can greatly influence its ownership capabilities and operations. These include the University of Minnesota (UM), the Medical Education and Research Foundation (MERF), Ramsey Clinic Associates (RCA), Gillette Children's Hospital, and third-party payers, both government (Medicare, Medicaid) and private (including insurers and contractors like HMOs). These organizations relate to SPRMC in a variety of ways for a variety of reasons, as shown in Figure 2-2.

According to information collected during the interviews, the bare facts of these relationships may be elaborated as follows:

1. MERF: Its functions will shrink in 1985 (to pursuit of research only). MERF is expected to be subordinated to a new parent company.

2. UM: About 80 undergraduate students are at SPRMC at any one time, for which UM paid $654,000 in 1984; the number of UM medical school undergraduates will decline 17% over 4 years, beginning in 1984 (from 239 to 200), and could decline more after that; the "base salary" is paid to cover teaching faculty activity only (i.e., not research); SPRMC faculty are not tenure-track appointments; the appointment process is in practice hazy and varies greatly by department.

Figure 2-2

SPRMC: Significant Related Organizations,
Nature of the Relationship,
and Purpose of the Relationship

Organization	Legal Form of SPRMC Relationship (Date)	Purpose/Major Provisions
MERF	Affiliation Agreement (1979)	Regulates medical staff billing behavior and reimburses SPRMC for some medical staff activity. • Physicians appointed to SPRMC medical staff agree to be bound by MERF Articles, Bylaws and policies; physicians assign fees to MERF. MERF pays SPRMC 7.5% of "cash receipts" from billings, rent for 7500 sq. ft. of space, and other SPRMC services, including expenses associated with research; MERF carries liability insurance and holds St. Paul, Ramsey County and the Commission harmless; MERF establishes a fund to support education and research at SPRMC; joint committees are established to "discuss long-range plans," set physician compensation, administer research resources, address subjects of mutual concern.
UM	Affiliation Agreement (1967)	Provides for medical education program at SPRMC. • Undergraduates are the responsibility of UM and residents the responsibility of SPRMC; UM pays for undergraduate resources; department service chiefs are nominated by UM Dept. Heads, approved by the Commission, and appointed by the Regents; other full-time are nominated by Service Chiefs, approved by cognate Dept. Heads, and appointed by the Commission and the Regents; salaries consist of a "base salary" negotiated with UM and an add-on at discretion of commission; salary check may be paid by UM at the individual's election; UM retirement benefits are available to full-time staff; part-time "clinical" staff (non-compensated) must qualify for UM appointment; Joint Ed. Council administers the agreement.
Gillette	Shared Services and Operating Agreement (1980)	Establishes shared services between the two hospitals. • Provides for shared space, staff and services.
RCA	According to its Bylaws its members are the Medical staff of SPRMC. No other direct relationship to SPRMC. Has Affiliation Agreement with MERF, which acknowledges MERF's Agreement with SPRMC. NB: All members of RCA have been appointed to the SPRMC medical staff, but one can be a member of the medical staff and not be in RCA.	To unify SPRMC medical staff, formerly about 100 UM appointees and 40 SPRMC non-classified employees under civil service jurisdiction, under one organization.
Coordinated Health Care	Agreement (9/84)	Provides for "delivery of certain...HMO benefits" to CHC members. • Payment is by monthly capitation.
Senior Health Plan	Shareholder (3/83) Agreement (4/84)	Provides for care of SHP enrollees by SPRMC. • Payment is by monthly capitation minus 10% withheld, then year-end settlement.

3. Gillette: Outright merger of the two pediatric departments was anticipated, but has never occurred. Occupancy has been extremely low recently, and the hospital is moving to expand its outpatient programs.

4. RCA: Beginning in 1985, it will absorb the physician billing functions now lodged in MERF, and it will directly pay the salaries of all RCA members, all of whom will go into a new, unified retirement plan; of 160 RCA members, about 110 are UM appointees, and about 50 are RCA employees who are clinical faculty. In 1984, the new leadership of RCA reduced the authorities of many long-time Department Chairmen. Future recruits needed for the teaching program will still go through the UM appointment route. RCA is hoping to form a parent corporation for itself together with MERF.

5. CHC: Although established through the combined efforts of SPRMC and RCA in the early 1970s as their entry into the HMO marketplace, CHC has always been an independent, non-profit corporation. CHC has contracts with 8 clinics and 6 hospitals in Minneapolis-St. Paul and western Wisconsin. Although it currently has modest enrollment, it is the fastest-growing HMO in the Metro Area, and has been acting increasingly independently.

6. Senior Health Plan: Since capitation payment for Medicare patients entails significant risk for providers, SPRMC's participation in this organization is viewed by some as evidence of progressive, even aggressive, movement by SPRMC in a risky and competitive environment.

CONSULTANT COMMENTS

SPRMC's mission, structure of governance and external relationships have given rise to a number of questions and controversies.[23/] Given that there seem to be three entities "in charge," that the ability to provide funding (county) is separated from the ability to specify mission (state), and that numerous parties can influence the scope, the size and thus the expense of operations without any complementary financial responsibility, it is no mean feat that SPRMC has managed as well as it has.

We believe, however, that the nominating process has not so far produced a group of Hospital Commissioners of sufficient strength and stature to carry SPRMC through a period of potentially traumatic change. The Commission is lacking in many of the technical and political skills essential in a contemporary hospital board. Commissioners will be faced with an ever-increasing number of relatively unpalatable alternatives, most of which will cause pain to one or another of SPRMC's many constituencies. It appears to us that the Hospital Commission cannot long retain the confidence of the public, unless it undergoes some substantial changes.

In particular, the divisions and anxiety within the physician group, which have been building for some time, have not been addressed by the Commission. It is not even clear that the Commission understands the problems perceived by the younger members of Ramsey Clinic Associates. We do not observe the balance of experience, insight and determination on the Commission to cope with these physician organizational matters and others like it in a timely and productive manner.

Moreover, the changes now taking place in the health care arena are threatening the delicate balance of forces that have enabled SPRMC to function and grow all these years. To recapitulate, these include:

- stabilization of population growth in SPRMC's primary service area;
- precipitous declines in hospital use throughout the Metro Area;
- intense competition among far too many hospitals for the admissions that will remain once HMOs, PPOs and government payers reduce admissions and days;
- intense competition between physician groups and hospitals.
- reductions and ceilings on third-party payments for a declining number of in-patient admissions.

Alternative possible responses to these changes are drastically different, but all are high-risk. It is not at all clear that unity of views or agreements on necessary actions could ever be reached under the current organizational framework at SPRMC. Nor is it clear that the Hospital Commission, as currently appointed and composed, has the capacity and commitment to promote a healthy long range future for SPRMC in a strongly competitive and uncertain environment.

Notes -- Chapter Two

11. Minn. Laws 1969, Ch. 1104, cited in M. L. Timmons to D. W. Gitch, "Financial Obligation or Authority of Ramsey County for Medical Care Provided to Indigents by St. Paul-Ramsey Medical Center Commission," July 25, 1983, p. 1. (Hereafter: Timmons, July 1983.)

12. Minn. Stat. Para. 383A41, Subd. 9 (1982), cited in ibid, p. 2.

13. Timmons, July 1983.

14. Ibid, p. 3.

15. Ibid, p. 4.

16. Ibid, p. 2, 5.

17. Ibid, p. 3.

18. Ibid, p. 5.

19. M. L. Timmons to D. W. Gitch, "Legal Structure of St. Paul-Ramsey Medical Center," August 30, 1984, p. 5. (Hereafter: Timmons, August 1984.)

20. Ibid, p. 4.

21. Ibid, p. 5.

22. Ibid, p. 8.

23. SPRMC-Ramsey County Joint Study, "Minutes," August 9, 1982 - May 14, 1984.

CHAPTER THREE

PERFORMANCE ASSESSMENT

The performance of a health care institution can be measured in two primary ways: (1) against its own goals and mission; or (2) in relation to other providers. In the increasingly competitive environment of the Twin Cities, these two alternative standards for performance evaluation are increasingly intermingled. Ramsey County is concerned not only that adequate care be provided for the indigent, but that it be provided as efficiently as possible. HMOs, PPOs, insurance companies, and patients themselves, as noted in Chapter One, are increasingly adopting this same standard. SPRMC must continue to attract significant incremental volumes of private patients to contain unit costs by maintaining adequate occupancies and volumes in its services in order to efficiently provide indigent care of high quality. Both SPRMC's ability to accomplish its unique mission and its ability to survive as an institution will require strong performance along the following five dimensions:

- Cost and quality control. Lower cost providers of high quality health care services will be increasingly rewarded with higher market shares and lower unit costs, while those with higher costs will suffer economic loss.

- Long range (strategic) planning and marketing. SPRMC, like other hospitals, must accurately anticipate the services desired by its potential patients, both public and private, and be able to design and offer programs to meet those needs.

- Quick adaptation to changing market forces. In the face of changes as dramatic as one-day reductions in average length of stay, and because other providers also will be able to perceive market needs, hospitals which can more quickly plan and implement new programs and shift resources among existing programs will prosper, while those which are more rigid or have more time-consuming decision processes will find it harder to survive.

- Development and operation of organized care systems. Citizens in the Twin Cities area are increasingly showing a preference for HMOs. SPRMC's tertiary services require referrals from other providers. SPRMC's ability to make itself attractive to existing HMOs and to organize its own internal and external referral networks will be important to its future success.

- Integration of governance and management. Management must be accountable, and governance must be flexible in the current environment. Effective functional relations between current governance and management is a critical performance dimension for SPRMC.

This chapter evaluates SPRMC's current performance on each of these five dimensions.

CHARGES, COSTS AND QUALITY CONTROL

Patient Charges

St. Paul-Ramsey Medical Center's overall average charges per case are higher than those of the competing community hospitals in its immediate area. The price gap between SPRMC and its competitors has remained roughly the same over the past two years. These relationships are shown in Figure 3-1.

In certain services, SPRMC also competes with major teaching centers. SPRMC's charges per case are lower than those of Hennepin County Medical Center and the University of Minnesota Hospitals, the other two teaching hospitals locally with significant medical education expenses and indigent care burdens. However, the charges of Hennepin County include the full salaries of all the hospital's physicians. In addition, as measured by the case mix indices computed by Medicare, SPRMC's overall case mix is less intense than those of the other two hospitals.

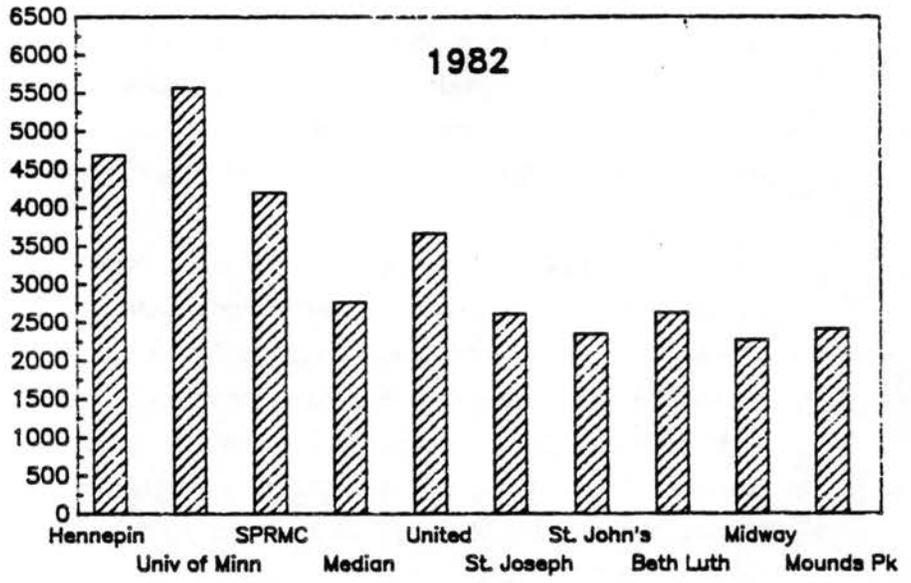
Figure 3-2 shows the relationship between St. Paul-Ramsey and its competitor hospitals on average charges per case for selected diagnoses as reported to the Council of Community Hospitals in 1983. According to this source, SPRMC was higher than all its competitors on 24 of the 81 individual diagnoses in which SPRMC reported cases. The Council of Community Hospitals' study distinguishes cases within diagnoses by severity.

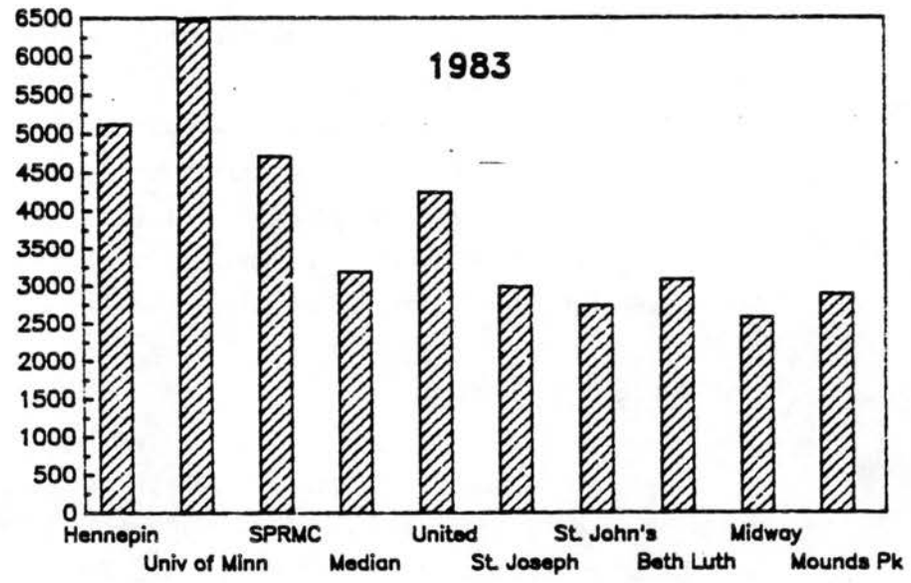
Patient Care Costs

SPRMC's higher charges are due primarily to its higher costs of producing services, and to a lesser extent, its higher markups of charges over costs. Figure 3-3 shows the relationship between average charges and average operating costs per admission (adjusted for differences in outpatient volume).

Figure 3–1

AVERAGE CHARGES PER CASE
SPRMC & COMPETITIVE HOSPITALS, 1982–83

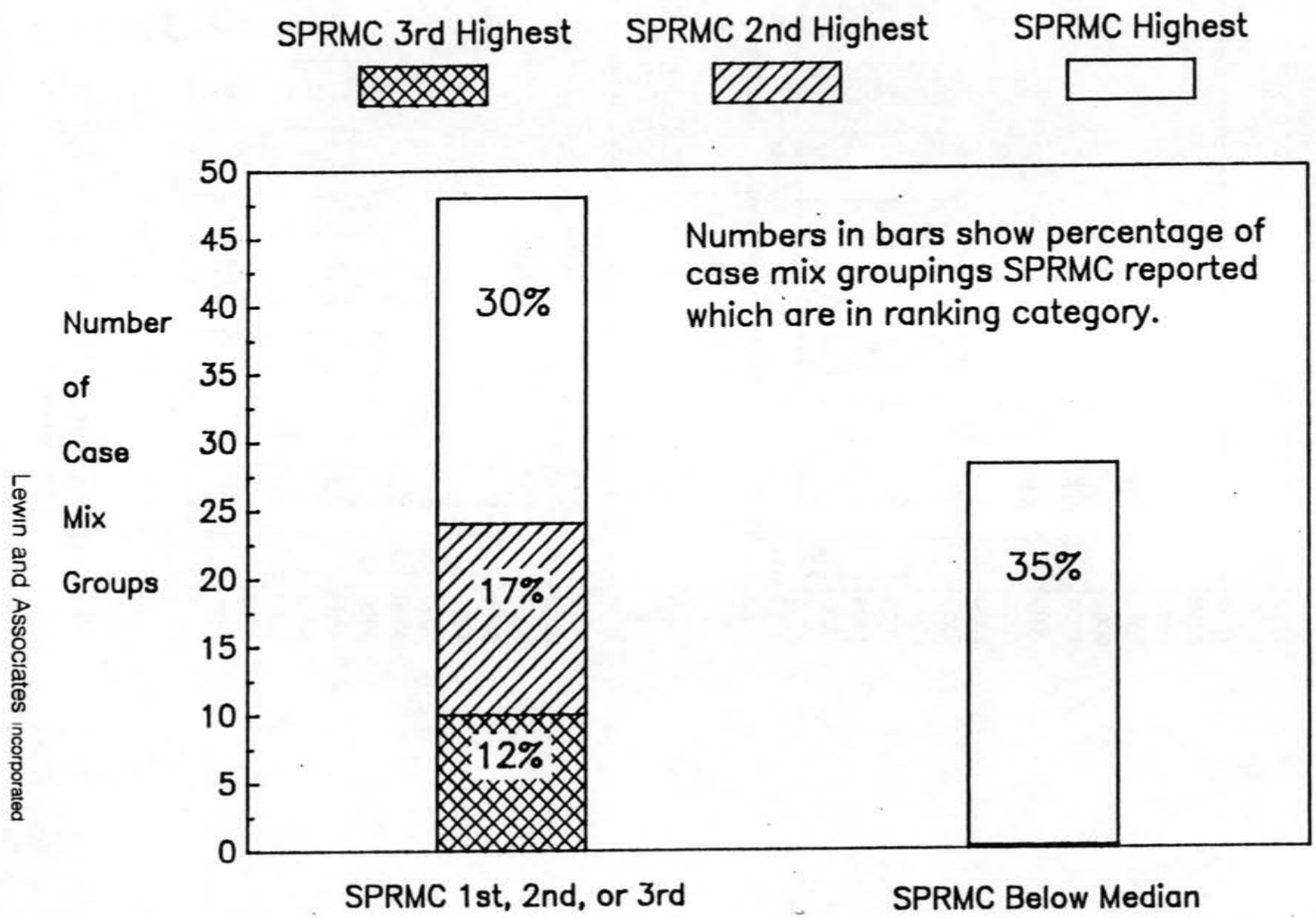




Source: Minnesota Rate Review Program
Peer Group Report, Oct. 5, 1983

Figure 3-

RANK OF SPRMC'S CHARGES PER CASE BY DIAGNOSIS IN RELATION TO COMPETING HOSPITALS, 1983



Competing Hospitals: Bethesda, Hennepin, Midway, Mounds Park, Samaritan, St. John's, St. Joseph's, United, & University.

Source: "Hospital Prices by Case Mix Product," COCH, August 1984

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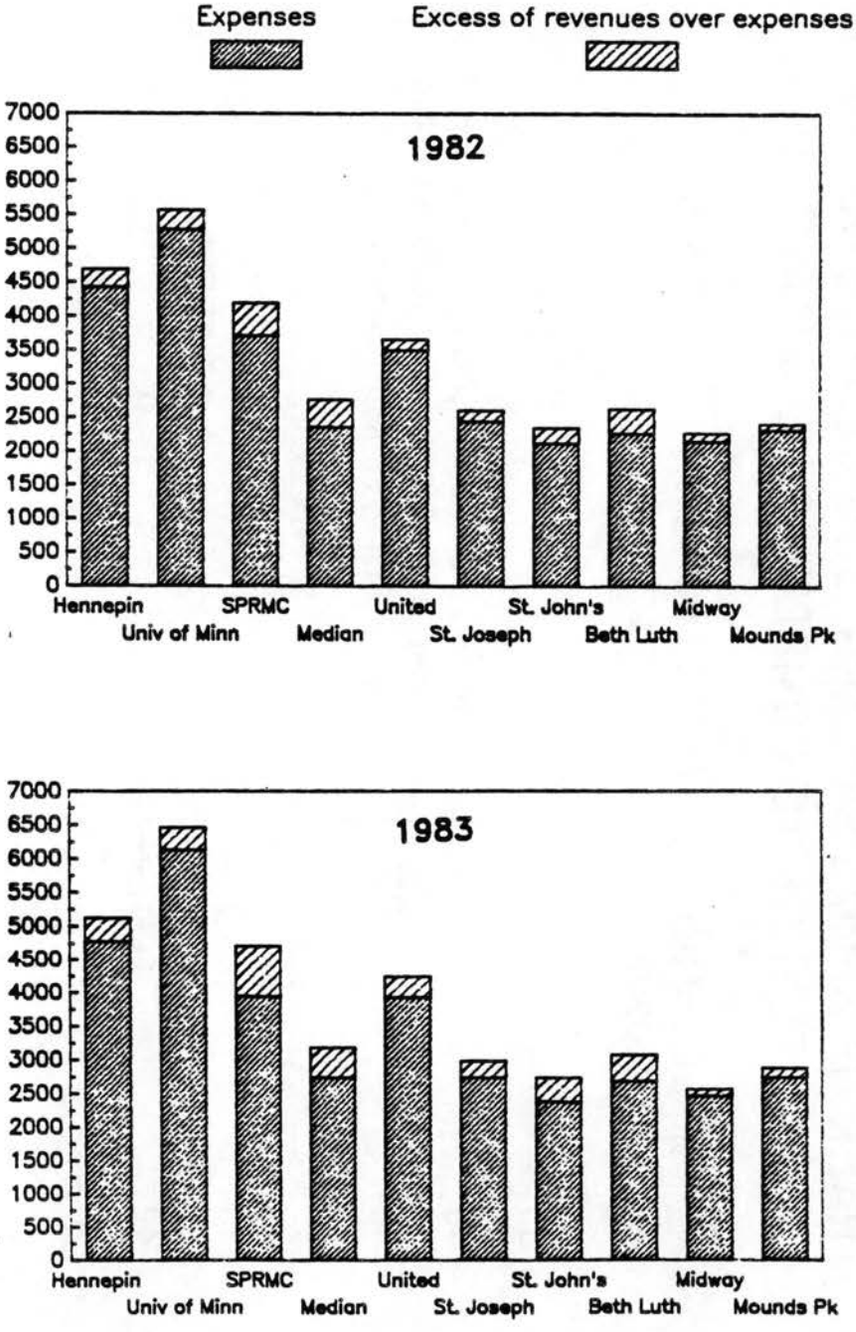
Figure 3–3

CHARGES & OPERATING COSTS PER CASE SPRMC & COMPETITIVE HOSPITALS, 1982–83



Source: Minnesota Rate Review Program Peer Group Report, Oct. 5, 1983

SPRMC's higher costs are due in part to the medical education costs it bears and its somewhat more intense mix of cases (than its competition, other than Hennepin and the University of Minnesota), but are also the result of SPRMC's higher salaries per full-time equivalent employee and higher numbers of full-time equivalent employees per adjusted occupied bed. Figure 3-4 shows average costs per adjusted admission controlled also for differences in case mix using the Medicare case mix index. Figure 3-5 presents comparisons of full-time equivalent staff per adjusted occupied bed.

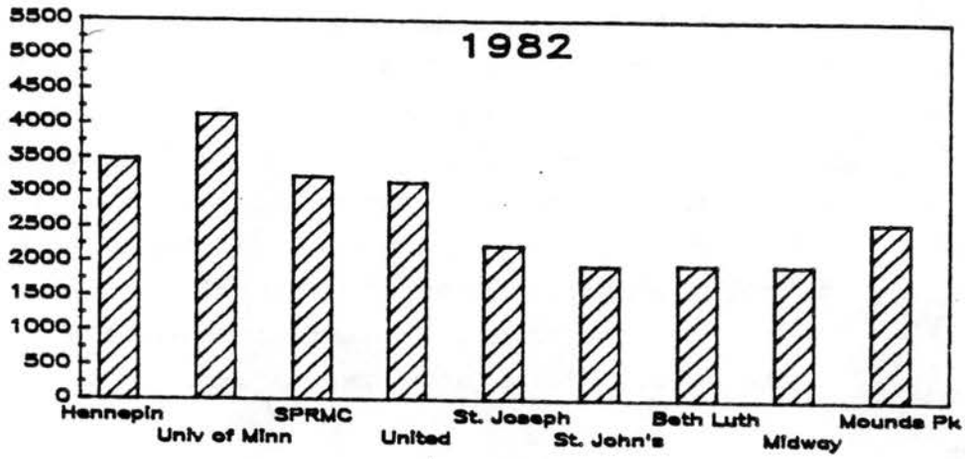
Interestingly, SPRMC's higher average charges per case are not due to length of stay inefficiencies. Even in 1983, before the full effect of SPRMC's recent length of stay decline, SPRMC's overall Medicare length of stay was 12 percent lower than the metropolitan average, and its non-Medicare length of stay was 6 percent lower according to the Metropolitan Hospital Board's DRG Market Share Report (all patient discharges, 1/1/83-12/31/83).

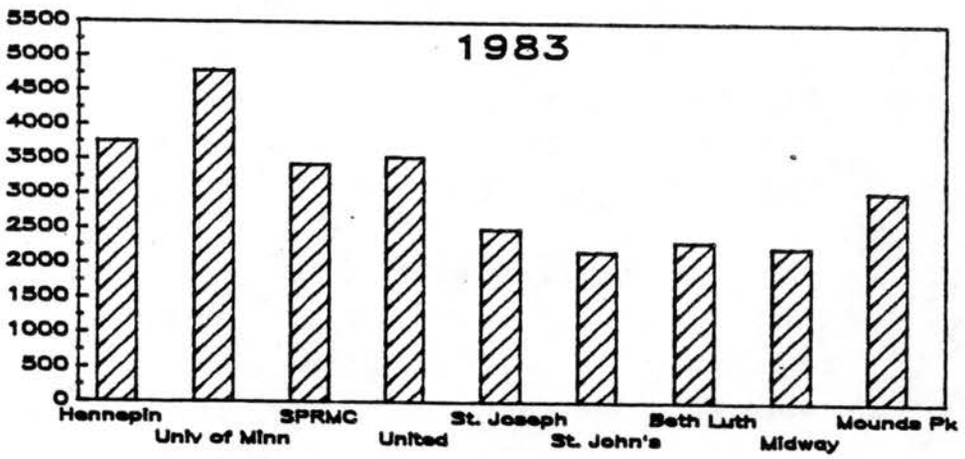
Another factor which does not increase the hospital's charge per case significantly is its indigent care burden, the majority of which is financed by the County. Above a budgeted amount of bad debts which the hospital sets to be roughly equivalent to those of community hospitals in its area (2 percent), the County has reimbursed the hospital for the costs of its services to indigents. The amounts of the budgeted bad debts increase the hospital's required charges, but the amount of this increase is not significantly higher than that of other community hospitals.

The hospital's managers realize the magnitude of their cost per case problem, and have instituted measures to run the hospital more efficiently:

Figure 3—4

CASE—MIX ADJUSTED INPATIENT COSTS PER ADMISSION SPRMC & COMPETITIVE HOSPITALS, 1982—83





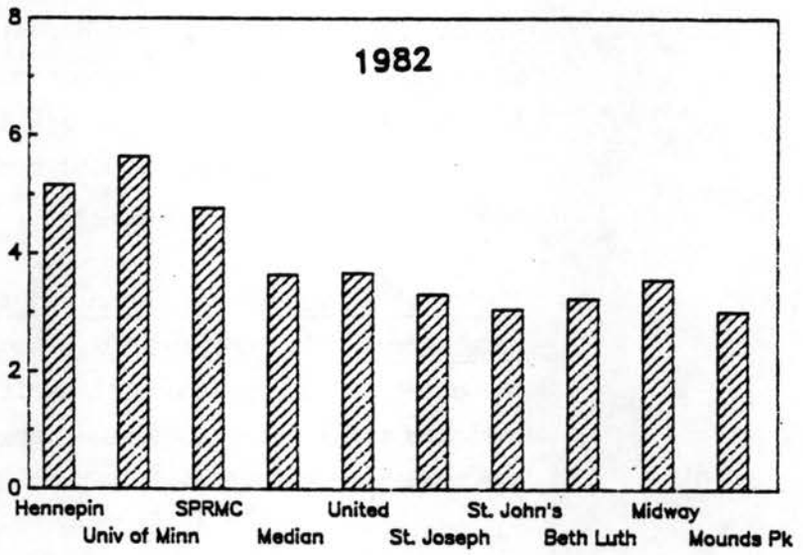
Case Mix Indices for the hospitals as reported by HCFA were:

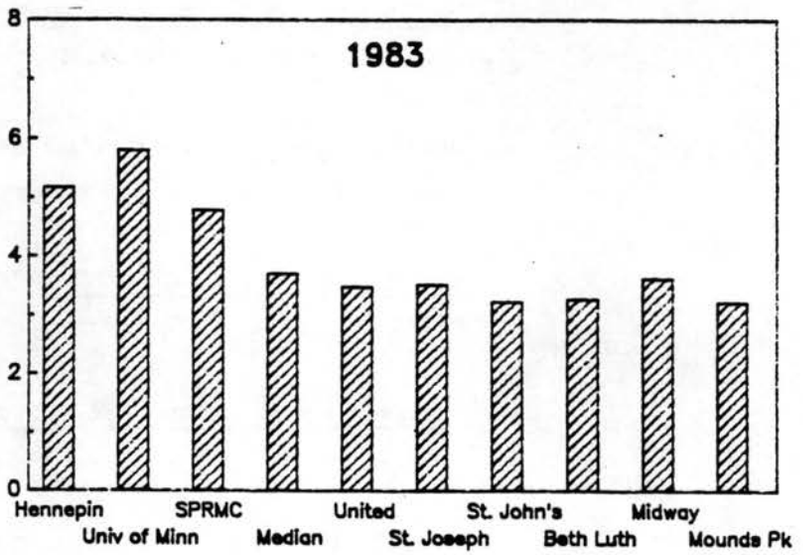
Hennepin	1.2734	Univ of Minn	1.2813	SPRMC	1.1501
United	1.1108	St. Joseph	1.0950	St. John's	1.0914
Beth Luth	1.1560	Midway	1.0975	Mounds Pk	0.8959

Source: Minnesota Rate Review Program
Peer Group Report, Oct. 5, 1983

Figure 3–5

FTEs PER OCCUPIED BED
SPRMC & COMPETITIVE HOSPITALS, 1982–83





Source: Minnesota Rate Review Program
Peer Group Report, Oct. 5, 1983

- The hospital's collection policies (despite its open-door admissions policy) are aggressive. The hospital uses collection agencies as well as internal collectors, and sues patients who have the ability to pay but do not. It collects deposits on scheduled admissions, and assists indigent patients in applying for Medicaid and GAMC. These policies have resulted in strong cash flow and reduced numbers of days in accounts receivable during 1984.

- Financial accounting is organized to maximize reimbursement. SPRMC and RCA coordinate the hiring of personnel and the purchase of capital equipment to maximize total reimbursement. Appropriate government overheads are recovered from third parties.

- The accounting books of SPRMC are separate from those of the County except for the funds that the County provides. These funds include:

  — uncollectibles, all of which are certified by the county attorney (FY 1985 budget: $3.1 million);

  — the county portion of GAMC (FY 1985 budget: $0.8 million);

  — community service and paramedics ($112,000 in FY 1985).

  This total of $4.1 million is slightly more than 4.9 percent of the hospital's projected $83.5 million in operating expenses for fiscal year 1985. In addition, Ramsey County and the City of St. Paul pay the

hospital's debt service of about $1.3 million (principal $958,000 in 1985). Total city and county support for the institution is thus about $5.4 million, or 6.5 percent of SPRMC's operating expenses. This compares to the $14 to 15 million (14-15 percent) of Hennepin County's estimated $100 million in operating expenses provided to it by that county.

- Other than capital funds for construction, the hospital has not borrowed funds from the County. It has drawn on its funded depreciation account rather than on the County in times of tight cash flow. The system's managers would borrow from the County only as a last resort, knowing that to do so might cause the County to greatly tighten its oversight.

- The hospital's management budgets to earn a surplus in each year. These surpluses are required to replace the hospital's operating equipment without the infusion of additional county funds.

- The management letters provided by the hospital's outside auditors concur that its financial management systems are fundamentally sound and have improved in recent years. SPRMC has implemented most of the significant recommendations made by the auditors for improving its systems.

- The hospital has acted to control the growth in its charges per case. The Council of Community Hospitals' studies of average hospital charges per diagnosis in 1982 and 1983 showed that SPRMC's average charge fell in 46 percent of the diagnostic categories in which it reported cases (compared to 18 percent for all

metropolitan hospitals) and grew by less than 10 percent in another 33 percent of the categories (compared to 60 percent for all Twin Cities facilities). Following study of their 1983 results, SPRMC managers reduced their charges for one case type on which the charge comparison showed SPRMC to be higher than all other hospitals.

- Many of the hospital's other management systems are efficient and well managed. SPRMC has saved significant funds through its energy conservation program. Its new materials management relationships offer additional cost savings. Its nursing scheduling is based on patient acuity, and operating room scheduling has recently been changed to make better use of space and staff. Its utilization review and medical records departments are also strong, as witnessed by the hospital's ability to quickly adapt to PPS.

In addition, over the last year, SPRMC has undertaken two significant initiatives to directly control its costs:

- It has negotiated lower payments for medical education supervision with its physicians. The amount of this reduction, $1.5 million annually, will reduce hospital costs per case by about $105.

- With the assistance of Touche-Ross and Company, the hospital has developed a plan for reducing the number of its full-time equivalent personnel by about 5 percent in FY 1985 from the roughly 1950 FTEs the hospital currently employs. These reductions, and the slowed increase in salary costs they portend, will also help control the hospital's cost per case.

Quality

The quality of medical care given at an institution is clearly more difficult to measure than the costs of providing that care. The hospital received a full accreditation from the Joint Commission on Accreditation of Hospitals at its last review, an important external indicator of the quality of services provided. The results of the current year's review are still pending. Given the limited time available to this study, we performed no evaluation of the quality of care at a detailed level. However, three other general indicators of quality are available. First, a 1982 survey of the perceptions of community residents and patients about the hospital revealed that patients who had used the hospital were in the main quite satisfied with the quality of care they received. Second, from our interviews, SPRMC managers felt the hospital should have no problems adapting to the new review requirements that would be imposed by the professional review organization. Finally, the hospital has not had high malpractice or liability suit experience.

Consultant Comments

The ability to deliver high quality patient care services at reasonable prices will clearly be a key to the success of all hospitals in the Minneapolis-St. Paul area. Private patients are rapidly joining HMOs or are becoming more cost-conscious themselves. The state agencies and County Commissioners who control the financing of public patients are increasingly interested in ensuring access to the most efficiently delivered services possible. In many areas of the country Medicaid and county assistance plans are examining the possibilities of competitive bidding or capitation contracts for these services.

SPRMC has advantages that should allow it to develop a low-cost position. It has a well maintained physical plant and virtually no debt. While its layout makes achieving operating efficiencies more difficult and lacks a few patient amenities, the plant is fundamentally sound. The county and city pay the outstanding indebtedness on the capital construction bonds. The hospital's medical staff is closed, which provides a significant possibility of close relations between hospital and physician managers on developing more efficient ways of delivering high quality services. However, despite its success in particular management areas, SPRMC's costs of care through 1983 were higher than those of its competitors.

Over the last two years, the activities of management, described above, have begun to pay off in reduced rates of increase in total operating cost. SPRMC's 1985 approved budget of $83.5 million compares to 1983's total operating expenses of $82.5 million -- a compound increase of less than 1 percent over the two years.

LONG RANGE PLANNING AND MARKETING

St. Paul-Ramsey Medical Center, as an institution, to date has not achieved internal consensus on its mission and has no organized, comprehensive strategic planning or market analysis function. Planning and market studies have been done for specific services like emergency medicine and home care nursing, and certain aspects of the external environment have been reviewed, such as average charge information on SPRMC's competitors, but these analyses have not been built into an integrated picture of the medical center's environment, its current programs, and future opportunities. Until recently, the hospital had no manager in charge of planning, and it still has no director of marketing,

although it plans to hire one in conjunction with RCA. Without concurrence on mission and a planning team integrated with management and able to make hard program decisions, commit resources to them, and review programs against performance measures and eliminate ones that don't measure up, SPRMC will find it increasingly difficult to maintain its viability.

In part because of this lack of focused planning at SPRMC, and because of its own lack of success in such ventures as satellite clinics, Ramsey Clinic Associates has invested significant time and resources to analyzing the market forces it and the hospital face. The result is a long-range plan which articulates a vision of the future of the physician organization and its relationships to the hospital from the physicians' point of view.

Clearly, the physicians' organizations's planning activities have been running ahead of those of the Hospital Commission, and on a track that has great potential to upset current organizational and accountability relationships between the two organizations.

Consultant Comments

Planning at the medical center would benefit from more attention at all levels. The center should continue its development of a larger scale and more integrated planning capability that would function in concert with RCA. One consequence of the lack of integrated planning is that new program ideas, which the medical center's staff develops quite well, cannot be evaluated for their consequences for the institution's existing activities. In part these difficulties are a consequence of a controversial mission, and a Hospital Commission which has not always been well educated in the dynamics of health care

changes. This leads to problems in new program implementation, and a lack of clarity concerning the institutional resources that can and should be allocated to the new programs. It also tends to focus management's attention on its new programs, and away from improvement of existing activities such as routine medical-surgical inpatient and outpatient care.

QUICK ADAPTATION TO CHANGING MARKET FORCES

From our interviews, it appears that the management organization and style of the hospital is heavily dominated by committee structures and development of internal consensus. This is typical of many community and teaching hospitals. This type of organization and style of operation may improve new programs by incorporating the ideas of many individuals and clearing away objections before the programs are undertaken, but they often slow the development of effective responses and blur program responsibility. As a consequence, rapid change within the hospital often depends on the emergence of "champions" for particular ideas or programs. Senior Health Plan and the occupational health services programs are two examples. In the absence of a strategic plan and clear consensus on goals, however, the commitment of resources to programs, even "championed" ones, is uneven, making implementation difficult and evaluation more so.

We believe the criticisms of the slowness of the hospital's response to the "financial crisis" at the end of 1983 were in large measure justified. Management apparently did not fully anticipate the extent to which the year-end downturn in volume would persist. However, operating results for the current year indicate a return to profitability despite the fact that the full impact of staff reductions has not yet been felt. In addition, the hospital management's handling of two significant

and far-reaching changes over the last 18 months appears to have been highly effective:

- Computer system implementation was rapid and smooth. Until December 1983, the hospital did not produce its own patient bills, but contracted with two separate billing services to produce them. Planning to assume all computer functions in-house began around January of 1983 and relied heavily on outside consultants. However, within the year, the hospital had installed the hardware and programs necessary for accounting and billing, and the remainder of hospital business functions were computerized by March of 1984. Consultants have been replaced by internal staff.

  The short implementation time, relatively low levels of errors, and lack of serious untoward effects on patient billing and accounts receivable are all evidences of managerial strength. Managers with whom we spoke throughout the hospital feel they receive the information they need to perform their functions, and complaints from patients about bills have declined. The hospital is now looking for a state-of-the-art order entry and results reporting system to help minimize lost charges and duplicative paperwork and perhaps allow additional staff reductions.

- Implementation of the prospective payment system was rapid and effective, and has resulted in changed practice patterns. Length of stay for all patients fell from 7.56 to 6.40 days between July 1983 and July 1984, resulting in the hospital's feeling that it will have little to fear from the more intensive review requirements that will be imposed by the developing

PRO. Physician practices in many departments have changed. For example, in ophthalmology, which had longer stays than the eye services at other Twin Cities hospitals as recently as 1983, virtually all cases are now being performed on an outpatient basis. The medical center's success in working with physicians on this managerial problem and others similar to it is further evidence of managerial strength.

Finally, SPRMC's managers are able to conceive and develop new business opportunities or to take up good suggestions from the medical staff such as the Senior Health Plan, Occupational Health Services, and Coordinated Health Care. These programs have been developed to address specific market needs.

Consultant Comments

The medical center's organization structure and managerial style, like that of many teaching hospitals, relies heavily on committees and consensus. These structures are not well adapted to quick decision making and action. However, the hospital's managers have accomplished two wide ranging changes quite well and begun to set the stage for necessary productivity improvements.

DEVELOPMENT AND OPERATION OF ORGANIZED CARE SYSTEMS

Among the most important findings of our environmental assessment was that growth in HMO enrollment in St. Paul has lagged behind that of the remainder of the Twin Cities area.

Given SPRMC's higher than average costs and its lagging behind its competitors somewhat in developing HMO ties, its stable number of admissions and proportions of insured admissions may be due to this lag in St. Paul HMO enrollment. If so, this would leave the hospital extremely vulnerable to increases in St. Paul's HMO population.

The hospital's involvement with HMOs has been mixed. Following its early cooperation with RCA in developing the Coordinated Health Care HMO, that organization grew slowly until recently, and its links with SPRMC have weakened. The hospital has limited contracts with other area health maintenance organizations, particularly for after-hour care and obstetrical care for Group Health patients. The hospital's high average costs of care and its lack of unity with the medical staff have hampered its ability to enter HMO contracts. Moreover, it has not ever been easy to arrange prepaid care in a concentrated educational milieu without a number of program adjustments.

Development of SPRMC's own organized health care systems, including its handling of referrals to its specialized services and increasing the activity of its primary and secondary care services, will be very important in the future. These types of improvements of the hospital's "nuts and bolts" patient care systems can only be done with the full cooperation of physicians.

Consultant Comments

SPRMC has lagged behind other local hospitals in developing ties with health maintenance organizations and developing its own organized health systems. Both activities require close cooperation with RCA's physicians and must be high on SPRMC's managerial agenda over the near term.

INTEGRATION OF GOVERNANCE AND MANAGEMENT

How has the hospital's governance system affected its management's performance? We believe they are closely interrelated, and that many of the management problems cited are rooted in fundamental inconsistencies between the current structure and the changing demands of the environment. Our observations are the following:

- The hospital's current governance system imposes a few direct barriers but no insurmountable ones to sound financial management, the reduction of costs, or operating profitability. The oversight of the hospital's finances by the Hospital Commission and the County Commissioners perhaps is more intensive, detailed, and time-consuming than that which would be provided by a not-for-profit hospital board. The County Commission members are more familiar with the cash basis fund accounting maintained by the County than with the accrual-based books maintained by the hospital, which has created some misunderstandings in the past.

- A most important disadvantage the hospital faces is the necessity of following county civil service rules in the hiring, classification, and pay scales for its employees, which have occasionally resulted in higher rates of pay than comparable rates in competing private hospitals (such as outpatient nursing and clerical staff), and at times some surprises (such as the clerical wage adjustment negotiated by the County or all county clerical employees at the end of 1983) that adversely affect the hospital's budget and cash planning.

- The hospital's ability to plan programs and make decisions in a competitive environment is hampered by the "sunshine" requirements imposed on the hospital's board and the multiple governance layers through which decisions must pass. The split of responsibilities between the Hospital Commission and the County Board of Commissioners increase the problems, and slows decision making.

- Apprehensiveness about political processes and "second-guessing" have reduced management's willingness to act quickly and take risks. Public criticism, rather than private rebuke, has occasionally dampened management morale. Political pressure distracts management from long range planning. Fires started by the hospital's own board consume management's attention. In turn, management's attempts to avoid conflict are perceived by the Hospital Commission as obfuscation or "stonewalling" and reinforce the Hospital Commission's view that constant oversight is needed to preserve the public trust.

Figure 3-6 details the limits the current governance structure places on management.

These limitations and political pressures have themselves driven a wedge between the hospital and its physicians, who have been somewhat quicker than the hospital management or the Hospital Commission to appreciate the changes occurring in Minneapolis-St. Paul. As consultants to the physicians, the Hospital Commission, and the County Board, we strongly support responsible public oversight of services the public needs. However, our

Figure 3-6

Limitations on Hospital Management Imposed by SPRMC Governance

Financial Management. The state legislation which establishes the Medical Center Commission (the "commission legislation") confers upon Ramsey County broad powers over the medical center's financial affairs. First, the medical center must obtain the county's approval of the medical center's annual budget. Minn. Stat. Section 383A.41, Subd. 6. In this process the county may review the entire operating budget of the medical center on a line item basis, and approve, reject or revise that budget as it deems appropriate.

In addition, the commission legislation prohibits the medical center from borrowing funds necessary for its operation and maintenance in an amount which at any time exceeds $4,000,000. Id. Subd. 8. Moreover, the commission legislation requires that the medical center obtain the county's approval before entering into any such lending arrangement, and forbids the pledging of any physical asset of the medical center as security for such borrowing. Id.

With respect to capital financing, the commission legislation vests in the county, and not in the medical center, the authority to issue (upon the request of the medical center) tax-exempt revenue bonds to finance capital improvements at the medical center or the acquisition of additional facilities. Id. Subd. 9. The medical center has no independent power to issue bonds to finance capital improvements.

Personnel Administration. The commission legislation specifically subjects medical center employees (with the exception of eight senior managers) to the Ramsey County civil service laws and rules. Id. Subd. 5. Consequently, it is the county and its civil service commission, rather than the medical center, that establishes rules affecting medical center personnel with respect to personnel and wage classifications, hiring, promotion and termination procedures, and disciplinary actions and procedures. The county may change rules governing these matters without consulting with the medical center, even where such changes affect the medical center financially. Moreover, the county's civil service director, and not medical center management, negotiates labor contracts for the medical center.

The vesting of key personnel responsibilities outside of the medical center compromises management control. Moreover, according to medical center managers, many of the county-wide personnel rules and administrative procedures impose delays (e.g., in the classification of new positions), restrict managerial prerogatives (e.g., the inability of managers to award merit pay increases), and place the medical center at a competitive disadvantage with other area hospitals (e.g., managerial compensation).

Purchasing. The commission legislation requires the medical center to follow the State of Minnesota public purchasing laws, except where purchases are made through a nonprofit cooperative hospital service organization. Id. Subd. 10. These laws require that contracts for goods and services over $15,000 be publicly advertised and awarded to the lowest bidder. The medical center must also obtain the approval of Ramsey County in order to purchase any real property. Id. Subd. 15.

Ability to Enter into Joint Ventures. The Minnesota Public Hospital Law, which expressly authorizes public hospitals to form nonprofit corporations, enter shared service and other cooperative arrangements, enter partnerships, hold stock in business corporations and undertake related ventures, imposes limitations on the activities of hospitals, like the medical center, that receive a "direct financial subsidy" from a taxing authority. Specifically, the law provides that such hospitals may only invest funds in these undertakings for a three-year period and must recover their investment, with interest, in no more than ten years. It would appear that hospitals with purchase-of-service contracts or grants from taxing authorities, rather than "direct financial subsidies," would not be subject to these restrictions.

Prepared by Wood, Lucksinger, and Epstein

concern is that the organization is weakened and morale depressed by failure to use more informal and private channels or the Hospital Commission itself when constructive criticism is warranted.

The limitations on SPRMC management imposed by the current governance structure, with the exception of civil service rules, are not the clear prohibitions and restrictions on action imposed on managers of some public hospitals. However, we believe that in the highly volatile Twin Cities environment they may become no less deleterious to the hospital's ability to survive and accomplish its unique mission.

We also believe these limitations are inherent in the current makeup of the Hospital Commission. The County Commissioners on the Hospital Commission face a fundamental dilemma: to be able to continue to provide effective indigent care services with a low public subsidy, SPRMC must compete with other area providers and sometimes take business away from them. However, the County Commissioners are elected by all the people of Ramsey County, and thus must respond to the interests of other providers in the County as well. Calls from constituents alleging unfair competition must be dealt with, albeit sometimes to SPRMC's detriment and almost always at the expense of slowing SPRMC's program planning. Their responsibility to the public as a whole necessarily makes the County Commissioners inappropriate and at times possibly ambivalent trustees of this competing public hospital.

Despite the innumerable problems and our critique of the current governance apparatus, the County Commissioners have emerged as strong, consistent supporters of SPRMC. They have voted improvements, funded indigent care, supported education, and generally exhibited confidence in the management. Our concern is

that this support continue, but that the limitations of the current charter be removed in order to deal with a rapidly changing health care environment.

OVERALL COMMENTS ON MANAGEMENT PERFORMANCE AND GOVERNANCE

On balance, we believe SPRMC's management has performed capably. It has adapted to significant changes in its environment, required accommodation throughout the organization, and is poised to begin necessary improvements in productivity. The hospital's expected operating results for 1984 have rebounded strongly from 1983 and not borne out the dire predictions of financial crisis made last winter. Hospital middle managers and physicians have been able to develop new programs and enter into cost-reducing or market-enhancing agreements such as the recent prime vendor agreement with American Hospital Supply Company and the joint venture with Health Central, Inc. and the Wilder Foundation to develop Senior Health Plan. In short, management has capitalized on the flexibility afforded them under the hospital's governance structure. In an increasingly volatile market, however, their existing powers may not be sufficient to ensure the institution's survival.

On the other side of the hospital's performance record lie several important weaknesses. Top management of the hospital is not perceived as being directive, sufficiently sensitive to political interests, decisive, or focused toward a specific vision of the hospital's future. Second, neither management nor the Hospital Commission has been effective in developing and communicating a coherent long range view of the future of the institution. In many ways, RCA's focus on its own planning has been a reaction to the failure of the Hospital Commission, hospital managers and physician managers to reach accommodation in

this essential area. SPRMC management, due to philosophical and personality differences with physician managers, has presided over a period of increasing friction with the physician organization at a time when closer ties are clearly required for the survival of both the hospital and the physician group. Third, management was slow to react effectively to the downturn in patient census with necessary budget retrenchment and has remained slow in implementing necessary productivity improvements. Finally, management has at times exacerbated problems with the Hospital Commission through the managers' very desire to avoid conflict.

The Future

Book II. New Directions for Strategic Planning, Organization, and Governance

Lewin and Associates incorporated

CHAPTER ONE

CLARIFYING SPRMC'S ROLE

INTRODUCTION

In this chapter, we propose a more clearly articulated role for SPRMC to provide a framework for continuing many present programs and devising new ones. We believe that unless SPRMC clarifies its role and receives enthusiastic support for a single restated mission from our three clients, the prognosis for a successful SPRMC is in doubt.

In the absence of this consensus and support, we foresee painful attrition, physician and management disillusion, and public frustration and eventual loss of valued community services.

In our discussions with our clients, we have concluded that there can be cohesion around the future role of this important enterprise. In the remainder of this chapter we spell out our recommendations for a redefined SPRMC and the major purposes it should serve.

THE ST. PAUL-RAMSEY MEDICAL CENTER NOW AND IN THE FUTURE

SPRMC is now a complex organizational unit including SPRMC and Gillette hospitals, a physician's organization, a research foundation, and an important array of affiliations including a strong educational commitment to the University. Its

past is wedded to its perception as the Ancker Hospital, a county teaching hospital for the care of the poor. More recently it has been viewed as the valued regional trauma center by the public. The image of SPRMC is that of an acute care hospital with a dedicated faculty and housestaff taking care of patients.

We see this enterprise as one which has been evolving and adapting in the face of very traditional and somewhat inaccurate perceptions of what, in fact, is happening. A few examples of somewhat erroneous perceptions among SPRMC's leaders are illustrative:

- Commissioners who think SPRMC is only a hospital when it is already so much more.

- Young physicians who feel department chairmen are only interested in classical medical education and not in clinical service (which is not true).

- Management which has felt that all Ramsey Clinic Associates physician activity must be concentrated at the hospital site which may not, in fact, be of optimal benefit in the future.

- County staff who perceive that teaching costs and medical education costs are the major culprit in cost escalations (which they are not).

Our perception of SPRMC's future role is described in the following paragraphs:

"The St. Paul-Ramsey Center for Health Care (formerly SPRMC) will provide a full range of health, medical, and related social support services for lower income persons of Ramsey County and neighboring counties when requested and financed by them on behalf of their residents. Further, the Center will organize its health services as a spectrum of preventive, sub-acute, acute care, and chronic services for population groups of all economic circumstances seeking such services in the greater metropolitan area. There will be an expanding emphasis on non-hospital and non-institutional services.

The Center will continue to rely primarily on physicians qualified as faculty members (jointly appointed with the University of Minnesota School of Medicine), fellows, residents and students. The Center will continue to support medical education as a primary teaching affiliate of the University, but will adjust its teaching programs to a reduced student body, a lower concentration of specialty residencies and perhaps a different mix of residencies. Its research programs will be limited to those which can be funded by contract or contributions.

The Center, although able to provide group practice, fee-for-service care, will organize its delivery of health services increasingly through prepayment and capitation. Its own specialty and tertiary services shall be of such caliber as to attract other prepaid group members as well as its own members. Expensive tertiary care or tertiary care which requires high volume to achieve high quality and cost effectiveness will not be provided merely to support the teaching function, but rather may be developed in partnership with other teaching hospitals or a nearby community hospital. The new Center will actively attempt to rationalize care in St. Paul by seeking merger and consolidation opportunities so as to realign the supply of beds with the need for inpatient acute care. It will selectively build medical expertise in a limited number of program areas and may internally reduce excess physician capacity where others can perform at least as well.

> The St. Paul-Ramsey Center for Health Care will emphasize services for the inner city elderly and for new ethnic arrivals and will serve Ramsey County as an adjunct to its public health department to the extent the Center can be useful. Within the limitations of financing and organizational flexibility, it may take on a stronger social support focus in an effort to preserve the average citizen's independence of the health and medical care system. The Center may offer case management and referral services to an identified population including those who have sufficient private resources. The Center may also decide to add new programs, within the same organization or in captive non-profit or for-profit subsidiaries, if such activities serve the principal purposes of the enterprise.
>
> The new Center for Health Care is committed to a highly productive, moderate cost system of care, accessible to persons of lower socio-economic background as well as to those with funds. It expects to be an effective competitor with other health care organizations in the Metro area; expects to meet fully its historic responsibilities to Ramsey County and its elected officials; and expects to afford the citizens of Ramsey County and the larger regional area broad health care services including some selective specialty care."

This statement is set forth as an example of suggested future roles and as a stimulus for guiding SPRMC's planning for the next decade. It recognizes that:

- The future focus must be on total health care services, not merely on one or two components, such as "hospital" or "outpatient" care. Hospital care cannot be the only important objective.

- The role emphasizes the historic obligation of SPRMC to serve the poor and lower income populations of Ramsey County, but not to the exclusion of other

financed poor in nearby counties nor the broad band of middle and higher income patients who can benefit from a university qualified medical staff and an organization which offers superior programs.

- The role anticipates a reduction in medical education responsibilities and the eventual regionalization of highly specialized services among teaching institutions and certain private community hospitals. Implicit is the notion that medical education in the clinical setting will have to be more adaptive to new blends of patients and a changing array of "health" services, and that it must be carried out in more efficient forms of organized medical practice that will be attractive and economical for patients.

- The role does not place a geographic or program boundary once the stipulated needs of the County are met. Nor does the role imply that the County must rely solely or absolutely on the Center indefinitely. Further, the Center may seek to treat patients from neighboring Wisconsin communities and other out-of-state localities.

- The role statement suggests a limited medical research activity, but not financed through patient revenues.

- The role explicitly places a responsibility on the Center to seek merger and service consolidation as a method of rationalizing health services and reducing their excessive costs. It recognizes that the Center intends to be extremely competitive and is determined

to tailor community programs to community needs and resources.

- The role statement stipulates "moderate cost" goals, ones that are affordable to purchasers, including the government.

IMPLICATIONS OF A REDEFINED ROLE FOR THE CURRENT ORGANIZATION AND ITS PROGRAMS

In contrast to the mission described in Chapter 2 of Book I, the redefined role stated above sets expanded directions and tries to resolve basic issues that have separated the medical staff, Hospital Commission members, County Commissioners, and management.

The amended role statement is intended to have profound impacts on the status quo, less perhaps on the current programs than on the current organizational and governance structures and on the way medical care is delivered at SPRMC.

Implications for the Governing Board

The redefined St. Paul-Ramsey Center for Health Care will require a board capable of organizing and delivering a full range of services, most of which will be out-of-hospital. That same board will have to possess exceptional financial skills, be willing to take prudent risks, and enter into agreements with other major providers of services. This new role imposes expectations on a board to plan beyond narrow geographical boundaries and to compete in a new and somewhat harsh marketplace.

The new role anticipates flexible budgeting, reduced fixed costs and greater control of variable cost factors, and flexible pricing.

We believe that this restated role requires a governing body that has reasonable stability and can attract a broad range of community, corporate, and political expertise. It must be apolitical, enjoy public confidence, and look constantly at programs that will serve bona fide community needs. It must be able to accumulate surplus funds, to borrow and accumulate reserves for new projects, to advertise, and to joint venture with private, non-profit partners, including religious affiliated hospitals and agencies in and around the metropolitan area.

Unlike over 80 percent of U.S. hospital boards, there is no physician member of SPRMC's current governing Commission. Further, even the chief operating officer of the current organization, although an active meeting participant, is denied a vote. A revamped health care organization should have physician and management representatives on the governing board and should delegate to a medical staff organization control over most medical staff activities, once the staff by-laws are board-approved.

Implications for the Medical Staff

With respect to physicians, the new role prescribes a cohesive, well organized medical staff for program expansion in services outside the hospital as well as in selected specialties. Qualified and respected community physicians who accepted the Center's goals could be encouraged to associate with the hospital, serve as volunteer clinical faculty, and admit patients who would participate in the teaching program. It requires physician

leadership that can combine an active group practice at the hospital and outside it with residency and medical student training without sacrificing the quality of either activity. The new role will not tolerate the dichotomy that has developed between the chiefs of service and the RCA board over the management of funds and the direction and quality of clinical programs. The new organization must rely on a unified medical staff wholly committed to the restated goals of the Center and directly involved in cost control and prudent choice of new technology.

Additionally, physicians can and should play an expanded role, but not a dominant one, in the governance of a redirected health care organization, just as they do in other major programs whose principal foci are clinical care and teaching. For optimal effectiveness the medical group should be viewed as an integral element of the new organization, staked in the broad successes of the enterprise, treated as professionals, and immune from intrusive external regulation, but accountable to peers, outside professional review, and the new organization's governing board.

Implications for Relationships with Government

The new role suggests alternative relationships with local and state government. It affords the option for local government to acquire personal health care services from more than one organization, although we will make specific recommendations against over-quick acceptance of that option in a later discussion.

Representatives of the state government now nominate one individual from each of nine senatorial districts, despite the

fact that some of these individuals bring no unique knowledge to the Hospital Commission, have few friends and associates who are users of the medical center, or who can be particularly influential in bringing resources to SPRMC. The nominating role of state senators was expected to maintain state interest and responsibility in a hospital located a few blocks from the state capitol. To the best of our knowledge, the legislature is vitally interested in the welfare of SPRMC, but perhaps no more so than in other valuable public and private health resources in the metro area and throughout the state.

The revised role statement demands the Center's continuing and special responsibility to the County Commission: first, to assure the Commission that the health care enterprise will maintain an open-door policy; second, that it will control costs; and third that if the County has special needs, these will be met at St. Paul-Ramsey if the County feels the organization is best qualified to provide the needed services. Fair compensation should be the guideline in a contract of at least 4-5 years duration. Can accountability to the County be assured in the 1980's without County Commissioner membership on the Hospital Commission? We believe so and will present alternative proposals in Chapter 2 of Book II.

FINANCIAL REALITIES IN LONG RANGE PLANNING

In laying out future roles for St. Paul-Ramsey we have been cognizant of underlying financial trends that are relevant to strategic planning as well as to possible governance changes. The following is an itemization of our most educated assessments of the future financial "realities" for SPRMC or any successor organization.

Operating Funds

Adequate funding will depend upon:

- Medicaid payment rates and the extent to which future prepaid Medicaid patients choose SPRMC.

- Medicare payment rates and the extent to which SPRMC is able to reduce its costs of care to the national average DRG payment limits (which could hurt SPRMC) by 1986-87.

- Medicare payments for education and indirect educational costs. SPRMC currently benefits from a generous program which is based on resident numbers and which will be phased down in the next few years.

- The volume of prepaid, commercially insured, and Blue Cross patients attracted to SPRMC.

- The ability of physicians and hospital leadership to organize care economically, increase departmental and individual productivity, and place patients in less expensive alternative care settings.

Capital Financing

Adequate funding will depend upon:

- Annual operating surpluses. These should be reasonable, perhaps 5-7 percent above operating costs,

and should be allowed to accumulate in a reserve balance to be held in case of an unexpected downturn and for replacement and additions to the plant.

- Continued annual subvention by the County and city governments for payments to the bondholders until full bond redemption in 1994.

- A favorable resolution of the capital allowance passthrough by Medicare that will allow SPRMC to recover its full current capital costs and fund future capital needs.

- Prudent judgment on management's part to control the rate of investment and on the physicians' part to control the diffusion of high technology medicine.

On balance, the future of SPRMC financing rests on a delicate combination of a sufficient volume of services, a blend of privately and publicly sponsored patients, strong governance and management, and effective physician involvement in cost control and prudent technology choices.

CHAPTER TWO

STRENGTHENING THE GOVERNANCE AND STRUCTURE OF SPRMC

INTRODUCTION

We have concluded that despite the better than average performance of SPRMC as a public hospital enterprise, improvements can and should be made in its governance, organization, management, and program emphases. They should be made within the next six to eight months in order to preserve the organization's strengths, afford it greater flexibility and allow a revamped health care corporation to compete more effectively in a turbulent and unsettled medical marketplace. To do less runs the mid-term risk of maintaining a fettered, often ponderous and plodding organization that will eventually lose its current public and professional support and be reduced to an isolated sickbay for the segregated poor and homeless. Responsibility to the sick poor has been, now is, and, for the foreseeable future, will be the undeniable obligation of SPRMC. The larger and equally important concerns are that in the competitive milieu of the Twin Cities, few organizations are likely to compete for the poor and underfinanced patients, few providers are properly organized to perform those services, and no organization can mount and sustain a viable care program over a period of years if its only patients are those who are destitute.

St. Paul-Ramsey has been and continues to be an extraordinary community asset. Despite its imperfections (and there are some), the medical center has been generally responsive

and has provided excellent emergency services to the community. It has been an essential safety valve for the private health system, and a potent economic force for its more than 2,000 employees and physicians who work and live in the Metro area. Although more costly than most of its competitors in the past, SPRMC does not compare unfavorably to other regional teaching hospitals. Nevertheless, it has a responsibility to increase its efficiencies. Its balance sheet shows a healthy organization with a modest long-term debt. Further, the direct county support consisting of $5.4 million annually (about $3.1 million for indigent care and uncollectibles, $1.0 million for General Medical Assistance and community service, and $1.3 million for capital debt service) makes up less than 6.5 percent of SPRMC's operating budget, among the lowest proportions of public support to any public hospitals in the country. This is not a reason for complacency, but is a reason for some pride. Of course, like all hospitals, both private and public, approximately half of SPRMC's funds come from such government programs as Medicaid (10%) and Medicare (40%).

Why then, do we propose a change in SPRMC's governance structure? We believe that change in SPRMC's governance is the only way to achieve the following objectives which are central to the full development of a redirected St. Paul-Ramsey Center for Health Care, a new organization designed for the next era -- the 1985-1995 decade:

Objective 1. Preserve an array of valuable community services which have been offered at SPRMC and which are essential to the well-being of a vulnerable population.

Objective 2. Preserve the vitality of an institution in which the public is already invested, which has offered unique services, and which has brought the presence of medical education to Ramsey County.

Objective 3. Develop a stronger, more skilled corporate board to set policy and direction for a redefined mission, one that emphasizes a wider range of health care programs.

Objective 4. Provide a new governance structure that can more effectively accommodate physician participation in the governance and operation of the center.

Objective 5. Create an organization that can merge and consolidate excess health services capacity through partnership and joint effort with others.

Objective 6. Create a climate favorable to securing and retaining competent management, one in which goals are set and program accomplishments can be measured.

Objective 7. Reduce the burden on government and upon government officials, by strengthening accountability and minimizing onerous oversight.

These objectives are laid out in our priority order and are behind our discussion of options, analyses, and recommendations to which we now turn.

We have been asked to describe and comment upon five relatively distinct approaches to governance of a public hospital system. Several studies of one or more of these alternatives have

been prepared or aspects analyzed by Ramsey County or the staff of SPRMC, including the Joint Study Task Force Report of July, 1983, the reports by Krings and Thorpe in 1982, in documents produced by A.T. Kearney, and in other working papers. We do not intend to detail every advantage, disadvantage, and issue. This is hardly a new subject for our clients.

Five options are under consideration:

A. GOVERNMENT GOVERNANCE AND MANAGEMENT OPTIONS

1. Retain the Hospital Commission As Is or Modified.

2. Total County Management.

B. NON-GOVERNMENT GOVERNANCE AND MANAGEMENT OPTIONS

3. Sell or Lease to a For-profit Hospital Company.

4. Sell or Lease to a Public Benefit Hospital Corporation.

5. Sell or Lease to a Non-profit Corporation.

GOVERNMENT GOVERNANCE AND MANAGEMENT OPTIONS

Option 1: Retain the Current Hospital Commission or Modify It.

Much of Book I is devoted to the shortcomings and problems of the current governance method. Although the commission structure has a state of Minnesota legislative charter, we have argued that despite the generally acceptable performance of the St. Paul-Ramsey Medical Center in the past several years, the current commission system suffers from:

- A weak Hospital Commission usually dominated by County Commissioners.
- A weak nomination process that neither seeks nor assures a well balanced, professional Hospital Commission.
- Incomplete authorities that limit the Hospital Commission's ability to act unencumbered.
- Open meeting requirements that make strategic planning impossible in a competitive market.
- County Commissioner frustration that they must share authority with the Hospital Commissioners.
- A general lack of accountability, because no one is ultimately "in charge."

The inherent weakness of this governance structure is the blurred authority of the Hospital Commission, which is a creature of the County and the state and which has comprehensive responsibilities but incomplete authority to carry them out. Ultimately, the public appears to perceive the County Commission as the "owner" of SPRMC and will, under current circumstances, hold county government responsible for failures at the medical center. Many of the Hospital Commissioners who are not County Commissioners have an identical perception. We can conceive of no easy repair short of eliminating all County Commission participation on the Hospital Commission itself. Such a strategy would be disastrous, leaving the present Hospital Commission even weaker, but more accountable to the nominating senators than to the County. In contrast, if state senators were removed from the nomination process and County Commissioners were left to nominate and select Hospital Commission members, we would have a Commission with only legitimate but narrow county interests often unavoidably based toward serving short-run, local, political interests. A move toward greater county involvement may be sound but should be (as has been suggested by some County Commissioners), governance by the County Commissioners themselves, not their appointers (Option B).

We are also persuaded that revisions in the current commission structure will not eliminate an important set of secondary issues, namely civil service, county personnel rules, and collective bargaining outside of a revised Hospital Commission. We wish not to be misunderstood: Public employees are entitled to all of the hard won protections they have earned, and any non-commission option selected must preserve those rights to other civil service opportunities, to public pension programs and the like. However, because SPRMC competes in a mostly

privately managed health care provider environment; because 60-70 percent of hospital expense is personnel; and further, because more public hospitals have been sold or closed proportionate to other ownership types, public hospital employees have often advocated governance changes that provide real job protection benefits and ones that offer a greater chance of future organizational success. In our judgment, the time to advocate change is now.

Option 2: Total County Management

The second option is that of increasing the county government's role in operating and managing the activities of SPRMC by eliminating the Hospital Commission and returning it to the county government to be run as a conventional public agency. This option has these advantages:

- It clarifies organizational authority and responsibility at the County Commissioner level.
- It allows all of the County Commissioners an equal and direct role in setting policy.
- More county agency overhead can be absorbed in the SPRMC expense base.
- Public employees may view this as a "safe haven."
- It could force tighter linkages with public health and school health activities.

- If profitable, it would add net income to the County coffers.

This option returns the hospital and its programs to the county government from whence they came. Such a transfer would be relatively easy since few employees are outside of civil service and the assets of the Hospital Commission can be clearly identified should it be dissolved.

On the other hand, difficulties could be encountered between the County Commission and the physician's organization which numbers 150 teacher-clinicians and relates with the Commission through the MERF. It is unlikely that most physicians would agree to become full-time salaried employees of the County.

In addition, this option runs counter to nationwide trends. Only a few county or city governments continue to operate their hospitals as branches of county government, and for quite understandable reasons:

- Government officials already are overburdened.
- The risk of management failure is very high and so are the costs.
- Greater expertise in health care services is expensive, and increasingly available only outside of government.
- Ownership limits the options to buy care for the poor through competing groups.

- The incentives for government hospitals to collect third party reimbursement are usually weaker, since government stands behind all of the losses.

- Ownership of public hospitals has tended to guarantee a two-class hospital system.

For these and a host of other reasons, local governments have divested themselves of the daily responsibilities of operating hospitals. Except for clarifying final authority at the County Commissioner level, we see no virtue whatsoever in returning the hospital to county management. The risks to the County and to the public outweigh any conceivable benefits. We reject this option because we cannot find a single example of a local government directly operating a high quality, efficient operation anywhere in the United States in the 1980s.

NON-GOVERNMENT GOVERNANCE AND MANAGEMENT OPTIONS

The remaining three options describe non-government management alternatives:

- Option 3 - Sale or Lease to a For-profit Hospital Company.
- Option 4 - Sale or Lease to a Public Benefit Hospital Corporation.
- Option 5 - Sale or Lease to a Non-profit Corporation.

Each of these options moves SPRMC into governance modes that are more private than public. In a larger sense, a policy decision is made that implies that government need not be the "maker" of health care services for one or another patient groups if it can be a "prudent buyer of services." Proponents of these more private alternatives argue that legislation can be drawn to protect the public interest or, in certain circumstances, that contract language can be devised which would require a contractor hospital to perform services for which it will be paid. Cities and counties as large and diverse as Philadelphia; Louisville; Kansas City, Missouri; New York City; Contra Costa, California; Prince George's County, Virginia (a large suburban county adjacent to Washington, D.C.); and Seattle have created new organizational forms and closed or transferred their public hospitals to more effective non-governmental for-profit, non-profit, or public benefit corporations.

There should be little confusion as to the fundamental differences between non-profit and for-profit organizations in the

health field. Enormous growth has occurred in the investor-owned field, largely through consolidation of small hospital chains and independent public hospitals into larger, more national firms. In the last two years a few investor-owned companies have targeted troubled public teaching hospitals such as the University of Louisville and the University of Medicine and Dentistry Hospital in Newark, both of which are now being managed under contract by for-profit companies. It is a well known fact that American Medical International is interested in purchasing teaching hospitals such as the financially healthy but capital-short hospital of George Washington University.

Non-profit multihospital organizations and universities are also willing to manage public hospitals. In the case of California, The University Hospitals in San Diego, Orange, and Sacramento were purchased by the State Board of Regents which has now incorporated these institutions as non-profit corporations. In Prince George's County the government set up an elaborate process which formed a new non-profit corporation for their two public hospitals. A similar plan is now under way in Morgantown, West Virginia where the public University of West Virginia Hospital has secured legislation allowing its transfer to a separate non-profit corporation.

Minnesota leaders are less familiar with the public benefit corporation model in Minnesota and how it differs from a non-profit corporation. Our attorney consultants have presented the following discussion:

> The basic distinction between a non-profit corporation ("NPC") and a public benefit corporation ("PBC") is that the PBC is a public or quasi-public legal entity, whereas the NPC is a private legal entity.

The NPC is a private legal entity created pursuant to the Minnesota Non-profit Corporation Act ("NPCA"). Its purposes may include the provision on a non-profit basis of educational, scientific or a variety of other charitable services. Its purposes may or may not be those which are essentially or traditionally public or governmental in nature. NPCs are governed by their articles of incorporation and by-laws under the general authority and provisions of the NPCA.

In contrast, a PBC, as defined for purposes of this discussion, is created by special state enabling legislation to perform essentially a public function outside the normal governmental structure of the state and its political subdivisions. There is (in Minnesota) no general state enabling legislation authorizing the creation of a PBC. Therefore, in order to create a PBC, a special act of the State Legislature is required. The special enabling legislation in effect becomes the charter or the certificate of incorporation of the PBC. The special act generally sets forth in substantial detail a description of the purposes of the PBC, its powers and duties, and special provisions governing the manner in which it must conduct its activities.

Legislation establishing a PBC exempts it from State laws which would otherwise be applicable, modify such laws in respect to their application to the PBC, or expressly incorporate such laws. For example, the Minnesota Rural Development Finance Authority Act, Minn. Stat. Section 362A, establishes a public corporation which incorporates the provisions of the Minnesota Non-profit Corporation Act, with certain exceptions set forth in the Authority's enabling legislation. PBCs are a particularly useful legal mechanism where sponsorship of governmental functions or services are being transferred or where there is a desire to mandate governmental financial support of the PBC.

There are public legal entities, other than PBCs as contemplated here, that have been employed by states to perform public or quasi-public governmental activities. Under Minnesota Law, for example, entities serving solely public or governmental functions -- including public authorities, hospital district authorities, hospital boards, and certain special purpose "public corporations" -- are collectively termed "public corporations." See Id. Section 300.02, Subd. 3. The principal distinction between a PBC as defined here and other "public corporations" is that PBCs are organized independent of, and apart from, the governmental structures of the state and its political subdivisions, whereas other public

corporations are organized and operated within that structure. See Id. Section 471.49, Subd. 3. Generally speaking, public corporations which are operated as political subdivisions may levy taxes or cause taxes to be levied for their support. No such taxing power would be granted to a PBC for SPRMC.

The distinction between PBCs and NPCs and between PBCs and those public corporations which are political subdivisions are more than surface legal classifications of various corporate forms. As illustrated in Appendix A, the matrix of organizational alternatives, there are very real differences with respect to governance, finance, personnel and purchasing in a hospital operated as an NPC, PBC or as a political subdivision.

Threshold Policy Issues

In contemplating a more detached organizational relationship between the county government and a private or quasi-public public benefit corporation, what are the most serious public policy concerns and can they be mitigated? Before reviewing the three primary non-government options, we think these important policy matters must be addressed:

- Public accountability
- Guarantees for medical indigent care and financial viability
- Public oversight of private management
- Public or private employment
- Agreement on role

Each of these five critical elements must be resolved if government concerns are to be assuaged and a sensible arrangement worked out with a more flexible and potentially more effective organization.

Public Accountability. Public accountability can be effected through a variety of means such as control of a portion of the appointment process to the non-profit Board; Board membership itself; stipulations in the public benefit corporation enabling legislation such as annual reporting, public visiting committees, required public hearings, and required access to certain financial and business records; periodic renewal of certain contracts involving the payment of public funds; limits on the use of public property or former public property; and accreditation and licensure regulation.

Health care, even in the most competitive milieu, is still highly regulated and regulatable. Any agreement to transfer responsibility away from the County could contain a variety of safeguards -- ones which we would argue should be few in number but firm in effect.

Guarantees for Medical Indigent Care and Provider Financial Viability. In the first years of any new agreement the County must be willing to pay the reasonable costs of care for the indigent if it expects a single organization to stand ready to take all needy patients. SPRMC has established a modus operandi that makes the County the payer of last resort. The County must have periodic audit capability. Ceilings on rates can be determined; an upper limit set on the annual hospital surplus; and a provision made to reopen the contract and use other providers after an initial trial period or if expenses are out of line with comparable hospitals.

Public Oversight of Private Management. Although government is tempted to urge constant surveillance of private management, physician services, and particular programs, we would urge a more rational approach to management and medical accountability through external peer review and public reporting. The County could also provide a public ombudsman on the premises to review complaints of aggrieved patients, a "hot line," or some other device that would protect legitimate county interests.

Public or Private Employment. Government has an important stake in the provisions affecting public employees when there is a sale, lease, or transfer to a non-governmental or public benefit corporation. Public employees have the greatest stake. Ordinarily most legislation and implementing agreements require that the new entity accept all of the current work contract terms; some agreements allow the new entity to contract with the government for the services of employees who then continue to receive government paychecks. Other arrangements may specify voluntary transfer with similar pay and benefits to a new corporation; mandatory transfer but preservation of old pension arrangement rights; treatment of new employees in a new legislatively prescribed manner (if a PBC), etc. These issues are complex but clearly resolvable, provided employers and employees can agree that these changes are not a special exploitation opportunity for either party.

Agreement on Mission and Role. We have tried in Chapter 1, Book II to lay out an articulated role for SPRMC in the next decade. Our clients should come to closure so that regardless of whether there is new governance or old, there is general agreement.

The issue of role is the last and perhaps most important matter if any non-government governance option is to be seriously considered. It is pointless to invite private involvement or development of a public benefit corporation if there are going to be major disagreements on the fundamental purpose of this organization. Thus, the last of our threshold issues requires commitment to agree on the direction this enterprise must take.

Assuming the threshold policy issues can be addressed, we turn to the remaining options.

Option 3: Sale or Lease to a For-Profit Hospital Company

There has been previous consideration of for-profit company involvement in SPRMC. Undoubtedly, if invited, several companies would express an interest in purchasing the institution and guaranteeing the care of the poor in exchange for the County's assuring a payment stream on behalf of those for whom the County mandates services.

The major advantages in considering the for-profit option are:

- A sale would give the County instant capital (if purchased) with resultant debt retirement; or if a lease, a steady flow of rent to cover amortization and debt service.

- The probable partners have previous public hospital management experience (AMI, NME, HCA, Humana, NuMED, and others).

- The companies are concerned about their image and their respectability; hence, their interest in teaching, research, and indigent care hospitals.

- Investor-owned companies pay local taxes.

- The companies have usually outperformed previous substandard managers.

- This option saves the trouble of creating another entity, either non-profit or PBC, or maintaining a time-consuming Hospital Commission.

The list of advantages is quite attractive. Nevertheless considerable public resistance has been generated to arrangements with for-profit companies.

The following are reservations, allegations, or objections to selling or leasing public facilities and programs to private for-profit organizations:

- For-profit operation in health care leads to abuses, mismanagement of patients, and overcharges to payers.

- Investor-owned companies put the financial interests of their stockholders ahead of community services.

- Investor-owned companies expect and do generate handsome returns to their stockholders.

- Investor-owned hospitals discontinue unprofitable but valuable community services.

- Investor-owned hospitals have to charge more because they are more expensive for equivalent services, their plants are newer, and they pay taxes.

- Investor-owned hospitals take orders from their home offices, not from community trustees.

In our judgment many of these allegations are unfair, if not inaccurate. As students and researchers of the field we believe we can document the following statements:

- Investor-owned companies vary widely in their performance and capacity.

- Most investor-owned companies acknowledge they can improve poorly performing hospitals, and we agree. We also agree they do not perform, on average, better than well-run non-profit or public hospitals, or non-profit systems.

- Investor-owned hospitals consistently show higher charge patterns than similar non-profit organizations, higher mark-ups, and costs that are slightly higher. Length of stay for equivalent diagnoses has been equal to or slightly lower than non-profits. Investor-owned hospitals appear to use fewer FTEs in nursing and more part-time help. However, they seem to have higher administrative costs, operate lower occupancies, and have higher capital costs, which they attribute to newer buildings or recent purchases which have been recapitalized.

- Most studies comparing for-profit and public and non-profit hospitals show that investor-owned hospitals are located in more affluent areas, and provide less uncompensated charitable care than public hospitals and somewhat less unfinanced care than non-profits.

- Unpublished studies on recent acquisitions by for-profit companies show significant improvements in financial performance after the acquisition, in part due to more aggressive pricing.

- Capital formation is the investor-owned systems' primary advantage, but equity capital is not usually less expensive than tax-exempt financing.

Option 4: Sale or Lease to a Public Benefit Corporation

The public benefit corporation (PBC) model has been described in earlier pages of this chapter. In concept, through a legislative charter it creates a special entity of government which is not a unit of government but which carries out special statutory purposes of government. Converting the commission to a PBC would require new legislation and a carefully developed preamble that would state the purpose and role of the organization and detail its authorities, which would likely be broad so as to include all of the usual corporate powers. It could stipulate the terms of accountability and the other "threshold" issues discussed above, and would likely establish the mechanism for appointments to a corporate board.

The advantages of Option 4 appear to be:

- Legislation can be tailored to fit closely the needs of government and the new enterprise.
- The expectations of government and various provisions for accountability can be spelled out.
- Flexibility can be provided for management.
- Reasonable protections can be provided to the new corporation with respect to indigent care financing.
- An organization can be chartered by the state, which can later curtail the organization's powers if it is non-responsive.
- The buying power, legal services, or other resources of government can be made available to the corporation.
- The corporation can have its own bonding authority.
- Sunshine Law requirements can be limited to cover major strategic activities.

The establishment of a public benefit corporation for SPRMC would require special provisions for the appointment or creation of a successor Board. So too would a successor non-profit Board. Because PBC legislation would stipulate specific processes for appointment, we would make the following recommendations, in the event this option were accepted.

1. Board membership on the PBC should be specified by class in legislation. It should provide for a 15-member Board consisting of no more than three to four physicians; two publicly elected officials (e.g., a County Commissioner and a State Senator); at least two senior executives of major businesses in the region; an experienced attorney; a senior banker; a senior accountant; a person experienced in property management or real estate; two consumer advocates or representatives; and the CEO of the PBC.

2. A distinguished Blue Ribbon nominating committee of six to eight persons would be appointed by agreement among the president of a major local foundation, the executive director or current medical director of SPRMC, a current County Commissioner serving on the SPRMC Hospital Commission, and a leading business and civic leader. The Blue Ribbon nominating committee would then receive nominations, and screen and select from among the many nominees meeting the qualifications for Board membership. Once the Board was appointed the Blue Ribbon committee's task would be completed.

3. To attract a competent board, the PBC would be given substantial authority but also would be subject to a variety of public accountability measures. Terms would be four years in length, staggered initially, and renewable for a second successive term. Replacements for the Board would be nominated by the Board itself with prescribed outside consultation. The chairman of the Board could not be an elected official, the corporation's CEO, or an active physician, but would be selected from among the remaining board.

These are a few ideas to give body to the PBC approach.

Are there disadvantages to the PBC model? Here are a few:

- Changing the corporate charter is cumbersome, requiring legislation.
- The PBC has less flexibility than the non-profit model.
- Many perceive a PBC as a government model, making cooperative contracts and potential mergers more difficult.
- Model legislation gets "Christmas treed" on its way through the legislature.
- Local government may feel more threatened by a powerful board.

We believe the PBC is an attractive governance model and one that deserves thorough exploration. We are convinced that it is vastly superior to the current commission model and perhaps better suited to the Minnesota tradition than the for-profit model. However, it may be no better than the last option; sale or lease to a non-profit corporation.

Option 5: Sale or Lease to a Non-Profit Corporation

Legislation would also be required to set up a special private non-profit organization to govern the revamped SPRMC.

Although authorities for the corporation would be those normally reserved for any corporation, special provisions would have to be legislated to turn over public assets and deal with civil service employees and possibly Board appointments. For all practical purposes the Board then would have all the rights and privileges of any non-profit, charitable corporation in Minnesota and would be on a playing field that would be level with its major competitors. Initial membership on this Board could also be developed in a manner similar to that suggested for the PBC model.

The advantages of the non-profit corporation are as follows:

- Non-profit organizations have virtually unencumbered managerial prerogatives, provided no special benefits inure to the owners through profit distribution.

- Non-profit organizations are generally exempt from taxes, may receive charitable gifts whose donors obtain tax deductions, and can use tax-exempt financing under certain circumstances.

- Non-profit organizations may join with other similar tax-exempt non-profit organizations to purchase goods, raise funds, joint venture services, share management, etc.

- Non-profit organizations have been able to attract leading community citizens to boards which are perceived as prestigious.

- Non-profit organizations have total flexibility in personnel management.

- Non-profit organizations can develop strategic plans and activities in private.

Non-profit health care is the prevailing organizational model in the United States. The most productive hospital organizations in the country up to this time have been the great non-profit enterprises that have served science, served all economic classes, and educated our talented health professionals. Although non-profit organizations have been criticized for non-businesslike practices, our view is that some of our most innovative management has occurred in non-profit agencies and organizations; that the motives of high performance, low cost, and operating surpluses are equally powerful in many non-profit enterprises; and that non-profits are attracting their share of able management and highly skilled and responsive Boards of Directors.

As to disadvantages, they are:

- Capital formation is highly dependent upon earned surpluses and borrowing capacity, which might be less than under the current arrangement. Equity financing is not usually available.

- Some critics argue that the lack of profit motive weakens management's resolve to control costs or raise prices.

- Once established, a SPRMC non-profit corporation would be permanently in place (to some observers, an advantage) and totally free to dispose of assets, go bankrupt, or modify programs.

- The public reporting requirements for non-profit corporations are minimal.

- Oversight by government would be more difficult but not impossible.

- Government perceives a lower level of responsibility for this type of enterprise.

The non-profit model allows the strongest opportunity for operating independence and for government to cut loose a tough management responsibility. The County would be freer to contract with others and to treat SPRMC as just another neighboring community hospital. Because there currently are important financial ties to the County by SPRMC, there is little chance a non-profit can succeed in the first few years without a reasonable and exclusive contract for indigent services. That contract could eventually be phased down, assuming SPRMC was operating as a successful community health care corporation.

THE RECOMMENDATIONS OF YOUR CONSULTANTS: AN EIGHT-POINT PLAN

1. Replace the current Hospital Commission by securing special legislation for a public benefit corporation.

2. Spell out qualifications for Board membership, an appointment process, and process for board renewal.

3. Prescribe a four-year obligation of the County and the new corporation to enter into an agreement for the care of the indigent at prices not to exceed the Medicare in-patient payment per DRG; at out-patient rates comparable to the 50th percentile of hospital out-patient costs; and at fair capitation rates for those county populations where capitation rates can be set accurately.

4. Allow the assets of the Commission to transferred to the PBC. The County would continue to retire the bonds as long as the PBC cared for the indigent population.

5. Allow the PBC to accumulate annual surpluses to an upward limit beyond which the PBC would support additional indigent services at its expense.

6. Provide a title transfer clause so that, at the end of ten years, the PBC would be granted title to its land and buildings for so long as it maintained the facilities as a health care organization, or for an alternate purpose agreeable to the Ramsey County and the City of St. Paul.

7. Allow the PBC broad powers to provide new services and abandon non-essential activities in order to compete effectively.

8. Insist on a single medical staff organization that is a subsidiary to the PBC. It should have a charter that allows for an interlocking directorate for the subsidiary. The subsidiary should be allowed to conduct its professional duties in a protected and privileged atmosphere. The physicians should be

part of a professional corporation which takes its policy direction from the PBC. The subsidiary should have a president, other necessary elected officers, and a modified department structure that permits the leadership group to serve as the Executive Medical Board of the hospital. The PBC should ratify the by-laws of the physician subsidiary and any other corporate subsidiary which is established.

Appendix A

Detailed Comparisons of Alternative Governance Structures

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
A. Method of Creation	Special State Legislation	Amend SPRMC Statute	State Statute governing Ramsey County	Certificate of Incorporation for Non-Profit Corporation	Special State Legislation	Certificate of Incorporation for Business Corporation

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
B. Governance						
1. Policy-making and Management Responsibilities	Split Responsibilities: • SPRMC Commission: responsible for hospital operations; administration; scope of services; employment of personnel • County Board of Commissioners: responsible for appointing SPRMC Commission memebers; raising capital; approval of short-term borrowing; approving purchases of real	Split Responsibilities: Transfer from County to SPRMC Commission the following responsibilities: approval of purchases of real property; approval of short-term borrowing; personnel administration (increased SPRMC role)	County Commissioners responsible for policy-making and management	Independent Board of Directors responsible for policy-making and management	Board of Directors prescribed by Statute responsible for policy-making and management	Independent Board of Directors responsible for policy-making and management

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
	property; and overseeing personel policies, systems and administration					
2. Size of Governing Board	15 Commissioners	10 - 15 Commissioners	7 County Commissioners	At least 3 Directors (generally NCPs have between 10 and 30 Directors)	Prescribed by Statute (generally PBCs have between 5 and 15 Directors	At least 3 Directors
3. Board Composition/ Qualifications	• 4 County Commissioners • 9 citizen members representing certain Minnesota Senate Districts • 2 at-large citizen members	• County Commissioners • citizen members	All County Commissioners	Certificate of Incorporation and/or Bylaws set forth qualifications (usually members of local community)	Enabling legislation sets forth qualifications (usually includes some governmental representatives)	Certificate of Incorporation and/or Bylaws sets forth qualifications (usually owners or representatives of owners of hospital)

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
4. Board Appointment Mechanisms	• 4 County Commissioners appointed by County Commissioners	• County Commissioerns direct appointments	General Election of County Commissioners	Set forth in corporate bylaws; (usually self-perpetuating Board)	Set forth in enabling legislation (usually governmental agencies reserve the right to appoint some board members)	Set forth in corporate bylaws
	• 9 citizen members appointed by County Commissioners upon nomination of certain State Legislators • 2 at-large citizen members appointed by County Commissioners upon nomination of SPRMC Commission	• Increased number of appointments by County Commissioners upon nomination of SPRMC Commission (i.e., self-perpetuating)				

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
5. Board Meetings	Minnesota Open Meeting Law requires that meetings be open to public (except discussion of labor negotiations and pending or threatened litigation)	Open Meetings Law Applies	Open Meetings Law applies	Private Meetings	Open Meetings Law applies, unless enabling legislation is written to make inapplicable	Private Meetings

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
C. Corporate Powers	Statutory Powers SPRM Commission: • Employs personnel, subject (except for 8 senior managers) to County Civil Service Laws • appoints CEO • may hold personal property or may purchase and hold real property (subject to county approval) Ramsey County Board of Commissioners: • appoints SPRMC Commission members • approves annual budget	Transfer from County to SPRMC Commission the following powers: • employment of increased number of managers outside County Civil Service system • approval of purchase of real property • approval of line-by-line budget (County approves lump-sum budget only) • approval of short-term borrowing	County Board of Commissioners empowered to take actions currently vested in County Board as well as those now vested in SPRMC Commission	Certificate of Incorporation and Bylaws provide power to operate general acute care hosptial and related health care organizations	Enabling legislation would provide appropriate powers	Certificate of Incorporation and Bylaws would provide appropriate powers

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
	• approves short- and long-term borrowing • may issue revenue bonds to finance improvements on additional facilities at SPRMC • may levy tax or appropriate funds for operation and maintenance of SPRMC • approves purchase of real property • control of civil service system under which classified employees are placed					

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
D. Administrative/Executive Organization and Function	Executive Director responsible for administration of hospital	Executive Director responsible for administration	Option of administering hospital as part of central county operations or as separate unit under county aegis	Chief Executive Officer (CEO) responsible for administration	CEO responsible for administration	CEO responsible for administration

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
E. Personnel Administration						
1. Executive Structure	• SPRMC employs, without restriction, an Executive Director and seven principal assistants	• SPRMC employs, without restriction, increased number of managers	County-appointed Executive functioning pursuant to County personnel rules	Bylaws set forth executive structure	Enabling statute or Bylaws sets forth executive structure	Bylaws set forth executive structure
	• Balance of employees subject to Ramsey County Civil Service laws	• Balance of employees subject to Civil Service laws				
2. Rank and File (a) personel systems • method of administration	Governed by Civil Service Commission; SPRMC reimburses County's Civil Service Dept. $225,000 for services to SPRMC classified employees	Governed by Civil Service	Governed by Civil Service	Internal hospital personnel system	Enabling statute sets forth structure (usually internal hospital personnel system parallel in certain respects to Civil Service rules)	Internal hospital personnel system

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
• personnel classification system; recruitment and appointment; promotions; disciplinary system; layoffs/ terminations	Governed by Civil Service	Governed by Civil Service	Governed by Civil Service	Internal hospital personnel system	Enabling statute sets forth (usually internal hospital personnel system parallel in certain respects to Civil Service rules)	Internal hospital personnel system
• wage classification	County-wide governmental standard	MMC determines appropriate health care industry standard	"	"	Enabling statute prescribes	"
(b) Labor Relations						
• collective bargaining negotiations	Negotiations conducted by County	Negotiations conducted by County	Negotiations conducted by hospital	Enabling statute prescribes (usually negotiations conducted by hospital)	Negotiations conducted by hospital	

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
• grievance mechanism	County-administered mechanism	County-administered mechanism	County-administered mechanism	Internal hospital-administered mechanism	Enabling Statute prescribes	Internal hospital-administered mechanism
• no strike provision	Charitable Hospitals Act prohibits strikes by employees and mandates arbitration of labor disputes	Charitable Hospitals Act applies	Charitable Hospitals Act applies	Charitable Hospitals Act applies	Charitable Hospitals Act applies	No prohibition on strikes
3. Pension	Part of State/ County System	Part of State/ County pension system	Part of State/ County pension system	Non-governmental pension system	Prescribed in enabling statute	Non-governmental pension system

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
F. Finance						
1. Operations						
(a) Budget Process (development approvals; administration; modifications)	• Operating budget developed and approved by SPRMC	• Operating budget developed and approved by MMC	County develops and approves budget	• Operating budget developed and managed by hospital executives	• Prescribed in enabling statute; operating budget usually developed by management	Operating budget developed and managed by hospital executives
	• County has authority to approve budget annually, but has not exercised it.	• County approves lump-sum budget		• Board approves budget (usually annually) and any significant modifications		
				• Governmental authority sometimes approves lump-sum budget		

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
(b) Third Party Reimbursements						
• Rate setting/ Major Third Parties						
• Payor Mix		Probably same as SPRMC	Probably same as SPRMC	May seek to increase percentage of BC/BS and commercial patients	May seek to increase percnetage of BC/BS and commercial patients	May seek to increase percentage of BC/BS and commercial patients; decrease Medicaid; self-pay/ no pays; GAMC
(c) Cost of Services to Medically Indigent	SPRMC mandated to provide services to Ramsey County medically indigent	Likely to continue practices of SPRMC	Likely to continue practices of SPRMC	Likely to seek County subsidy/ contract	Likely to eek County sub idy/ contract	Likely to continue services if costs adequately covered

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
• Ramsey County Subsidy	• County "may" provide funds to SPRMC for indigent. Annual County subsidy approximately $4M for services to medically indigent of Ramsey County	▪	▪	▪	▪	▪
• Additional Uncollectible Accounts	• SPRMC provides additional $10M annually in bad debt and charity care	▪	▪	Could elect to limit volume of additional uncompensated services	Enabling legislation prescribes obligation (could mandate servcies to medically indigent)	Unlikely to continue providing additional uncompensated services
(d) Financial Management Systems	Maintain Public Depository; financial management generally independent of County	Same as SPRMC	Part of County financial management system	Independent financial management system	Prescribed in enabling legislation (usually independent financial management)	Independent financial management system

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
2. Capital Financing						
(a) Budget Process (development; approvals; administration; modifications)	• SPRMC submits to County requests for capital funds for facilties; construction	• Same as SPRMC	Part of County capital budgeting process	Independent capital budgeting process	Prescribed in enabling legislation (independent budgeting process or part of governmental budgeting process)	Independent capital budgeting process
	• SPRMC authority to borrow up to $4M on line of credit subject to County approval	• MMC authority to borrow short-term without County approvals				
(b) Third Party Reimbursement	SPRMC reimbursed for interest and depreciation (including amortization of debt service), even though County pays costs	SPRMC reimbursed for interest and depreciation (including amortization of debt service), even though County pays costs	County reimbursed for its actual interest and depreciation expenses	NPC reimbursed for actual interst and depreciation expenses	PBC reimbursed for interest and depreciation (including amortization of debt service); enabling statute establishes whether or not County, other governmental entity or hospital acutally pay costs	FP reimbursed for actual interest and depreciation expenses; also recieves return on equity reimburse-ment

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
(c) Financing Sources						
• County tax levy/ capital budget allocation	County capital budget allocation	County capital budget allocation	County capital budget allocation	No County capital budget allocation	Set forth in enabling statute; possible to continue County budget allocation	No County capital budget allocation
• Tax Exempt Bonds						
County/City	County/City may issue revenue bonds for SPRMC -- (72.5% - 27.5⅛% ratio, respectively)	Same as SPRMC	County may issue bonds	No access to County/City bond financing	Set forth in enabling statute (usually have own bonding authority)	No access to County/City bond financing
FHA § 242 Program	Eligible for § 242 as public hospital	Eligible for § 242 as public hospital	Eligible for § 242 program as public hospital	Eligible for § 242 program non-profit hospital	Eligible for § 242 program as public hospital	Ineligible for § 242 program

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
• Equity/Syndication	Public Hospitals Act permits joint ventures with private parties but applies restrictive investment rules	Public Hospitals Act permits joint ventures but applies restrictive investment rules	Public Hospitals Act permits joint ventures but applies restrictive investment rules	No limitations other than to preserve tax-exempt status	Public Hospitals Act permits joint ventures but applies restrictive investment rules unless enabling statute specifically provides otherwise	Unrestricted Access to equity financing
• Ad Valorem Tax	County authority to levy ad valorem tax to pay interest on bonds for construction of SPRMC	Same as SPRMC	General County taxing authority	No taxing authority	Set forth in enabling statute (usually not a taxing authority)	No taxing authority

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
G. Purchasing						
(a) Goods and Services						
(Administration; approvals; procedures)	• SPRMC required to follow State public purchasing laws except when making a purchase through a non-profit corporative service organization	• SPRMC required to follow State public purchasing laws except when making a purchase through a non-profit cooperative service organization	• Public purchasing laws apply	• No statutory restrictions	• Set forth in enabling statute; possible to structure outside general state public purchasing laws	• No statutory restriction
	• All contracts for goods and services (other than professional services) over $15,000 must be publicly advertised and awarded to lowest possible bidder					
	• Bulk purchases through County	• Bulk purchases through County	• Bulk purchase through County	• Cannot take advantage of County bulk purchases	• May take advantage of County bulk purchases	• Cannot take advantage of County bulk purchases

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
(b) Capital acquisition (administration; approvals; procedures)	• May acquire personal property without County approval, subject to public purchasing/ contracting laws (other than for purchase through non-profit cooperative hospital service organization)	• May acquire personal property without County approval, subject ot public purchasing/ contracting laws (other than for purchase through non-profit cooperative hospital service organization)	Subject to public and purchasing laws and County purchasing procedures	Internal hospital proceduers and administration	Enabling staute sets forth	Internal hospital procedures and administrat-ion

St. Paul-Ramsey Medical Center

Considerations	Existing Medical Center Commission (SPRMC)	Modified Medical Center Commission (MMC)	Direct County Operations (DC)	Non-Profit Corporation (NPC)	Public Benefit Corporation (PBC)	For-Profit Corporation (FP)
	• May acquire real property, subject to County approval and public purchasing contracting laws	• May agcuire real property without County approval				

Appendix B

Persons Interviewed During
Lewin and Associates Study of
St. Paul-Ramsey Medical Center Governance

County Commissioners

Diane Ahrens	Ramsey County Commissioner
John Finley	Ramsey County Commissioner
Ruby Hunt	Ramsey County Commissioner
Hal Norgard	Ramsey County Commissioner
Bob Orth	Ramsey County Commissioner
Don Salverda	Ramsey County Commissioner
Warren Schaber	Ramsey County Commissioner

Hospital Commissioners

Patricia Durkin	Member, Hospital Commission
Michael Eittel	Member, Hospital Commission
Emil Kucera	Member, Hospital Commission
Bruce Lundahl	Member, Hospital Commission
Harry Moberg	Chairman, Hospital Commission
Richard Moore	Member, Hospital Commission
Jane Preston	Member, Hospital Commission
Lena Quinlan	Member, Hospital Commission
Steve Schmidt	Member, Hospital Commission
Shelly Wright	Member, Hospital Commission

Hospital Administrative Staff

Jan Arcan	Administrative Assistant, Office of Medical Director, SPRMC
Dave Bergh	Director, Information Systems, SPRMC
Jim Dixon	Senior Associate Director, SPRMC
Bob Garland	Chief Financial Officer, SPRMC
Diann Giovannini	Associate Director, SPRMC
David Gitch	Executive Director (CEO), SPRMC
John Hanno	Manager, Business Office, SPRMC
Mary Hudson	Assistant Administrator, SPRMC
Rudy Jensen	Controller, SPRMC
Beverly Johnson	Director of Surgical Services, SPRMC
Barbara Lawrence	Director of Personnel, SPRMC
Marlene Marschall	Hospital Director (COO), SPRMC
Art McKee	Plant Operations Director, SPRMC
Jeff Meyer	Senior Assistant Director, SPRMC
Nancy Monohan	Director of Volunteers, SPRMC
Ann Newman	Director of Social Service, SPRMC
Jerry Nye	Director of Special Programs, SPRMC
Frank Quattlebaum, M.D.	Medical Director, SPRMC

William Riley	Associate Director, SPRMC
Vicki Schaefers	Director of Nursing, SPRMC
Diane Schmidt	Director, Ambulatory Care, SPRMC

RCA Board

Stephen Butzer, M.D.	Psychiatry
Brian Campion, M.D.	Cardiology
James Cicero, M.D.	Emergency Medicine
Charles Drage, M.D.	Internal Medicine
Ralph Faville, M.D.	Pediatrics
Philippe L'Heureux, M.D.	Radiology
John Scanlan, M.D.	Psychiatry; President, RCA
Lynn Solem, M.D.	Surgery

RCA Administrators and Other Physicians

Lawrence Boies, M.D.	Head, Otolaryngology
Erick Y. Hakanson, M.D.	Head, Obstetrics/Gynecology
Donald Landis	CFO (Retiring), MERF
Robert O. Mulhausen, M.D.	Head, Medicine
John Perry, M.D.	Head, Surgery
Craig Suwinski	Executive Vice President, RCA
Claud Swayze, M.D.	Head, Anesthesiology
Homer D. Venters, M.D.	Pediatrics
Maynard Wood	Controller, MERF

Other Area Providers

Norman Allan	Executive Director, Gillette Hospital
David Brown, M.D.	Dean, University of Minnesota School of Medicine
Tom Hoban	Executive Director, Hennepin County Medical Sociaty
Alan Johnson	Executive Director, Council of Community Hospitals
Jim Kenney (telephone)	Executive Director, Coalition on Health Care Costs
Jeanne Lally	Administrative Director, Senior Health Plan, Inc.
Tom Love, M.D.	President, Ramsey County Medical Society
Jerry McCarthy	CEO, St. John's Hospital
Daniel McLaughlin	Associate Administrator, Hennepin County Medical Center
Richard Nelson, M.D.	Pediatrics, Gillette Children's Hospital
Tom Rockers	CEO, United Hospitals
Steve Rogness	Executive Director, Minnesota Hospital Association

Government (Other than Ramsey County Commissioners)

Gary Davis	County Attorney's Office
John Derus	Chairman, Hennepin County Commissioners
David Fortney and Harry McPeak	County Attorneys
Reynaud Harp (telephone)	Deputy Commissioner for Policy Analysis (Insurance Lewin and Associates incorporated

	Commissioner)
Duane Johnson	Assistant to Executive Director, Ramsey County
Honorable Marilyn Lantry	Minnesota State Senator
Don Mead	Administrator, Ramsey County Civil Service
Margaret Sandberg	Assistant Commissioner of Human Resources, State of Minnesota
Margaret Thorpe	Staff Assistant, Ramsey County Board
Michele Timmons	Ramsey County Attorney's Office

Health Maintenance Organizations and Other Third Parties

Lorie Clayton	Representative, AFSCME
John Finnegan and Ron Clark	St. Paul Dispatch
Paul Riddle	Planner, Metro Health Board
Leonard Schaefer	President, Group Health Plan
Ingrid Sundgaard	Executive Director, Coordinated Health Care, Inc.

Other Consultants

Lynn Brownlee	A. T. Kearney (strategic planning consltants for RCA)
J. Michael Griem	A. T. Kearney
Bob Linden and Mark Wallace	Linden & Associates (ambulatory care consultants)
Kathy Cooney	Ernst & Whinney (consultants for the St. Paul Rehabilitation Center joint venture)