AGENDA

COTH ADMINISTRATIVE BOARD
August 6, 1972
Palmer House
PDR 5
9:00 a.m. - Lunch

I.	Call to Order - 9:00 a.m.	
II.	Approval of Minutes, Meeting of May 18, 1972	TAB A
III.	Report of the COTH Ad Hoc Membership Committee	TAB B
IV.	Current Status of the AAMC Committee on Financing Medical Education	TAB C
V.	Item Referred from the AAMC Executive Council: "Resolution On The Representation Of Basic And Clinical Scientists In Academic Health Centers"	TAB D
VI.	Health Services Advisory Committee Activities	
	A. Contract Renewal: HMO Development In Academic Health Centers	TAB E & F
	B. Prison Health Care	
	C. National Health Service Corp	
	D. Educational Aspects of HMO Development	
	E. New Directions for FY 1973	
VII.	Report of the RMP/CHP Committee	
VIII.	Current Status of NIRMP	
IX.	Report on the Renewal of Hill Burton Legislation	TAB G

X. Information Items

A.	COTH Annual Meeting Program	TAB H
B.	Special Annual Meeting Session with the Veterans Administration	TAB I
C.	Memorandum Concerning St. Joesph Infirmary	TAB J
D.	Proposed Statement on a Patient's Bill of Rights	TAB K
E.	Resignation of Don Arnwine	TAB L
F.	Discontinuation of the February Meeting of the AAMC Assembly	TAB M
G.	Hospital Administrators who have Participated in an LCME Medical School Accreditation Visit	TAB N

XI. New Business

XII. Adjournment

reference to manpower development = reexamine the need for manpower development.

ambulatory care reference; not to the point = excluding the inpatient points

COTH ADMINISTRATIVE BOARD MEETING
The Embassy Row Hotel
Washington, D.C.
May 18, 1972

Present:

George E. Cartmill, Chairman
Leonard W. Cronkhite, Jr., M.D., Chairman-Elect
Irvin G. Wilmot, Immediate Past Chairman
John H. Westerman, Secretary
Robert A. Derzon
Joe S. Greathouse, Jr.
Arthur J. Klippen, M.D.
Sidney Lewine
Herluf V. Olsen, Jr.
Roy S. Rambeck
David D. Thompson, M.D.
Thomas H. Ainsworth, Jr., M.D., AHA Representative

Staff:

Grace W. Berine
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Clara J. Williams
Catharine A. Rivera

I. Call to Order:

Mr. Cartmill called the meeting to order at 9:00 a.m. in Envoy C of the Embassy Row Hotel.

II. Consideration of Minutes:

The minutes of the meeting of February 4, 1972 were approved as distributed.

III. Management Advancement Program:

At 9:15 a.m., Marjorie Wilson, M.D., Director of the AAMC Department of Institutional Development joined the meeting to report on the Management Advancement Program which is being developed in her Department. The program

as presently conceived is a two phase effort. Phase I is primarily an individual executive development program directed toward exposing deans to management and administrative theory and practice as well as providing learning experiences in specific executive skills. Following the first year, it is anticipated that the program will be open to other individuals engaged in the management of medical centers.

Phase II is planned to focus on matters of institutional development and change, and includes the team approach to solving specific organizational problems at the local level. There is agreement that Phase II is the most important segment of the program, but Phase I is necessary as a first step for those individuals who are not familiar with management concepts and terminology.

A permanent steering group has been formed to guide the projects which is chaired by Ivan Bennett, M.D., Dean and Vice President of New York Universitv. The Carnegie Corporation has made a small planning grant to carry the overall program forward and to provide partial support for the initial seminar in September. The Grant Foundation has also approved a grant to help defray costs of the first orientation seminar.

The first seminar to be held the first week in September at Endicott House will be an intensive experience for one week. Additionally, three consultants - Dick Beckhart, Paul Lawrence and Floyd Mann - will serve as advisors to the permanent steering committee.

Dr. Wilson stated that the long range objective of the program is to stabilize the position of medical school dean, and to make that position more attractive and rewarding. In this fashion medical school management should be improved and strengthened to face the years of rapid institutional change which lie ahead.

IV. Membership:

Chairman Cartmill called the attention to the following Action #1 of the Board at its meeting in February:

> It was moved, seconded and carried that a moratorium be declared on new applications for COTH membership. The Chairman was directed to activate a committee with the following charge:
>
> A) To examine the institutional characteristics of the present COTH membership.
>
> B) To examine the current criteria for membership, and make recommendations for desirable changes for the future.
>
> C) To examine the selection process including the possibility of moving toward some form of institutional evaluation and review.

The Chairman appointed the following members to the committee:

Irvin G. Wilmot, Chairman
New York University Medical Center

Arthur J. Klippen, M.D.
Veterans Administration Hospital
Minneapolis, Minnesota

Sidney Lewine
Mount Sinai Hospital of Cleveland

Charles B. Womer
Yale-New Haven Hospital

The Committee was requested to work with the staff in drafting an interim report to be reviewed at the August 6 meeting of the Board.

Dr. Knapp reported that two applications, and two requests for applications for membership, had been received since the membership moratorium was declared in February. Since no resolution of the problem is expected until 1973, there was discussion of the possibility of lifting the moratorium on new COTH members, or making exceptions to it. There was a consensus that a years delay would not be detrimental to any of the applicants for membership. The staff was directed to provide literature and publications as well as other reasonable assistance to all interested teaching hospitals during the interim period.

In follow-up to Action #4 of the February 4 Board meeting, it was reported that the staff did review the status of St. Joseph Infirmary in Louisville, and ascertained that the hospital no longer functions under 501(c)(3) corporate status. On recommendation of AAMC legal counsel, COTH membership of St. Joseph Infirmary has formally been discontinued.

The invoices for 1972-73 dues were mailed on May 1, 1972. Approximately 100 members have mailed checks since the May 1 billing date. Five hospitals stated they no longer wished to participate as COTH members. For fiscal year 1971-72 four hospitals canceled membership and four have dues payment outstanding.

V. JCAH Requirements and the University Owned or Operated Teaching Hospitals:

It was recalled that the following action was passed at the February meeting of the Board:

> It was moved, seconded and carried that the staff be directed to explore the possibility of co-sponsoring with the Joint Commission on Accreditation of Hospitals a two day seminar or conference on "Hospital Accreditation Standards in the University Setting"

The purpose of this jointly sponsored institute would be to discuss the problems in the accreditation process of those teaching hospitals which are owned or operated by universities.

Dr. Knapp reported that a letter had been written to Dr. Porterfield on February 18, and on March 20 a response was received indicating the JCAH would be interested in such a program.

In an effort to gain a better understanding of the nature and extent of the problem, Dr. Knapp wrote to 10 university owned hospital directors whose institutions had been accredited since July 1, 1971. The following questions were asked:

1. During the most recent JCAH review, were there problems in applying the standards due to the organizational pecularities of being a university owned or operated teaching hospital?
2. If so, do you believe these problems could be usefully discussed at one or two day seminar which might result in a model set of guidelines for use by JCAH field staff?
3. Would you be willing to serve as a member of a planning committee if such a seminar were to be organized?

Members of the Board reviewed the responses to this letter and a general discussion followed. In almost every case it was reported that the quality of the surveyors and the review process had improved since the last visit. This improvement was largely attributed to the intensive staff development program recently initiated by the JCAH.

In summary, there was a consensus that while some problems do exist, they are not insurmountable; and in view of the extensive revision of the standards and procedures which already has taken place, it would not be wise to pursue a program of this type at this time.

During the course of the discussion, two other issues were raised. The first concerned a letter from David Pomrinse, M.D., Director of the Mount Sinai Hospital in New York City. The letter appears as Appendix A to these minutes. The matter concerns the following statement which was a negotiating point in the New York City Ghetto Medicine Program:

> "The patient shall be informed by a physician as to the identity of the physician(s) premarily responsible for his care. Patients who may be observed by participants in a hospital teaching program during the course of their care shall be so informed by a physician and their signed consent to such observation shall be obtained. To the extent possible, the patient shall be informed by a physician as to the general nature of his medical problem, the general prognosis if feasible and the nature and purpose of the treatment and procedures which are contemplated. Appropriate instruction in self care should be given to the patient."

Dr. Ainsworth, and others, stated that this question was most likely raised as a result of the efforts of the National Welfare Rights Organization. Additionally, the American Hospital Association is reviewing a "Proposed Statement On A Patient's Bill Of Rights" approved by the Committee on Health Care for the Disadvantaged. The statement is presently being evaluated by the AHA Regional Advisory Boards. The staff was requested to obtain a copy and have it available for review at the August Board meeting.

The second issue raised during the preceding discussion concerned the role of the health administrator in the process of medical school accreditation. After discussion, the staff was requested to prepare a list of hospital directors who have participated in medical school accreditation surveys since 1968, and to develop a staff paper on "The Role of the Health Administrator on the Medical School Accreditation Team."

VI. Report by Dr. Cooper:

At 11:30 a.m. Dr. Cooper joined the group and described AAMC testimony presented that morning before the Senate Subcommittee on Health on the Health Maintenance Organization and Resources Development Act of 1972. He also reported recent events concerning the establishment of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education. The final proposals, which have been approved by the AAMC, AHA, CMSS and ABMS,

will be brought before the AMA House of Delegates at its upcoming meeting in San Francisco.

Dr. Cooper stated that the Committee on Financing Medical Education, chaired by Dr. Sprague, would have an interim report prepared in time for the AAMC Assembly Meeting in November. Members of the staff and committee have been meeting with Dr. Hogness of the Institute of Medicine in an effort to gain a working relationship as the Institute pursues its mandate to determine the cost of medical education.

It was also reported that the AAMC is working with the AHA in efforts to make the new Hill-Burton charity care regulations more acceptable.

VII. Division of Health Services Progress Report:

Dr. Kalinowski reported that on May 15 a meeting was held at the Commonwealth Fund in New York City to discuss prison health services. In addition to the AAMC and Commonwealth staff, representatives were present from HSMHA, LEAA, ABA, the D.C. Department of Corrections and four medical schools which are providing health services in prisons (Miami, Buffalo, Gerogetown and Meharry). The meeting took the form of a seminar in which each organization described its activities, and the schools discussed their programs and reviewed the types and nature of problems encountered in the development of their programs. The future role of the AAMC in prison health care activities is still in the formative stage.

During the past nine months, the Association of American Medical Colleges through its Division of Health Services, has conducted a program to foster the development of Health Maintenance Organizations in academic medical centers. Principal activities in this project were to identify the critical issues for academic medical centers in the decision to develop an HMO--the planning, development and early operational period of an HMO--and to conduct a series of regional

workshops attended by representatives of academic medical centers--both those centers actively involved in HMO's and those with interest in planning and developing HMO's. Over five hundred participants representing 100 academic medical centers attended the eight workshops held. A major objective of this activity was identification of a series of prototype HMO's whose development--in the judgement of the AAMC Health Services Advisory Committee, the group of HMO Workshop Coordinators, and the AAMC staff--should be encouraged and fostered in order to benefit the populations to be served, the field of health services delivery, medical education and research.

This program has been financed by a grant from HSMHA which will be terminated on June 30, 1972. Dr. Kalinowksi stated that the final stages of negotiation are being completed with HSMHA to continue the program which will provide for an eighteen month activity of technical assistance to medical centers which are in various stages of developing an HMO.

Early in November, 1971, Dr. Kalinowski met with Dr. David Kindig of the Director's Office, National Health Service Corps, to explore what areas of cooperation could be fruitful for the two organizations. Experience with other U.S. volunteer groups, VISTA and the Peace Corp, has demonstrated the necessity for volunteers to receive professional, educational and other support services. The need for a professional link to whom the isolated volunteer in the field can turn for advice and consultation has been proven to be of great programmatic support for maintaining the volunteer in the field.

Based upon this discussion and approach, a proposal has been submitted to the NHSC in which the Division of Health Services would coordinate a program to support preceptors from the academic medical centers who would work with NHSC volunteers in the field. The details and financing of the program are presently being negotiated with the NHSC.

VIII. Item Referred From AAMC Executive Council - "Organization of Sub-Council Activities."

The guidelines for sub-council organization presented as Tab L in the agenda book were reviewed and briefly discussed.

ACTION #1 IT WAS MOVED, SECONDED AND CARRIED THAT GUIDELINES FOR SUB-COUNCIL ORGANIZATION BE APPROVED AS PRESENTED.

A copy of the guidelines appears as Appendix B to these minutes.

IX. COTH Annual Meeting Program:

The overall theme of the annual meeting is entitled "From Medical School To Academic Medical Center." A number of possible COTH program titles were presented by the staff including the following:

... Institution Stability And Social Responsibility: Contrast Or Compromise

... The Implications Of An HMO For A Teaching Hospital

... The Crystal Ball For Graduate Medical Education

Following disucssion of these as well as other possible topics, there was a consensus that the recent experiences in Philadelphia and New York State with regard to hospital reimbursement are forerunners of what may happen elsewhere in the country and therefore would be of most current interest to COTH membership and other attendees at the meeting. Thus, the following title for the program was selected:

"External Fiscal Controls On The Teaching Hospital"

...The Philadelphia Experience
...The New York State Experience

It would be anticipated that the presentation would set forth the environment in which early negotiations occurred, the role of all parties concerned,

the central issues involved, and the present and future implications of current conditions. Additionally, a retrospective view of the process in terms of what advice and counsel might be given colleagues throughout the country approaching similiar circumstances would be useful.

X. Adjournment:

There being no further new business, the meeting was adjourned at 2:30 p.m. The next Board meeting will be held on Sunday, August 6, 1972 in PDR 5 of the Palmer House from 9:30 a.m. to 3:00 p.m.

APPENDIX A

The Mount Sinai Hospital

FIFTH AVE. AND 100th STREET • NEW YORK, N. Y. 10029

May 10, 1972

Dr. John A.D. Cooper, President
Association of American Medical Colleges
1 Dupont Circle
Washington, D.C. 20036

Dear John:

I am enclosing some material which I picked up at negotiations with community representatives with whom we are discussing a contract under New York City's Ghetto Medicine Program. I send this to you not because of its importance for that Program, but rather because the advocate attorney who introduced it stated that this was in the sixth draft of Joint Commission recommendations and was about to be finally adopted by the JCAH.

We succeeded in revising the proposal extensively for the New York City Program and I am not concerned about that. I am seriously concerned, however, that Joint Commission standards should not include a position which would seriously inhibit the ability of teaching hospitals to function in a Medical School Program. I urge you to take whatever steps the AAMC can to change the Joint Commission's position.

I would be happy to assist in anyway you think appropriate.

Sincerely,

S. DAVID POMRINSE, M.D.
Director

SDP/sg
cc: Dr. Hans Popper
Enclosure

The following paragraph should be inserted on Page 8, following Line 18. It was accidentally omitted from the draft which you have.

The patient shall be informed by a physician as to the identity of the physician(s) primarily responsible for his care. Patients who may be observed by participants in a hospital teaching program during the course of their care shall be so informed by a physician and their signed consent to such observation shall be obtained. To the extent possible, the patient shall be informed by a physician as to the general nature of his medical problem, the general prognosis if feasible and the nature and purpose of the treatment and procedures which are contemplated. Appropriate instruction in self care should be given to the patient.

GUIDELINES FOR SUB-COUNCIL ORGANIZATION

There shall be the following classes of sub-council entities, organized in accordance with the definitions and specifications listed below:

A. ORGANIZATION -- an Organization of the AAMC is defined as a membership component, associated specifically with one Council of the Association, and having voting participation in the governance of the AAMC.

1. Its establishment requires a bylaws revision approved by the AAMC Assembly.

2. The Association shall assume responsibility for staffing and for basic funding required by the Organization.

3. The Organization shall be governed by rules and regulations approved by the parent Council.

4. All actions taken and recommendations made by the Organization shall be reported to the parent Council.

B. GROUPS -- a Group of the AAMC is defined as representatives of a functional component of constituent institutional members. Groups are created to facilitate direct staff interaction with representatives of institutions charged with specific responsibilities and to provide a communication system between institutions in the specific areas of a Group's interest. Grouprepresentatives are appointed by and serve at the pleasure of their deans. Groups are not involved in the governance of the Association.

1. Establishment of a Group must be by the President of the Association with the concurrence of the Executive Council.

2. All Group activities shall be under the general direction of the AAMC President or his designee from the Association staff.

3. Groups may develop rules and regulations, subject to the approval of the AAMC President. An Association staff member shall serve as Executive Secretary.

4. Budgetary support for Groups must be authorized by the Executive Council through the normal budgetary process of the AAMC.

5. The activities of Groups shall be reported periodically to the Executive Council.

C. COMMITTEES -- a Committee of the AAMC is defined as a standing body reporting directly to one of the official components of the Association (Executive Council, Councils, Organizations, Groups), charged with a specific continuous function.

1. Committees of the Executive Council may be charged with roles related only to governance, program, liaison, and awards.

2. Committees of the Councils and Organizations may be charged with roles related only to governance and program.

3. Committees of the Groups may be charged with roles related only to program.

D. COMMISSIONS -- a Commission of the AAMC is defined as a body charged with a specific subject matter function, assigned for a definite term of existence, and reporting directly to one of the official components of the Association. All previous "ad hoc committees" shall become known as Commissions.

1. A Commission may be charged by the AAMC component to which it is to report, or by the Executive Council.

2. No Commission may be charged for a term longer than 2 years, at the end of which it shall be re-charged or dissolved.

4/17/72

DRAFT

COTH AD HOC MEMBERSHIP COMMITTEE REPORT

The first meeting of the committee was held on June 16 in New York City. The chairman, Irvin Wilmot, presided and all members were present. The charge to the committee as set forth by the Administrative Board is as follows:

> It was moved, seconded and carried that a moratorium be declared on new applications for COTH membership. The Chairman was directed to activate a committee with the following charge:
>
> A) To examine the institutional characteristics of the present COTH membership.
>
> B) To examine the current criteria for membership, and make recommendations for desirable changes for the future.
>
> C) To examine the selection process including the possibility of moving toward some form of institutional evaluation and review.

A wide variety of background material was reviewed by the committee including the three task force reports presented at the 1971 COTH Annual Meeting. Additionally, the institutional characteristics of the present membership were examined in depth. At the time of the analysis, there were 404 COTH members, 41 of which had no reported affiliation with a school of medicine. Sponsorship of residency programs ranged from less than five to more than twenty. Other statistical indices reviewed included size, institutional expenditures, and the scope of services provided.

The Committee is well aware that there have been suggestions from various quarters that the COTH membership be grouped or classified on the basis of some uniform criteria. In this context it is worthwhile to recall the presentation made last year by Stan Ferguson, Chairman of the Task Force To Analyze the Higher Costs of Teaching Hospitals. His Task Force identified the following dimensions which characterize the unique nature of the teaching

hospital:

1) the size and scope of the intern and resident staff;
2) the number of fellowship positions;
3) the extent to which the full range of clerkships is offered to undergraduate medical students;
4) the volume of research undertaken;
5) the extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;
6) the nature and substance of the medical school affiliation arrangement;
7) the appointment or employment of full-time salaried chiefs of service;
8) the number of other full-time salaried physicians;
9) the number of special service programs offered, e.g., neonatal care units, pediatric evaluation centers or renal dialysis units;
10) the level of complexity demonstrated by the diagnostic mix of patients cared for;
11) the staffing pattern and ratios resulting from the distinctive patient mix;
12) the scope and intensity of laboratory and X-ray services;
13) the financial arrangements and volume of service rendered in outpatient clinics.

Individual hospitals meet each of these characteristics in varying degrees. Ideally, the objective would be to examine the extent to which each hospital meets each chosen criteria, and classify accordingly.

Some of these dimensions are already in use in various parts of the country as the basis for grouping hospitals for reimbursement purposes. However, the choice of variables differs, as it should, according to local or state needs and conditions.

Since there is such a wide variance in the extent to which teaching hospitals meet these various dimensions, and since a classification system at the national level could conceivably disrupt local or regional negotiation, the committee does not believe that it would be appropriate to classify or categorize the COTH membership according to teaching activities or commitments.

However, in this regard, the Committee does have two recommendations. The first appears as Appendix A to this report, and is concerned directly with the issue under discussion. The Committee recommends that this statement entitled, "DIFFERENTIAL CHARACTERISTICS OF TEACHING HOSPITALS", be approved by the COTH institutional members and forwarded through appropriate channels to be adopted as AAMC policy.

The second recommendation of the Committee is in response to our charge to examine the current criteria for membership, and appears as Appendix B to this report. In setting forth these criteria, the Committee kept in mind the fact that the AAMC, of which COTH is an integral component, is devoted to the advancement of medical education. Therefore, the Committee believes that the criteria for COTH membership should continue to be based on the hospital's commitment to undergraduate and graduate medical education.

It is anticipated that a number of teaching hospitals which are presently COTH members may not meet the newly proposed membership criteria. It is the Ad Hoc Committee's recommendation that these hospitals continue to be active members of the Council. In three years time the criteria should again be reviewed, and at that time the ability of all present members to meet these criteria should be assessed.

In response to our final charge, the committee does not find it appropriate to recommend that the seelction process for new COTH members be changed. Institutional visitations for the purpose of evaluating prospective COTH members would be a time consuming and expensive process. Additionally, the recent establishment of the Liaison Committee on Graduate Medical Education as well as other developments in graduate medical education make the present an inopportune time to establish another process of hospital review and evaluation.

IRVIN G. WILMOT, Chairman

Arthur J. Klippen, M.D.
Sidney Lewine
Charles B. Womer

DIFFERENTIAL CHARACTERISTICS OF TEACHING HOSPITALS

The criteria set forth to obtain membership in the Council of Teaching Hospitals were established to provide a basis from which hospitals could organize and promote the hospital as an educational institution. Hospitals differ greatly in the scope, breadth and depth of their commitment to educational purposes, the characteristics of patients they serve, and the nature and scope of services they provide. Consequently, membership in COTH of AAMC cannot be assumed to represent program or operating equivalence, or even similarly to any significant degree.

At least three major factors must be considered when attempting to characterize or classify hospitals:

-- The nature and scope of the hospital's educational objectives, and the degree of institutional commitment to meet the incremental costs of providing the environment for undergraduate and graduate medical education, and allied health education;

-- The severity of illness, complexity of diagnosis, and socio-economic characteristics of the patients served by the hospital;

-- The comprehensiveness and intensiveness of services provided by the hospital.

There is a great variation in the extent to which each teaching hospital meets these dimensions. Any attempt to characterize or classify teaching hospitals must recognize the limitations of grouping all teaching hospitals based upon their membership in COTH.

CRITERIA FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS

Current eligibility for membership in the Council is determined on the basis of one of the two following criteria:

a. *Teaching Hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry; and, which are elected by the Council of Teaching Hospitals;*

or

b. *Those hospitals nominated by an AAMC Medical School Institutional Member or Provisional Institutional Member, from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals*

The Ad Hoc Committee recommends that the criteria for membership be revised to read as follows:

Eligibility

Eligibility for membership in the Council of Teaching Hospitals is determined on the basis that:

1) the hospital has a documented, institutional affiliation arrangement with a school of medicine for the purpose of significantly participating in ~~undergraduate~~ medical education;

AND

2) the hospital sponsors or significantly participates in approved, active residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

maybe to strike the word undergrad.

Requirement

1) Approval by the COTH Administrative Board;

2) Approval by the AAMC Executive Council.

Procedure For Application

1) Application by the hospital with an endorsement by the Dean of the affiliated school of medicine;

OR

2) Nomination of the hospital by the dean of the school of medicine.

In the case of specialty hospitals, the Administrative Board shall make exceptions based on the extent to which the teaching hospital meets the criteria within the framework of the specialized objectives of the hospital. It is thus the intent that rehabilitation, psychiatric ~~and~~ children's and such other ~~hospitals~~ which sponsor or participate in ~~graduate~~ medical education and have institutional affiliations for the purpose of significant participation in ~~undergraduate~~ medical education are eligible for COTH membership.

By exception, and in unusual circumstances where a hospital has demonstrated a continuing major commitment to ~~graduate~~ medical education, as demonstrated by the range and scope of programs offered, the Administrative Board may waive the requirement for medical school affiliation.

specialty hospitals

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

D R A F T -- For Discussion Purpose
JSM-- July 12, 1972

MEDICAL EDUCATION --
THE PATIENT CARE COST COMPONENT

The Committee on the Financing of Medical Education has proceeded with the view that the undergraduate educational program requisite to the qualification of an individual for the M. D. degree is comprised of an integral mix of teaching, research and patient care activity--all three of which are essential to the process. Given this view then, the measurement of the costs of undergraduate medical education requires some method of deriving from the overall teaching, research and patient care expenditures of an academic medical center the proportion and amounts of such expenditures which can appropriately be attributed to undergraduate education.

The Association of American Medical Colleges cost allocation process does provide for distributing instructional costs among the various educational programs, but no firm conceptual approach or methodology has yet been devised for separating research and patient care costs on a program basis. The Research Task Force is engaged in assessing the utility of alternative approaches to the program distribution of

research costs. Similar effort must be directed to the problem of determining what part, if any, of the patient services expenditures of an academic medical center should be considered as applicable to education, specifically undergraduate medical education, and thus be included in the measurement of the costs of such programs.

The approach to the resolution of this problem would appear to involve submitting the total expenditures for hospital and clinic services of an academic medical center to a sequence of three reductions:

1. Teaching Function Costs

The first reduction is relatively straightforward and is already provided for in the AAMC cost allocation methodology. Included here are the costs of those activities financed under the teaching hospital budget of an academic medical center which can be appropriately considered as teaching in nature. This would include, for example, the teaching activities of the nursing and other hospital staff and associated expenses. As noted, methods for determining and allocating the costs of such hospital teaching functions are already a part of the current cost allocation program. Thus these particular costs are being identified and separated in the current cost allocation studies.

2. Incremental Hospital Costs Due To Teaching

The second reduction is conceptually a relatively

clear matter, but there is at present no agreed upon methodology much less an appropriate body of data to carry out the necessary quantification process. Included here are those increased hospital operating costs resulting from the conduct of teaching functions within the clinical setting. This would include, for example, the costs of increased laboratory testing, added hospital days, greater housekeeping costs, etc. which result from the conduct of teaching activities and specifically undergraduate teaching programs. There have been numerous observations of the substantial differences in operating costs between teaching and non-teaching hospitals. The major part of those differences has been considered to be the combined effects of the added costs of teaching functions, the greater expense involved in treating a more seriously ill patient population and the more extensive services provided. Almost nothing has been done in separately measuring these several factors of difference much less making any attempt to distribute these incremental costs due to teaching programs among the several educational programs involved. Advice on how to proceed in carrying out this second reduction is urgently needed.

3. The Sharing of Joint Costs

The third reduction of the patient care costs of an academic medical center in reaching for the full costs of educational programs is principally a conceptual and policy

problem, rather than a methodological one. Described thus far in the preceding steps one and two are those costs encompassed in the patient care expenditures of an academic medical center which result directly, and to a degree indirectly, from the conduct of teaching activities. Carrying out the reductions of these costs, as proposed in steps one and two, would leave as a remainder, those expenditures for what might be termed regular patient care activity shorn of teaching costs.

The question that remains is whether any part of this body of patient care costs should be allocated to the cost of medical education. The reason this question arises is the simple fact that the conduct of an undergraduate medical education program requires access to a particular volume of patient care activity. Without it there can be no medical education program. At the same time that patient care activity is being carried out to provide needed hospital care for sick people and thus serves another objective; namely, providing health care.

Thus, some part or all of the patient care activity of an academic medical center serves more than one objective and therefore constitutes a joint endeavor serving dual purposes. Since this patient care activity is essential to each such purpose, there is reason to argue that its costs ought to be shared to the extent that they are truly joint. (In many instances, the patient care program of an

academic medical center may be of a substantially greater magnitude than that required to provide an adequate teaching program. Such additional patient care activity would be above and beyond that which could be considered as jointly serving educational programs, and its cost would have to be assigned to other program objectives.)

The fact that this regular patient care activity is reimbursable by its recipients or their agents does not change the theoretical problem of how its costs should be assigned. If, indeed, the costs of this regular patient care activity are fully reimbursed that would appear to have the practical effect of eliminating the problem. But, if they are not fully reimbursed, as could be the case if any number of indigent patients, not eligible for public support, are treated, the basic issue remains except that is presented in a somewhat more acute form; namely, who shall bear the burden of the deficit?

The inclusion of this third element of patient care costs related to medical education represents a substantial departure from existing cost measurement approaches. While it may be conceptually valid, it presents major policy considerations, but it does offer the possibility of clarifying and placing on a truly comparable basis, the cost measurement of medical education programs. The methodological process of obtaining this third level of cost involves an agreement on the volume of patient care activity requisite

to the teaching of a specific number of students, i.e. the number of patients or patient admissions per student.

In summary, advice is required on the elements of patient care expenditures in an academic medical center that should be assigned to medical educational and specifically undergraduate education programs and the appropriate methodology for deriving such data.

RESOLUTION ON THE REPRESENTATION OF BASIC AND CLINICAL SCIENTISTS IN ACADEMIC HEALTH CENTERS

ACTION: The Administrative Board recommended adoption of the following resolution:

Modern education of both undergraduate and graduate medical students requires an academic environment which provides close day-to-day interaction between basic medical scientists and clinicians. Only in such an environment can those skilled in teaching and research in the basic biomedical sciences maintain an acute awareness of the relevance of their disciplines to clinical problems. Such an environment is equally important for clinicians, for from the basic biomedical sciences comes new knowledge which can be applied to clinical problems. By providing a setting wherein clinical and basic scientists work closely together in teaching, research and health delivery, academic health centers uniquely serve to disseminate existing knowledge and to generate new knowledge of importance to the health and welfare of mankind.

Schools of medicine and their parent universities should promote the development of health science faculties composed of both basic and clinical scientists. It is recommended that organizational patterns be adopted which reduce the isolation of biomedical disciplines from each other and assure close interaction between them.

The Association of American Medical Colleges should vigorously pursue this principle in developing criteria for the accreditation of medical schools.

This resolution will be forwarded to the COD and COTH Administrative Boards for their consideration and will be presented for approval to the Council of Academic Societies in the fall.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

Reference: OS:VJF
HSM 110-72-393

OFFICE OF THE ADMINISTRATOR

JUN 30 1972

Association of American Medical Colleges
Attn: Dr. John Cooper
One Dupont Circle, N.W.
Washington, D.C. 20036

Gentlemen:

Enclosed is a signed copy of the contract document, executed by the Contracting Officer on behalf of the Government.

Any changes in the terms or conditions of the contract document must be made in writing by the Contracting Officer. In the event changes are requested or recommended they should be submitted in writing to this office.

Sincerely yours,

Marcus T. Dodge

Enclosure

Marcus T. Dodge
Contracting Officer

PHS-FL-45
3-70

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

CONTRACTOR'S COPY

NEGOTIATED CONTRACT

CONTRACT NO HSM 110-72-393	PAGE 1 OF 15 PAGES
NEGOTIATED PURSUANT TO 41 USC 252 (c) (10)	TYPE OF CONTRACT Cost Reimbursement

ISSUING OFFICE
Health Services and Mental Health
Administration
5600 Fishers Lane
Rockville, Maryland 20852

CONTRACT FOR
Organization of Health Maintenance
Organization in University Medical Center

CONTRACTOR (Name and Address)
Association of American Medical
Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

ACCOUNTING AND APPROPRIATION DATA
Appropriation: 7520342
Allotment: 2-2001 2531
CAN: 2-3990023 Vendor Code: 301827
(RFP HSM 110-HMO-22 (2))

PLACE OF PERFORMANCE
Washington, D. C.

CONTRACT AMOUNT
$329,571.00

MAIL VOUCHERS TO
See ARTICLE XVIII

SPONSOR
Health Maintenance Organization Service

EFFECTIVE DATE JUN 30 1972	EXPIRATION DATE See Delivery Schedu

CONTRACTOR REPRESENTS

1. That it ☐ is, ☒ is not, a small business concern. If he is a small business concern and is not the manufacturer of the supplies to be furnished hereunder, he also represents that all such supplies ☐ will, ☐ will not, be manufactured or produced a small business concern in the United States, its possessions, or Puerto Rico. (A small business concern for the purpose Government procurement is a concern, including its affiliates, which is independently owned and operated, is not dominant in t field of operation in which it is contracting and can further qualify under the criteria concerning number of employees, avera annual receipts, or other criteria, as prescribed by the Small Business Administration.) (See Code of Federal Regulations, Ti 13, Part 121, as amended, which contains detailed definitions and related procedures.)
2. That it is a ☐ REGULAR DEALER IN, ☐ MANUFACTURER OF, the supplies covered by this contract. NA
3. That it is an ☐ INDIVIDUAL, ☐ STATE OR LOCAL AGENCY, ☐ PARTNERSHIP, ☐ JOINT VENTURE, ☒ NONPROFIT, ☐ EDUCATIONAL INSTITUTION, ☒ CORPORATION organized and existing under the laws of the sta of Illinois

The Contractor agrees to furnish and deliver all the supplies and perform all the services set forth in the attached Special Pro sions, for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and govern by the Special Provisions and the General Provisions. To the extent of any inconsistency between the Special Provisions or the G eral Provisions and any specifications or other provisions which are made a part of this contract, by reference or otherwise, the S cial Provisions and the General Provisions shall control. To the extent of any inconsistency between the Special Provisions and t General Provisions, the Special Provisions shall control.

IN WITNESS WHEREOF, the parties hereto have executed this contract on the day and year last specified below.

Association of American Medical Colleges
NAME OF CONTRACTOR

BY [signature]
SIGNATURE OF AUTHORIZED INDIVIDUAL

TYPED NAME

TITLE Director, Division of Health Services

6/30/72
DATE

UNITED STATES OF AMERICA

BY [signature]
SIGNATURE OF CONTRACTING OFFICER
Marcus T. Dodge
Contracting Officer

TYPED NAME

JUN 30 1972
DATE

PHS-4910-1 (9-66)

THIS CONTRACT CONSISTS OF:

1. COVER PAGE PHS 4910-1

2. CONTENTS OF CONTRACT PHS 4910-2

3. SPECIAL PROVISIONS PHS-4910-3

4. GENERAL PROVISIONS, HEW FORM 315 (REV. 8/64) NEGOTIATED Cost Reimbursement Contract and Alterations thereto date 12/69.

ARTICLE I - DESCRIPTION AND SCOPE OF WORK

A. The contractor will plan and carry out activities directed toward the development of at least five (5) Health Maintenance Organization's in University Medical Centers. The contractor will concentrate his activities as outlined in this contract, on a small and select number of university medical centers likely to assure the development of five (5) HMO's.

Definition of an HMO, for the purposes of this contract is:

An HMO is an organization which can be either a separate legal entity or a cooperating group consisting of legally recognized organizations functioning on a contractual basis with these characteristics:

- has an organized health care delivery system which includes health manpower and facilities capable of providing or otherwise arranging for the provision of comprehensive health services, which include as a minimum, ambulatory physician care, inpatient hospital and physician care, emergency care and outpatient preventive medical services.

- has a voluntarily enrolled population consisting of individuals and families who have chosen through the process of dual choice individually or as members of a defined group of individuals to contract with the HMO for the provision of a range of health services which the HMO assumes responsibility to make available.

- has a financial plan which guarantees the delivery of the agreed upon set of services on a prenegotiated and prepaid per person or per family basis.

- has an identifiable managing organization which assures legal, fiscal, public and professional accountability.

- has arrangements whereby the organization to a significant degree bears the risk of providing health services on a prenegotiated basis and requires that providers of professional services in the system participate to some degree in sharing this assumed risk.

B. In performance of this contract, the contractor specifically shall:

1. Establish a Project Advisory Committee to provide overall advice and guidance in implementing, reviewing and evaluating the progress of this project. This expert committee would include the members of the existing AAMC Health Services Advisory Committee, the DHEW Project Officer, the Project Director, and such additional members as are required by the needs of the project. When appropriate throughout the course of this project, subcommittees of this body would be appointed to deal with problems.

2. Consider but not be limited to the following selection criteria

   a. Evidence of a conscientious and effective effort by the university medical center to reach a "go-no go" decision

   b. Potential for early successful operation

   c. Service to medically underserved areas

   d. Involvement of consumer in planning and during developmental and operational phases

   e. Service to Federal beneficiaries.

3. Provide (1) the personnel, (2) materials, and (3) facilities required to perform the identified functions and tasks which will enable a university medical center to proceed toward the development of an HMO.

4. Using those prototype HMO programs approved by the Health Services Advisory Committee as focusing on the major distinct sets of problems to be dealt with in developing the potential of the HMO concept in the entire field, criteria for each prototype will be developed. These criteria will be developed by the AAMC staff with advice and review of the Project Advisory Committee. The criteria developed will be used in determining the respective qualifications of academic medical centers for possible participation in the prototype programs and by HSMHA in making the ultimate selection of the five prototype institutions for the purposes of this contract.

5. Send letters to academic medical centers inviting them to demonstrate their respective capacities and potential to meet the specified criteria for prototype HMO development projects.

ARTICLE II - ARTICLES OR SERVICES TO BE FURNISHED AND DELIVERY TIME

The Contractor shall submit to the Project Officer, Health Services and Mental Health Administration, 5600 Fishers Lane, Rockville, Maryland 20852j the following items in the quantities and during the periods listed below:

Item	Description	Quantity	Delivery
1.	Letters to academic medical centers inviting participation in HMO prototype programs.	5	Two and one-half (2 1/2) months from effective date of contract.
2.	Report of first meeting of Project Advisory Committee including review of institutional responses.	5	Four (4) months from effective date of contract.
3.	Progress in the development of five (5) prototype HMO projects.	5	Monthly reports beginning two (2) months from selection of prototype projects.
4.	Status report on developmental and operational experiences of five (5) prototype HMO projects	5	As an HMO becomes operational and each mont thereafter until project completion.
5.	Preparation and submission of project methodologies employed, evaluation reports and recommendations as detailed in the Scope of Work.	5	Eighteen (18) months from effective date of contract.

6. To utilize the Project Advisory Committee for review and rating the responses under paragraph B., 1. above for recommendations to HSMHA.

7. Address but not be limited to the following tasks in assisting university medical centers to:

   a. Plan an organization which can accept responsibility for delivery of comprehensive health care to its prepaid enrollees.

   b. Plan the health care delivery system to provide at a minimum ambulatory physician care, inpatient hospital and physician care, emergency care, outpatient preventive medical services, with assured access for the enrollees and with mechanisms to assess and insure the quality of care provided.

   c. Plan for revenue sources to assure fiscal viability.

   d. Plan for marketing and enrollment services which can realistically support the operation of the HMO.

   e. Develop a prepaid benefit package(s) appropriate to service needs of enrollees.

   f. Plan for an information system as approved by the Project Officer which not only provides for adequate internal controls needed for successful operation, but also provides information for evaluation of effectiveness by the Secretary, DHEW.

   g. Identify legal barriers to the formation of an HMO.

   h. Develop a plan for integration of education, training, evaluation and research activities that could be undertaken within the HMO and identification of sources of dollar support for such activities.

8. To work with HSMHA in directing its good offices toward the integration and coordination of the various funding processes in order to permit the balanced and holistic development of the projects.

9. To coordinate the development of a process of documentation by participating prototype institutions to capture in standardized fashion the significant chronological essence of problems and events. The aim of this activity will be to form a basis for communicating the experience of the prototype HMO's to other academic medical centers so that the effort will benefit the entire field of health service delivery and medical education.

10. Appoint Technical Assistance Teams (TATS) to work with prototype projects, one for each project. The issue of the TAT concept is to provide a framework of continuity through which the basic management and technical expertise can be made available to specific prototype projects with supplemental augmentation by specialized consultative resources as needed on an ad hoc basis. The leaders of the Technical Assistance Teams would be prime consultants with broad and appropriate experience in the areas of health care delivery and the academic medical center environment. These TAT coordinators would be responsible for the organization, planning and management of TAT operations in collaboration with AAMC and HMOS-HSMHA staff and the Project Advisory Committee. Subcontracts could be made with primary consultants to provide for support of TAT activities. Selection of all consultants would be by the AAMC Project Director with the advice and consultation of the Project Advisory Committee and the HSMHA-HMOS project officers. The nucleus in basic membership of the TAT would consist of four individuals each with special skills in one of the following areas: a) overall organization and management of a prepaid group practice; b) medical care or health care programs in the academic setting; c) systems analysis or planning; d) the special area of emphasis in the prototype. These basic TAT members would have a continuing relationship with a particular prototype project. The ad hoc TAT consultants, however, will work with the various prototypes as problems emerge calling for their special expertise. For example, when legal issues become a problem, an appropriate legal consultant would work through the TAT on the issue as necessary. HSMHA policies and guidelines will be followed in connection with the appointment and remunerations of all consultants.

11. Develop definitions of a series of prototype HMO's and criteria for each prototype and to disseminate this information to academic medical centers; and identify a group of academic medical centers who have the qualifications and desire to work closely with the AAMC and HMOS-HSMHA in planning and developing a prototype HMO from which HSMHA will select five for the purposes of this project.

12. Report in writing quarterly to the DHEW Project Officer reports of methodology and progress of each project in carrying out, but not limited to, the following activities:

    - the university medical center's understanding of the processes in planning and launching an HMO. This statement should include, but not be limited to

- local health care delivery system status

- support or resistance to HMO formation in the target community

- major obstacles to formation of an HMO

- major reasons for formation of an HMO at this time

- perceived technical assistance needs

- consultation with and comments from the appropriate Areawide Comprehensive Health Planning Agency are required.

13. Work closely with the university medical centers toward:

a. The structuring of Health Maintenance Organization (intended or existing)

(1) Articles of incorporation or other organization documentation.

(2) Compliance with all legal and statutory requirements concerning charter of incorporation, ownership of property, professional practice, taxes, etc.

(3) Specific structure and process to establish and review HMO policies including plans for enrollee involvement.

(4) Process by which HMO is to relate to State Comprehensive Health Planning Agency, the appropriate areawide health planning agency, and the State Hill-Burton agency.

b. Assuring adequate financial arrangements (intended or existing)

(1) Projected cost estimates for start-u

- Cost estimates of physical plant rnization, replacement, expansion, or rental

- Estimate or marketing costs

(2) Actuarial analysis; determination of costs - i.e., projected cost per unit, per enrollee, per resource.

(3) Identification of revenue sources

- Initial capital investment
- Initial operating costs/deficits
- Borrowed funds
- Payment sources

(4) Specific plans for covering operating losses or for the distribution of operating surplus.

(5) Contingency financing plan to cover build-up or phase out costs if the HMO does not reach a break-even on schedule.

c. Assuring Health Plan Marketing (intended or existing)

(1) A general description of the population in target market.

(2) Description of the intended (or existing) enrollment population according to demographic characteristics, size, projected enrollment growth, etc.

(3) Projected enrollment of population

- Description of geographic areas to be marketed
- Types of groups - i.e., union, Federal beneficiaries, etc.
- Marketing strategy and projected marked penetration
- Decisions affecting benefit(s) package that will be competitive and marketable to each group.

d. Designing of the Health Care Delivery System (intended or existing)

(1) Projected staffing patterns, staff organization and recruitment, arrangements for facilities and for inpatient care, continuity of care, emergency care, 24-hour access, scope of services to be provided, and related health record and data systems.

(2) Development of mechanisms and procedures for assessment and assurance of quality of care, e.g., provision for medical audit, internal peer review and monitoring of quality.

(3) Development of practices and services which emphasize the health maintenance concept, etc.

- Preventive services such as immunization programs, screening, routine physical, etc.
- Follow-up and recall of abnormal findings, well-baby visits, etc.
- Outreach efforts
- Enrollee health education
- Continuing education opportunities for physicians
- In-service training for nurses, paramedics, etc.

ARTICLE III - DESIGNATION OF PROJECT OFFICER

Paul Kosco, Group Practice Development Branch, HMOS is hereby designated as Project Officer for this contract. The Project Officer or his authorized representative's responsibility will be to coordinate with the Contractor in administering the technical aspects of this contract. The Project Officer is not authorized to make any changes which affect the contract amount, terms, or conditions. The Contracting Officer is the only party authorized to bind the Government.

ARTICLE IV - DESIGNATION OF PROJECT DIRECTOR

Work and services shall be conducted under the direction of Dr. Robert H. Kalimouski The Government reserves the right to approve any necessary successor to the designated Project Director.

ARTICLE V - REVIEW AND APPROVAL

Review and approval of the work hereunder shall be performed by the Contracting Officer or his duly authorized representative.

ARTICLE VI - NOTICE TO GOVERNMENT OF DELAYS

Whenever the Contractor has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this contract, the Contractor shall, within ten (10) days, give notice thereof, including all relevant information with respect thereto, to the Contracting Officer.

ARTICLE VII - PROCUREMENT OF ALL MATERIAL, DATA, AND SERVICES

Except as otherwise provided herein, procurement of all material, data, and services necessary for performance under the terms of this contract shall be the responsibility of the Contractor.

ARTICLE VIII - COMPETITION IN SUBCONTRACTING

The Contractor agrees to select subcontractors on a competitive basis to the maximum practical extent consistent with the objectives and requirements of this contract.

ARTICLE IX - CONSULTANT SERVICES

Except as otherwise expressly provided elsewhere in this contract, and notwithstanding the provisions of the clause of this contract entitled "Subcontracting", the prior written approval of the Contracting Officer shall be required:

(a) Whenever any employee of the contractor is to be reimbursed as a "consultant" under this contract; and

(b) For the utilization of the services of any consultant under this contract exceeding the daily rate set forth elsewhere in this contract or, if no amount is set forth, $100.00, exclusive of travel costs, or where the services of any consultant under this contract will exceed ten days in any calendar year.

Whenever Contracting Officer approval is required, the contractor will obtain and furnish to the Contracting Officer information concerning the need for such consultant services and the reasonableness of the fees to be paid, including, but not limited to, whether fees to be paid to any consultant exceed the lowest fee charged by such consultant to others for performing consultant services of a similar nature.

ARTICLE X - IDENTIFICATION OF DATA

The Contractor shall identify the technical data delivered to the Government pursuant to the requirements of this contract with the number of this contract, and the name and address of the contractor or subcontractor who generated the data.

ARTICLE XI - DEVELOPMENT AND USE OF FORMS

Any forms which may be developed by the Contractor for use in the performance of this contract shall be submitted to the Project Officer for review and approval prior to their use. The Project Officer shall be responsible for obtaining clearance from the Office of Management and Budget, if required, prior to his approval for use by the Contractor.

ARTICLE XII - PUBLICITY AND PUBLICATIONS

A. The Contractor agrees that it will acknowledge Health Services and Mental Health Administration, Department of Health, Education, and Welfare support whenever projects funded in whole or in part by this contract are publicized in any news media.

B. The Contractor shall include in any publication resulting from the work performed under this contract an acknowledgement substantially as follows:

"The Project upon which this publication is based was performed pursuant to Contract No. HSM 110-72-393 with the Health Services and Mental Health Administration, Department of Health, Education, and Welfare."

ARTICLE XIII - CONTRACTOR AND SUBCONTRACTOR LISTING REQUIREMENT

A. As provided by 41 CFR 50-250, the Contractor agrees that all employment openings of the Contractor which exist at the time of the execution of this contract and those which occur during the performance of this contract, including those not generated by the contract and including those occurring at an establishment of the Contractor other than the one wherein the contract is being performed but excluding those of independently operated corporate affiliates, shall, to the maximum extent feasible, be offered for listing at an appropriate local office of the State employment service system wherein the opening occurs and to provide such periodic reports to such local office regarding employment openings

and hires as may be required: Provided, That this provision shall not apply to openings which the contractor fills from within the contractor's organization or are filled pursuant to a customary and traditional employer-union hiring arrangement and that the listing of employment openings shall involve only the normal obligations which attach to the placing of job orders.

The Contractor agrees further to place the above provision in any subcontract directly under this contract.

ARTICLE XIV - COMPENSATION

A. The total cost to the Government for the performance of this contract shall not exceed $329,571.00. The Contractor agrees to use its best efforts to perform all work and obligations under this contract within the total cost set forth herein, subject to the clause of the General Provisions entitled "Limitation of Cost".

B. For the performance of this contract, the Government shall reimburse the Contractor the cost thereof (hereinafter referred to as "allowable cost") determined by the Contracting Officer to be allowable in accordance with the clause of the General Provisions entitled "Allowable Cost and Payment," and the provisions below:

1. Purchase Orders and Subcontracts

a. The following shall require prior written approval of the Contracting Officer:

(1) purchase or rental of items of nonexpendable property having unit value exceeding $100.00 (For the purpose of this contract, nonexpendable property means property or equipment having a normal life expectancy of one year or more.) and

(2) purchase orders or subcontracts for any of the work contemplated under this contract exceeding $1,000.00.

b. The Contractor shall give advance notification to the Contracting Officer of all proposed purchase orders or subcontracts which require prior approval in accordance with the clause of the General Provisions entitled "Subcontracts." The advance notification shall include:

(1) a description of the supplies or services to be called for by the subcontract;

(2) identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the degree of competition obtained;

(3) the proposed subcontract price, together with the Contractor's cost or price analysis thereof; and

(4) identification of the type of subcontract to be used.

2. Consultants

a. Any fee or other payment to consultants requires prior written authorization by the Contracting Officer in excess of $150 per day.

3. Salaries and Wages

a. Salaries and wages of employment directly employed in performing the work required by this contract.

b. Actual cost of fringe benefits not to exceed 13% of salaries and wages.

4. Travel

Travel and subsistence expenses exclusively in direct performance of this contract.

a. The Contractor shall be reimbursed for actual transportation costs and travel allowances (per diem) of personnel, authorized to travel under this contract, in accordance with the established policy of the contractor. Such transportation cost shall not be reimbursed in an amount greater than the cost of first class rail or of economy air travel, unless economy air travel and economy air travel space are not available and the contractor certifies to the facts in the voucher or other documents submitted for reimbursement. Travel allowances (per diem) shall be reimbursed in accordance with the contractors established policy, but in no event shall such allowances exceed $30.00 per day.

b. The Contractor shall be reimbursed for the cost of travel performed by its personnel in their privately-owned automobiles at the rate of ten cents per mile, not to exceed the cost by the most direct economy air route between the points so traveled. If more than one person travels in such automobile, no additional charge will be made by the Contractor for such travel between such points.

c. Travel for general scientific meetings and foreign travel requires prior written authorization by the Contracting Officer.

5. Rental, Rearrangement and Alteration of Facilities

a. Rental or lease of facilities including office space requires prior written authorization by the Contracting Officer.

b. Rearrangement, alteration, or relocation of facilities requires prior written authorization by the Contracting Officer.

6. Overtime

a. Overtime, shoft or other incentive premium requires prior written authorization by the Contracting Officer.

7. Indirect Costs

a. Indirect costs shall be determined in accordance with Clause 27 of the General Provisions of this contract. Meanwhile, indirect costs under this contract shall be provisionally reimbursed in

an amount equal to 60.7% of total direct salaries and wages including vacation, holiday and sick pay chargeable to this contract.

C. Except as herein above authorized, the Contractor shall not incur costs unless the prior written authorization of the Contracting Officer has been obtained as required herein. Incurrence with the intent of claiming reimbursement as direct costs shall therefore be at the Contractor's own risk, when without such prior authorization.

ARTICLE XV - HEW CONTRACT FINANCIAL REPORT

Financial reports on Form HEW 515-4/69 shall be submitted by the Contractor in accordance with the instructions on the reverse of the form, and in an original and 2 copies not later than the 15th of the following quarter. The line entries for subdivisions of work and elements of cost (types of expense) to be reported within the total contract shall be determined by the Contracting Officer after giving consideration to the recommendations of the Contractor. Subsequent changes and/or additions in the line entries shall be similarly determined. The Contracting Officer shall notify the Contractor of each change and addition and the reporting period to which each shall apply. Financial reporting shall commence with a report for the first calendar quarter following the date of this contract.

ARTICLE XVI - NOTICE OF MAXIMUM PERMISSIBLE ESCALATION IN WAGE AND PRICE STANDARDS

Contractor is advised of standards established under Executive Orders 11615, 11627 and 11640 setting maximum permissible percentages of escalation in wage rates and price increases. Such standards call for wage rate increases of no more than 5.5 percent per annum unless specific exceptions have been granted by the Pay Board. The price standard established by the Price Commission has the objective of holding economy-wide price increases to 2.5 percent per annum (3 percent per annum in the case of small business firms). To achieve this target, firms are allowed to increase prices to reflect allowable costs incurred since the last price increase or since January 1, 1971, whichever was later, and such costs as firms are continuing to incur, adjusted to reflect productivity gains. These price increases may not result in profit margins on sales which exceed the firm's profit margins for the highest 2 of the last 3 fiscal years ending before August 15, 1971. Average productivity gains are estimated to be 3 percent or higher for the economy annually for 1972 and 1973.

ARTICLE XVII - OFFICE EQUIPMENT

Notwithstanding any other provision of this contract to the contrary, the contractor shall not purchase or lease under this contract any items of office equipment, including office furniture or machines. Recovery of cost of such items shall be allowable only to the extent that they are properly includable in the indirect cost charged to this contract.

ARTICLE XVIII - SUBMISSION OF INVOICES AND PLACE OF PAYMENT

One each month the Contractor may submit to the Government an invoice for the allowable cost to the Contractor for the performance of the work hereunder. The Government shall make provisional payment of all invoices submitted hereunder pending the completion of a final audit of the Contractor's cost records. Invoices shall be submitted in accordance with Billing Instructions, a copy of which is attached hereto and made a part hereof.

To expedite payment of invoices or vouchers under this contract, the invoices or vouchers (except COMPLETION INVOICES OR VOUCHER) shall be sent directly to the Paying Office for Payment as follows:

PAYING OFFICE
DHEW HSMHA ACCT/FIN Rm 16A-36
5600 Fishers Lane
Rockville, Maryland 20852

Where applicable, invoices or vouchers shall be sent through the cognizant DCAA auditor.

THE COMPLETION INVOICE OR VOUCHER will be forwarded to the aforementioned paying office through the Health Services and Mental Health Administration, 5600 Fishers Lane, Rockville, Maryland 20852, marked for the attention of the Contracting Officer, Room 16A-40.

Prior to the payment of invoices under this contract, the Contractor shall place on, or attach to, each invoice submitted the following certification:

"I hereby certify that amounts invoiced herein do not exceed the lower of (i) the contract price, or (ii) maximum levels established in accordance with Executive Order 11640, January 26, 1972.

The Contractor agrees to insert the above certification in all subcontracts for supplies or services issued under this contract.

ARTICLE XIX - SUBCONTRACTOR COST AND PRICING DATA

The Subcontractor Cost and Pricing Data clause is incorporated herein and made a part hereof.

ARTICLE XX - AUDIT AND RECORDS

The Audit and Records clause is incorporated herein and made a part hereof.

ARTICLE XXI - PRICE REDUCTION FOR DEFECTIVE COST AND PRICING DATA

The Price Reduction for Defective Cost and Pricing Data is incorporated herein and made a part hereof.

FINAL REPORT

Project Title: HMO Program Development in the University Medical Center (#03-P-000, 419-01-0)

Grantee: Association of American Medical Colleges

I. BACKGROUND AND APPROACH

In summary, the specific objective was to foster the development of health maintenance organizations in the university medical center environment through experiences derived from a planned series of HMO projects. Secondary aims included improving the educational and research functions of medical schools in regard to the delivery of health care and accordingly to advance the effective integration of medical education and medical care. Extramural aims included fostering improvement in patterns of interrelationship of the university medical centers with the medical care delivery and health manpower education systems around them. From an overall standpoint, the goal in undertaking the project was to more effectively bring to bear the resources of the university medical center in the improved delivery of medical care through the HMO approach.

Underlying the AAMC motivation in undertaking this project was a belief that a unique and special importance attaches to the involvement of the academic medical center in the development of new and innovative experimentations in health care delivery systems. It is the prime producer of manpower necessary for the delivery system. It has unique conceptual, quantitative and analytical capabilities and it has access to the full spectrum of disciplines in the health, social and behavioral sciences that are essential to dealing with the complexities of health care system development.

However, along with the unique potential, there are unique problems attendant to the academic health center involvement in the development of HMOs and other approaches to the delivery of health care. Our approach therefore was to focus on those critical issues that represented the real barriers to major involvement of the academic medical center in the development of HMOs for the improved delivery of primary, comprehensive continuing health services. Our thesis was that if the most important of the critical issues common to such institutional involvement could be identified and analyzed, a basis could be provided for the development of approaches to these solutions in the form of prototype experiments.

Another very important aspect of the AAMC HMO project design was in a centripetal approach in which primary emphasis was placed on contributions from those with field experience.

The project was conducted with a very small central staff and sought to achieve maximal involvement of those from the university medical center milieu having actual relevant experience and competence in HMO and similar types of health care delivery programs. This was done in a number of ways:

1. The newly established Health Services Advisory Committee of the AAMC was used as a major resource for review and advice. This group is chaired by Dr. Robert M. Heyssel, Director of the Office of Health Care Programs, who developed the Johns Hopkins sponsored HMO programs in East Baltimore and at the new town of Columbia, Maryland. Members of the committee include: Dean Luther Christman, College of Nursing and Allied Health, Rush Medical College; Dr. Christopher C. Fordham, University of North Carolina School of Medicine; Dr. Alfred Haynes, Charles R. Drew Postgraduate Medical School; Robert Lindee, Vice President of the Kaiser Family Foundation; Dr. Richard Meiling, Ohio State University School of Medicine; Dr. Ernest Saward, University of Rochester School of Medicine and Dentistry; Dr. Stuart Sessoms, Duke University Medical Center; Mrs. Anne Somers, Rutgers Medical School; Dr. Robert Weiss, Harvard Medical School; and John Westerman, University of Minnesota Hospitals.

2. Key people at the schools having active HMO involvement were used as a special consultant group to gain the benefit of the perspectives and insights of those struggling with the actual problems in real life.

3. The workshop mechanism was selected as the modality of choice in defining the critical issues and determining approaches to solution in order to secure involvement of all the "workers" active and interested in the field.

4. A major aspect of the workshop decision was to highlight the experience of those institutions who had actual experience in HMO development and operations. Therefore, presentations by key people closely involved with such developments at Yale, Harvard, Johns Hopkins and Washington University (St. Louis) were focused on the problems and difficulties encountered rather than "success-story" statements of a promotional type.

In summary, in a field such as HMO program development in the academic medical center where there are no experts but only experts in particular aspects, our strategy was to look at those who were out where the action was--actively engaged in the struggle to bring university health service programs into being and make them go.

II. THE CRITICAL ISSUES OF UNIVERSITY MEDICAL CENTER INVOLVEMENT IN HMO PROGRAMS

In order to provide the fundamental frame of reference for the project, we undertook to develop a basic list of those significant factors which attach to university medical center endeavors with such projects. A tentative array and outline of these so-called "critical issues" was developed by a staff consultant on a basis of a literature review of available reports on HMO-type programs--both academically and non-academically related (a copy is attached). In line with our strategy of involvement, we asked the key people at thirty of the academic medical centers that were the most advanced in feasibility study,

planning and development of HMOs to give it critical scrutiny for validity and completeness in the light of their experience.

The tentative list of critical issues provided a sound baseline and received a general validation from the consultant group with regard to the essential adequacy and accuracy of its content. However, some valuable suggestions were made for the inclusion of additional factors and more detailed breakdown of some items. The most frequent suggestions, for example, proposed more focus on mental health, and consumer education aspects and the problems of change stresses in institutions and professions. A general comment common to a number of the reviewing consultants was the fundamental interrelationship of the principal issues. For example, it was felt to be difficult--if not impossible--to deal with the issue of "organizational structure" of the HMO apart from that of its "governance."

The list of critical issues--as modified by the suggestions of the peer consultant group and--after review by the AAMC's Health Services Advisory Committee then provided a focus for the series of HMO Workshops designed for the participation of academic medical center staffs throughout the country. The general groupings were:

1. The definition and articulation of objectives of the institution in HMO project development
2. The organizational structuring of the HMO
3. Governance
4. Intramural relationships
5. Extramural relationships
6. Professional medical component
7. Management component
8. Fiscal structure
9. Legal aspects
10. Facilities

A copy of the full outline is attached.

III. AREA WORKSHOPS

The "area workshop" was chosen as the major "modus operandi" for the project. As previously noted, its use as the mechanism of choice was based on the theory that the best source of knowledge and insight about the principal problems and barriers of university medical center endeavors in HMO type programs--as well as for the delineation of realistic approaches to their solution--are those in active engagement with these issues in the academic medical center milieu. At

the same time, we wanted to expose and stimulate the interest of those institutions that had not given serious attention to the question of involvement with HMO type programs. Therefore, a series of eight workshops was structured geographically so as to delivery a thoroughly balanced distribution of participants with active HMO involvement in each. The idea was that this more experienced group would form the nucleus of the workshop function but that all schools in the area would be invited. Another sturctural consideration was size. We were very anxious to preserve the informality and free-wheeling exchange of the workshop form as opposed to the ridigities of the large conference type affair, so we aimed at forty as an optimal size and sought to keep any from being too small or too big in numbers by prescribing the constituency for each workshop. More than 500 individuals participated in the workshops, all--except speakers and consultants--at their own expense. This included some 364 people from 109 academic medical centers--or almost every one in the country. The other attendees included university administrators and trustees, representatives of medical associations, hospital administrators, insurance company executives, students, consumers, and other interested individuals.

Key staff of the Health Maintenace Organization Service of HSMHA, the Bureau of Health Manpower of NIH, and regional office representatives participated in several of the workshops. A feature of the Southeastern Area Workshop at the University of North Carolina was a presentation by Dr. Vernon Wilson, Administrator of HSMHA.[1]

Northeast Area (January 13-14, 1972)

Coordinator: John D. Thompson, Ph.D.
Associate Dean
Yale University School of Medicine

Schools Represented: University of Connecticut, Yale University, Boston University, Harvard University, Tufts University, Dartmouth Medical School, Albany Medical College, Mount Sinai School of Medicine, University of Rochester, State University of New York at Syracuse, University of North Carolina, Brown University, and University of Vermont. (Total: 13)

Attendance (Total)	58
University Medical Center Staff	54
Others	4

Middle Atlantic Area (January 29-30, 1972)

Coordinator: Robert R. Huntley, M.D., Professor and Chairman
Department of Community Medicine and International Health
Georgetown University School of Medicine

Schools Represented: George Washington University, Georgetown University, Howard University, Loyola University Medical Center, University of Kentucky, University of Louisville, Johns Hopkins University, University of Maryland, Meharry Medical College, University of Tennessee, Vanderbilt University and University of West Virginia. (Total: 12)

Attendance (Total)	48
University Medical Center Staff	39
Others	9

Middle U.S. Area (February 8-9, 1972)

Coordinator: Gerald T. Perkoff, M.D.
Director, Division of Health CAre Research
Washington University School of Medicine

Schools Represented: Chicago Medical School, University of Illinois (Abraham Lincoln), Loyola University, Rush Medical School, Southern Illinois University, Indiana University, University of Iowa, University of Kansas, University of Michigan, Michigan State University, Wayne State University, Mayo Graduate School of Medicine, University of Minnesota at Minneapolis, University of Missouri at Kansas City, St. Louis University, Washington University, Creighton University, University of Nebraska, Case Western Reserve University, Medical College of Ohio at Toledo, Ohio State University and University of Wisconsin. (Total: 22)

Attendance (Total)	70
University Medical Center Staff	51
Others	19

Philadelphia Area (February 14, 1972)

Coordinator: Aaron D. Freedman, M.D.
Associate Dean
University of Pennsylvania School of Medicine

Schools Represented: Hahnemann Medical College, Jefferson Medical College, Medical College of Pennsylvania, Pennsylvania State University, University of Pittsburgh, University of Pennsylvania, Temple University and Philadelphia College of Osteopathic Medicine. (Total: 8)

Attendance (Total)	49
University Medical Center Staff	37
Others	12

Southeastern Area (February 15-16, 1972)

Coordinator: Cecil G. Sheps, M.D.
Vice Chancellor for Health Sciences
University of North Carolina School of Medicine

Schools Represented: University of Alabama, University of South Alabama, University of Florida, University of Miami, Emory University, Medical College of Georgia, University of Mississippi, Bowman Gray School of Medicine, Duke University, University of North Carolina, Medical University of South Carolina, University of Virginia, and Virginia Commonwealth University. (Total: 13)

Attendance (Total)	38
University Medical Center Staff	32
Others	6

Western Area (February 28-29, 1972)

Coordinator: John E. Kralewski, Ph.D.
Director, Division of Health Administration
University of Colorado Medical Center

Schools Represented: University of Arizona, University of Arkansas, University of Colorado, Louisiana State University at New Orleans, Tulane University, University of New Mexico, University of Oklahoma, Baylor University, University of Texas System, and the University of Utah. (Total: 12)

Attendance (Total)	52
University Medical Center Staff	32
Others	20

Pacific Coast Area (March 1, 1972)

Coordinator: Julius R. Krevans, M.D.
Dean of the School of Medicine
University of California at San Francisco

Schools Represented: Charles R. Drew Postgraduate Medical School, University of California at Davis, Irvine, Los Angeles, San Diego, and San Francisco, Loma Linda University, University of Southern California, Stanford University, University of Nevada, University of Oregon, University of Utah, and University of Washington. (Total: 13)

Attendance (Total)	76
University Medical Center Staff	58
Others	18

New York Area (March 9-10, 1972)

Coordinators: John E. Deitrick, M.D., Director
Associated Medical Schools of Greater New York

Sherman Kupfer, M.D.
Associate Dean
Mount Sinai School of Medicine

Schools Represented: Indiana University, University of Missouri, College of Medicine and Dentistry of New Jersey at Newark, Rutgers Medical School, Albany Medical College, Columbia University, Cornell University, Albert Einstein College of Medicine, Mount Sinai School of Medicine, New York Medical College, New York University, State University of New York Downstate Medical Center, SUNY at Stony Brook, SUNY Upstate at Syracuse, University of Rochester, and University of Puerto Rico. (Total: 16)

Attendance (Total)	115
University Medical Center Staff	61
Others	54

In determining the host sites, the workshops were placed at university medical centers where unique approaches to HMO development were underway. This facilitated a diversity of approaches. The Washington, D.C. workshop had a bonus in this regard since both Georgetown and George Washington Universities had support for the development of two quite different types of HMO. This brought about a sharing of the host responsibility. Dr. Thomas Piemme of George Washington collaborated closely with Dr. Huntley, the coordinator, and the workshop was held on the George Washington campus.

To assure a reasonable degree of uniformity amongst the diversity, however, a general protocol was developed for all the workshops. It formed the basis of a contract with the respective coordinators. The key elements centered in the contract included the following:

Purpose: To permit sharing of experiences in HMO planning and operation to provide expert consultation for dealing with the critical problems of HMO development; and to make recommendations concerning the priority of issues for which research and evaluation should be undertaken in experimental prototype HMO projects.

Program: Coordinators were responsible for development of the programs for the workshop in colaboration with a steering committee composed of some of the individuals having primary responsibility for HMO-type projects at their home institutions. This group was free to plan and structure the workshop as they saw fit, except for the following mandated requirements:

1. The agenda had to include consideration of at least three of the major topics within the scope of the prime critical issues identified by the project staff and the AAMC Health Services Advisory Committee;

2. The program had to include presentation of three to six papers of publishable quality, each dealing with one or more of the critical issues.

Report: The submission of a report on the proceedings of the workshops was asked for within thirty days of its completion. A specific format was prescribed, the prime essence of the report being a) the principal papers read at the sessions, and b) identification of the recommendations of the workshop covering the nature and priority of the issues for which research and evaluation should be undertaken in prototype HMO experimental projects.

IV. WORKSHOP OUTPUT AND GENERAL CONCLUSIONS

Original basic assumptions about the problems and potential of the academic medical center were well borne out by the workshop results. A general message which came through clearly in all of the meetings without exception was that there are some very real barriers to effective large-scale involvement of academic medical centers in HMO program development.

It was very clearly recognized that the successful planning and operation of a prepaid group practice is a complex and difficult process in itself. Moreover, the fact that a university is involved not only tends to intensify some of these basic difficulties but brings into play a whole set of problems that are unique to the academic medical center itself. These include its basic nature as an academic institution; the complex and deep-seated set of relationships within the university community; the exquisitely sensitive and intricate set of relationships to the community outside the walls including professional, governmental and societal. The problem is further complicated by the fact that there is a great degree of difference among these variables and their combinations from institution to institution. In this regard there was a general sense of opinion that not all university medical centers could or should be involved in an HMO development. On the other hand, there was a diversity of opinion as to the nature and extent of the involvement wherever a course was deemed feasible and appropriate. It was suggested that this was a matter for each university to study and determine in the light of its own situation.

On the other hand, in spite of the sanguine reality and blunt frankness in addressing the problems implied above, the workshop constituency nevertheless produced clear evidence of a widespread and strong tide of interest among academic institutions in the HMO phenomena. Most importantly through all of the caveats and concerns expressed there emerged a powerful and pervasive pan-institutional conviction that if HMOs are destined to be a major method for improved delivery of health care in the country, the academic medical center has a unique and exclusive potential and responsibility with regard to them and must, therefore, inevitably be involved with them.

In addressing themselves to the critical issues of university HMO involvement, the workshops sought to shed light on the barriers and possible solutions. It is the aggregate of the papers presented, group discussions, and recommendations of the workshops that provides the sense of direction and priority of concern about the critical issues which are recommended as targets for prototype project focus.

V. PROTOTYPE HMO'S FOR UNIVERSITY DEVELOPMENT

The dictionary gives four meanings for the term prototype:

1. The original or model on which something is based or formed;

2. Something that serves as an example of its kind;

3. Something analogous to another thing of a later period;

4. An archetype; a primitive form regarded as the basis of a group.

It is interesting to note that all four of the definitions have a meaning of special significance when applied to the HMO prototypes to which this project is addressed. It is contemplated that they could be models to serve as examples for the entire field of academic medical centers and at the same time that they represent experimental ventures from which a sequence of new growth, mutations and variants would evolve. The benefits of being a prototype HMO project under this program would include: prestige and satisfaction in terms of the opportunity to break new ground and add new knowledge; and the benefit of special technical assistance. The burdens would include submission to a certain amount of group discipline including standardization of definitions, systems and reporting and the assumption of a responsibility for documentation of the prototype experience.

The role of the prototype project was succinctly put in the original grant application submitted to HSMHA as follows:

> "The proposed project, therefore, undertakes to carry out a systematic process to provide definition and criteria concerning the issues that are critical to university medical center involvement in HMO program development. This will permit the delineation of a series of prototype HMO projects which focus on the major distinct sets of problems which must be dealt with in developing the potential of the HMO concept in the entire field."

The purpose of benefiting the entire field rather than solely the grantee institutions was clearly set forth in the original letter of intent sent by Dr. John A.D. Cooper, President of the AAMC,to Dr. Vernon Wilson, Administrator, Health Services and Mental Health Administration, before undertaking this project in the following terms:

> "Selection must be accomplished in such a manner as to make the entire body of university medical centers feel a relationship to and benefit from the prototype experiments."

Procedure for Qualification of Prototype Projects

After the final version of this report has been accepted by HSMHA, it is proposed that it be transmitted to all academic medical centers through normal AAMC channels. It would be accompanied by a general invitation for expressions of interest by institutions in the possibility of participation

in a prototype project. Both institutions already funded for HMO development as well as those not yet supported are considered for prototype participation. On the basis of the communications received, the critiera for the particular prototype in which a school expressed interest could be sent to them along with a request for a prospectus which would set forth in detail their capacity and potential to meet the criteria. An expert committee assembled by the AAMC would then review the prospective submissions in terms of their qualifications in the light of prerequisite criteria. Ultimately HSMHA would make that determination as to the specific number and types of prototype projects to be supported under the program. AAMC in line with a contractual arrangement with HSMHA, would provide coordination, technical assistance and guidance in their planning and development. This would include assistance in the development of applications for prototype project planning grants and in the planning and developmental process itself, if an award is made by HSMHA.

Recommendations for Prototype Development

The eight HMO workshops conducted by the AAMC focused on the critical issues that the Steering Committee for each session saw as the most significant, insofar as effective application of the HMO concept in the academic health environment was concerned. Analysis of the eight workshop reports, including more than 40 presentations and transcripts or reports of many of the discussion groups at the sessions, indicates that the issues of primary general concern included:

1. The problems of structure and governance with particular reference to the relative degree of involvement and control by the university.

2. The problem of adaptation of the HMO modality which presumes a balanced population target group to the areas of geographic and socio-economic imbalance -- both urban and rural -- in which many university medical centers are located.

3. The recognition that the true importance and full potential of the university related HMO development cannot be realized unless effective integration of relevant educational and research programs is accomplished. Special reference in this regard is made to the subject areas of primary continuing comprehensive care and the essential components of the HMO process itself.

4. Fiscal problems - both those germane to the organization and operation of HMO's generally, as well as to a special set of problems unique to such projects in the university medical center environment.

On the basis of the foregoing considerations, the following recommendations are made:

1. One or more prototype projects of the following types should get priority consideration:

   a) A major collaborative effort with an HMO based outside the academic medical center. Special importance is attached to the affiliated community hospital in this regard.

b) A major HMO development within the university medical center that is designed to serve a population group representative of the general community.

c) A university related HMO model especially adapted to the problems of sparsely populated rural areas.

d) A university related HMO model especially adapted to the problems of densely populated urban areas.

2. A substantive prerequisite for prototype project qualification should be a demonstrated institutional commitment and capability to develop an effective and symbiotic relationship between the HMO and relevant educational and research programs. Particular reference in this regard is to the subject areas of primary, comprehensive care. In view of the existing fragmentation of funding sources, however, institutions should not have to struggle to meet this requirement alone. The AAMC and HEW should help to develop coordinated, conjoint plans for support of such integrated programs of service, education and research as proposed by the institutions sponsoring prototype projects.

3. Special consideration should be given in prototype projects to the particular problems of HMO development in publicly supported institutions.

4. Prototypes should be given ample funding to permit a thorough and comprehensive effort so that the benefit of the experiments in the planning and development of university related HMO's will be provided for the entire field. Special attention should be given to the application of cost accounting theory to the problem of identifying educational costs in the very complex joint-cost situation inherent in the HMO-university relationship. Such a focus could help provide for more accurate approaches to the determination of the "quality differential" of such care programs in the academic medical center and improved methodology for the identification and separation of the cost of service, education and research.

DISCUSSION: <u>The Critical Issue of Structure and Governance</u>

The question of the undertaking of a major involvement in HMO development raises very fundamental issues relating to the organization of the university and its governing processes and policies. Major attention to the analysis of these implications was given in several papers presented at the various workshops and other forums.[2,3,4,5,6,7,8]

On the basis of this consideration, the most frequent forms of university HMO involvement may be classified as follows:

University involvement with extramural HMO project

1. Community hospital
2. Citizens group
3. Medical group
4. Medical foundation
5. New community
6. Other entities

University involvement with intramural HMO project

1. Academic medical center
2. Other university locus

Within the above forms, a wide degree of variation is possible in the extent of involvement and control of the university with regard to the HMO. The range is from an HMO sponsored and operated by the university per se[10] to the integration of the university student health service into a community sponsored HMO project.[12] The pioneer university related HMO programs demonstrate this diversity.[2,13,14,15,16,17,18,19] For example, the Harvard Community Health Plan is run by a separate corporation controlled by the University; the East Baltimore Medical Program is an independent corporation with which Johns Hopkins Medical Group (a partnership controlled by Johns Hopkins) have a contractual agreement to provide health services; the Columbia HMO project of Johns Hopkins is based upon a contractual agreement between the Columbia Hospital and Clinics Foundation (a university controlled corporation), the above mentioned Johns Hopkins Medical Group and an independent corporation - the Connecticut General Life Insurance Company; the Yale Health Plan is a university family HMO operated by the University corporation which has a formal affiliation agreement with the Yale-New Haven Health Center (which includes the School of Medicine and the Yale-New Haven Hospital).

Another major concern under the governance heading that cuts across the classification spectrum is the question of whether the school is publicly or privately supported. All of the initial pioneering HMO efforts emanated from private schools but several public school sponsored HMO projects are in the planning or developmental stages. The workshops gave consideration to the special problems in this regard.[20,21]

A fairly sharp diversity of opinion emerged at the workshops over the relative merits of the different modes of university HMO involvement, particularly with regard to the matter of direct sponsorship and operation by the university as opposed to a "back-up" or other role with regard to an HMO under other than direct university auspices. More than a dozen speakers addressed themselves directly to one side or the other of this issue. Appropriately, Dr. I.S. Falk, one of the great pioneers of the prepaid practice field, effectively framed the two aspects of the question:

"If an Academic Medical Center is primarily oriented to teaching, training, and research in the accustomed and prevailing patterns, if the outlook is that it will be reluctant to change the emphases or the course of its interests, and if it is so situated that it has the privilege of making its own policy decisions, it nonetheless has a responsibility to examine its role with regard to the health care of the community. It should be or become knowledgeable about such needs from both the local and national standpoint. In the circumstances of the present times,it should accept an obligation to participate and assist in the design and development of needed community- based service organizations for the availability and delivery of medical care. Thus it could contribute to local area services, and to experimentation and evaluation on systems for the availability and delivery of medical care. Beyond that level, the Academic Medical Center may and indeed should participate, through formal affiliation, in making its resources for care available to community plans on mutually agreeable contractual terms. And still further, it should assist the community plans as in matters of recruiting needed staff, in plan operations, in service reviews and evaluation, etc.

In return, the Academic Center should accept the community plan as a source of patients for its education, training and research programs, and as loci for health manpower training in a group practice setting and for joint research and evaluation programs. But the Academic Medical Center should not itself undertake to sponsor, control, operate and finance continuing programs which - in the years ahead - are destined I believe to become the principal medical care delivery systems of the community.

However, if an Academic Medical Center has major interest or overriding obligations for patient care, locally or in a larger area, as may be the case for a state-supported medical center, it may have many of the same obligations and may also have to become heavily involved in sponsoring and in operating one or more HMO's or even a regional system of HMO's. It may nevertheless find many values in adapting the New Haven pattern,as by sponsoring or assisting the development of associated or affiliated community-based organizations serving many of the purposes that are served by the Community Health Center Plan in the New Haven design." [16]

The majority of opinions - and most of the university related HMO's in existence or under development - reflects a preference for the approach of involvement through affiliation with an extramural HMO entity - whether sponsored or independent in lieu of direct operation by the academic institution per se. [3,7,8.9,24,25] There is, however, a vigorous minority viewpoint.[10,20,26,27,28,29] The majority attitude stresses that the extramural approach facilitates the advoidance of what they consider to be inherent weaknesses of the direct institutional approach. These include lack of management expertise, conflict with educational and teaching goals, established departmental structures, faculty status and reward systems, lack of competence or interest in primary care, financial vulnerability, town and gown problems and difficulties of involving outsiders (consumers) in governance. On the other hand, the contrary view is largely based on the belief that with the extramurally related program - the interface with essential academic functions is more likely to be remote and therefore tend to dilute and attenuate the university participation. This school of thought believes that the intramurally based HMO is an effective approach to bringing about more substantial integration of the academic and service functions. In addition to those which expressed a specific point of

view some of the presentations simply assessed the relative assets and liabilities of the two approaches without indicating a preference for one or the other.[6,22,31]

A great deal of stress was placed by Workshop participants on the importance and necessity for a diversity of university related approaches to the delivery of care in general and HMO's in particular.

As stated in the Conclusions and Recommendations of the Southeastern Area HMO Workshop at Chapel Hill, "medical schools should be able to stimulate the creation of a variety of models appropriate to their ability to be involved. There was an apparent consensus at the Workshop that the HMO concept should be allowed to evolve in a number of ways." [25]

Closely related to this was the opinion that there ought to be experimentation by academic medical centers with new and innovative approaches that would provide experimental departures from the established Kaiser prototype HMO. One idea in this regard independently suggested by two different individuals of wide experience in the medical care field urged experimentation with an approach based on satellite primary care teams, related to, but not based at, an ambulatory care center in a prepaid gruop practice. [32,46]

On the basis of the foregoing it is difficult to limit the recommendations for the various prototypes for university medical center development. It would be desirable to have major prototype developments for each of the types listed in the above classification as well as some "new departure" innovative experiments. However, for the purposes of this report it is necessary to be selective and limit the recommended prototypes to a few amply financed and well developed efforts of the most generic application. For the reasons set forth below, two prototypes to offer guidance and insight on the critical problems of structure and governance are recommended - an affiliated community hospital based HMO and an intramurally based HMO.

The Affiliated Community Hospital Based HMO

A possible middle-ground approach of considerable promise which lies between the extremes of the intramural-extramural issues involved the affiliated community hospital teaching HMO. [11,21,33] As a collaborative endeavor of the university and an affiliated community hospital an HMO could avoid or at least mitigate many of the obstacles identified as possible constraints for such a program within the university environment as indicated above. On the other hand, such an arrangement would place the HMO in a service-oriented environment where there is both existing competence and interest. However, speical importance is seen in the fact that such a framework would have great potential for the development of a new dimension of community hospital based medical education in primary continuing and comprehensive care. Anne R. Somers, a member of the AAMC Health Services Advisory Committee, has articulated the major benefits of such an arrangement in recent articles. [34] It is envisioned that the program would provide a basis for a type of interface between the spheres of education and service to which the Carnegie Commission Report attached such importance. Such an environment would also be conducive to the improved integration of ambulatory and hospital type training - a problem with which educational efforts in freestanding ambulatory centers have experienced considerable difficulty. As a collaborative endeavor of two universities and the

community hospital it could foster a continuing sense of identification and responsibility in both entities, without dominance in either.

University Based HMO

With regard to the difference of views concerning direct operation of HMOs by academic institutions, it is noted that, except for the atypical "university family" type of program, the arguments on both sides are essentially a priori judgments. The only empirical evidence concerning an institutionally operated HMO serving a community population derives from the 318-family controlled study of the Washington University (St. Louis) School of Medicine. The program is now in the process of expansion to an operational scale of 25,000 enrollees.

The issue of locus of responsibility for HMO development within the university structure also evokes differences of opinion. The medical school based model of Washington University (St. Louis) is one type and represents a unique approach in the face of questions concerning the capacity of a medical school to effectively operate such a program as an integral part of the university medical center. In this setting, the HMO tends to assume for the primary care area the essential function that the university hospital serves for specialty, inpatient type care. A major aim is to maximize exposure of medical students and house officers to such a primary and comprehensive care program and thereby exert influence on attitudes and value scales in formative professional stages. A thorough institutional planning effort by the Division of Health Care Research at Washington University School of Medicine has carefully explored the anatomy of such an approach and defined the issues.[35] Such an innovative thrust should be encouraged to assure consideration of diverse parameters.

On the other hand, an expert consultant in reviewing a proposed plan for HMO development by an academic institution recommended against HMO development at the medical school level because he believed the objectives of the two organizations would conflict and would diffuse education and research efforts on the one hand and jeopardize the HMO effort on the other. In contradistinction, however, the university level was seen as an appropriate base. In this connection it was noted that the university administration is already involved in medical care in various ways including the provision of student health services, ocupational health services, and athletic health services, as well as financing health care benefits for faculty and employees as a fringe benefit.

In addition, such a university base for an HMO may also possibly afford a more effective axis for integration of central services (such as computer and transportation services) and the wide spectrum of scientific disciplines outside of the health sciences that are relevant to a project such as an HMO. These would include the fundamental social sciences such as economics, sociology, and anthropology as well as the political sciences, management engineering and business sciences. This is not to say that a university medical center based HMO could or would not achieve effective involvement of these relevant resources but rather that the university level represents a possible alternative. The importance - and in an oblique way the problem - of getting effective involvement of other disciplines in a medical school based endeavor is illustrated by the following quotations from Workshop Reports.

"It should be noted that this workshop intentionally concentrated on the medical school and the HMO. The sparse mention of other components of academic health sciences centers should not be interpreted to mean they should or could be forgotten as universities consider the HMO movement." [25]

* * *

"Throughout the evening discussion we shall assume the presence of an operational HMO in the medical school. We shall also assume the HMO is organized to permit the participation of undergraduate students in all of the health professions (medicine, dentistry, nursing, social work, medical administration and physician assistants) as well as interns and residents. For the purpose of this discussion, I shall confine my remarks to the education of medical students, interns and residents." [37]

* * *

For the foregoing reasons one or more prototype projects involving the university based approach are recommended. It is to be noted that the recommended prototypes are distinguished from those university HMO programs which are designed primarily to serve the university family population (i.e., faculty, students, employees) in the contemplation that they could be designed to serve a representative community population - either with or without the university component.

DISCUSSION: The Critical Issue of Target Population Imbalance

Two elemental components of the basic HMO concept are (a) the marketing capability to enroll an adequate number of members and (b) an enrolled group that is representative of the socio-economic mix of the community in general.[3] Since many university medical centers are located in densely populated urban areas with a heavy proportion of disadvantaged people[30] and in sparsely populated rural areas, it is necessary to give consideration to special adaptations of the HMO mechanism in the light of these circumstances.[38,39]

Urban Areas

The obstacles of developing a university related HMO in an inner city area are heavily economic, bureaucratic, and socio-political in nature.[3,23,40,41] The experience of the Johns Hopkins East Baltimore HMO project[15,41] puts into sharp focus the problem of obtaining support for enrollment of a population group from a disadvantaged area. The major difficulites involve (1) what are described in East Baltimore as the "nightmare" of attempting to relate to the eligibility, funding and regulations of a multiplicity of programs at all levels of government and (2) how to finance the enrollment of the medically indigent - the so-called "gray zone"people who are not beneficiaries of any governmental program but are too poor to pay.[23,24,39,40]

The socio-political aspects of the establishment of health services programs in disadvantaged areas by universities have been documentd by Drs. Geiger and

Gibson (primarily with reference to the Tufts Columbia Point and Mississippi OEO sponsored programs).[42,43] The issue of community involvement in governance poses many new problems under such circumstances and nature of the HMO approach which essentially prescribes a high degree of efficiency and cost control -- gives a new dimension of difficulty.[3,9,30,32,40]

It is clear that the university which can draw on a wide spectrum of relevant disciplines in the social, political and managerial sciences-- along with those of health -- has a latent potential to make a major contribution to the development of trail-breaking approaches to these problems.[32] Therefore, it has the potential capability of developing new and innovative societal mechanisms for the integration of multiple funding sources and agencies of government. Similarly it has the capacity to devise experimental approaches for funding care for the medically indigent. It is feasible for a prototype to develop and test methods not possible on a general basis and develop a sound basis of data and information from which permanent general application could be devised.[25] The same is true of consumer or community involvement. Despite the growing recognition of the importance of this aspect as reflected by the increasing tendency to write such a requirement into legislation and program regulations, there has been very little scientific attention given to the development of methodology and processes that can effectively accomplish this task.[38] Again the university has unique tools with which to attack this problem and special attention by HMO prototype projects is recommended. Some effective efforts in this direction which offered promising indications of this potential were described at the workshops - with particular reference to the programs at Southern Illinois University[12,44] and Temple University.[45]

Rural Areas

The problems of adapting the HMO concept to serving rural areas have been described by one of the consultants to the project as "exquisitely difficult." A major focus was put on the need in this regard by the Western Area Workshop at the University of Colorado.[31,37,49] In addition there were significant contributions at other workshops to the importance of this aspect such as that of the Univeristy of Kentucky at the Middle Atlantic Area session in Washington, D.C.[23] and at the Middle U.S. session at St. Louis.[31] While some of the fundamental issues (such as funding for enrollment of the medically indigent) tend to be the same as with the inner city program, the configuration of the problems in the rural area is distinctive. Here the demographic problems involve distances and the spread of the population, rather than density. The spectrum of problems embrace - in addition to new types of medical organization and personnel utilization - those in the field of communication, transportation and intergovernmental relationships. It was suggested that under such circumstances of scarce resources, sparse population and great distances the normal competitive choice characteristics of the HMO concept may not be feasible and some sort of franchising approach may be necessary.[31] In this regard, the fact that in most instances universities in such rural areas are state institutions with varying degrees of legal responsibility for that constituency may be a special factor in dealing with the problem. As such, the university may represent the only institution capable of accomplishing the task of bringing together the consortium of diverse resources and institutions necessary to such an endeavor. A rural prototype to guide developments in the field in this regard appears to be much needed.

DISCUSSION: The Critical Issue of Educational and Research Functions Relevant to Hmo Concept

HMO's and Educational Programs in Primary Care

While the issue of the form of university involvement evoked a strong difference of opinion among workshop participants one aspect of the substantive nature of that involvement brought forth a powerful and impressive expression of unanimity. This refers to the importance and priority attached to the need for strong educational programs for all the health professions (but particularly for physicians) in primary, continuing, comprehensive care geared to and based upon HMO and other type primary care programs.[4,23,27,50,51,52,53]

The case made may be summarized as follows:

a) One of the most crucial constraints on major growth and expansion of the HMO approach in the U.S. is the lack of an adequate supply of appropriately trained, oriented and motivated health professionals at all levels.[1,3,52]

b) The production of such health manpower services requires major emphasis on the development of educational programs in primary care for all levels of health professionals.[20,21,23,37,52,54]

c) Such educational programs must be based upon and geared to actual primary care programs such as an HMO.[5,10,37]

It is important to note that the HMO was not indicated as the exclusive mechanism of choice as a training ground in primary and comprehensive care. The consensus was that there ought to be a variety of mechanisms for teaching projects and one paper assessed the specific strengths and weaknesses of the HMO approach for the purpose.[53] However, the major point made is that the university needs such appropriate environments for effective development of primary care training and a university involvement in an HMO should be approached in the light of this vital need.[30,33]

Insofar as the HMO as a training base is concerned, a dilemma emerged with regard to the university related HMO program. The weight of authority indicated that such programs should not be burdened with teaching functions to a major degree until the program is well established both financially and operationally. Considering the normal preoperational lead time of several years plus an average of two or three years to reach the break even point, the deferment of substantial educational applications in this regard becomes a matter of concern. As pointed out, in the report of the Middle Atlantic Area Workshop, "this discussion highlights the irony that the primary purpose for universities to develop prepaid plans for defined populations was to reform and restructure the educational system."[23] In addition it was noted that university sponsored HMOs so far have developed only minimal educational applications.[23,33] A parallel point involves a strong consensus at the workshops to the effect that as a general role, university HMO projects should not merely involve the development of an operative HMO as a pruely service function.[38,55]

Full recognition was given to the great difficulties of integrating such a service program as an HMO with educational and research functions in the

academic setting. The workshops elicited opinions to the effect that there is a great lack of an adequate body of data and knowledge about the content and methodology for teaching primary, continuing comprehensive care. It was demonstrated that much more needs to be known in this regard about such things as team care and the functions and interrelationships of the physician's assistant and other allied health personnel in the actual ambulatory care setting such as the HMO.[23,50,56,57,58] The early findings of a project at the Mount Sinai School of Medicine to develop an educational program for medical students in a prepaid group practice setting gives promising evidence of the possibilities and potential in this regard.[59] More serious, however, were the indications of the lack of status and empahsis accorded primary care in educational programs of many university medical centers.[4,5,10,20,21,27,30,39,51,60,61] Therefore, it is proposed that to be a true prototype for this field, a project should exemplify the application of the unique and distinctive qualities and resources of the univeristy medical cneter to the effective implementation of the HMO concept. In this particular regard, prototype projects should address themselves to the solution of the dilemma of integration of educational programs with their HMO development effort.

It is to be stressed that this attitude is not to be taken as a dilution in any degree of the genuine and primary service commitment that is inherent to the HMO.[23,48] It is based on the conviction that the relationship should be fundamentally a symbiotic one of mutual interdependence. As one of the workshop papers put it, "There can be no debate whether the program priorities are education or research or service, but the belief that excellent education and research can only occur in the context of a program of excellent service, consistent with the realities of what people want and whay they will pay for."[52]

For the foregoing reasons, major linkage between university prototype HMO projects and an emphasis on the development of educational programs in primary and comprehensive care is strongly advocated.

HMOs and Research Functions

Workshops also put strong emphasis on the unique potential of the academically related HMO to develop and refine knowledge that is essential and urgently needed for the growth and development of the HMO concept.[1,4,8,54,65]

The target areas include the elemental components of the medical care process and the HMO conept, as well as clinical and epidemiological knowledge. The following are culled from the Workshop Reports:

> ...Pellegrino in keynoting the New York Workshop stressed the need to put forthright emphasis on definition, evaluation, teaching and affiliation of health maintenance. He pointed out that although the efficacy and economy of "health maintenance" measures were a major factor of appeal for legislative and public acceptance of the HMO concept that actually there was little known or done about them.[60]
>
> ...Heyssel and Carter at the Washington session pointed out that to effectively put new emphasis on the maintenance and promotion of health in the community requires different but no less scientific approaches to generate new knowledge concerning: the impact of social settings on

health, the effectiveness of health education campaigns on population; the appropriate roles in maintenance and promotion of health for both new health professionals and traditional health counselors.[52]

...Kass at Chapel Hill dramatically identified a number of important disease entities for which effective treatment is limited by lack of knowledge about their natural history - a type of biomedical data that cannot be adequately studied in hospitalized populations and which requires an HMO type of population group.[62]

...Brook[63] and Anderson[64] at the Pacific Coast Workshop focused on the problem of quality and assurance and revealed some of the limitations in existing technological capability in this area, as well as some practical approaches. In view of the increasing attention being given to this issue in legislative proposals, administrative regulations and professional circles, the need for attention in this regard is very clear.

The New York area meeting gave special emphasis to the relevance and relationship of research functions to an HMO program in a university setting. In a special panel on the subject, Shapiro of HIP pungently pointed out that "our lack of knowledge about the natural history of disease can be matched by the inadequacy of our information about the natural history of medical care and the factors that effect it." He described the current state of understanding about patterns of care and health status as "primitive." He also saw the great value that a series of prototype projects could have through the provision of parallel sets of data which would permit more meaningful patterns of utilization of health services and health status.[56] McGuire in discussing the issues of educational research applications stated "...because of the very nature of the target population for whom the HMO is designed, I believe that involvement of the academic community in such programs will, for the first time, enable the educational researcher to determine the real relation between the criterion of effective education and the ultimate criterion toward which all education is directed, namely the effectiveness of health care delivery."[57] Friedson, in discussing the behavioral aspects, also found serious gaps in knowledge fundamental to the understanding and assessment of the HMO delivery system. He cited how little we really know about the actual work of the every day practitioner and about how interoccupational teams operate and perform. He closed his analysis with the following statement:

> "Finally, there is the issue of government of the HMO. Actually apart from administrative anecdotes and personal memoirs, we have very little information at all as to how medical practices, group or individual, are governed. How actually are formal rules and regulations carried out? What exactly is the relationship of the administration to the medical staff? How much can the administration be said to govern rather than keep house, and how does the administration gain influence over medical staff behavior?"[58]

All of the above mentioned items have in common the fact that (a) a very little is known about them; (b) the need to obtain knowledge is urgent; (c) the university medical center has appropriate capacities; and (d) an HMO-type setting is essential. Therefore, university HMO prototypes should be designed for compatibility with the above indicated research functions that are of prime relevance to HMO development.

DISCUSSION: The Critical Issue of Fiscal Constraints

The major critical barriers of a fiscal nature include:

a) The fundamental necessity of an effective linkage between entitlement for care with development of delivery mechanisms such as the HMO is a major expansion of the approach is to be effectively accomplished without reinforcing the two-class system of medical care.[23,39]

b) A need to provide for a substantial incentive to foster academic medical center involvement in HMO type programs.[24]

c) The essential importance of assurance of continuity of support to protect institutional integrity after having been lured into accepting responsibilities that are financially of a serious magnitude and from which extrication is not easy.[65]

d) The economic impossibility of saddling university related (or any other type) HMO's with an open enrollment requirement.[32,40,66]

e) The problem of separating education from service costs in the very complex situation inherent in the HMO-university relationship.

With the exception of the last item listed, the solution to the above mentioned critical fiscal issues requires action that is well beyond that of funding a limited number of prototype university HMO projects. Major legislative and administrative steps would be required. It is possible as indicated below, however, through the medium of the prototype projects to acquire a sense of direction and to develop and test some mechanisms or approaches. For example, while categorical support for the "gray zone" population is not yet genuinely possible, it will be feasible to work out a pilot approach for prototype project purposes in connection with the urban and/or rural models.

A special note is in order with regard to the university incentive factor mentioned in item (b) above. The workshops were unanimous in stressing the importance of building sound footings for such projects by a thorough planning process that addresses itself in a substantially objective manner to the complex issues of human and organizational behavior, involving a variety of groups (family, students, practicing physicians and consumers) that such a unconventional or new type program as the university related HMO necessarily involves.[25] Without special support, an HMO development effort in the academic environment may very likely be understaffed and underfinanced. An academic entrepreneur trying to float a proposal that goes against the traditional grain of the institution encounters strong pressure to avoid or insulate some of the highly complex and controversial factors. Therefore, a thorough planning process involving the development of objective, analytical data and full consideration of long-run implications, so desinged as to develop a real sense of institutional understanding and commitment to the undertaking is considered essential. Such a scientific and systematic approach is much more expensive and time consuming than the intuitive or evangelical approach but in the long run will assure sound development in a situation where misguided or superficial approaches can do serious harm to both the institution and the community. It has been stated by some not familiar with the academic situation that planning for a university medical center related HMO is less expensive because many of the facilities or resources required for an HMO

are already available. Even from a technological standpoint, this is a misguided view - but from the aspects of human and organizational behavior mentioned above it is a serious distortion. The problems are complex and difficult, and the planning effort must be commensurate. The implication is that prototype HMO planning and development should be adequately funded so that they can provide an example and guide which will lead to the effective development of such programs throughout the field.[65]

The Special Problem of Cost Analysis

The problem of separating the interwoven costs of service, education and research in the academic medical center is one to which considerable attention was given at the Workshops in general recognition of its importance. It has become a major issue in health insurance regulations in Pennsylvania, New York and elsewhere. Significant problems in Medicare reimbursement have arisen over this point. The emergence of the HMO on the academic scene raises a new dimension of the problem. As a frankly service operation in which the enrollee purchases a package of benefits for a certain premium, it is fundamental that the tendency to pass the costs of education off in the service bill cannot operate in this situation. The problem is compounded by the lack of information on the primary care process in the academic setting or the relative magnitude or values of service and educational aspects. On the other hand, as pointed out by Dr. Falk in the workshop discussion at Yale, a new HMO is a well-defined entity, a contained system with a prospective budget developed on an actuarial basis relative to utilization data. The addition of training functions involves the problem of giving opportunities for persons in training to participate, under supervision, in the provision of service, however, this is measurable in terms of training time and supervisory time. It involves additional increments of space, overhead and supporting staff, all of which are definable elements on which price tags can be put.[47] In summary, an important special objective of HMO prototype projects should be the development of cost analysis methodology designed to identify and apportion the service, education and research costs of such university related programs. This may also be helpful in developing some improved approaches to the measurement of the "quality differential" of operating care programs in the university medical center setting.[48]

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PMK

92D CONGRESS
2D SESSION

S. 3716

IN THE SENATE OF THE UNITED STATES

JUNE 16, 1972

Mr. KENNEDY (for himself, Mr. CRANSTON, Mr. EAGLETON, Mr. JAVITS, Mr. MONDALE, Mr. NELSON, Mr. SCHWEIKER, Mr. STAFFORD, Mr. STEVENSON, and Mr. WILLIAMS) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide for continued assistance for health facilities, health manpower, and community mental health centers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Facilities, Manpower, and Community Mental Health Centers Act of 1972".

PART A—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 2. Section 314 of the Public Health Service Act is amended by redesignating subsection (g) as subsection (i) and inserting in lieu thereof the following:

"Approval of New Construction

"(g) On or after July 1, 1973, assistance under parts A, B, and C of title VI of this Act shall be made only after the Secretary receives comments (within ninety days) from (A) each appropriate State comprehensive health planning agency (designated under subsection (a) of this section), (B) each appropriate areawide comprehensive health planning agency (designated under subsection (b) of this section), and (C) each appropriate regional medical program (under title IX of this Act), approving such projects.".

EXTENSION OF ASSISTANCE UNDER TITLE VI OF THE PUBLIC HEALTH SERVICE ACT

SEC. 3. Section 601 of such Act is amended to read as follows:

"SEC. 601. In order to assist the States in carrying out the purposes of section 600, there are authorized to be appropriated—

"(a) for the fiscal year ending June 30, 1973 and each of the next two fiscal years—

"(1) $85,000,000 for grants for the construction of public or other nonprofit facilities for long-term care;

"(2) $100,000,000 for grants for the construction of public or other nonprofit outpatient facilities; and

"(3) $15,000,000 for grants for the construction of public or other nonprofit rehabilitation facilities;

"(b) for grants for the construction of public or other nonprofit hospitals and public health centers, $160,000,000 for the fiscal year ending June 30, 1973 and for each of the next two succeeding fiscal years;

"(c) for grants for modernization of facilities referred to in paragraphs (a) and (b) $150,000,000 for the fiscal year ending June 30, 1973 and for each of the next two succeeding fiscal years."

EXTENSION OF LOAN GUARANTEES AND LOANS FOR MODERNIZATION AND CONSTRUCTION OF HOSPITAL AND OTHER MEDICAL FACILITIES

SEC. 4. (a) (1) Section 621 (a) (1) of the Public Health Service Act is amended by striking out the phrase "during the period July 1, 1970, through June 30, 1973,".

(2) Paragraph (2) of such section is amended by striking out the phrase "during the period July 1, 1970, through June 30, 1973,".

(b) Section 622 (b) of the Public Health Service Act is amended by striking out the phrase "ending before July 1, 1973."

(c) Section 631 of the Public Health Service Act is

amended by striking out "1971." and inserting in lieu thereof "1973.".

(d) (1) The title of part C of title VI of the Public Health Service Act is amended to read as follows:

"PART C—CONSTRUCTION OR MODERNIZATION OF EMERGENCY ROOMS AND DEVELOPMENT OF AREA EMERGENCY MEDICAL SERVICE SYSTEMS".

(2) Section 633 of such Act is amended to read as follows:

"AUTHORIZATION

"SEC. 633. To assist in and improve and expand the provision of adequate emergency medical services in the Nation for the treatment of accident victims, victims of sudden illness, and handling of other medical emergencies there are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1973; $100,000,000 for the fiscal year ending June 30, 1974; and $150,000,000 for the fiscal year ending June 30, 1975, for special project grants for the planning and development or expansion of comprehensive area emergency medical service systems. Sums made available under this section may be used for construction, training and manpower development, communication, transportation, public education, coordination of services and facilities and other components necessary for

the implementation of a plan submitted in accordance with section 635."

(3) Part C of such title is further amended by adding at the end thereof the following new sections:

"ELIGIBILITY FOR GRANTS

"SEC. 634. Funds appropriated pursuant to this part shall be available for grants by the Secretary, only after consultation with the National Emergency Medical Services Advisory Council established by section 638, and funds available for grants under section 633 shall be provided on a matching basis of up to 75 per centum in accordance with criteria of need as determined by the Secretary pursuant to regulations he shall prescribe, to States, political subdivisions, or regional arrangements, compacts, or consortiums comprising the governmental jurisdictions for at least those areas included in a standardized metropolitan statistical area (as determined by the Office of Management and Budget) in the case of programs to be carried out in such standardized metropolitan statistical areas, presenting a plan for the provision of comprehensive and coordinated emergency medical services for a geographical area which encompasses an area at least congruent with an areawide comprehensive health planning agency as established under section 314(b) of this Act or multiples of such area, which plan must meet re-

the implementation of a plan submitted in accordance with section 635."

(3) Part C of such title is further amended by adding at the end thereof the following new sections:

"ELIGIBILITY FOR GRANTS

"SEC. 634. Funds appropriated pursuant to this part shall be available for grants by the Secretary, only after consultation with the National Emergency Medical Services Advisory Council established by section 638, and funds available for grants under section 633 shall be provided on a matching basis of up to 75 per centum in accordance with criteria of need as determined by the Secretary pursuant to regulations he shall prescribe, to States, political subdivisions, or regional arrangements, compacts, or consortiums comprising the governmental jurisdictions for at least those areas included in a standardized metropolitan statistical area (as determined by the Office of Management and Budget) in the case of programs to be carried out in such standardized metropolitan statistical areas, presenting a plan for the provision of comprehensive and coordinated emergency medical services for a geographical area which encompasses an area at least congruent with an areawide comprehensive health planning agency as established under section 314(b) of this Act or multiples of such area, which plan must meet re-

quirements consistent with the provisions of section 635 set forth in regulations prescribed by the Secretary.

"PLANS

"SEC. 635. Each plan submitted pursuant to section 634 must include the following—

"(a) reasonable assurance that there has been or will be established in or for the area with respect to which such grant is sought, an area emergency medical services planning council pursuant to the provisions of section 636;

"(b) proposals for programs (carried out in coordination with education and training programs assisted under titles III, VII, VIII, and IX of this Act and in a manner consistent with the appropriate provisions of such title) for the training and continuing education of health professionals and paraprofessionals (with priority for the recruitment and training of veterans of the Armed Forces of the United States with training or experience in the health care field) in the provision of emergency medical services to victims of accident and sudden illness which education programs must meet criteria established by the Secretary in regulations and, in the case of the training of paraprofessionals, must include supervised clinical training for at least one-half of the program;

"(c) provision for a communications system includ-

ing, at least, a central, areawide communication network linked with other appropriate area, State, and national networks, and with maximum accessibility for the public through a universal emergency telephone number and other means, which system shall allow transmission of information by voice, telemetry, or other electronic method and shall provide for cross-frequency patching capability;

"(d) provision for an emergency medical transportation system, which shall include such air and water borne transportation as is necessary to meet the individual characteristics of the area;

"(e) provision for the establishment of easily accessible, continuously operational fixed location emergency medical service facilities in sufficient numbers and situated at strategic locations in the area to meet the emergency medical services needs of the area;

"(f) provision for emergency access to specialized critical care units in the area, including provision for the necessary transportation systems for such access, and, where such resources are nonexistent or inadequate in the area, for access to such units in a neighboring area where access is feasible in terms of time and distance;

"(g) assurance that necessary emergency medical services, to the maximum extent feasible, shall be provided to all patients requiring services and shall be pro-

vided without prior inquiry as to, or regard to ability to pay;

"(h) provision for developing for submission for approval to the Secretary, within one year of receipt of funds under this part, a plan assuring an operational system for providing emergency medical services during mass casualties, natural disasters, or national emergencies;

"(i) provision for transfer to facilities and programs providing such followup care and vocational rehabilitation as is necessary to reflect the maximum recovery and restoration of the patient;

"(j) provision for a program of public education and information in the area served (taking into account the needs of visitors to the community to know or be able to learn immediately the means of obtaining emergency medical services), stressing appropriate methods of medical self-helps;

"(k) provision for periodic, comprehensive, and independent review and evaluation of the extent and quality of the emergency services provided in the area; and

"(l) provision for a standardized patient record-keeping system meeting standards established by the Secretary in regulations, which records shall cover the treatment of the patient, from initial entry into the sys-

tem through discharge from the emergency medical services system, and shall, to the maximum feasible extent, be consistent with ensuing patient records used in followup treatment and rehabilitation of the patient.

"AREA EMERGENCY MEDICAL SERVICES PLANNING COUNCIL

"SEC. 636. (a) The composition of the Area Emergency Medical Services Planning Council to be established in accordance with the plan submitted under section 635 shall include representatives of the State agency and appropriate areawide health planning agency or agencies (if any) established under section 314, of the regional medical program established under title IX of this Act in the area, of all public safety agencies having responsibilities within the area, of hospital councils, public, voluntary, and nonprofit private agencies, institutions, and organizations concerned with health or health education, of the local government or governments or units thereof exercising jurisdiction in the area, of uniformed services of the Federal Government operating installations in the area, of the Veterans' Administration medical facilities in the area, of communications networks, mass media, and public utilities, of firms, organizations, and other entities having responsibilities related to the provision of emergency medical services, and representatives of the gen-

eral public who are related to the provision of health care and who shall comprise at least one-third of the Council's voting membership.

"(b) The functions of such Council shall include development of a plan for areawide emergency medical services in consultation with the congruent areawide comprehensive health planning agency or agencies established pursuant to section 314(b), and shall include continuous monitoring and evaluation of the operation of the emergency medical service system with a view to making recommendations for the improved effectiveness of operation.

"INTERAGENCY TECHNICAL COMMITTEE ON EMERGENCY MEDICAL SERVICES

"SEC. 637. The Secretary shall establish an Interagency Technical Committee on Emergency Medical Services which shall be responsible for coordinating those aspects and resources of all Federal programs and activities relating to emergency medical services to assure the adequacy and technical soundness of such programs and activities and to provide for the full communication and exchange of information necessary to maintain the necessary coordination and effectiveness of such programs and activities. The Secretary or his designee shall serve as Chairman of the Committee, which shall include appropriate scientific, medical, or technical representation from the Department of Transportation,

the Department of Justice, the Department of Defense, the Veterans' Administration, the National Science Foundation, the Office of Science and Technology, the Federal Communications Commission, the Office of Emergency Preparedness, and such other Federal agencies, and parts thereof, as the Secretary determines administer programs directly affecting emergency medical service functions or responsibilities.

"NATIONAL EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

"SEC. 638. (a) The Secretary shall establish a National Emergency Medical Services Advisory Council with which he shall consult on a continuing and regular basis in administering this part. The Council shall consist of the Secretary or his designee, who shall serve as Chairman, the Director of the National Institutes of Health, and the Administrator of the Health Services and Mental Health Administration in the Department of Health, Education, and Welfare, all other members of the Interagency Technical Committee established under section 637, and eighteen members appointed by the Secretary, nine of which appointed members shall be members of the general public who are not related to the provision of emergency medical services, and nine shall be individuals experienced in the provision or development of emergency medical services.

"(b) The functions of the Council shall be to review and

advise the Secretary through a subgroup which it shall appoint, on applications received for grants under this part and to make recommendations to the Secretary with respect to carrying out the provisions of this part.

"(c) Each appointed member of the Council shall be appointed for a term of four years, except that—

"(1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and

"(2) of the members first appointed after the effective date of this part, five shall be appointed for a term of four years, five shall be appointed for a term of three years, five shall be appointed for a term of one year, as designated by the Secretary at the time of the appointment. Appointed members may serve after the expiration of their terms until their successors have taken office.

"(d) A vacancy in the Council shall not affect its activities, and fifteen members of the Council shall constitute a quorum.

"(e) Members of the Council who are not officers or employees of the United States shall receive for each day they are engaged in the performance of the functions of the Council compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, including traveltime; and all members, while

so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703, title 5, United States Code, for persons in the Government service employed intermittently.

"SEC. 639. (a) No application for a grant or contract under this part shall be approved unless—

"(1) the State comprehensive health planning agency established pursuant to section 314(a) and the areawide health planning agency established pursuant to section 314(b) have had an opportunity to comment thereon, within ninety days of the submission to those agencies of copies of such application, and the applicant has submitted to the Secretary a reply to any such comments with a view toward accommodating any objectives by and remedying any differences with such agency or agencies.

"(2) the applicant agrees to maintain such records and make such reports to the Secretary as the Secretary requires as necessary to carry out the provisions of this part.

"PAYMENTS AND CONDITIONS

"SEC. 640. (a) Grants under this part shall be paid in advance or by way of reimbursement in such installments

and on such conditions as in the judgment of the Secretary will best carry out the provisions of this part.

"(b) Nothing in this part shall limit or otherwise restrict the use of funds which are granted under other provisions of this Act or other Federal law and which are available for the conduct of medical emergency transportation and service programs from being used in connection with programs assisted through grants under this part where the former programs meet the standards and criteria established by the Secretary under this part.

"(c) Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(d) No grants may be made under this part in support of an emergency medical service system except where all components of such system meet standards and criteria established in regulations by the Secretary after taking into account standards established by appropriate national professional or technical organizations.

"REPORTS

"SEC. 640A. The Secretary shall prepare and submit to the Congress, one year after enactment of this part and every year thereafter, a report on the administration of this part, which shall include an evaluation of the adequacy of the provision of emergency medical services throughout the

Nation and the extent to which the needs for such services is being adequately met through assistance under this part and otherwise and his recommendation for any legislation necessary to promote the provision of and provide emergency medical services throughout the Nation at a level adequate to meet such needs."

STATE ALLOTMENTS

SEC. 5. Section 602(a) of the Public Health Service Act is amended to read as follows:

"SEC. 602. (a) (1) For each fiscal year beginning after June 30, 1973, the Secretary shall make allotments to each State from the sums appropriated under subparagraph (1), (2), or (3) of paragraph (a) or under subsection (b) of section 601 for grants for construction of respectively—

"(A) public or other nonprofit facilities for long-term care,

"(B) public or other nonprofit outpatient facilities,

"(C) public or other nonprofit rehabilitation facilities, and

"(D) public or other nonprofit hospitals and public health centers. Each allotment shall be made on the basis of the population, the financial need, and the extent of the need for construction of facilities for which grants from the allotment are to be made of the respective States.

"(2) For each fiscal year beginning after June 30, 1973, the Secretary shall, in accordance with regulations, make allotments among the States for grants for modernization of the facilities referred to in section 601. Such allotments shall be made from the sums appropriated under paragraph (c) of section 601 and shall be made among the States on the basis of the population, the financial need, and the extent of the need for modernization of such facilities of the respective States.

"(3) If—

"(A) the allotment for any State under paragraphs (1) and (2) for any fiscal year for grants for construction or modernization of facilities described in any one of the clauses (A), (B), (C), and (D) of such paragraph is less than,

"(B) the amount of the allotment for grants for construction of facilities described in such clause for the fiscal year ending June 30, 1973, as computed under this subsection (as in effect prior to the date of the enactment of this paragraph) and subsection (b) (as in effect on and after such enactment) then such allotment shall be increased to that amount the total of the increase thereby required being derived by proportionately reducing the allotment to each of the remaining States under subsection (a) and the preceding para-

graphs of this subsection for grants for construction of facilities described in such clause but with such adjustments as may be necessary to prevent any such allotment of any such remaining States from being thereby reduced to less than that amount.".

LOAN LIMITATIONS

SEC. 6. (a) Part A of title VI of the Public Health Service Act is amended by adding at the end thereof the following new section:

"SEC. 611. In any fiscal year no loan guarantee may be made under this part and no agreement to make interest subsidy payments may be entered into under this title if the making of such guarantee or the entering into of such agreement which would cause the cumulative total of—

"(1) the principal of the loans guaranteed under this title in such fiscal year, and

"(2) the principal of the loans for which no guarantee has been made under this title and with respect to which an agreement to make interest subsidy payments is entered into under this title in such fiscal year, to exceed the amount of grant funds obligated under this title in such fiscal year; except that this paragraph shall not apply if the amount of grant funds obligated under this title in such fiscal year equals the sums appropriated for such fiscal year."

REGIONAL MEDICAL PROGRAM

SEC. 7. (a) Section 902 of such title is amended by inserting "(including area health education and service centers)" immediately after "regional medical program" in subsection (a).

(b) Title IX of such Act is further amended by adding at the end thereof the following new section:

"AREA HEALTH EDUCATION AND SERVICE CENTERS

"SEC. 911. (a) Notwithstanding limitations with regard to the diseases with which this title is concerned, the Secretary is authorized to make grants to and enter into contracts with regional medical programs for the purpose of developing area health education and service centers.".

(c) The title of title IX of the Public Health Service Act is amended to read as follows:

"TITLE IX—REGIONAL COOPERATIVE ARRANGEMENTS FOR EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATION TO IMPROVE HEALTH SERVICES AND MEDICAL CARE"

AVAILABILITY OF APPROPRIATIONS

SEC. 8. Notwithstanding any other provision of law, unless enacted after the enactment of this Act expressly in limitation of the provisions of this Act, funds appropriated for any fiscal year to carry out any program for which appropriations are authorized by the Public Health Service Act or the Mental Retardation Fund and Community Mental

Health Centers Construction Act of 1963 shall remain available for obligation and expenditure until the end of such fiscal year.

CONTINUATION OF SUPPORT OF NATIONAL HEALTH SURVEYS AND STUDIES

SEC. 9. Section 305 (d) is amended to read as follows:

"(d) There are authorized to be appropriated to carry out the purposes of this section $25,000,000 for the fiscal year ending June 30, 1973, and $25,000,000 for the fiscal year ending June 30, 1974.".

CONTINUATION OF ASSISTANCE FOR ALLIED HEALTH PROFESSIONS

SEC. 10. (a) Section 791 (a) (1) of the Public Health Service Act is amended to read as follows:

"SEC. 791. (a) (1) There are authorized to be appropriated for grants to assist in the construction of new facilities for training centers for allied health professions or replacement or rehabilitation of existing facilities for such centers $40,000,000 for the fiscal year ending June 30, 1973; $40,000,000 for the fiscal year ending June 30, 1974;".

(b) (1) Subsection (a) (1) of section 792 of such Act is amended to read as follows:

"SEC. 792. (a) (1) There are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1973; and $15,000,000 for the fiscal year ending June 30, 1974;".

(2) Subsection (b) of such section is amended to read as follows:

"(b) There are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1973; and $30,000,000 for the fiscal year ending June 30, 1974, for special improvement grants to assist training centers for allied health professions in projects for the provision, maintenance, or improvement of the specialized function which the center serves."

(3) Subsection (c) (1) of such section is amended to read as follows:

"(c) (1) There are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1973; and $30,000,000 for the fiscal year ending June 30, 1974, for grants and contracts for special projects under this subsection."

(c) Section 793 (a) of such Act is amended by striking out all of the first sentence through "1973" and inserting in lieu thereof the following:

"SEC. 793. (a) There are authorized to be appropriated $12,000,000 for the fiscal year ending June 30, 1973; and $12,000,000 for the fiscal year ending June 30, 1974; to cover the costs of traineeships for the training of allied health professions personnel to teach health service technicians or in any of the allied health professions to serve in any

of such positions in administrative or supervisory capacities or to serve in allied health professions specialties determined by the Secretary to require advanced training."

(d) Subsection (b) of section 794A of such Act is amended to read as follows:

"(b) For the purpose of carrying out the provisions of this section there are authorized to be appropriated $1,250,000 for the fiscal year ending June 30, 1973; and $1,250,000 for the fiscal year ending June 30, 1974;".

(e) Subsection (f) of section 794B of such Act is amended to read as follows:

"(f) There are authorized to be appropriated for the purpose of carrying out the provisions of this section $10,000,000 for the fiscal year ending June 30, 1973; and $10,000,000 for the fiscal year ending June 30, 1974;".

(f) Subsection (e) of section 794C of such Act is amended to read as follows:

"(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section $6,000,000 for the fiscal year ending June 30, 1973; and $6,000,000 for the fiscal year ending June 30, 1974;".

(g) The first sentence of subsection (c) of section 794D of such Act is amended to read as follows:

"(c) There are authorized to be appropriated to the Secretary for Federal capital contributions to student loan

funds pursuant to subsection (a) (2) (B) (i) $10,000,000 for the fiscal year ending June 30, 1973; and $10,000,000 for the fiscal year ending June 30, 1974, and there are also authorized to be appropriated such sums for the fiscal year ending June 30, 1975, and each of the two succeeding fiscal years as may be necessary to enable students who have received a loan for any academic year ending before July 1, 1974, to continue or complete their education."

STUDY OF COSTS OF EDUCATING STUDENTS IN THE VARIOUS ALLIED HEALTH PROFESSIONS

SEC. 11. (a) (1) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as "Secretary") shall arrange for the conduct of a study or studies to determine the national average annual per student educational cost of schools of the various allied health professions which lead to a certificate of degree or other appropriate evidence of completion of a course of training for practice in the various allied health professions.

(2) Such studies shall be completed and an interim report thereon submitted not later than March 30, 1974, and a final report not later than January 1, 1975, to the Secretary, the Committee on Labor and Public Welfare of the Senate, and the Committee on Interstate and Foreign Commerce of the House of Representatives.

(3) Such studies shall develop methodologies for as-

certaining the national average annual per student educational costs and shall, on such basis, determine such costs for school years 1972–1973, 1973–1974, and the estimated costs for school year 1974–1975 in the respective disciplines. The study shall also indicate the extent of variation among schools within the respective disciplines in their annual per student educational costs and the key factors affecting this variation. The studies shall employ the most recent data available from the allied health professional schools in the country at the time of the study.

(4) Such studies shall also describe national uniform standards for determining annual per student educational costs for each allied health professional school in future years and estimates of the cost to such schools of reporting according to these uniform standards.

(5) The report shall also include recommendations concerning how the Federal Government can utilize educational cost per student data to determine the amount of capitation grants under the Public Health Service Act to each allied health professional school.

(b) (1) The Secretary shall request the National Academy of Sciences to conduct such studies under an arrangement under which the actual expenses incurred by such Academy in conducting such studies will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the

Secretary shall enter into such an arrangement with such Academy for the conduct of such studies.

(2) If the National Academy of Sciences is unwilling to conduct one or more of such studies under such an arrangement, then the Secretary shall enter into a similar arrangement with other appropriate nonprofit private groups or associations under which such groups or associations will conduct such studies and prepare and submit the reports thereon as provided in subsection (a) (2).

PART B—AMENDMENT TO THE MENTAL RETARDATION FACILITIES AND COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION ACT

COMMUNITY MENTAL HEALTH CENTERS

SEC. 12. (a) Section 201 of the Community Mental Health Centers Act is amended to read as follows:

"SEC. 201. There are authorized to be appropriated for grants for facilities of public and other nonprofit community mental health centers under this title $100,000,000 for the fiscal year ending June 30, 1973; $40,000,000 for the fiscal year ending June 30, 1974; and $50,000,000 for the fiscal year ending June 30, 1975;".

(b) Section 207 of such Act is amended to read as follows:

"SEC. 207. No grant may be made under any provision of the Public Health Service Act for any fiscal year, for

construction of any facility described in this title unless the Secretary determines that funds are not available, under this title to make a grant for the construction of such facility.".

(c) Section 224 (a) of such Act is amended to read as follows: "There are hereby authorized to be appropriated to enable the Secretary to make initial grants to community mental health centers, under the provisions of this part, $60,000,000 for the fiscal year ending June 30, 1973; $90,000,000 for the fiscal year ending June 30, 1974; and $100,000,000 for the fiscal year ending June 30, 1975. For the fiscal year ending June 30, 1973, and each of the thirteen succeeding fiscal years there are hereby authorized to be appropriated such sums as may be necessary to make grants to such centers which have previously received a grant under this part and are eligible for such a grant by the year for which sums are being appropriated under this sentence.".

(d) Section 247 (d) of such Act is amended to read as follows:

"(d) To carry out the purposes of this section there are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1974; and $60,000,000 for the fiscal year ending June 30, 1974; and $60,000,000 for the fiscal year ending June 30, 1975."

(e) Section 271 (d) of such Act is amended to read as follows:

"(d) (1) There are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1973; $45,000,000 for the fiscal year ending June 30, 1974; and $55,000,000 for the fiscal year ending June 30, 1975; for grants under this part for facilities and for initial grants under this part for compensation of professional and technical personnel and for training and evaluation under section 272.

"(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1974, and for each of the next eight fiscal years such sums as may be necessary to continue to make grants with respect to any project under this part for which an initial staffing grant was made from appropriations under paragraph (1) for any fiscal year ending before July 1, 1975."

(f) Section 256 (e) of such Act is amended to read as follows:

"(e) There are authorized to be appropriated to carry out this section $35,000,000 for the fiscal year ending June 30, 1973; $65,000,000 for the fiscal year ending June 30, 1974; and $70,000,000 for the fiscal year ending June 30, 1975;".

(g) (1) Section 220 (b) is amended by striking in

paragraph (1) the word "four" immediately after the word "next" and inserting in lieu thereof "twelve".

(2) Paragraph (2) of such subsection is amended by striking the word "three" immediately after the word "next" and inserting in lieu thereof "twelve".

(3) Such subsection is further amended by adding at the end thereof the following new paragraph:

"(3) In any year where funds appropriated do not reach the level required to fully further applications for assistance under paragraphs (1) and (2), the Secretary shall distribute the funds available as follows: 30 per centum for applicants under paragraph (1) and 70 per centum for applicants under paragraph (2)."

(h) (1) Section 220(a) of such Act is amended by striking the words "of professional and technical personnel" and inserting in lieu thereof the words "for operational costs".

(2) The caption for part B of such Act is amended to read as follows:

"PART B—GRANTS FOR INITIAL COSTS OF OPERATION OF CENTERS".

(i) Section 220 of such Act is further amended by adding at the end thereof the following:

"(d) Notwithstanding subsection (b) of this section, the Secretary may make additional grants to each center

equal to 5 per centum of such costs, which maintains a bona fide program under parts, C, D, F, and G, for each such program. In no case shall grants exceed 100 per centum of such costs for any project."

(i) Section 221 (a) of such Act is amended by adding immediately after paragraph (5) the following new paragraphs:

"(6) the services to be provided by the center are made available to any health maintenance or health service organization if in the catchment area for such center;

"(7) such center has a program whereby it screens, and where practicable provides treatment for, persons within its catchment area, who are civilly committed to a State mental health facility;

"(8) such center has a program for the followup care of persons within its catchment area, who are discharged from a State mental health facility."

(j) Part C of such Act is amended by adding at the end thereof the following new section:

"SEC. 248. No application for a grant under this part for a program to provide services for persons in an area in which is located a facility constructed as a new facility after the date of enactment of this section with funds provided under a grant under part A of this title of this Act

shall be approved unless such application contains satisfactory assurance that, to the extent feasible, such program will be included as part of the programs conducted in or through such facility.".

(k) Part B of such Act is amended by adding at the end thereof the following new section:

"SEC. 225. (a) In the case of any community mental health center, alcoholism prevention and treatment facility, specialized facility for alcoholics, treatment facility for narcotic addicts, and other persons with drug abuse and drug dependence problems, or facility for mental health of children, to which a grant under part B, C, D, or F, as the case may be, is made from appropriations for any fiscal year beginning after June 30, 1970, to assist it in meeting a portion of the costs of compensation of professional and technical personnel who provide consultation services, the Secretary may, with respect to such center or facility, make a grant under this section in addition to such other staffing grant for such center or facility.

"(b) A grant under subsection (a) with respect to a center or facility referred to in that subsection—

"(1) may be made only for the period applicable to the staffing grant made under part B, C, D, or F, as the case may be, with respect to such center or facility; and

"(2) may not exceed whichever of the following is

the lower: (A) 15 per centum of the costs with respect to which such other staffing grant is made, or (B) that percentage of such costs which when added to the percentage of such costs covered by such other staffing grant equals 100 per centum.

"(c) For the purposes of making initial grants under this section, there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1973, $5,000,000 for the fiscal year ending June 30, 1974, and $5,000,000 for the fiscal year ending June 30, 1975."

MENTAL HEALTH OF THE ELDERLY

SEC. 13. The Community Mental Health Centers Act is amended by adding at the end thereof the following new part:

"PART G—MENTAL HEALTH OF THE ELDERLY

"GRANTS FOR TREATMENT FACILITIES

"SEC. 281. (a) Grants from appropriations under section 282(a) may be made to public or nonprofit private agencies and organizations (1) to assist them in meeting the costs of construction of facilities to provide mental health services for the elderly within the States, and (2) to assist them in meeting a portion of the costs (determined pursuant to regulations of the Secretary) of compensation of professional and technical personnel for the operation of a facility for mental health of the elderly constructed with a grant

made under part A of this part or for the operation of new services for mental health of the elderly in an existing facility.

"(b) (1) Grants may be made under this section only with respect to (A) facilities which are part of or affiliated with a community mental health center providing at least those essential services which are prescribed by the Secretary, or (B) where there is no such center serving the community in which such facilities are to be situated, facilities with respect to which satisfactory provision (as determined by the Secretary) has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of mental health problems of the elderly.

"(2) The grant program for construction of facilities authorized by subsection (a) shall be carried out consistently with the grant program under part A, except that the amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of $66\frac{2}{3}$ per centum (or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area), as the Secretary may determine.

"(c) Grants made under this section for costs of compensation of professional and technical personnel may not exceed the percentages of such costs, and may be made only

for the periods prescribed for grants for such costs under section 242.

"(d) (1) There are authorized to be appropriated $20,000,000 for the fiscal year ending June 30, 1973; $30,000,000 for the fiscal year ending June 30, 1974; and $40,000,000 for the fiscal year ending June 30, 1975, for grants under this part for facilities and for initial grants under this part for the compensation of operating expenses and for training and evaluation grants under section 282.

"(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1974, and each of the next eight fiscal years, such sums as may be necessary to continue to make grants with respect to any project under this part for which an initial staffing grant was made from appropriations under paragraph (1) for any fiscal year ending before July 1, 1975.

"TRAINING AND EVALUATION

"SEC. 282. The Secretary is authorized, during the period beginning July 1, 1973, and ending with the close of June 30, 1975, to make grants to public or nonprofit private agencies or organizations to cover part or all of the cost of (1) developing specialized training programs or materials relating to the provision of services for the mental health of the elderly; or developing inservice training or short-term or refresher courses with respect to the provisions

of such services; (2) training personnel to operate, supervise, and administer such services; and (3) conducting surveys and field trials to evaluate the adequacy of the programs for the mental health of the elderly within the several States with a view to determining ways and means of improving, extending, and expanding such programs."

92D CONGRESS
2D SESSION

S. 3716

A BILL

To amend the Public Health Service Act to provide for continued assistance for health facilities, health manpower, and community mental health centers.

By Mr. KENNEDY, Mr. CRANSTON, Mr. EAGLETON, Mr. JAVITS, Mr. MONDALE, Mr. NELSON, Mr. SCHWEIKER, Mr. STAFFORD, Mr. STEVENSON, and Mr. WILLIAMS

JUNE 16, 1972
Read twice and referred to the Committee on Labor and Public Welfare

COTH LUNCHEON & BUSINESS MEETING

Friday, November 2

12:00 p.m. — COTH Luncheon

1:30 - 2:30 p.m. — COTH Institutional Membership Business Meeting

Presiding: George E. Cartmill
Chairman, COTH 1971-72

2:30 - 5:00 p.m. — COTH General Session

Presiding: Leonard W. Cronkhite, Jr., M.D.

Theme:

"External Fiscal Controls On The Teaching Hospital"

- The Philadelphia Experience

  H. Robert Cathcart
  President
  The Pennsylvania Hospital
  Philadelphia, Pennsylvania

- The New York State Experience

  Thomas L. Hawkins, Jr., M.D.
  Executive Vice President and Director
  Albany Medical Center Hospital
  Albany, New York

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

June 5, 1972

H. Robert Cathcart
Vice President
The Pennsylvania Hospital
8th and Spruce Streets
Philadelphia, Pennsylvania 19107

Dear Bob:

I am very pleased to learn from George Cartmill, COTH Administrative Board Chairman, that you have accepted his invitation to present one of two principal papers at the COTH General Session during the Annual Meeting of the Association of American Medical Colleges, to be held at the Fountainbleau Hotel in Miami from Thursday, November 2 to Monday, November 6, 1972. The COTH General Session is scheduled for Friday, November 3 from 2:00 p.m. to 4:30 p.m.

In discussing the theme for the COTH portion of the meeting, there was agreement among Administrative Board members that the recent experiences in Philadelphia and New York State with regard to hospital reimbursement are forerunners of what may happen elsewhere in the country and therefore would be of most current interest to COTH membership and other attendees at the meeting. Thus, the following title for the program was selected:

"External Fiscal Controls On The Teaching Hospital"

- The Philadelphia Experience
- The New York State Experience

Thomas L. Hawkins, Jr., M.D., Executive Vice President and Director, Albany Medical Center Hospital has agreed to describe events as they took place in New York State.

We would like to plan that each of the presentations would be thirty to forty minutes in length to be followed by discussion from the floor. It would be our hope that the presentation would set forth the environment in which early negotiations occurred, the role of all parties concerned, the central issues involved, and the present and future implications of current conditions. Additionally, a retrospective view of the process in terms of what advice and counsel might be given colleagues throughout the country approaching similar circumstances would be very helpful.

In order that we can proceed with our plans, I'd be appreciative if you would ask your secretary to send a copy of your Curriculum Vitae and a glossy personal photograph. I would also appreciate receiving an advance copy of your paper when it is completed.

I am enclosing an expense voucher for your use in connection with attendance at the meeting. Advance hotel reservations will be taken care of from this office.

I will keep you informed of any further details as plans for the meeting move forward. If you have any questions or if I can be helpful in any way, please let me know.

Sincerely,

RICHARD M. KNAPP, PH.D.
Director
Division of Teaching Hospitals

RMK:car

Encl.

cc: George E. Cartmill

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

June 5, 1972

Thomas L. Hawkins, Jr., M.D.
Executive Vice President and Director
Albany Medical Center Hospital
New Scotland Avenue
Albany, New York 12208

Dear Dr. Hawkins:

I am very pleased to learn from Irvin Wilmot, Immediate Past Chairman of the COTH Administrative Board, that you have accepted his invitation to present one of two principal papers at the COTH General Session during the Annual Meeting of the Association of American Medical Colleges, to be held at the Fountainbleau Hotel in Miami from Thursday, November 2, to Monday, November 6, 1972. The COTH General Session is scheduled for Friday, November 3 from 2:00 to 4:30 p.m.

In discussing the theme for the COTH portion of the meeting, there was agreement among Administrative Board members that the recent experiences in New York State and Philadelphia with regard to hospital reimbursement are forerunners of what may happen elsewhere in the country and therefore would be of most current interest to COTH membership and other attendees at the meeting. Thus, the following title for the program was selected:

"External Fiscal Controls On The Teaching Hospital"

- The Philadelphia Experience
- The New York State Experience

H. Robert Cathcart, Vice President, The Pennsylvania Hospital has agreed to describe events as they took place in Philadelphia.

We would like to plan that each of the presentation would be thirty to forty minutes in length to be followed by discussion from the floor. It would be our hope that the presentation would set forth the environment in which early negotiations occurred, the role of all parties concerned, the central issues involved, and the present and future implications of current conditions. Additionally, a retrospective view of the process in terms of what advice and counsel might be given colleagues throughout the country approaching similar circumstances would be very helpful.

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Sincerely,

RICHARD M. KNAPP, PH.D.
Director
Division of Teaching Hospitals

RMK:car

Encl.

cc: Irvin G. Wilmot

Joint Session of
The Council of Deans
with
Officers of the Veterans Administration,
Department of Medicine and Surgery,
and Veterans Administration Hospital Directors

Thursday, November 2

THEME: The VA-Medical School Relationship: Current Concepts and New Directions

I. Selection and Appointment of Hospital Directors, Chiefs of Staff, and Service Chiefs

II. Extension of VA-Educational Programs

- New Medical Schools
- New Support for Existing Programs
  - -Medical School Expansion on Clinical Campus
  - -Modernization of Facilities
- Area Health Education Centers

III. New VA Programs and Mechanisms of Health Care Delivery

- Ambulatory Care
- Extension of Care to Dependents
- VA as a Community Health Resource
- VA Participation in HMO Arrangements
- The Contract Mechanism - Its Use and Limitations

Note: Briefing Sheets will be provided on current legislation of interest and on the VA FY 73 budget.

7-10-72

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SERVICE EDUCATION RESEARCH

INTER-OFFICE MEMO

Retain – 6 mos. ☐
1 yr. ☐
5 yrs. ☐
Permanently ☐
Follow-up Date

DATE July 10, 1972

TO: FOR THE RECORD

FROM: John A. D. Cooper, M.D.

SUBJECT: Telephone conversation with Mr. Mike Bromberg, Federation of American Hospitals

I received a telephone call today from Mr. Mike Bromberg who is with the Federation of American Hospitals--the national organization representing proprietary hospitals.

The Federation had received a letter of inquiry from the St. Joseph Infirmary, Louisville, Kentucky about our letter to the hospital concerning their status as members of the COTH. The hospital had apparently asked the Federation to intercede with us and to try to set up a meeting with the AAMC to discuss the membership problem. I explained to Mr. Bromberg that our lawyer had advised us that only organizations holding the 501(c)(3) classification could be voting members in the Association. Mr. Bromberg said that he would ask his legal counsel to give an opinion and would send it along to us for transmittal to our legal counsel. Apparently, the St. Joseph Infirmary wishes some sort of a meeting on this matter.

Mr. Bromberg also told me about management contracts which were being entered into with hospitals that are members of COTH. I told him that the hospital's status was the important matter, and that if it retained its 501(c)(3) status, it could continue to be a member of COTH.

COPIES TO: Dr. Richard Knapp ✓
Mr. Jack Myers

PROPOSED STATEMENT ON A PATIENT'S BILL OF RIGHTS

Approved by Committee on Health Care for the Disadvantaged
April 28, 1972

The American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for both the patient and the hospital. Further, the Association presents these rights in the expectation that they will be defended by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for proper medical care delivery. The patient in a hospital setting, however, has a dual relationship with the physician and the institution involved. It is in recognition of this fact that these rights have been developed.

1. The patient has the right to considerate and respectful treatment.

2. The patient has the right to complete current information concerning his diagnosis, treatment, and prognosis in terms of his understanding. He has the right to know by name the physician responsible for coordinating his care.

3. The hospital and physician must have the informed consent of the patient prior to treatment. Such information should include, but not necessarily be limited to, the specific treatment to be used, other possible treatments and the reason for the one selected, the risks involved, the time of incapacitation, and the name of the person responsible for treatment.

4. The patient has the right to refuse treatment at any time, and the hospital is obligated to ensure taht he is informed of the medical consequences of such action.

5. The patient has the right to privacy concerning his own medical care program. Case discussion, information, examination, and treatment are to be confidential. Those not directly involved must have the permission of the patient to be present.

6. All communications and records between the patient and the hospital should be confidential.

7. Within its capacity, the hospital must respond to the request of a patient for services. The hospital must provide evaluation, treatment, and/or referral as indicated by the urgency of the case. When medically indicated, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer.

8. The patient should be informed of the relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to know the professional relationships among all individuals, by name, who are treating him.

9. The patient has the right to know whether or not the hospital engages in clinical research, and he has the right to refuse to participate in such research projects.

10. The patient has the right to know in advance what appointment times are available. Whoever the patient sees at the appointed time, he has the right to expect continuity of care.

11. The hospital must provide a mechanism whereby the patient is informed of his continuing health care requirements following discharge.

12. The patient has the right to examine his bill.

13. The patient has the right to know what hospital rules and regulations are which are applicable to his conduct as a patient.

No legalistic catalogue of rights can, however, guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

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15 May 1972

Mr. George E. Cartmill, Jr., President
Harper Hospital
3825 Brush Street
Detroit, Michigan 48201

Dear George:

As you know, I have contemplated leaving the University of Colorado for several months. I have recently accepted the position of President of the Charleston Area Medical Center in West Virginia.

This consortium of hospitals is eligible for membership in the Council of Teaching Hospitals under the present criteria, but inasmuch as we had declared a moratorium on the acceptance of new members, I feel that it will be necessary for me to resign from the administrative board. It is my hope in time to meet whatever new criteria evolve for membership and become active once again in COTH.

George, I have very much enjoyed the association with you men and with the Council.

I certainly want to wish you the very best and if I can be of any service to you, do not hesitate to let me know.

Sincerely yours,

Don L. Arnwine
Director of Hospitals

cc: Richard Knapp, Ph.D.

DISCONTINUATION OF THE FEBRUARY MEETING, FUTURE EXECUTIVE COUNCIL MEETING DATES

ACTION: The Executive Council voted:

1. that the Assembly discontinue its semi-annual meeting, and meet once a year at the Annual Meeting; a special meeting of the Assembly may be called (as specified in the AAMC Bylaws) should the need be determined;

2. that the Councils (and OSR) work with staff in planning Spring meetings at a date and place of their choice;

3. that the Executive Council meet on the following dates during the coming year:

December 15, 1972
March 16, 1973
June 22, 1973
September 14, 1973

HOSPITAL ADMINISTRATORS WHO HAVE PARTICIPATED IN AN LCME MEDICAL SCHOOL ACCREDITATION VISIT

1.	Don L. Arnwine President Charleston Area Medical Center Charleston, West VA	University of California San Francisco Campus	1/71
2.	Samuel P. Asper Administrator Johns Hopkins Hospital Baltimore, MD	Mayo Graduate School of Medicine	9/71
3.	Ernest N. Boettcher, M.D. Director St. Louis University Hospitals 1325 South Grand Boulevard St. Louis, MO 63104	Creighton University Boston University University of California Irvine	1/68 2/70 4/71
4.	George E. Cartmill President Harper Hospital 3825 Brush Street Detroit, Michigan 48201	Dartmouth Medical School	2/72
5.	H. Robert Cathcart Vice President The Pennsylvania Hospital 8th and Spruce Streets Philadelphia, PA	The University of Texas Medical Branch at Galveston	1/70
6.	Joe S. Greathouse, Jr. Director Vanderbilt University Hospital 1161 21st Avenue South Nashville, Tennessee 37203	Northwestern University	1/70
7.	T. Stewart Hamilton, M.D. President and Executive Director Hartford Hospital 80 Seymour Street Hartford, Connecticut 06115	Dartmouth Louisiana State University University of Kentucky State University of New York Downstate Medical Center	10/68 2/70 4/71 4/72
8.	Bernard J. Lachner Vice President for Administration Ohio State University 190 N. Oval Drive Columbus, Ohio 43210	Medical University of South Carolina	1/71

9.	Matthew F. McNulty, Jr. Vice President for Medical Center Affairs Georgetown University Medical Center 3700 Reservoir Road, NW Washington, D.C. 20007	Washington University Mount Sinai School of Medicine University of North Carolina	3/68 3/70 3/71
10.	Gerald W. Mungerson General Director Boston Hospital for Women 221 Longwood Avenue Boston, Massachusetts 02115	University of Utah	3/70
11.	Stuart M. Sessoms, M.D. Director Duke University Medical Center PO Box 3708 Durham, North Carolina 27706	Saint Louis University University of Puerto Rico	10/69 2/71
12.	John H. Westerman Director University of Minnesota Hospitals 412 Union Street SE Minneapolis, Minnesota 55455	West Virginia University	12/69
13.	John Stagl Executive Vice President Passavant Memorial Hospital 303 E. Superior Street Chicago, IL 60611	Texas Tech University School of Medicine at Lubbock Creighton University	8/71 3/72
14.	David B. Wilson Assistant Director of the Medical Center University of Mississippi School of Medicine 2500 N. State Street Jackson, Mississippi 39216	Georgetown Meharry Medical College The University of Texas Medical School at Houston	3/69 3/70 10/71
15.	John V. Sheehan, Ph.D. Hospital Director Veterans Administration Hospital First Avenue at E 24th Street New York, New York 10011	Rush Medical College	3/72
16.	Cecil G. Sheps, M.D. Vice Chancellor Health Sciences The University of North Carolina School of Medicine Chapel Hill, North Carolina 27514	The Chicago Medical School	4/69

17.	Peter Rogatz, M.D. Director University Hospital State University of New York at Stony Brook Stony Brook, New York 11790	Medical College of Pennsylvania	3/70
18.	Lad F. Grapski President Allegheny General Hopsital 320 E. North Avenue Pittsburgh, PA 15212	Medical College of Wisconsin	9/68