

AGENDA

COTH ADMINISTRATIVE BOARD
Thursday, November 2, 1972
Hotel Fontainbleau
Champange Room
3:00 p.m. - 5:30 p.m.

- I. Call to Order - 3:00 p.m.
- II. Approval of Minutes, Meeting of August 6, 1972 TAB A
- III. Membership TAB B
 A) Pending Applications TAB C
 B) Other Membership Problems
- IV. COTH Nominating Committee Report - Mr. Wilmot
- V. Meetings During The Coming Year TAB D
 A) Administrative Board Meetings
 B) Spring Regional Meetings
 C) Other Special Meetings
- VI. Committee Reports TAB E
 A) VA Sharing Task Force - Mr. Greathouse TAB F
 B) RMP/CHP Committee - Dr. Sessoms TAB G
 C) Subcommittee on Quality - Dr. Weiss TAB H
 D) Task Force On Graduate Medical Education
 And Faculty Practice Plans - Mr. Womer
- VII. Legislative Report TAB I
- VIII. New Business
- IX. Adjournment

COTH ADMINISTRATIVE BOARD MEETING
PDR 5
Palmer House
Chicago, Illinois
August 6, 1972

PRESENT:

George E. Cartmill, Chairman
Leonard W. Cronkhite, Jr., M.D., Chairman-Elect
Irvin G. Wilmot, Immediate Past Chairman
Robert A. Derzon
Joe S. Greathouse, Jr.
Arthur J. Klippen, M.D.
Sidney Lewine
Russell A. Nelson, M.D.
Roy S. Rambeck
Stuart M. Sessoms, M.D.
David D. Thompson, M.D.
Thomas H. Ainsworth, Jr., M.D., AHA Representative

STAFF:

John A. D. Cooper, M.D.
Grace W. Beirne
Robert H. Kalinowski, M. D.
Richard M. Knapp, Ph.D.
Catharine A. Rivera

I. Call to Order:

Mr. Cartmill called the meeting to order at 9:00 a.m. in Private Dining Room 5 of the Palmer House.

III. Consideration of Minutes:

The minutes of the meeting of May 18, 1972 were approved as distributed.

III. Report of the COTH Ad Hoc Membership Committee:

Mr. Wilmot reported on the meeting of the COTH Ad Hoc Membership Committee held in New York City on June 16, 1972. It was recommended that paragraph 3 on

on page 3 of the Report be changed to read as follows:

"The Committee holds that membership in the Council of Teaching Hospitals of the AAMC should be determined and interpreted solely for the purpose of advancing the objectives of COTH and its constituent members. The current request for classification of hospitals within COTH arises from the new practice by various agencies of classifying teaching hospitals for reimbursement purposes. The Committee believes that it is an error to use membership, or a category of membership in COTH, for such purposes. It is therefore recommending that no attempt be made to do so in the future until and unless such an effort serves the purpose of advancing the objectives of the Council of Teaching Hospitals and its constituent members."

Two specific recommendations are contained in the Report. Appendix A, entitled "Differential Characteristics of Teaching Hospitals," was approved as presented. A discussion then ensued concerning Appendix B which recommended changes in the current criteria for membership in COTH. Following discussion, there was general agreement that since the distinction between undergraduate and graduate education is becoming increasingly "blurred," reference in the criteria for medical school affiliation should be made to medical education generally, rather than specifying undergraduate or graduate education.

Specific changes in Appendix B are as follows:

Page 1, number (1) Under Eligibility
Strike "undergraduate"

Page 2, Paragraph 1, Sentence 2
After "children's" insert "and such other specialty"

Strike "graduate" and "undergraduate"

Page 2, Paragraph 2
Strike "graduate"

The Report as modified appears as Appendix A to these minutes.

ACTION #1 IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH AD HOC MEMBERSHIP REPORT, AND THE RECOMMENDATIONS CONTAINED THEREIN, BE APPROVED AS MODIFIED. THE ADMINISTRATIVE BOARD RECOMMENDS THIS REPORT BE FORWARDED TO THE COTH INSTITUTIONAL MEMBERSHIP, AAMC EXECUTIVE COUNCIL AND AAMC ASSEMBLY TO BE ADOPTED AS AAMC POLICY.

IV. Current Status Of The AAMC Committee On Financing Medical Education:

Dr. Cooper reported on the current status of the AAMC Committee on Financing Medical Education. He stated that there was increasing concern about continuing the present approach - that is, to present as a separate set of numbers identified as the real cost of undergraduate medical education. Essentially, the magnitude of dollars and effort devoted to undergraduate medical education is not large enough to encompass or account for the size of the financial problems being experienced. In other words, this group of institutions is not in financial difficulty due solely to the undergraduate medical education process. Thus, the Report in October will view the matter in a much larger context.

Specifically, it was agreed at a recent meeting on July 11 that:

The Committee's report to the Assembly will seek to establish the view of the Association concerning (1) the complexity of the medical education process -- the interrelatedness of the elements that are integral to that process (instruction, research, service); (2) the indivisibility of that process, beginning with the curriculum leading to the M.D. degree through the years of internship and residency; (3) that only upon the completion of this continuum can the national objectives to increase the number of persons capable of performing the functions of physicians in the delivery of health care be satisfied.

The report will therefore stress the essentially arbitrary nature of efforts to establish estimates of the cost of undergraduate medical education, since this is a discrete concept only in the sense that a degree is awarded upon its completion and not in terms of the preparation of an individual for the independent practice of medicine.

However, because of pressures for such estimates, the Association will present a set of preliminary figures, for consideration as a guide to the

probable costs of this segment of the continuum - to be followed by more definitive views of the entire medical education process, its costs, and financing, in the context of the broad range of activities of the contemporary medical center complex.

Dr. Cooper stated that the question which most likely is of greatest concern to COTH is the patient care cost component of medical education. Dr. Anlyan is Chairman of a Task Force which is reviewing this question. Chuck Womer from Yale is the COTH representative on this Task Force. A staff paper prepared for use by the Task Force entitled, "Medical Education -- The Patient Care Cost Component," is attached as Appendix B to these minutes.

An intensive discussion took place concerning the staff paper, with the following points being made:

- when students participate in the patient care process, productivity is frequently decreased with a subsequent decrease in revenue which is difficult to state in cost accounting terms;
- the third component in the staff paper should definitely be excluded; if the cost allocation methodology is pursued, it should be done on an incremental rather than a joint cost basis;
- it may not be wise or possible to prospectively set forth specific program costs, since the diversity of arrangements and scope of programs in the medical centers could be threatened by a single cost accounting approach to the problem;

- the matter of public statements concerning educational costs must be carefully reviewed, since the third party payors will use to advantage any statement which implies that patient care dollars are being used to support certain educational programs.

Dr. Cooper suggested that the sense of the Administrative Board's discussion be communicated to Dr. Anlyan's Task Force, and that the COTH officers serve as ex officio members to that Task Force as well as the overall Financing Committee.

V. "Resolution On The Representation Of Basic And Clinical Scientists In Academic Health Centers"

This item was initiated by the Council of Academic Societies, and referred for action by the AAMC Executive Council. The statement was reviewed and briefly discussed.

ACTION #2 IT WAS MOVED, SECONDED AND CARRIED THAT THE ADMINISTRATIVE BOARD OF THE COUNCIL OF TEACHING HOSPITALS ENTHUSIASTICALLY SUPPORT THE "RESOLUTION ON THE REPRESENTATION OF BASIC AND CLINICAL SCIENTISTS IN ACADEMIC HEALTH CENTERS." PARTICIPATION BY BASIC SCIENTISTS IN HOSPITAL ACTIVITIES HAS BEEN INCREASING STEADILY. THEIR CONTRIBUTION TO HOSPITAL LABORATORIES AND RADIOLOGY DEPARTMENTS HAVE BEEN LONG-LASTING AND OF INCREASING IMPORTANCE. NEWER DEVELOPMENTS IN BOTH DIAGNOSTIC AND THERAPEUTIC UNITS, SUCH AS NUCLEAR MEDICINE, HEMODIALYSIS, PATIENT MONITORING

ACTION #2 ...

AND CARDIAC SURGERY, HAVE INVOLVED SUBSTANTIAL PARTICIPATION ON THE PART OF BASIC SCIENTISTS. IN ADDITION, BASIC SCIENTISTS PLAY AN ESSENTIAL ROLE IN THE FUNCTION OF COMMITTEES WHICH MONITOR CERTAIN PROFESSIONAL ACTIVITIES OF HOSPITALS, SUCH AS THE INFECTIONS COMMITTEE, THE RADIATION SAFETY COMMITTEE, AND THE COMMITTEE ON HUMAN INVESTIGATIONS.

SINCE THE TEACHING HOSPITAL WILL GAIN IN INCREASED CAPABILITY OF ITS CLINICAL, TEACHING, AND INVESTIGATIVE FUNCTIONS THROUGH FURTHER INTEGRATION OF THE BASIC MEDICAL SCIENTISTS INTO THE HOSPITAL PROGRAM, THE COUNCIL OF TEACHING HOSPITALS WELCOMES THE ACTIONS CONTEMPLATED IN THE RESOLUTION WHICH WILL FURTHER THIS RESULT.

VI. Health Services Advisory Committee Activities:

Dr. Kalinowski reported that the Advisory Committee met on May 31, 1972. A final report on the HMO contract has been submitted to HSMHA. An editorial board has been established to review presentations at the eight regional workshops for publication, possibly as a supplement to the Journal of Medical Education. A new eighteen month contract has been signed, the purpose of which is to plan and carry out activities directed toward the development of at least five HMO's in university medical centers.

Three general areas were recommended by the Advisory Committee as programs which should be initiated during the coming year:

- (1) projects directed toward upgrading the performance of hospital out-patient departments;

- (2) activities related to primary care education programs, particularly as they might be developed in HMO's;
- (3) efforts which would serve to bring about more analytical attention to the problems of measuring the quality of health services.

Dr. Kalinowski stated that the staff is visiting a number of institutions which are making concerted efforts to improve the quality of care provided in outpatient departments. Concerning primary care, discussions have been held with the Bureau of Health Manpower in an attempt to generate interest in primary care educational programs and the possibility of funding some projects in concert with HMO's and other primary care efforts.

A subcommittee of the Health Services Advisory Committee has been appointed to study quality of care issues and methodologies, and is scheduled to meet on September 28-29. Members of the subcommittee are as follows:

Robert J. Weiss, M.D., Chairman
Associate Dean for Health Care Programs
Harvard Medical School

David R. Challoner, M.D.
Vice Chairman of Medicine
Indiana University Medical Center

Christopher C. Fordham III, M.D.
Dean
University of North Carolina
School of Medicine

Richard L. Meiling, M.D.
Vice President for Medical Affairs
The Ohio State University
College of Medicine

John H. Westerman
Director
University of Minnesota Hospitals

VII. Report of the RMP/CHP Committee:

Dr. Sessoms, Chairman of the Committee, reported that the group had its first meeting on June 15. Other members of the committee are:

Andrew D. Hunt, Jr., M.D.
Dean
College of Human Medicine
Michigan State University

William S. Jordan, Jr., M.D.
Dean
University of Kentucky
College of Medicine

Alexander M. Schmidt, M.D.
Dean
The Abraham Lincoln School of Medicine

William H. Stewart, M.D.
Chancellor of the Medical Center
Louisiana State University

James V. Warren, M.D.
Chairman
Department of Medicine
The Ohio State University

William R. Willard, M.D.
Dean
College of Community Health Sciences
The University of Alabama

Dr. Sessoms pointed out that the RMP and CHP legislative authority will expire on June 30, 1973. Consequently, it is important that the AAMC be prepared to state its position when the time arises. Three general questions are being pursued:

- how do RMP and CHP presently function, and how are these programs affecting the AAMC constituency?
- in what fashion do we think RMP and CHP should perform, and how should they relate to the AAMC constituency?

- what action, legislative or administrative, is necessary to achieve these goals?

The staff is visiting situations where it is reported that RMP and CHP are integrating objectives and staff to achieve a common goal. In addition, various regional and national administrators of these programs are being contacted for their views on the question. The next meeting is scheduled for September 6-7, 1972, when Dr. Wilson, Administrator of HSMHA, Dr. Margulies, RMP Chief, Mr. Janes, CHP Chief and Deputy Administrator Gerald Riso will be present to discuss the two programs with the Committee.

VIII. Current Status of NIRMP:

Dr. Cooper reported that with the current confusion regarding the status of the internship, as well as other matters, NIRMP is experiencing some difficulties in maintaining its function. Additionally, some specialty groups are not fully cooperating with the plan. He stated that various procedural alternatives for improving the effectiveness of the plan were being discussed and he asked for suggestions.

One specific suggestion offered was that no hospital be allowed to accept a student that has already signed with another hospital under penalty that the latter hospital be dropped from participation in NIRMP. The Board members stated that they would work in their own hospitals toward discouraging abuse of the system.

IX. Information Items:

Dr. Knapp reported briefly on the following information items:

- A. COTH Annual Meeting Program
- B. Special Annual Meeting Session with the Veterans Administration
- C. Memorandum Concerning St. Joseph Infirmary

- D. Proposed Statement on a Patient's Bill of Rights
- E. Resignation of Don Arnwine
- F. Discontinuation of the February Meeting of the AAMC Assembly
- G. Hospital Administrators who have participated in an LCME
Medical School Accreditation Visit
- H. Renewal of Hill Burton legislation

Concerning the Hill-Burton legislation two points were made by several members of the Board:

- the emphasis on the need for new and modernized ambulatory facilities should not be taken to the point where inpatient needs are completely excluded;
- the reference to facilities which provide the environment for manpower development should be strongly emphasized.

With the discontinuance of the February meeting of the AAMC Assembly, it was pointed out that the Council of Deans and Council of Academic Societies are planning spring sessions. There was a brief discussion of the question of whether COTH should follow suit. Tentative agreement of the Board was that no new meeting should be planned. However fuller discussion of the matter should take place at the November 2 meeting of the Board.

X. Adjournment:

There being no further new business, the meeting was adjourned at 2:30 p.m. The next meeting of the Board will be held on Thursday, November 2 in the Champagne Room of the Fontainbleau Hotel from 3:00 p.m. to 5:30 p.m.

APPENDIX A

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 the 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 Stanley 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 number and scope of allied health education programs sponsored by the hospital, or in which the hospital participates;
- (5) the volume of research undertaken;
- (6) the extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;
- (7) the nature and substance of the medical school affiliation arrangement;
- (8) the appointment of full-time salaried chiefs of service;
- (9) the number of other full-time salaried physicians;
- (10) the number of special service programs offered, e.g., neonatal care units, pediatric evaluation centers or renal dialysis units;
- (11) the level of complexity demonstrated by the diagnostic mix of patients;
- (12) the staffing pattern and ratios resulting from the distinctive patient mix;
- (13) the scope and intensity of laboratory and X-ray services;
- (14) 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.

The Committee holds that membership in the Council of Teaching Hospitals of the AAMC should be determined and interpreted solely for the purpose of advancing the objectives of COTH and its constituent members. The current request for classification of hospitals within COTH arises from the new practice by various agencies of classifying teaching hospitals for reimbursement purposes. The Committee believes that it is an error to use membership, or a category of membership in COTH, for such purposes. It is therefore recommending that no attempt be made to do so in the future until and unless such an effort serves the purpose of advancing the objectives of the Council of Teaching Hospitals and its constituent members.

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 selection 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 similarity, 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 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.

REQUIREMENT

(1) Approval by the COTH Administrative Board;

(2) Approval by the AAMC Executive Council

(3) Approval by the AAMC Assembly

PROCEDURE FOR APPLICATION

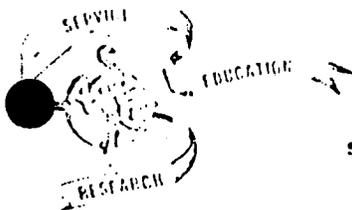
(1) Application by the hospital with an endorsement by the Dean of the affiliated school of medicine;

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, children's, and such other specialty hospitals which sponsor or participate in medical education and have institutional affiliations for the purpose of significant participation in medical education are eligible for COTH membership.

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



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPENDIX B

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.

Applications Received ---

COMMUNITY HOSPITAL OF INDIANAPOLIS, INC.
Indianapolis, Indiana

Received 3/7/72

Nomination by Glenn W. Irwin, Jr., M.D., Dean
Indiana U. School of Medicine

RIVERSIDE METHODIST HOSPITAL
Columbus, Ohio

Received 3/7/72

Self-nomination

THE WATERBURY HOSPITAL
Waterbury, Connecticut

Received 7/18/72

Nomination by Lewis Thomas, M.D., Dean
Yale University School of Medicine

VETERANS ADMINISTRATION HOSPITAL (Brentwood)
Los Angeles, California

Received 10/3/72

Nomination by Sherman M. Mellinkoff, M.D., Dean
UCLA School of Medicine

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)
Hospital: Veterans Administration Hospital (Brentwood) (Psychosocial Medicine)

Wilshire & Sawtelle Blvds. Name
Los Angeles, California 90073 City Street
State Zip Code

Principle Administrative Officer: JOHN A. VALLANCE Name
Director Title

Date Hospital was Established 1923

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating			
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery			
OB-Gyn			
Pediatrics			
Psychiatry	1946	24	21
Other			

Information Submitted By:

MAX UNGER, M. D.
Name
September 28, 1972
Date

Chief of Staff (Clinical)
Title of ~~Hospital~~ ~~Chief~~ ~~Executive~~
Max Unger, M.D.
Signature of ~~Hospital~~ ~~Chief~~ ~~Executive~~
Chief of Staff (Clinical)

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

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OFFICE OF THE DEAN
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

September 26, 1972

Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Colleagues:

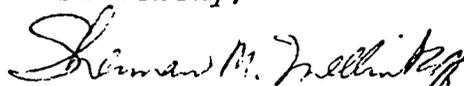
On behalf of the UCLA School of Medicine, I am pleased to nominate the Brentwood Veterans Administration Hospital for Psychosocial Medicine in West Los Angeles for membership in the Association of American Medical Colleges Council of Teaching Hospitals. Its eligibility for membership is under criterion (a), i.e., "nominated by a medical school Institutional Member... from among the major Teaching Hospitals affiliated with the Members."

On October 5, 1971, an affiliation agreement between the Brentwood VA Hospital and UCLA gave de jure status to the fruitful de facto collaboration in teaching, research and therapy which had already been a vital element in UCLA's teaching endeavor. Junior medical students from UCLA are regularly scheduled for psychiatry clerkships at the Brentwood VA Hospital. Our seniors take a wide variety of psychiatric electives at Brentwood, and our psychiatry house officers rotate back and forth between Brentwood and UCLA. All the physicians on the Brentwood VA Hospital staff participating in teaching have UCLA faculty appointments, and psychiatrists from both institutions collaborate on a wide spectrum of joint seminars, conferences and rounds.

The dynamic leadership of Dr. L. Jolyon West, Chairman of the Department of Psychiatry at UCLA, Dr. Max Unger, Chief of Staff for Clinical Services at the Brentwood VA, and Dr. Philip May, Director of Program Evaluation for Research and Education at Brentwood, has enabled the Brentwood VA Hospital to make great strides for excellence. Its membership in the AAMC Council of Teaching Hospitals would further catalyze its progress for the benefit of today's and tomorrow's veterans and their doctors and of medicine in general.

With best regards,

Sincerely,


SHERMAN M. MELLINKOFF, M.D.

cc: Dr. Philip May
Dr. Max Unger
Dr. L. J. West

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Waterbury Hospital
Waterbury Name 64 Robbins Street.
City Street
Connecticut 06720
State Zip Code

Principle Administrative Officer: Richard A. Derr
Name
Administrator
Title

Date Hospital was Established 1883 (date incorporated)

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered (effective July 1, 1972)	Total Internships Filled
Rotating	1914	8	8
Straight	1971 in Medicine	4	4

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered (Effective July 1, 1972)	Total Residencies Filled
Medicine	1948	10	9
Surgery	1948	7	7
OB-Gyn			
Pediatrics	1950	2	2
Psychiatry			
Other Pathology	1948	4	0
Urology	1947	1	1

(in association with Yale-New Haven Hospital
whereby residents at the 3rd-year level at YNH
in Urology each spend 6 months rotating through
Urology Service at The Waterbury Hospital)

Information Submitted By:

Mr. Richard A. Derr
Name
July 14, 1972
Date

Administrator
Title of Hospital Chief Executive
[Signature]
Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. 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 are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Yale University School of Medicine

Name of Dean Lewis Thomas, M.D., Dean c/o Robert Scheig, M.D., Associate Dean of Regional Activities

Address of School of Medicine 333 Cedar Street, New Haven, Connecticut 06540

FOR COTH OFFICE USE ONLY			
Date _____	Approved _____	Disapproved _____	Pending _____
Remarks _____			

Invoiced _____		Remittance Received _____	

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

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If nominated by a School of Medicine, complete the following:

Name of School of Medicine Indiana University
Name of Dean Glenn W. Irwin, Jr., M.D.
Address of School of Medicine 1100 West Michigan Street
Indianapolis, Ind. 46202

FOR COTH OFFICE USE ONLY	
Date _____	Approved _____ Disapproved _____ Pending _____
Remarks _____	_____
_____	_____
_____	_____
Invoiced _____	Remittance Received _____

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Riverside Methodist Hospital
Name
Columbus 3535 Olentangy River Road
City Street
Ohio 43214
State Zip Code

Principle Administrative Officer: Edgar O. Mansfield, Dr. P.H.
Name
Administrator
Title

Date Hospital was Established 1891 Protestant Hospital, 1898 White Cross Hospital, 1961 Riverside Methodist Hospital

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1918</u>	<u>24</u>	<u>22</u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1939</u>	<u>9</u>	<u>7</u>
Surgery	<u>1946</u>	<u>12</u>	<u>9</u>
OB-Gyn	<u>1939</u>	<u>8</u>	<u>5</u>
Radiology	Approval for 3 granted in 1971. One position offered for first time 7/72		
Pediatrics	<u>-</u>	<u>--</u>	<u>--</u>
General Practice	<u>1956</u>	<u>3</u>	<u>0</u>
Psychiatry	<u>-</u>	<u>--</u>	<u>--</u>
Plastic	<u></u>	<u></u>	<u></u>
Other Surgery	<u>1971</u>	<u>2</u>	<u>1</u>
Neurosurgery	<u>1941</u>	<u>8</u>	<u>7</u> Combined with Ohio State Univ.
Orthopaedics	<u>1947</u>	<u>12</u>	<u>10</u> Combined with Ohio State Univ.

Information Submitted By:

Edgar O. Mansfield, Dr. P.H.
Name

Administrator
Title of Hospital Chief Executive

February 24, 1972
Date

Edgar O. Mansfield
Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

Letters of interest since Moratorium --

GENERAL ROSE MEMORIAL HOSPITAL
Denver, Colorado

4/18/72

MOUNT SINAI HOSPITAL
Minneapolis, Minnesota

4/26/72

THE BRYN MAWR HOSPITAL
Bryn Mawr, Pennsylvania

6/6/72

VETERANS ADMINISTRATION HOSPITAL
Baltimore, Maryland

9/19/72

THE CHILDREN'S HOSPITAL OF AKRON
Akron, Ohio

9/19/72

CONFEDERATE MEMORIAL MEDICAL CENTER
Shreveport, Louisiana
(request placed by Dean Edgar Hull)

9/19/72

(former COTH members)

FAULKNER HOSPITAL
Boston, Massachusetts

9/27/72

SHADYSIDE HOSPITAL
Pittsburgh, Pennsylvania

9/28/72

Charleston Area Medical Center

P.O. BOX 1393

CHARLESTON, W. VA. 25325

■ GENERAL DIVISION & McMILLAN DIVISION
(304) 348-6200

■ MEMORIAL DIVISION
(304) 348-4321

August 25, 1972

Richard Knapp, Ph.D.
Council of Teaching Hospitals
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dick:

As you can see I am now relocated and find the new circumstances very much to my liking.

I talked with Grace on the phone the other day and understand that you are carrying on very well in the absence of a full-time director. Grace has arranged to get me back on the mailing list and has provided me with registration information for the Miami meeting.

The Charleston Area Medical Center is an organization that resulted from the consolidation of five hospitals and now has one Board of Trustees and by January 1 will have one Medical Staff. Memorial Hospital, which is one of the principals, is a member of the Council of Teaching Hospitals. As you know, I desire to remain active in the Council and am wondering if the membership of Memorial can simply be transferred to the name of the Charleston Area Medical Center or if it will be necessary for us to reapply for membership. We are working on the development of a medical division of the West Virginia University School of Medicine here in Charleston and intend to fully integrate our house staff programs with West Virginia University. All of this will be done under the umbrella of the Charleston Area Medical Center and one way or another I feel that membership status should so indicate. I do not want to deprive the individual hospital administrators of this relationship but would like to legitimize our participation and formalize the status of the Charleston Area Medical Center.

I would appreciate your response to this request. In the meantime, we would certainly be pleased to have you visit with us if your travels bring you this way and if I do not see you before, I will see you in Miami.

Sincerely yours,

Don
Don L. Arnwine
President

dhh

RECEIVED

AUG 30 1972

AAMC-WASH., D. C.

MEETINGS FOR THE COMING YEAR

Thursday, December 14, 1972
Friday, December 15, 1972

COTH Administrative Board
AAMC Executive Council

Thursday, March 15, 1973
Friday, March 16, 1973

COTH Administrative Board
AAMC Executive Council

Thursday, June 21, 1973
Friday, June 22, 1973

COTH Administrative Board
AAMC Executive Council

Sunday Preceding American Health Congress
September 14, 1972

COTH Administrative Board
AAMC Executive Council

MINUTES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

VETERANS ADMINISTRATION SHARING
TASK FORCE MEETING

AAMC Headquarters
Washington, D.C.
October 7, 1971

PRESENT:

Joe S. Greathouse, Jr., CHAIRMAN
Clyde G. Cox
L. H. Gunter
Kenneth J. O'Brien
Hugh R. Vickerstaff
James W. Varnum

GUEST:

Mr. William Freer
*Special Assistant to the Assistant Chief Medical
Director for Planning and Evaluation*

EXCUSED:

John Reinertsen

STAFF:

John M. Danielson
Robert H. Kalinowski
Richard M. Knapp, Ph.D.

Following the call to order and introduction of members, Mr. Greathouse asked John Danielson to present his views on the role and function of the Task Force.

John Danielson stated that in order to improve communications with Veterans Administration Hospital members of COTH he had been meeting quarterly with an advisory group lead by L. H. Gunter, and composed of the following individuals: John Chase, M.D., Arthur Klippen, M.D., Malcom Randall, John B. Sheehan, M.D. This group does not preempt the AAMC-VA Liaison Committee, but rather its purpose is to draw attention to issues of concern to VA teaching hospitals about which COTH could have a significant impact. This group

recommended that the issue of "sharing" as set forth in P.L. 89-785 as well as a future expansion of this concept is one that deserved special attention. Thus, this ad hoc task force was formed.

The charge to the task force is to make recommendations to speed the implementation of P.L. 89-785. Mr. Danielson also requested each member to review H.R. 10880, "Veterans Medical Care Act of 1971", and submit a critical review which the COTH staff might use in making recommendations when rules and regulations are being drawn for this legislation. He stated that his understanding was that such legislation will probably be passed as set forth in H.R. 10880.

The task force will report to the COTH Administrative Board. However, the possibility of adding a dean and a faculty representative to the task force should be discussed.

At this point, John Danielson presented his personal thoughts concerning national trends as they relate to current changes in the Veterans Administration. He believes much of the current reorganization is a reflection of setting the stage for some form of national health insurance.

The VA has the largest organized system for delivering health services in the country owned by the federal government. The introduction of recent legislation, specifically P.L. 89-785 and H.R. 10880, move this system in a direction which will make the goals and objectives of the VA hospitals more comparable to hospitals in the non-profit voluntary arena. This step puts these institutions in a position which could be used as the basis for standardization and other indicators as the control group.

Further, John Danielson stated that he believes there will be a regional system developed, and that there will be a regional health authority reporting to

a cabinet level Department of Health. The anticipated "freeze" on hospital costs will most likely be permanent, although the allowable percentage will probably change. One of the possible implications of such action may be that the university hospitals may be forced to terminate some of their high cost tertiary care programs and other contract programs for which not nearly full cost is being reimbursed. It is possible that the VA teaching hospitals may be requested to finance a number of these programs.

Bill Freer stated that it is his understanding that the VA policy toward "sharing" is not one of "tokenism", but a leadership attitude of moving forward as rapidly as possible. There are individuals in the system who wish to see the VA system preserved as an entity; but even they now see the need to share and cooperate. Hugh Vickerstaff stated that this latter group does serve as an "intellectual road block". The deans and VA leadership talk one way, but the associate deans and those responsible for university business affairs say that it is very difficult to do business.

Bill Freer officially undertook his new responsibility for "sharing" activities on June 1, 1971. When working with the management audit group, a standard question to hospital directors was (and still is), "What are you doing in the area of sharing ... and why aren't you doing more?" The standard reply was, "Every time we send something into the central office, that's the last we hear of it". This is one of the reasons this new position was established. One procedure he has initiated is that any sharing agreement turned down by general counsel for legal reasons must go through his office for review.

He outlined four major problems which consistently come to his attention:

- 1) the rigid legislative guidelines, including the problem of interpreting the definition of "specialized medical service";

2) speeding up the "turn-around time" for proposals, and the difficulty of proper communication to all individuals with responsibility for sharing agreements;

3) determining whether or not the institution will "deliver", or would it be more appropriate to contract with individuals for service;

4) the difficulty of instituting effective cost accounting for buying and selling which is acceptable for the purposes of both parties to the agreement.

At this point, Joe Greathouse asked each member of the group to describe local institutional arrangements and identify significant accomplishments and specific problems. During this exchange of ideas, there was some confusion concerning the definition of the various types of agreements. Ken O'Brien submitted the following outline with examples from Little Rock to clarify the matter:

I. Scarce Medical Specialty

The VA cannot recruit and must contract with medical schools and clinics for the specialty. These contracts must provide that the services will be performed at a VA facility.

Authority: 38 USC 4117

Little Rock contracts with UAMC for Radiological and Nuclear Medicine Specialties. (Contract No. V 598P-525)

II. Exchange of Use of Specialized Medical Resources

The VA has resources not available at the hospital in the medical community, and the other hospital has a resource not available at the VA--these hospitals can contract to use each

other's resources.

Authority: 38 USC 5053

Little Rock (Contract No. V598P-557)

Contracts with UAMC for VA to furnish Pulmonary Function testing service and Percutaneous Cordotomy Facilities; and UAMC to furnish Radiotherapy Service and Nuclear Medicine Studies.

III. Mutual Use of Specialized Medical Resources Provided to a VA Hospital

Another hospital (or medical school with hospital facilities) in the medical community has a resource which VA needs and does not have. The VA can make an agreement to obtain that resource when the agreement will obviate the need for a similar resource to be provided in the VAH.

Authority: 38 USC 5053 (a) (1).

Little Rock does not have an agreement of this type.

IV. Mutual Use of Specialized Medical Resources Provided by a VA Hospital

The VA has a resource which has been justified on the basis of Veterans care, but is not utilized to the maximum capacity.

Authority: 38 USC 5053 (b)

Little Rock has three agreements as follows:

Contract No. V 598P-545 -- with Arkansas State Hospital whereby VA furnishes Radio Paging facilities to State Hospital for tie-in with VA paging system.

Contracts V 598P-546 and V 598P-555 with Baptist Medical Center and UA Med Center, respectively, whereby VA furnishes nursing training in Pulmonary Resuscitation and Cardiac Defibrillation.

Bill Freer pointed out that the primary distinction concerns buying and selling. There is flexibility in getting the service into a VAH; but, the flexibility for selling VAH services is not there. The only way to do so is under the "sharing" concept.

Following the descriptions of sharing activities at each institution Hugh Vickerstaff and Joe Greathouse described in depth some of the problems encountered in Nashville. Joe Greathouse made the following points:

- the physical proximity issue is a key one which is reflected medically as well as in terms of psychological barriers;
- the transportation problem is a real "hassle";
- the psychological barriers are very real, and are of no small significance. Birmingham appears, however, to have overcome this difficulty. The problem in Nashville has been fed on both sides by the feelings in "maintaining identities". The VA is viewed by the medical faculty as a separate resource which is professionally isolated.

- the above problem has been intensified by the administrative inability to implement some shared activities which in fact work, to hold out as examples. This has dampened enthusiasm on both sides of the street.

- there are two private medical schools in Nashville with vastly different orientation. The VAH could get caught in the middle if sharing is negotiated on an institutional basis.

Hugh Vickerstaff reinforced these points and stated that the matter of self identity is the key to the problem. The attitude of "...we must

protect ourselves from the 'grasping' university" does still prevail. This type of intellectual roadblock does exist, and should be recognized. The new spirit in the VA Central Office needs to be more actively set forth through the VA bureaucracy. Further, there must be imbued in the VA Hospital Directors an attitude of seeking out and initiating these sharing arrangements. Getting that first agreement off the ground is a most important hurdle.

Clyde Cox stated that Birmingham has no contracts and planned none for the future. Joe Greathouse asked if this implied the contract vehicle itself could be a barrier. Clyde Cox agreed. In other words, where the contract mechanism is used extensively, it is a barrier to moving toward the sharing concept. This point is related to the compartmentalized nature of the medical center. The contract allows the compartmentalized units of the center to work out individual arrangements rather than viewing the relationship as a broad institutional commitment.

Bill Freer stated that it's his impression that the Teague Committee is interested in promoting sharing and de-emphasizing contracts.

At this point the Chairman posed the following question: "What can the Task Force do to close the gaps in terms of: (1) the difference between what the deans and hospital directors want, and how faculty and others operate; (2) the difference between what the VA central office wants, and what's happening in the field.

Ken O'Brien suggested:

- 1) the central office should publish a list of successful ventures, and how they were accomplished;

- 2) a strongly worded, "let's get going" letter from Dr. Jim Musser's office to the effect that, "we have about three years before it's done for us."

Bill Freer stated that his office is going to publish a quarterly newsletter directed to this issue.

Joe Greathouse asked if case studies might be more helpful outlining how the agreement was developed, its magnitude, problems which were overcome and pitfalls to avoid. He also asked if there might be any merit to asking the AAMC to undertake an information gathering effort from some key institutions. Ken O'Brien suggested that the local Dean's Committees be requested to discuss this matter. Joe Greathouse emphasized the need to know what's going on. Hugh Vickerstaff stated emphatically that what goes to the VAH Directors should be fully communicated to all of Dr. Musser's staff.

At this point Clyde Cox said the task force should recommend that P.L. 89-785 be broadened to include capital expenditures to meet the full dimensions of the sharing concept. The present law refers to existing facilities and services. Authority is needed to participate in construction. If this could be done, "... many of the problems we've discussed here today would be eliminated because there would then be a full partnership to begin with, and the operating service sharing commitment would be obvious and explicit."

Joe Greathouse asked if the VA is trying to do something about the "cost" or "pricing" matter. Bill Freer stated that this is the most frustrating problem with which he has to deal. The Controller General has ruled that the VA must be reimbursed for full cost. This ruling has been used for presentations to Congress as well as for operating procedures at the local level. The two are not subject to the ruling in the same way. Additionally, the university frequently has to use different cost-finding procedures. The question is whether the cost procedures developed by the VA can be used by the university to recover from third parties. Joe Greathouse said he thought the mere fact that a bill is presented - especially if it's cost based - is usually enough justification, and then asked

if the station hospitals have the capacity to develop cost analyses.

Bill Freer indicated he believes they are developing this capability. One other difficulty is the fact that for 27 specific medical services, the VA must use the unit cost printed out by the RCS 14S4 - this factor has "killed" a number of proposed sharing agreements. There was not uniform familiarity with this report or this problem among all members of the task force.

The Chairman suggested that the group should work toward preparation of some type of report. In the meantime, if there are expressions from this group which would be helpful, perhaps they should be initiated.

Ken O'Brien stated that the one formal "tie" with the university is the Dean's Committee. In many cases, the university hospital director is not on the committee, which is unfortunate. It may be desirable to review the present role, composition and function of Dean's Committees. In view of this point, the Chairman again said that since the task force is into areas of concern to deans and faculty, perhaps their views should be represented in the deliberations of the task force.

Bill Freer stated that the need for improved communication is very evident, and that he believes there needs to be a better articulation of the problems at the local level so the central office can review them accordingly.

There was a consensus that a final report of the task force deliberations should contain:

- 1- the range of existing opportunities, and recommendations on how these opportunities for achieving sharing agreements might be more rapidly implemented;

- 2- recommendations for legislative or regulation alteration which would promote more intensively the achievement of facility and service integration.

The Chairman asked that each task force member:

1) identify issues which should be specified on the Agenda of the next meeting;

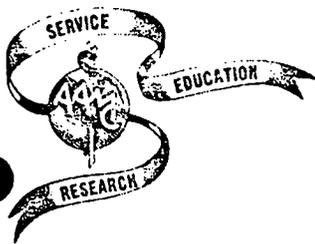
2) submit comments on H.R. 10880;

3) talk with others in the field to determine how they see the problems and issues;

4) forward general comments on the first meeting to Dick Knapp.

The next meeting of the Task Force will take place in Washington, D.C. some time during the first two weeks in December.

The meeting was adjourned at 2:10 p.m.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

MINUTES

RMP-CHP COMMITTEE
September 6-7, 1972
Embassy Row Hotel - AAMC Conference Room
Washington, D.C.

Present

Stuart M. Sessoms, M.D., Chairman
Alexander M. Schmidt, M.D.
James V. Warren, M.D.
William R. Willard, M.D.

Absent

Andrew D. Hunt, Jr., M.D.
William S. Jordan, M.D.
William H. Stewart, M.D.

AAMC Staff

Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Joseph S. Murtaugh
Stephen J. Ackerman
Grace Beirne
Prentice Bowsher
Rosemary Wilson
Alexa Burt

RMP-CHP Committee Minutes

I. Meeting with HSMHA Officials, September 6

The RMP-CHP Committee held an informal meeting with Dr. Vernon Wilson and key members of his staff at the Embassy Row Hotel on the evening of September 6, 1972. Dr. Wilson, who was accompanied by his deputy, Mr. Gerald Riso; Mr. Robert Janes, chief of CHP programs; and Dr. Harold Marguiles, chief of RMP; led a discussion on the evolution and background of HSMHA-HEW policy on the issue. This was followed by a period of full and free discussion involving the entire group. Key points in the HSMHA policy as articulated by Dr. Wilson were:

- A. The concept of an "implementing agency" designed to serve as an approval authority for the expenditure of all federal funds (and possibly funds from state and other sources) for health care programs within the state.
- B. The principle that "planning" and "action" functions must be kept separate and lodged in completely separate agencies.

II. Committee Discussion, September 7,

All members of the committee participated in a group discussion on the perceptions and insights derived from the discussions with Dr. Wilson and his staff and then went on to a general discussion with regard to the subject of the RMP-CHP issue generally and the committee's approach in carrying out its function. Among the concepts and formulations contributed by various individuals during the course of the discussion were the following:

- A. General Policy Issues: Federal-State Relationships
 1. Fundamental policies of the Nixon Administration which have a determining influence on the programs involved include:
 - a. Decentralization
 - b. Revenue sharing
 2. It is a sound approach to build on the strengths that we already have in this area.
 3. In this regard, legislative authorizations could put emphasis on the end rather than the means (the end being the availability and accessibility to the means of quality health care for all through overall planning and regulation and/or control of the health care system) and authorize means (program mechanisms) to be oriented to the end purpose.
 4. In line with Dr. Wilson's statement, the states should be given a good deal of flexibility and responsibility for self-determination in re the means or agencies used to achieve the end.

B. Planning Decision Making and Action Process in Re the Health Care System

1. The policy that mandates the separation of planning and action is viewed as an obsolete concept by some political scientists.
2. A more current concept of planning was described as a process of bringing together the forces having the power to create change in a given situation.
3. A case in point was cited involving an academic medical center which found it necessary to obtain 32 different approvals before the construction of a new hospital could be undertaken. The point made was under such circumstances, if there was to be a viable health care plan that the 32 "real-power" interests would have to be involved in its development.
4. Unless CHP has the real power wielders and money controllers built into its structure, it cannot do the job.
5. The so-called implementing agency should have a positive role with regard to the health care system as well as the negative one of refusing fund approval.
6. Planning, decision making, and implementation are actually different essential steps in one continuous process. It can, therefore, be effectively accomplished either within one agency or through inter-related agencies. Policy and process should determine the structure-- not vice versa.

C. Implications for Academic Medical Centers

1. The control or dominance of medical schools in RMP is waning but activity and involvement is increasing. Examples: regionalization of health care on a capitation basis and manpower planning and development.
2. There is ambivalence of viewpoint in re the medical school relationship here. Some say this is where the talent is, but others question the extent or appropriateness of the talent. There is also an anti-medical school attitude prevalent in some quarters.
3. The focus should be on the university rather than the medical school.
4. Academic medical centers have a vital stake and interest in the community related health care functions that demand rationalization and coordination of approach.

D. Some Prime Issues Needing Resolution

1. Need for clear articulation of the mission and objectives for the programs involved
2. Clarification of the distinction of the implementing agency and the planning agency
3. A construct of the planning agency or process
4. Determination of how can the CHP process be strengthened? Or if a new reconstituted process is necessary.
5. Where does the Experimental Health Service Delivery System program fit in? (lack of satisfaction with the HSMHA explanation on this point)
6. Identification and definition of the devices and framework that can meet the needs
7. Assessment of the implications to the extent that these things involve the academic health centers?

III. Report on Site Reviews on RMP-CHP Interrelationships

A. Arkansas, Connecticut and Vermont

Dr. Kalinowski and Mr. Ackerman gave a report on their visits with key officials from the above three states. A written staff report was distributed. The highlights derived include:

1. RMP as a general rule is rich in talent and money; CHP is poor.
2. RMP's power, however, is short-circuited by the lack of a clear mandate, purpose, and public responsibility.
3. In summary: RMP has a capability but not a mandate; CHP has a mandate but not capability; present HEW policy prevents them from putting it together.
4. The Experimental Health Services Delivery System Program is a part of the problem rather than a part of the solution.
5. RMP has developed a strong constituency--partly political because it puts money in every Congressional jurisdiction and partly professional because practicing physicians trust it as a program that serves their interest and is not inimical to it.
6. Few would vote for continuation as is.

7. All three programs gave evidence of the fact that nothing substantial could be accomplished in the rationalization of the health care system without finding some way of providing for the substantial participation of the practicing physicians group.
8. A major problem in the existing situation has been the paradox of an unduly weak federal tendency to articulate the specific national purpose and relationships of the programs concerned on the one hand, and an unduly strong tendency to direct states and communities in the nature and details of implementing action.

B. Louisiana

Dr. William Stewart could not attend the meeting because he was out of the country. In lieu of a report on the Louisiana situation, a letter which he had sent to Dr. Kalinowski was distributed. Its essence is as follows:

"After reviewing the minutes of the last meeting, I am convinced that it is vital to develop new objectives for a combined CHP-RMP program before a discussion of the wisdom of the combination can be undertaken. It could be that the original objectives of CHP and RMP are still valid or that they are no longer valid for a variety of reasons. The real problem could be that no clear purpose expressed as current operational public policy exists. No organizational changes or name changes of these programs is going to solve this problem."

C. Illinois

Dr. Max Schmidt gave a report on his review of the situation in Illinois. Major points in the report included:

1. There are good close relationships among key people in the state and some good program activities along with a good deal of specific problems.
2. The RMP has a number of substantive program activities; medical school domination is lessening but RMP-type activities are growing.
3. The governor has appointed Dr. Snoke as coordinator of health care, but he has little resources to work with and his function parallels that of the state health agency with a resulting atmosphere of competitive sensitivity.
4. A general agreement exists that CHP should have the supraordinate role, but CHP has produced no substantial plan or program.
5. RMP feels that in absence of a plan, the CHP review represents another technical project review on top of the one already made by the RMP advisory group, rather than one of a conceptual or strategic nature.

6. Despite their problems, there are active, cooperative projects, a good example being the "interagency task force for health manpower" in which CHP, RMP, the Medical Society, Hospital Council and State Board of Health have joint involvement.

IV. Synthesis of Essential Concepts and Basic Forces

It was suggested that it might be productive for the committee to attempt to define the essential concepts and fundamental forces pertaining to the RMP-CHP problem without regard to the specific agency structure or specific prescription of solution at this point. On the basis of total group discussion, the following outline of such prime factors was evolved.

A. Major forces

1. Comprehensive health planning on a geographic basis
2. Revenue sharing
3. Decentralization of decision making
4. Enlargement of public base in decision making
5. Super agency as conduits of funds (veto power)
 - a. Regional office
 - b. Implementive agency
 - c. CHP (A)

B. Planning process

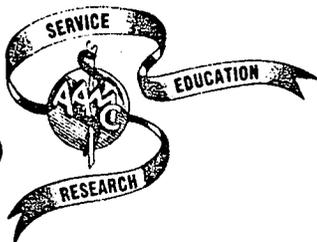
1. Quality of people
 - a. Funding
 - b. Power and authority
2. Subject and content of planning
 - a. Health vs. medical care delivery
 - b. Manpower development and distribution
 - c. Resource investment
 - d. Quality
 - e. Evaluation
3. Geographic Area
4. Public acceptance and accountability
5. Object of plan to be controlling
6. Relationships to action process

C. Action process

1. Relationship to planning
2. Resource allocation
 - a. Facilities
 - b. Manpower
 - c. Money
3. Assignment of authority and responsibility
4. Feedback mechanism

V. Committee Position Paper

It was agreed that the AAMC staff should develop a position paper based on the above outline and with reference to the similar outline with regard to the problems of the health care system derived from the first meeting. The draft position paper would be submitted to the committee for review prior to the next meeting and when finalized would be transmitted for the views and comments of the AAMC constituency through appropriate channels.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
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MINUTES

SUBCOMMITTEE ON QUALITY OF CARE
September 28-29, 1972
Embassy Row Hotel - AAMC Conference Room
Washington, D.C.

Committee Members Present

Robert J. Weiss, M.D., Chairman
David R. Challoner, M.D.
Richard L. Meiling, M.D.
John H. Westerman

Absent

Christopher C. Fordham III, M.D.

AAMC Staff

John A. D. Cooper, M.D.
Joseph S. Murtaugh
August G. Swanson, M.D.
Marjorie Wilson, M.D.
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Stephen J. Ackerman
Lily O. Engstrom
Grace W. Beirne
Charles Fentress

Guests, September 28, 1972

Phil Caper, M.D.
Paul Ellwood, M.D.

Guests, September 29, 1972

Samuel Asper, M.D.
Robert Brook, M.D.
Robert Heyssel, M.D.
David Kessner, M.D.
William Sale
Paul Sanazaro, M.D.

INTERIM REPORT AND MINUTES (SEPT. 28-29, 1972)
SUBCOMMITTEE ON QUALITY OF CARE

At its meeting in Phoenix, on April 23, 1972 the Council of Deans of the AAMC passed and referred the following resolution to the Health Services Advisory Committee:

"The Council of Deans recommends that the AAMC assume a leadership role in bringing together appropriate organizations for the purpose of developing standards and priorities by which the quality of health care services may be assessed, and for the purpose of assessing the appropriate role of the academic medical centers in the delivery of health care, especially in relation to any future national health insurance program."

A Subcommittee on Quality of Care, chaired by Dr. Robert Weiss of Harvard Medical School, was appointed by Dr. Robert Heyssel, Chairman of the Health Services Advisory Committee, to review the state-of-the-art in quality-of-care assessment and to submit recommendations to the Council of Deans, Council of Academic Societies and Council of Teaching Hospitals on the appropriate role of the academic medical center in the evaluation and assurance of quality health care. Members of the subcommittee are: Robert J. Weiss, M.D., Harvard Medical School; David R. Challoner, M.D., Indiana University Medical Center; Richard L. Meiling, M.D., the Ohio State University; and John H. Westerman, University of Minnesota Hospitals.

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On Thursday, September 28, and Friday, September 29, the Subcommittee met with:

Dr. Philip Caper, Senate Subcommittee on Health

Dr. Paul Ellwood, American Rehabilitation Foundation

Dr. David Kessner, Institute of Medicine

Dr. Paul Sanazaro and Dr. Robert Brook, DHEW

Dr. Sam Asper and Mr. William Sale, American Hospital Association

The committee attempted to develop an understanding of the legislative thrust of Title IV of the Kennedy HMO bill as well as the various methodologies that are currently employed in quality assessment.

Various methodologies proposed

- A. The Institute of Medicine has been conducting a study to evaluate, on a limited scale, the quality of health care received by specific population groups in the District of Columbia. Borrowing the concept of using radioactive tracers to study how a body organ handles a critical substance such as iodide, specific health problems were chosen to be "tracers" that would lend themselves to pinpointing the strengths and weaknesses of a particular medical practice setting or health care system. The manner in which the physician or health team routinely administers care for a set of common well-defined ailments could be an indicator of the general quality of care and the efficacy of the system delivering that care.
- B. Dr. Sanazaro described the federal government's efforts in the area of quality assurance, specifically the Experimental Medical Care Review Organizations (EMCRO) and the Prototypal Professional Services Review Organizations (PPSRO). Since early 1971 HSMHA

has funded a total of 10 EMCROs, eight of which are now operational and two are in the process of developing their programs. With the exception of one EMCRO in which there is some participation by faculty of a medical school, the rest are sponsored by medical societies or medical care foundations. Generally academic medical centers have not been involved in this program. (See Appendix for a list of those organizations that have become involved with EMCROs that are either in the operational or developmental phase.)

EMCROs that have been funded have developed sets of criteria for diagnosis and treatment procedures for specific disease entities against which the actual pattern of health care is measured. Dr. Sanazaro indicated that funds will be available to set up additional EMCROs next year.

The PPSRO, to be established at the state level, is another experimental quality control mechanism that HSMHA would like to explore. The federal government will provide monetary incentives and technical assistance for establishing PPSROs to those organizations that offer evidence of commitment to developing and implementing a quality assurance program. Validation studies will be conducted to assess the quality of care in various parts of the country to determine if differences in care result in differences in patient outcome.

C. The Quality Assurance Program of the American Hospital Association provides guidelines and methodology for incorporating quality care into the hospital setting. Using both utilization review and the medical audit, the proposed program consists of four parts:

1) criteria development; 2) description of the actual practice;

3) evaluation, i.e. how does the actual practice compare with the established criteria; 4) corrective action and 5) reassessment, i.e. after corrective action has been taken, does actual practice meet the established criteria?

D. H.R. 1 provides for the establishment of Professional Standards Review Organizations (PSRO) consisting of substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and on-going review of services covered under the medicare and medicaid programs. The PSRO would be responsible for assuring that services were (1) medically necessary and (2) provided in accordance with professional standards. The provision is designed to assure proper utilization of care and services provided in medicare and medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of practicing physicians in an area. The provision requires recognition of and use by the PSRO of utilization review committees in hospitals and medical organizations to the extent determined effective.

(1) Until January 1, 1976, the Secretary of HEW would be able to make an agreement only with a qualified organization which represents a substantial proportion of the physicians in the geographical area designated by the Secretary.

(2) A professional standards review organization would not be required to review other than institutional care and services unless such organization chooses to include the review of other services and the Secretary agrees.

(3) Until January 1, 1976, at the request of 10 percent or more of the practicing physicians in a geographical area designated by the Secretary, the Secretary would be required to poll the practicing physicians in the area as to whether or not an organization of physicians which has requested to conclude an agreement with the Secretary to establish a professional standards review organization in that area substantially represents the practicing physicians in that area.

If more than 50 percent of the practicing physicians in the area responding to the poll indicate that the organization does not substantially represent the practicing physicians in the area, the Secretary could not enter into an agreement with that organization.

Based upon its meeting with congressional and administrative spokesmen, together with individuals who are leaders in the rapidly expanding but little tested field of quality-of-care assessment, the subcommittee was, on the one hand, convinced of the real potential in this field, but on the other hand, was anxious about the admitted lack of definition of quality. At the same time, pilot programs, national in scope and funded by federal, state and private agencies add to the confusion and imprecision of current assessment technology. The premature adoption of these measures may lock academic health centers into a system which would seriously affect teaching and the delivery of health care.

In the past, the academic health centers have dealt with quality determination of the basis of the excellence and prestige of the institution

and the accumulated credentials of its faculty. These might be described as a heavy reliance on "input" measures while little attention has been focused on "process" and "outcome" measurement, areas that are less well understood and defined.

These impressions, however, have not slowed down legislative action to create programs to promulgate and implement standards, on the basis of controlling costs and/or improving quality. The power of the government being the largest single source of health care dollars has fairly serious implications for the promulgation of these standards, especially if the standards adopted are only those developed by the current private practice sector.

Subcommittee discussion and recommendations

From the preceding description of the forces at play, we believe that we in the academic health centers are not sufficiently involved in the development of health care standards and quality control research that will have considerable impact upon the practice of medicine within the academic health centers as well as in the rest of the health delivery system.

Although the academic health center in the past has not had responsibility for the practice of medicine after a student completes his medical training, the subcommittee believes that a new dimension of professional responsibility is now upon us. The ways in which we practice intra-institutional medicine will eventually have to submit to the same standards of quality found in our medical research. Our belief is that since the student will in any case undergo professional scrutiny and some sort of peer review and quality control of practice when he leaves the institution, he should see teaching physicians' involvement in quality-of-care assessment as part of

their teaching role. If the academic institutions do not involve themselves in the research and application of quality control standards which are appropriate to the academic health centers, we believe that they will then be forced to accept standards which are not appropriate for themselves. Regardless of when national health insurance becomes a reality, the concern for quality is an immediate one.

The subcommittee therefore believes that medical education and services should begin developing mechanisms for assuring quality. Quality assessment should be inculcated in the student while enrolled in the medical school as well as in the related affiliated institutions so that there is concern for quality in every setting of the student's education and training.

The subcommittee believes that this question of the development of quality standards is not restricted to the Council of Deans, but has obvious broad implications for the Council of Teaching Hospitals and the Council of Academic Societies. For this reason, it makes the following recommendation in the spirit that the issue is pan-AAMC rather than restricted to any one Council.

The subcommittee recommends that the AAMC undertake a 4-point program:

1. Assist in the development of prototype quality assurance programs in selected academic health centers.
2. Encourage all academic health centers to begin a program of education of staff and faculty in the current research and direction of quality control programs as they apply to health delivery.
3. Encourage establishment of training grants, scholarships, loans and stipends for professionals to be trained in the quality area.

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4. Seek legislative support for the creation of academic health center PSROs as regional PSROs develop.

APPENDIX

Experimental Medical Care Review Organizations (EMCRO)
Funded by the Health Services and Mental Health Administration

1. Mississippi State Medical Association (statewide) \$307,000
2. Utah Professional Review Organization (statewide) \$679,000
3. Albemarle County Medical Society, Charlottesville, Virginia (6 counties)
\$201,000 (has some University of Virginia medical faculty participation)
4. Maine Medical Association (statewide) \$50,000 developmental funds
5. Iowa Foundation for Medical Care (statewide) \$65,000 developmental funds
6. Medical Association of Georgia (statewide) \$341,000
7. Multnomah Foundation for Medical Care, Portland, Oregon (1 county) \$243,000
8. New Mexico Foundation for Medical Care (statewide) \$203,000
9. Hawaii Medical Association (statewide) \$443,000
10. Sacramento Foundation for Medical Care (4-5 counties) \$283,000

The following summaries of EMCRO projects represent information compiled several months ago and may not reflect the current status of these projects.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

TO: TASK FORCE ON COST OF GRADUATE MEDICAL EDUCATION & FACULTY PRACTICE PLANS
FROM: Robert H. Kalinowski, M.D. and Richard M. Knapp, Ph.D.
SUBJECT: Minutes of September 19, 1972 meeting

Present:

Dr. William Anlyan
Dr. Christopher Fordham
Dr. Arnold Reiman
Mr. Charles Womer

Guest:

Mr. Ronald Lochbaum

AAMC Staff:

Dr. John Cooper
Dr. Robert Ball
Miss Grace Beirne
Mr. Thomas Campbell
Mr. Charles Fentress
Dr. Robert Kalinowski
Dr. Richard Knapp
Mr. Joseph Rosenthal
Dr. Marjorie Wilson

Following approval of the Minutes of the July 19th meeting, Dr. Anlyan requested that Dr. Cooper report on the September 13th meeting of the parent committee. Dr. Cooper stated the purpose of that meeting was to:

- 1) Obtain the Committee's views of the direction and content of its report to the Assembly, focussing upon a first draft statement of this report, prepared by Mr. Murtaugh (this draft was sent to Committee members on September 8, 1972), and
- 2) Review the progress of the Task Force on Cost of Medical Education in its detailed study of the cost of undergraduate medical instruction at eight medical schools.

Committee Report

The Committee had made the decision (at earlier meetings) to focus its attention on the problems arising from Federal policy to provide financial support to medical schools on the basis of the enrollment of undergraduate medical students and increases in that enrollment, and the coupled Congressional directive to the Secretary, DHEW to launch a study to establish the methodology for ascertaining the "annual per student educational cost" of the program leading to the M.D. degree, to determine such costs for the 1971-72, 1972-73, and 1973-74 (estimated) school years; to describe national uniform standards for each medical school to use in determining these costs, and to recommend how these cost determinations could be used in fixing the payments to the school through capitation grants.

Congress called for an interim report on March 30, 1973, and a final report by January 1, 1974. The National Academy of Sciences - Institute of Medicine is conducting this study. (Comprehensive Health Manpower Training Act of 1971).

Because of the urgent need for the Association to make known its views on these critical matters, the Committee decided, as shown in the minutes of the July 12th meeting, to provide a report to the Assembly at the November annual meeting which would:

"establish the view of the Association concerning (1) the complexity of the medical education process -- the interrelatedness of the elements that are integral to that process (instruction, research, services); (2) the indivisibility of that process, beginning with the curriculum leading to the M.D. degree through the years of internship and residency; (3) that only upon the completion of this continuum can the national objective to increase the number of persons capable of performing the functions of physicians in the delivery of health care be satisfied.

The report will therefore stress the essentially arbitrary nature of efforts to establish estimates of the costs of undergraduate medical education, since this is a discrete concept only in the sense that a degree is awarded upon its completion and not in terms of the preparation of an individual for the independent practice of medicine.

However, because of pressures for such estimates, the Association will present a set of preliminary figures, for consideration as a guide to the probable costs of this segment of the continuum - to be followed by more definitive views of the entire medical education process, its costs, and financing, in the context of the broad range of activities of the contemporary medical center complex."

Following the prescriptions outlined in the July 12th directive, Mr. Murtaugh prepared the draft statement, reviewed by the Committee at this meeting. This first draft, however, did not include preliminary findings of the Committee's Task Force groups on the costs of undergraduate medical education process. It is now evident that because of the inherent difficulties in establishing cost estimates for the research and patient care components, and because the group studying the patient care aspect has only recently been organized, cost estimates will not be available in time for the report to the Assembly in November.

In view of this, and as a result of the day's discussion, the Committee decided to:

- (1) Provide the Assembly in November with an interim progress report of the Committee's work, leading to

- (2) A full report - a more definitive statement of the Association's views - following the July 12th directive, and including preliminary estimates of the costs of undergraduate medical education - to be released, after Executive Council/Assembly review, early in the spring of 1973. The timing of the release of this report is crucial, in view of the convening of the new Congress, which will be concerned with the extension of the Comprehensive Health Manpower Training Act of 1971, and the scheduled release of the interim report by the Institute of Medicine.

From the standpoint of a time frame for Task Force activity, Dr. Anlyan suggested that the group move forward with overall Committee on the undergraduate effort and then "review the bidding".

At this point, the Task Force discussed the components of the hospital budget which could be specifically ascribed to undergraduate medical education. These are as follows:

- house staff costs which can be allocated to the function of instructing undergraduate medical students (this would also include teaching physicians who are paid on the hospital budget);
- the cost of nursing, technician or other staff time as well as the allocation of other hospital cost centers (such as medical records, nursing service or social service) devoted to undergraduate medical education;
- the cost for hospital space allocated to undergraduate students.

Each of these three components of the hospital budget are included in the medical center cost studies. Mr. Campbell reported that the special eight center study was under way, but specific data on these allocations are not yet available.* Mr. Campbell further elaborated on the methodology used to allocate educational program costs to these three components.

Preliminary data available on the eight center study do indicate that while there are dollars in the hospital budget devoted to undergraduate education; the amount is relatively small when calculated as a percentage of the hospital budget. Following a lengthy discussion, the Task Force agreed on the following general statement.

Given the general attributes of a teaching hospital in terms of the presence of graduate medical educational programs, the character of its patient population, the scope of service provided, and the staffing levels implicit in the discharge of such

*the eight centers involved are as follows:

- a) Duke U. Sch. of Med. - Case Western Reserve U. Sch. of Med.
- b) Georgetown U. Sch. of Med. - St. Louis U. Sch. of Med.
- c) U. of Kansas Sch. of Med.-S.U.N.Y., Upstate Med. Ctr.
- d) U. of Iowa Sch. of Med. - Ohio State U. Sch. of Med.

activities, the conduct of an undergraduate medical educational program in such a setting has only a minor effect (probably not exceeding 1%) on the overall patient care costs of such institutions. The Task Force will review cost study data when it becomes available to determine if there is a need to reconsider its position.

A further matter of concern is the problem of estimating the effect of teaching undergraduate medical students on such items as length of stay of patients, utilization of laboratory and x-ray services, as well as other measures of patient care and hospital service. After full discussion of the matter, the Task Force did not come to full agreement. The following statement characterizes the feeling of the group:

The current evidence available concerning the additional effect of the presence of medical students on laboratory, x-ray and other service utilization cannot be considered either sufficient or conclusive. Further, if any part of the costs of such increased services are considered educational in nature, they would in large part be attributed to graduate rather than undergraduate medical education.

At this point in the meeting Dr. Anlyan led a general discussion of the costs of graduate medical education and the need for more data and information concerning medical faculty practice plans. The staff was directed to examine the patient care components in the eight center study with specific reference to the cost of graduate medical education and to set forth a plan to:

- 1) examine institutional policies concerning faculty practice plans;
- 2) collect these plans from each of the schools;
- 3) determine the cash flow generated by these practice plans.

The next meeting of the Task Force is to be held on a date yet to be determined in early December.

PERTINENT SECTIONS OF THE
SENATE FINANCE COMMITTEE REPORT ON H.R. 1

Limitation On Federal Participation For Capital Expenditures
(Section 221)

Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (Medicare) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive area-wide planning for the development and utilization of all types of health care facilities. But the acceptance of the purposes of State and area-wide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end results of such planning. Thus, while a significant amount of Federal money is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. The committee and the Committee on Ways and Means believe that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, the committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health planning agencies. It is estimated that 200 areawide planning agencies are receiving grants and that about 125 of such agencies are operational.

To avoid the use of Federal funds to support unwarranted capital expenditures and to support health facility and health services planning activities in the various States, the committee has approved, with a minor change concerning health care facility construction which was already in progress, the House provision which would authorize the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services and health maintenance organizations under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of \$100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. Where the expenditures are in the form of rental expenses for facilities or equipment which would have been excluded from reimbursement if they had been acquired by purchase, the Secretary would disallow the "higher" of the actual rental expenses or an amount which he finds to be the reasonable equivalent of the amount which would have been excluded from reimbursement if the facilities or equipment had been purchased. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. It is generally expected that the agency will be the agency established under section 314 (a) of the Public Health Service Act. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) An adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level. The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred (on an estimated or proportionate basis without necessarily specific and highly detailed cost-finding of costs with respect to each facility decision undertaken) by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationships between such agencies, either within States or across State lines.

It is not intended that any new planning agencies be established where existing State and local agencies are available and capable of

assuming necessary responsibility. The statewide agency may make use of local agencies to assist it. Existing local planning agencies should be utilized, however, only to the extent that they are broadly representative of health care interests in the community. The Secretary should assume himself that a local planning agency selected to make such recommendations to the statewide agency is broadly representative of the interests of various types of health care and services and that no single type of facility or service would control the planning and approval mechanism. Additionally, such local agencies should employ or regularly utilize the services of personnel knowledgeable in health care planning. It is expected that decisions to approve capital expenditures would be made only after thorough consideration has been given to alternative health care resources already available in the area or approved in a given community or medical service area, including outpatient and other alternative sources of care which may lead to reduced needs for inpatient beds. The statewide agency with overall responsibility should, wherever possible, be the Comprehensive Health Planning Agency.

These limitations generally would be effective with respect to obligations for capital expenditures incurred after December 31, 1972 or earlier, if requested by the State. However, the committee modified the House bill to, as indicated above, make the provision inapplicable to construction toward which preliminary expenditures of \$100,000 or more had been made in the 3-year period ending December 17, 1970, the date on which the amendment providing a similar exception was offered to H.R. 17550.

Limitations On Coverage Of Costs Under Medicare (Section 223)

The committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. The committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. The committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Where high costs do in fact flow from the provision of services substantially in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not intended that patients who desire unusually expensive service should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs present obstacles to the achievements of these objectives. The committee believes that the objectives can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

Accordingly, the committee has approved a provision in the House bill which would authorize the Secretary of Health, Education and Welfare to set limits on costs recognized as reasonable for certain classes of providers in various service areas. This authority differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis- relatively high costs that cannot be

justified by the provider as reasonable for the result obtained would not be reimbursable--so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance except with respect to emergency care, provision would be made for a provider to charge the beneficiary for the costs of items or services substantially in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made. The committee expects that the provision will not be applicable where there is only one hospital in a community--that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

The committee, along with the Committee on Ways and Means, recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And the committee recognizes that these provisions will apply to a relatively small number of institutions. The data that are available for this purpose will often be less than perfectly reliable--for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree of which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care--for example, the costs of the "hotel" services (food and room costs) provided by hospitals--the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits.

In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity--particularly relatively high personnel costs in relation to patient loads where occupancy rates are low--in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

For other than emergency care, providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services substantially in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. The committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charges by such providers.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be made on the basis of cost previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from \$4 to \$9 a day with a median cost of \$5 a day and the limit for food services set by the Secretary for 1971 was \$7.20 a day, the hospital previously experiencing costs of \$9 a day could charge patients \$1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

The provision would be effective with respect to accounting periods beginning After December 31, 1972.

Payment For Supervisory Physicians In Teaching Hospitals
(Section 227)

When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services to other patients--that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than one of a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of

teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patients care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

In the typical community hospital and other teaching settings where patients are expected to pay fees for these services, fee-for-service payment for physicians' services would continue to be made by the medicare program. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

To deal with these problems, H.R. 1 as passed by the House and approved by the committee, contained a provision, originally developed by this committee in 1970, which would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. The committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervision on a regularly scheduled basis to nonprivate patients. Such services would be reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time, which, if not contributed, would have to be obtained through employed staff on a reimbursable basis. Medicare payments for such services would be made available on an appropriate legal basis by the fund to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' services were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physicians. To facilitate efficient administration, a presumption may be made that all of the patients in an institution are private patients but only where the institution offers satisfactory evidence that all patients are treated the same with respect to arrangements for care and accommodations, that all patients receive their principal physician services from an attending physician, and that all of the patients are billed for professional services and the great majority pay. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

It is recognized, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collect from all referred patients for his services.

In some cases hospitals that normally do not bill for physician services have special centers, such as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers. Also, the outpatient department of a hospital may organize the provision of and billing for physicians' services in that department differently from the inpatient setting. In such cases, the decision regarding whether cost or charge reimbursement is appropriate should be made separately from inpatients and outpatients. However, if the services are contracted for on a group basis, and medicare and medicaid directly or indirectly pay for such services, the normal basis of reimbursement by the two programs would be one of cost if the services are provided by a directly or indirectly related organizations.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed; all of the institutions patients were regularly billed for professional services; reasonable efforts

were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

The committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a cost or charges basis, reimbursement would be on the basis of costs.

Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Another provision in this section would permit a hospital to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. In order to receive reimbursement the hospital would be required to pay the reasonable cost of such services to medicare patients to the institution that bore the cost. The committee expects that such costs will be reimbursable only where there is a written agreement between the hospital and medical school specifying the types and extent of services to be furnished by the school and disposition of any reimbursement received by the hospital for those services.

This amendment would be effective with respect to accounting periods beginning after December 31, 1972.