

AGENDA

COTH ADMINISTRATIVE BOARD
Thursday, March 15, 1973
Embassy Row Hotel
ENVOY C
9:00 a.m. - 3:00 p.m.

- I. Call to Order
- II. Approval of Minutes, Meeting of November 2, 1972 TAB A
- III. Report on the revision of the MCAT TAB B
- James Erdmann, Ph.D., Director, Division of
Educational Measurement and Research
- IV. Membership Applications Separate
Attachment
- A) Community Hospital of Indianapolis
 - B) Veterans Administration Hospital, Baltimore *ple*
 - C) Saint Johns Hospital, Springfield, Ill.
 - D) Memorial Hospital of Springfield, Ill.
 - E) Riverside Methodist Hospital, Columbus, Ohio *le*
 - F) Bryn Mawr Hospital, Bryn Mawr, Pa. *le*
 - G) The Waterbury Hospital, Waterbury, Conn. *le*
 - H) Veterans Administration Hospital, Los Angeles *-*
- V. Regional Meetings TAB C
- VI. Staff Reports
- A. Dr. Kalinowski
 - 1. Professional Standards Review Organizations TAB D
 - 2. RMP/CHP Legislative Renewals TAB E
 - 3. Current Status of HMO Contract
 - B. Dr. Knapp
 - 1. Social Security Amendments TAB F
 - 2. Proposal for COTH Research Awards TAB G
 - 3. House Staff Survey and TAB H
Development of a COTH Monograph
 - 4. Hill Burton Legislative Extension TAB I
- VII. Annual Meeting TAB J
- VIII. Guidelines for Academic Medical Centers Planning to TAB K
Assume Institutional Responsibility for Graduate Medical
Education

- IX. Report from the Ad Hoc Committee on Continuing Education TAB L
- X. Information Items
- A) Report of the AAMC Officers' Retreat TAB M
 - B) Functions and Structure of Schools of Basic Medical Sciences TAB N
 - C) Minutes of the First Meeting of the Liaison Committee on Graduate Medical Education TAB O
- XI. Other Business
- XII. Adjournment

NEXT MEETING OF THE ADMINISTRATIVE BOARD

Wednesday, June 20 Dinner Embassy Row Hotel
6:30 p.m. - 9:30 p.m.

Thursday, June 21 Embassy Row Hotel
9:00 a.m. - 3:00 p.m.

COTH ADMINISTRATIVE BOARD MEETING
Hotel Fontainebleau
Miami Beach, Florida
November 2, 1972

PRESENT:

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

EXCUSED:

Thomas H. Ainsworth, Jr., M.D.
Edward J. Connors
Arthur J. Klippen, M.D.

GUESTS:

Merle S. Bacastow, M.D.
Robert J. Weiss, M.D.
Charles B. Womer
Dennis Pointer, Ph.D.

STAFF:

Stephen J. Ackerman
Grace W. Beirne
Alexa Burt
Lily Engstrom
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 3:00 p.m. in the Champagne Room of the Hotel Fontainebleau.

II. Consideration of Minutes:

The minutes of the meeting of August 6, 1972 were approved as distributed.

III. Membership:

A. Pending Applications

It was reported that four membership applications and eight letters expressing interest in COTH membership had been received since the February, 1972 moratorium was declared. Assuming the Report of the COTH Ad Hoc Membership Committee would be passed, the staff was directed to inform the twelve prospective member institutions of the new criteria for membership, and request that appropriate documentation be forwarded so that the application could be reviewed at the next meeting of the Administrative Board.

B. Other Membership Problems

The matter of institutional representation in COTH and payment of dues to COTH has been raised in the context of some recent hospital mergers. An example is the Charleston Area Medical Center which is an organization that resulted from the consolidation of five hospitals and now has one Board of Trustees. One of the principal hospitals is already a member of the Council of Teaching Hospitals.

After discussion, there was general agreement that COTH membership should be in the name of the newly established corporation, that the chief executive of that corporation should be the COTH representative

and that single membership dues should be paid. Further, there was a consensus that it is premature to delve further into this matter, and that future problems in this area be dealt with on a case-by-case basis by the Administrative Board after appropriate documentation by the staff.

IV. Nominating Committee Report:

Chairman Wilmot stated that other members of the Committee were George Cartmill and John Stagl. The committee report is as follows:

Administrative Board

CHAIRMAN

Leonard W. Cronkhite, Jr., M.D.
Children's Hospital Medical Center

CHAIRMAN-ELECT

Robert A. Derzon
University of California, San Francisco

THREE-YEAR TERM

Daniel W. Capps
University Hospital, University of Arizona

Sidney Lewine
The Mount Sinai Hospital of Cleveland

Charles B. Womer
Yale-New Haven Hospital

TWO-YEAR TERM

David H. Hitt
Baylor University Medical Center

ONE-YEAR TERM

Eugene L. Staples
West Virginia University Hospital

AAMC ASSEMBLY

THREE-YEAR TERM

John W. Colloton
University of Iowa Hospitals and Clinics

THREE-YEAR TERM

David H. Hitt
Baylor University Medical Center

John F. Imirie, Jr.
Medical College of Virginia Hospitals

Bernard J. Lachner
Evanston Hospital

Stanley R. Nelson
Henry Ford Hospital

Marvin F. Neeley, Jr.
Milwaukee County General Hospital

J. W. Pinkston, Jr.
Grady Memorial Hospital

Mitchell T. Rabkin, M.D.
Beth Israel Hospital, Boston

John V. Sheehan
Veterans Administration Hospital, New York

John Reinertsen
University of Utah Hospital

John M. Stagl
Passavant Memorial Hospital

Charles B. Womer
Yale-New Haven Hospital

ONE-YEAR TERM

David L. Everhart
New England Medical Center Hospital

Dan G. Kadrovach
Hermann Hospital, Houston

V. Meetings During the Coming Year:

A. Administrative Board Meetings

Since the next regularly scheduled meeting of the Board (December 12) follows the annual meeting so closely, it was left to the discretion of the incoming Chairman to decide whether a meeting is necessary. Board

meetings scheduled for the 1973 administrative year are as follows:

Wednesday, March 14, 1973	Dinner	Embassy Row Hotel 6:30 p.m. - 9:30 p.m.
Thursday, March 15, 1973		Embassy Row Hotel 9:00 a.m. - 3:00 p.m.
Wednesday, June 20, 1973	Dinner	Embassy Row Hotel 6:30 p.m. - 9:30 p.m.
Thursday, June 21, 1973		Embassy Row Hotel 9:00 a.m. - 3:00 p.m.
August 19, 1973 (Sunday Preceding American Health Congress Chicago, Illinois)		Palmer House 9:00 a.m. - 3:00 p.m.

B. Spring Regional Meetings

There was agreement that spring regional meetings should be re-activated in early 1973. The new Chairman, Dr. Cronkhite will appoint an individual in each region to work with the staff in planning the program for the meetings.

C. Other Special Meetings

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 an annual spring session (in addition to regional meetings). There was a brief discussion of whether COTH should follow suit. There was consensus that no such meeting should be planned at this time. However, if the new COTH Director believes such a meeting would be useful, or if the Chairman believes an issue, or set of issues, requires this type of attention, this decision should be reconsidered.

V. Committee Reports:

The following committee reports were presented by the designated individuals. The reports or recent minutes reflecting the progress of these activities appear as appendices to these minutes.

- | | |
|--|------------|
| . VA Sharing Task Force | Appendix A |
| . RMP/CHP Committee | Appendix B |
| . Subcommittee On Quality Of Care | Appendix C |
| . Task Force on Graduate Medical
Education and Faculty Practice Plans | Appendix D |

With the exception of the VA Sharing Task Force, the groups will continue to work. The VA SHaring Task Force Report will be presented at the December 21 meeting of the AAMC/VA Liaison Committee.

During Mr. Greathouse's report on the VA, questions were raised regarding VA Circular # 10-73-184 which permits dual payment to medical residents for performing duties normally expected of house officers. A copy of this circular appears on the following page. Concern was expressed about establishing the precedent that if a house officer performs services which don't specifically relate to the educational program, he or she should be paid additional dollars. The discussion also included such matters as house staff work rules, fringe benefits, moonlighting, and general contractual arrangements. No action was taken, but the staff was requested to explore the possiblility of including some of these questions in the COTH annual house staff salary survey.

VII. Other Business:

Dr. Knapp made a brief presentation of the principal provisions of H.R. 1 and indicated that a staff analysis of the bill would be mailed to all AAMC constituents in the next two weeks.

Mr. Cartmill thanked the members of the Administrative Board and staff for their support during the year. Members of the Board joined in expressing their appreciation of Mr. Cartmill's leadership during this most important year.

VIII. Adjournment:

There being no further business, the meeting adjourned at 5:15 p.m.

August 15, 1972

SUBJECT: COVERAGE IN THE ADMITTING AREA

TO : Directors of VA Hospitals, Domiciliary, VA Outpatient Clinics,
and Regional Offices with Outpatient Clinics

In order to meet the critical problem faced by some VA hospitals in staffing the admitting office, Central Office will consider granting authority to appoint medical residents presently on VA rolls as fee basis physicians for coverage during nights, weekends, and holidays. Approval can be granted only on an individual station basis when the following conditions are met and certified to the appropriate Regional Medical Director; (1) the Deans Committee has determined that admitting office duty is not a valid training experience in the VA and (2) no other means of providing medical coverage in the admitting office is available to station management. Medical residents appointed on this basis will be paid the fee per tour established by the Regional Medical Director in addition to their regular resident stipend.

Requests for this exception will be submitted to the appropriate Regional Medical Director (O52A) and will contain the following information: (1) description of index and community hospital practices and rates for similar duty, (2) statement that Deans Committee has officially determined that admitting office duty in the VA is not a valid training experience for residents and that they concur in the proposal being submitted, (3) number and duration of tours to be established per week, and (4) explanation and justification why station management has determined that this method of coverage is necessary instead of using staff physicians and/or non-VA fee basis physicians.

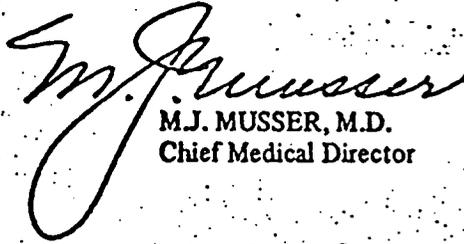
Dual appointment and pay of residents on VA rolls for any purpose other than performing an established tour of admitting office duty is prohibited. Existing RMD authorities for fee basis admitting office tours of duty are not to be construed as authorities for the dual appointment and compensation of residents on VA rolls; separate authority is required for this purpose. If the station is requesting authority for fee basis admitting office tours of duty in which private physicians and residents on VA rolls will be utilized, this should be so indicated in the submission.

If the appropriate RMD approves fee basis tours of duty for admitting office coverage and the utilization of residents on VA rolls for such tours, then stations so authorized must keep a record of the names of all such residents given dual appointments for this purpose, the number, type and duration of each tour performed, and the total amount paid each resident under his fee basis appointment. This information is required to be reported annually to Central Office. Reports will be due August 1 of each year covering the preceding fiscal year, and will be submitted to the

CIRCULAR EXPIRES AUGUST 14, 1973

appropriate Regional Medical Director (052A). A format for this report will be prescribed in a forthcoming issuance.

The appointment of a fee basis physician under 38 U.S.C. 4114(a)(1)(B) who is also appointed as a resident under 38 U.S.C. 4114(b) does not require the submission of additional data into the PAID System to reflect the fee basis appointment.



M.J. MUSSER, M.D.
Chief Medical Director

Distribution: COB: (10)(05) only, (052A)25, (054D)25, (152)25
SS (101B12) FSB: HA, DO, OC, OCRO

REPORT OF THE
 VETERANS ADMINISTRATION
 SHARING TASK FORCE

APPENDIX A

In October of 1971, COTH Director John Danielson appointed a Veterans Administration Sharing Task Force. This group was appointed as a result of several meetings held informally with Veterans Administration COTH members. The Task Force was charged with reviewing progress in VA-medical center sharing programs.

INTRODUCTION

Public Law 89-785, which enabled Veterans Administration hospitals to engage in sharing of medical facilities, equipment and information was enacted on November 7, 1966. This legislation authorized the VA to engage in agreements which provide for:

- the exchange of use of specialized medical resources when such an agreement will obviate the need for a similar resource to be provided in a VA facility.
- the mutual use or exchange of use of specialized medical resources in a VA facility which have been justified on the basis of veterans care but are not utilized to their effective capacity.

The implementation of this legislation has been of great interest and concern of the House Committee on Veterans' Affairs and of the present Chief Medical Director. The following data for FY '71 was contained in the Annual Report on Sharing Medical Facilities of the Administrator of Veterans Affairs and provides a status report for the first five years through June 30, 1971.

At that time the VA was operating 165 hospitals of which 99 were "Teaching Hospitals" affiliated with one of the nation's 109 medical schools. Sixty-six VA hospitals did not have such affiliations. Forty-five of the 165 VA hospitals had implemented sharing agreements as of June 30, 1971. Tables I and II set forth the dollar value of these sharing arrangements.

TABLE I

Number of VA Hospitals Receiving Services Under A
 Sharing Arrangement

Total Dollar Value	Number of Hospitals in Dollar Range	Dollar Range
\$ 26,804	7	Under \$ 12,000
265,903	7	\$ 25,000- 66,000
<u>420,084</u>	<u>3</u>	125,000-165,000
TOTAL \$ 712,791	17 (10% of VA Hospitals)	

TABLE 2

Number of VA Hospitals Which Furnished Services
Under A Sharing Arrangement

<u>Total Dollar Value</u>	<u>Number of Hospitals in Dollar Range</u>	<u>Dollar Range</u>
15,428	19	Under \$ 3,000
67,312	7	\$ 4,000- 14,000
99,995	3	22,000- 46,000
312,512	3	96,000-109,000
<u>330,082</u>	<u>2</u>	153,000-178,000
TOTAL \$ 825,329	34 (20% of VA Hospitals)	

On June 1, 1971, Mr. Bill Freer, as Special Assistant to the Assistant Chief Medical Director for Planning and Evaluation, assumed the responsibility for the administrative coordination of sharing proposals submitted by field stations for Central Office approval. His efforts have been helpful and additional progress was made in FY '72 as indicated in Table 3.

TABLE 3

Status of Sharing Arrangements
FY ' 72 Versus FY ' 71

	<u>FY ' 72</u>	<u>FY ' 71</u>	<u>Change</u>
No. stations with sharing programs	60	44	+16
No. of contracts	94	64	+30
Dollar value of services furnished by VA	\$1,359,000	\$888,000	+ \$469,000
Dollar value of services received by VA	1,126,471	712,790	+ \$413,681

* Dollar values are approximate

It is apparent from the above information that after six years the "sharing program" has not been broadly implemented. While there have been a few instances where VA hospitals have been quite successful in executing "exchange of use of specialized medical resources" and sharing agreements, the number and extent of the agreements are very few and limited when considering that there are 168 VA hospitals and their medical communities who are eligible.

The experience of a few VA hospitals demonstrates the major benefits to be realized by both parties in sharing services costly in terms of equipment, staff and space, regardless of how specialized or how routine they may be. Radiology and clinical laboratories are examples.

IMPEDIMENTS AND PROBLEMS IN MAKING PROGRESS

The VA Central Office

There is no question concerning the dedication of the Chief Medical Director to the successful implementation of the sharing program. We believe that this same enthusiasm is shared by the Chief Medical Director's principal advisers. We do not believe that the VA Central Office staff, including many Service Chiefs who pass judgments on the various proposals, have either an understanding of the objectives or sympathy for the successful implementation of the program as reflected by:

- a broad belief that sharing agreements are further means for the university to take advantage of the VA to the VA's detriment;
- a failure to understand that field stations need encouragement and a green light to go ahead and see if some of the sharing agreements can actually be implemented: to what degree, and to what benefit.

The natural resistance to change is often present and there is little evidence of a concerted dedication in helping to find out how proposals can be approved expeditiously. Further, there is a restrictive interpretation of what sharing includes under the current legislation, including interpretations of the General Counsel. The limiting effect in interpretation of a "special medical resource" is substantial. It does not appear to us that the intent of Congress was to be restrictive in the implementation of the sharing concept as is currently practiced by the Veterans Administration. In other words, the definition of specialized medical services should have a much broader interpretation than presently conceived by those who are making day-to-day decisions related to implementation of the program. The Chief Medical Director and his principal advisers in their communication with university officials and personnel of other health-related organizations seem to imply a much broader interpretation than is in fact the practice by the Veterans Administration.

Finally, there appears to be a lack of clear understanding of "mutual use" and "exchange of use" concepts as well as the relationship of contracts to sharing agreements. A more precise statement of definitions and nomenclature by the VA Central Office could be very helpful in clearing the confusion in terminology.

Field Stations Directors and Staff

A very large portion of the hospital directors and their key staff members are representative of a system which, until the past several years, did not truly identify with the community as a whole, although there are many outstanding examples of excellent relationships with affiliated institutions. Perhaps poorly labeled for want of a better term is what may be described as complacency, apathy, or maintenance of status quo on the part of too much of the VA's hospital management. The Chief Medical Director, in recent months, has voiced great concern over the lack of participation of hospital directors and their hospitals in activities of professional organizations related to health-care affairs and the

community in general. This lack of concern and involvement by hospital directors is bound to be reflected in their lack of enthusiasm, lack of imagination, and lack of success in the implementation of sharing programs. Additionally, many of them feel strongly that it is not in the best interest of the Veterans Administration to become involved with other institutions or the community in arrangements such as those that might be developed under the sharing program. They are suspicious of the motives of the community institutions and individuals as not being in the best interest of the Veterans Administration.

Relationship With the Community

The policy of the Veterans Administration, as a reflection of the Congress, to seriously become involved in the planning and implementation of programs related to our national health goals, is very little understood in many of our communities. The Community tends to want to wait to see if this policy is for real and the Veterans Administration can actually play a role in community health care delivery affairs. Even for aggressive VA hospital directors, it is going to take time and a concerted effort for them to make real converts of their community colleagues.

In order to achieve this objective, legislation or administrative directive should be sought which would require membership and full participation of the VA with the medical community planning groups to require consideration of the principles of certificate of need and sharing prior to construction of health care facilities either by VA or non-VA. Included in such legislation should be the legal requirement for all health care resources to be taken into account when planning facilities to meet health care needs of a given medical community. Further, P.L. 89-785 should be broadened to permit capital expenditures on the part of the VA to meet the full dimensions of the sharing concept.

Veterans Organizations

We believe that the Administrator, and the Chief Medical Director, have probably made good inroads in achieving support from the national officers of veterans' organizations for the sharing concept. At the state or local levels, we sense a lack of understanding of such concepts as sharing and there is evidence of open opposition to any programs that would bring about change in the role of a VA hospital. With the exception of some states, such as Alabama where the VA has had success in gaining support, this is of real concern to VA hospital directors. There is little question that a director needs the support of veterans' organizations.

The Academic Health Center

It is apparent that substantial barriers and impediments exist within most, if not all, academic health centers across this country to substantially utilize the opportunities that currently exist for sharing resources and programs with conveniently located VA hospitals where there exists appropriate organizational ties with individual academic health centers.

Most academic health centers could find themselves as a part of a larger University structure and in many instances as a part of the larger state government structure; thus there are in existence legal, policy, custom and similar barriers

to effecting one or another kind of sharing arrangement. State or university law or policy does not contain sufficient flexibility to meet VA statutory requirements in effecting a sharing arrangement.

There is a strong tendency within academic health centers to equate absolute control or something closely akin to it with togetherness, availability and usefulness for educational purposes in the broader academic health center context. Obviously the VA hospital must be to a point isolated against this degree of control by the non-VA portion of the academic health center. Thus it becomes a very real problem to convince clinical department chairmen, the deans, hospital directors outside the VA that much can be gained by forging strong sharing ties with approximately located Veterans Administration Hospital under a dean's committee arrangement.

There has been a strong historical tendency within academic health centers to design, seek support for, and implement programs on an individual, departmental basis. When this approach is applied within the academic health center to facilities and resources almost exclusively under the control of the dean, hospital administrator and department chairmen, this departmental thrust operates relatively effectively. However, when it involves dealing with a strong third party, the Veterans Administration, it tends to mitigate against the development of strong, effective sharing relationships on an institution to institution basis between the Veterans Administration Hospital, the university teaching hospital, and the school of medicine.

Without question, the above impediments and probably others of a similar nature have added very significantly to the lack of utilization of available sharing potential along pathways currently available to VA station managers. The resolution of these areas lies in strong, effective leadership at the dean and hospital director level within our academic health centers and probably in placing a significant portion of the VA Hospital academic health center interrelationship on an institution to institution basis so that the results are two mutually interdependent "corporations" rather than a series of isolated, often unrelated sharing arrangements within the same academic health center.

SUMMARY

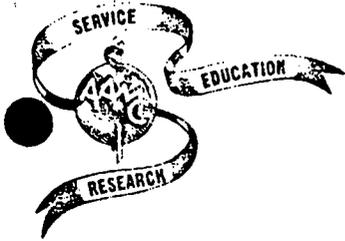
In reviewing the progress in achieving the objectives of sharing programs, there appear to be five major factors which have contributed to the relative slow pace of activity.

- Middle management level of the Veterans Administration does not appear to be sufficiently sympathetic to the objectives of the sharing concept.
- The limiting effect of the narrow interpretation of "special medical resource" is substantial.
- There appears to be confusion and lack of understanding of the sharing program, particularly outside the VA community of institutions.

- There is a tendency in academic health centers to express the need for control of a program in order to find it mutually useful.
- The tradition of strong departmental arrangements in academic health centers makes it difficult to forge institution to institution sharing programs rather than a collection of departmental contracts or agreements.

JOE GREATHOUSE, *Chairman*

CLYDE COX
KEN O'BRIEN
JOHN REINERTSEN
JAMES VARNUM
HUGH VICKERSTAFF



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
202/466-5127

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 center 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 Relman
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.

Status Report on
MCAT DEVELOPMENT ACTIVITY

A provisional name has been designated - Medical College Admission Assessment Program (MCAAP). The key word is "assessment". This word was deliberately chosen to suggest a broader range of data collection beyond that ordinarily implied by a testing format, e.g. biographical information. The purpose of the program is to update and expand the MCAT and increase the amount of useful information available during the admissions process.

A systematic effort is suggested for obtaining constituent input and consensus on instrument construction and research and development activity. This effort began in a serious way about a year ago when your response to a "Proposal for a Program of Pre-enrollment Assessment" was requested. Some concrete topics for discussion were identified which hopefully will provide a departure point for discussion at the spring meetings of the appropriate councils and subcouncilar units of the Association. Jim Angel, program director of MCAAP, will be working with the various regional chairmen to identify a regional representative who will facilitate discussions within regions where possible, organize the regional input, and supply continuity in later discussions.

Following regional meetings, the current plan is to organize regional conferences in June sponsored by MCAAP and devoted exclusively to discussion of plans and priorities for program development. Participation would be open to all interested representatives from all constituent bodies of the AAMC within that region. The various regional representatives previously identified would play a major role in transmitting the concerns of their organization at these discussions and in representing a synthesis of these concerns at a task force to take place in July. Invitation to the task force sessions would include the regional representatives and a few at-large members. The primary objective of the task force sessions would be consensus on immediate plans and priorities for test construction activities and research effort.

Concurrently, a contractor will be identified to interact with the constituency at these various opportunities and draw up a set of specifications which will also include its independent recommendations.

Finally, an advisory body will be identified from those contributing to the ultimate consensus in order to provide continuing guidance to the developing program.

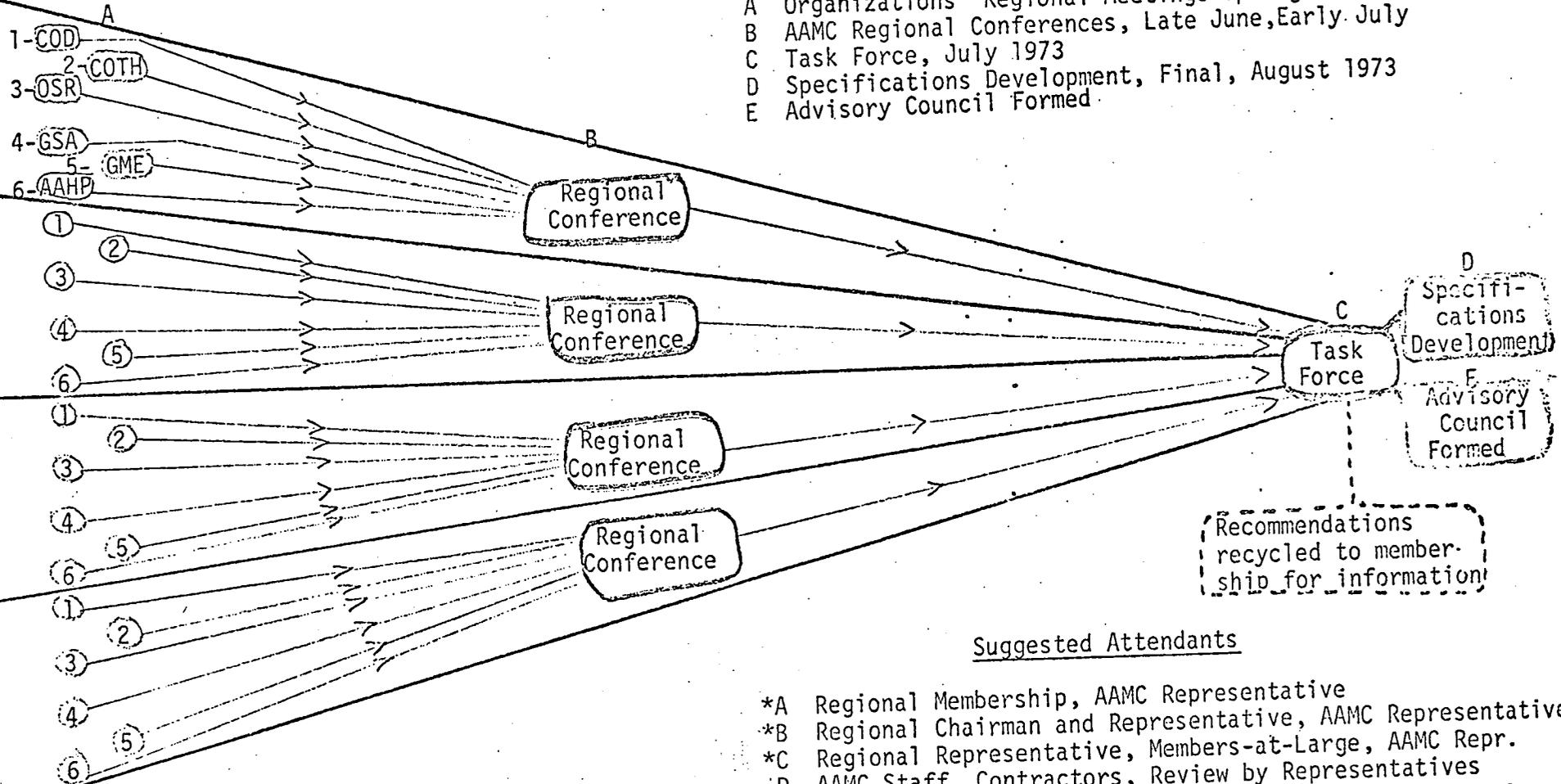
AAMC
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DIAGRAM OF COUNCIL/GROUP AND TASK FORCE INVOLVEMENT¹

MCAT Revision Planning

Meetings

- A Organizations' Regional Meetings Spring 1973
- B AAMC Regional Conferences, Late June, Early July
- C Task Force, July 1973
- D Specifications Development, Final, August 1973
- E Advisory Council Formed



Suggested Attendants

- *A Regional Membership, AAMC Representative
- *B Regional Chairman and Representative, AAMC Representative
- *C Regional Representative, Members-at-Large, AAMC Repr.
- D AAMC Staff, Contractors, Review by Representatives
- E Persons recommended by task force, AAMC Exec. Council
- *Some meetings possibly attended by contractor representative

¹ Plans being formulated for CAS participation also.

- 1 Council of Deans
- 2 Council of Teaching Hospitals
- 3 Organization of Student Representatives
- 4 Group on Student Affairs
- 5 Group on Medical Education
- 6 Association of Advisors to the Health Professions

Not named is Council of Academic Societies, which may have involvement of some dimension.

REGIONAL MEETING SCHEDULE

NORTHEAST REGION

May 17

Boston

Children's Hospital
Medical Center
Research Center

SOUTHERN REGION

May 4

Atlanta

The Hilton Inn

MIDWEST/GREAT PLAINS REGION

April 30

Chicago

Sheraton O'Hare

WESTERN REGION

April 13

Salt Lake City

Ramada Inn

Policy Statement of the AAMC on PSROs

TITLE XI of Public Law 92-603, the Social Security Amendments of 1972, calls for the establishment of PSROs nationwide to monitor and evaluate the costs and quality of health care for Medicare and Medicaid patients. At present, the Federal responsibility for developing this program has been divided among three agencies. HSMHA has been assigned the task of developing norms and standards as well as designing methodologies for collecting the necessary data in a uniform manner; SSA, because of its operational experience in administering the Medicare program, will assimilate the data through its EDP facilities, utilizing the capabilities of its carriers and intermediaries.

The PSRO office under the direction of the Secretary of HEW will have overall policy determination over both HSMHA and the SSA.

\$10M this fiscal year and \$30M next fiscal year have been requested for PSRO activities. Most of these funds will be utilized for contracts to prototype PSROs with some monies for central office operations and a small amount for research. The majority of the PSRO staff positions will be within the BHI of the SSA.

Although PSRO regulations will not be developed anytime within the near future, it is anticipated that some preliminary guidelines will be distributed for the use of "early" PSRO programs, as well as those organizations with plans to become PSROs (under Section 1169 of the Law, funds are provided for feasibility and planning grants to PSRO prototype projects).

By January 1, 1974, the Secretary of HEW will have designated the geographical areas for PSROs. Nationally there will be approximately 150-200 PSROs which will be established mostly below the state level.

The PSRO will be required to develop a series of profiles on institutions, physicians and patients. Although rudimentary patient and physician profiles now exist in the computer tapes of the intermediaries and carriers, they must be expanded to include additional data and must be collated to produce the requisite information.

Utilizing EDP techniques, matrices will be developed by PSROs which will facilitate the evaluation of practitioner and institutional performance in multiple areas of health care services.

The preparation, distribution and validation of data, starting at the local level and channelled through the PSRO central office and back to the local organizations will constitute a substantial administrative task to be performed by the 100 carriers and intermediaries for Medicare and a large number of different carriers and intermediaries for Medicaid. Changes will also have to be made in the present EDP system of the SSA to accommodate the demand for additional and different types of data.

Within the teaching hospital, the U.R. Committee could be used as a mechanism for developing an internal review system to meet the operating requirements of the local PSRO. If the norms, criteria and standards developed by the U.R. Committee are judged to be acceptable to the PSRO, the hospital can then be made responsible for reviewing its own health

care services subject to periodic sample auditing by the PSRO. In such cases, the U.R. Committee can make decisions in regard to patient care which are binding upon the carrier as well as the SSA.

Records and data will have to be reviewed to determine such things as appropriateness of admission, parameters of acceptable care for various disease states and perhaps comparison of surgical rates, for example, of hysterectomies and tonsillectomies with those of other hospitals in the area.

With the realization that the PSRO legislation needs to be more clearly interpreted, the Federal Government may develop a PSRO Model Review System to describe how a PSRO could be organized. This package would include a model charter, by-laws, membership guidelines, a budget, an appropriate data system and a reporting mechanism. The early directives to be distributed with this package could suggest the types of activities that should be conducted by a PSRO, e.g. pre-admission certifications program, development of a model treatment plan, etc.

In developing their programs, PSROs will be assisted by the technical and regional staffs of HSMHA and SSA. Once geographical areas have been designated, it is recognized that institutions such as teaching hospitals will require additional staff and resources to assist their U.R. Committees in meeting the requirements of the local PSROs.

The Association's Subcommittee on Quality of Care (Dr. Robert Weiss, Chairman; Dr. Clement Brown; Dr. David Challoner; Dr. Christopher Fordham; Dr. Richard Meiling; and Mr. John Westerman) will meet in April to develop further the AAMC's relationship to the evolving federal presence in quality and cost review.

The Subcommittee intends to meet with Dr. Bauer, Director of PSRO, and the Senate Finance Committee staff, and develop recommendations for teaching hospitals to meet PSRO criteria through multiple mechanisms. In addition, the dissemination of information, where teaching hospitals have successfully worked out mechanisms with prototype PSROs, will be one of the major goals of the Subcommittee.

Approval by the EC of a policy statement on the appropriate involvement of the AAMC membership in the development of PSROs is desirable at this time.

RECOMMENDATION

It is recommended that the Executive Council approve the following statement as an AAMC policy on PSROs:

The AAMC believes that the development and implementation of norms and standards for assessing the quality of health care is a vital responsibility of the medical schools and teaching hospitals. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students a life-long concern for quality in their practice.

The AAMC, therefore, strongly recommends that its member institutions become intimately involved in the development and operation of Peer Standards Review Organizations.

AAMC RMP-CHP LEGISLATIVE PROPOSAL

At a May 1972 meeting of the Association's Health Services Advisory Committee, John A.D. Cooper, M.D., AAMC President, proposed the establishment of an ad hoc committee to consider the implications for the Association in connection with the legislative authorizations for the Regional Medical and Comprehensive Health Planning programs, which expire June 30, 1973.

Committee membership included Dr. Stuart Sessoms, chairman; Dr. William S. Jordan Jr.; Dr. Alexander M. Schmidt; Dr. William Stewart; Dr. James V. Warren; Dr. William R. Willard; and Dr. Andrew Hunt. The committee was asked to give consideration to the following issues:

1. What do RMP and CHP do now, and how does that affect the Association constituency;
2. What does the Association think RMP and CHP should do, and how should that affect the Association constituency; and
3. What steps would be necessary to achieve this, with particular reference to a possible legislative proposal.

The committee has held a number of meetings, has questioned numerous experts in the field, and has received assistance from the Association staff, including reports on site visits to a number of CHP and RMP programs or agencies. Among the persons who appeared before the committee were John R.F. Ingall, M.D., Director, Regional Medical Program of Western New York, representing the RMP Coordinators Association; and Mr. Larry Newell and Mr. William Hiscock, representing the American Association of Comprehensive Health Planning. The major findings and conclusions of the committee are represented in the accompanying Outline of Proposed Legislation.

In essence, the Association's legislative proposal is based on the following principles:

1. There should be established a Council of Health Advisers in the Executive Office of the President to advise him on national health policy, on preparation of appropriate legislative proposals, and on preparation of a biennial Report on the Nation's Health. The Council should be assisted by a National Advisory Commission on Health Planning.
2. There should be established a program of grants to states for health planning and services which would be carried out by state health agencies which, in turn, would be comprised of a planning unit (providing comprehensive health planning at both the state and area level) and a health services unit (combining a number of existing federal health service development programs, the most important of which is RMP). The principal function of the health services unit should be to support programs to transfer more effectively the advancing knowledge in medicine and biomedical technology from the academic health centers to the practicing community. Block-grant financing should be provided through allotments to states of federal funds for health planning and health services. Public participation should be provided through appropriate advisory groups. State health planning and services should be required to meet federal standards

which the HEW Secretary would develop with the review and approval of a National Advisory Council on Health Planning and Services.

3. There should be a focus at the federal level on health services research and development which would be accomplished by providing for a permanent, open-ended authorization of appropriations for the National Center for Health Services Research and Development, whose authority is to expire June 30, 1973.

It is hoped that the Executive Council will study and comment on the Outline of Proposed Legislation, which follows, and take the following action.

RECOMMENDATION

It is recommended that the Executive Council adopt the principles listed above as Association policy on the extension of RMP-CHP legislation.

Outline of Proposed Legislation

Title I

Council of Health Advisers

Require the President to submit to Congress a biennial Report on the Nation's Health which shall include information on the status of the nation's health; on trends in the quality, management and utilization of health services; on the adequacy of the nation's health care resources; on the effect of government programs in the nation's health; and on methods or legislation for meeting identified deficiencies.

Establish in the Executive Office of the President a three-person Council of Health Advisers, comparable to the Council on Environmental Quality.

Authorize the Council to employ necessary officials and to fix their salaries, and also to employ necessary experts and consultants.

Specify the duties and functions of the Council --

(1) to assist and advise the President in the preparation of the Report on the Nation's Health;

(2) to gather timely and authoritative information concerning the conditions and trends in the nation's health both current and prospective, to analyze and interpret such information for the purpose of determining whether such conditions and trends are interfering, or are likely to interfere, with the improvement of the nation's health and to compile and submit to the President studies relating to such conditions and trends;

(3) to review and appraise the various programs and activities of the federal government for the purpose of determining the extent to which such programs and activities are contributing to the improvement of the nation's

health, and to make recommendations to the President with respect thereto;

(4) to develop and recommend to the President national policies to foster and promote the improvement of the nation's health to meet the social, economic, health, scientific, ethical, and other requirements and goals of the Nation;

(5) to conduct investigations, studies, surveys, research, and analyses relating to health care resources and health services delivery;

(6) to document and define changes in the health of the nation and to accumulate necessary data and other information for a continuing analysis of these changes or trends and an interpretation of their underlying causes;

(7) to report in alternate years to the President on the state and condition of the nation's health; and

(8) to make and furnish such studies, reports thereon, and recommendations with respect to matters of policy and legislation as the President may request.

Establish a 19-person National Advisory Commission on Health Planning to assist and advise the Council, which shall be composed of five members appointed by the President pro tempore of the Senate, five members appointed by the Speaker of the House, and nine members appointed by the President.

Require the Council to consult with the National Advisory Commission on Health Planning and to utilize other, nongovernment resources as appropriate.

Provide that the members of the Council shall be full-time employees and fix their pay rate in the Executive Schedule.

Authorize appropriations to carry out the title of \$300,000 in fiscal 1974, \$700,000 in fiscal 1975, and \$1,000,000 in fiscal 1976.

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Title II

Health Planning and Services

Findings and Declaration of Purpose

Describe the general need for the legislation and the purposes for it --

(1) promote the establishment of more efficient and effective health service systems, assure coordination among all federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the planning thereof;

(2) assist in the support of state programs of health planning, public health services, the initial support of new health services, and the support of health services meeting particular needs;

(3) provide support for research and development (including demonstration and training) related to improving the organization, planning, and delivery of health services; and

(4) provide support for demonstrations and experiments in the integration and coordination of federal health programs, and appropriate related programs, leading to the development of improved health systems extending high quality care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by federal health programs.

Grants to States for Health Planning and Services

Describe conditions to be met in order for a state to be eligible for assistance under the section: designation of a state agency to carry out the state's health planning and health service assistance functions (with

the option at the Secretary's discretion of separate agencies being so designated); provision for a state health planning and service assistance advisory council, a majority of whose membership shall be health care consumers; provision of assurances to the Secretary that the state agency will have authority to carry out its functions and that federal funds will increase state health spending rather than supplant it; provision of appropriate methods of administration, fiscal controls and reporting procedures. Provide that interstate compacts may also qualify for assistance.

State Health Planning

Describe the state health planning function. Planning shall be conducted according to criteria established by the Secretary and shall give first consideration to identification of acute problems and development of means to overcome them. State health planning shall be carried on in cooperation with education, welfare and rehabilitation agencies. State health planning shall include the relationship between the health needs of the people and the capability of the health care system to deliver health services; the development and distribution of health personnel; the establishment of methods of measuring the quality of health care provided in the state; and the evaluation of health care planning and services in the state. The state health planning agency shall review and approve applications for all health related projects in the state to be assisted under the Public Health Service Act, the Social Security Act, or other appropriate provisions of law, except that it shall not consider applications related to biomedical research or health professions education. Require the state planning agency to review its plans at least annually. Require the state health planning agency to work with health care facilities in the state on a capital expenditure program. Require the Secretary to carry on a continuous program of health service planning in consultation with state planning agencies and provide for federal takeover of state health planning if the

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state agency does not carry out its responsibilities. Exclude planning with respect to the national supply of professional health personnel from the general emphasis on state-by-state planning.

State Health Service Assistance

Describe the state health service assistance function. The state health service agency shall be responsible for providing adequate health services to the people of the state. Services assisted or provided shall meet criteria as to their scope and quality prescribed by the Secretary and shall be in accordance with state health plans. If a state designates separate planning and assistance agencies, then the approval of the planning agency must be obtained prior to approval of a project by the service assistance agency. The priority of projects to be assisted is to be based on the relative need as determined in the state health plan. Except for assistance with respect to the national supply of professional health personnel, health services assistance shall proceed primarily on a state-by-state basis. If the designated state agency does not carry out its responsibility, the Secretary shall assume responsibility for coordinating the service assistance functions within the state. Applications for health services assistance may be made by any public or nonprofit private entity or combination. No application shall be disapproved by the state action agency until the agency has afforded the applicant an opportunity for a hearing. The state health service assistance agency may make grants or enter into contracts for any of the purposes currently provided for in existing Public Health Service Act sections 304 (health services research and development); 314(e) (health services development); 904 (establishment and operation of RMPs); 910 (multiprogram services); 314(d) (public health services).

State Allotments and Payments to States

Provide for the allotment of appropriated funds to states on the basis of the population, per capita income, and the extent of the need for

health service assistance, provided that no state would receive less than one percent of the appropriation. Funds may be reallocated by the Secretary if not fully used by the state to which they were initially allotted. From each allotment, the state shall be paid from time to time the federal share of expenditures incurred in carrying out the state's health planning and health service assistance functions. The federal share is to be 90 percent for states which designated a single agency to carry out the two functions, 75 percent for states which designated separate agencies, and 80 percent for states with separate agencies but also with certificate of need legislation.

Project Grants for Areawide Health Planning

Provide for project grants by the state health planning agency to other public or nonprofit private agencies or organizations for areawide health planning, similar to the planning currently authorized in existing section 314(b). There must be an areawide health planning council, a majority of whose membership must be health care consumers; and the areawide health planning agency is to assist health care facilities in the development of a capital spending program.

Project Grants for Training, Studies, and Demonstrations

Provide permanent, open-ended authorization for project grants by the state health planning agency to any public or nonprofit private agency, institution, other organization, or combination to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward development of improved or more effective comprehensive health planning.

Withholding of Payments

Provide for the withholding of funds by the Secretary when he determines after reasonable notice and opportunity for hearing that there is a failure to comply substantially with either the applicable provisions of the law, the state health plan, or applicable regulations.

Definitions

Define terms used, including the terms regional medical program, medical center, clinical research center, hospital, nonprofit, and construction.

Annual Report

Provide for an annual report to the Congress from the Secretary on the effectiveness of the activities carried out under the legislation, on the relationship between federal and nonfederal financing for activities undertaken under this legislation, and on recommended changes in the law.

Authorization of Appropriations

Authorize appropriations of \$600 million in fiscal 1974, \$700 million in fiscal 1975, and \$800 million in fiscal 1976 for this program of grants to states for health planning and services, and provide that no funds shall be available to pay for hospital care except in connection with research, demonstration or training carried out under the program.

General Provisions

Provide such general provisions as are necessary to make the new program of grants to states for health planning and services conform to routine Public Health Service Act and DHEW legislative requirements.

Federal Standards

Provide a mechanism under which the Secretary, with the participation and approval of the newly established National Advisory Council on Health Planning and Services, shall provide for the development of federal standards for health planning and services, in cooperation with appropriate regional, state and local review organizations as determined by the Secretary. Require state health planning and health service agencies to meet such standards. Provide for the development of interim standards, pending the development of permanent standards.

National Advisory Council on Health Planning and Services

Establish a 23-member National Advisory Council on Health Planning and Services to advise and assist the Secretary in the preparation of general regulation

for, and as to policy matters arising with respect to, the administration of this program of grants to states for health planning and services, with particular attention to the relationship among comprehensive health planning, the improved organization and delivery of health services, and the financing of such services. The Council shall review at least annually the grants made under the program to determine their effectiveness in carrying out their purposes. The Council is to be comprised of four ex-officio members -- the Secretary, the Chairman of the Council of Health Advisers, the chief medical officer of the VA, and a medical officer designated by the Defense Secretary -- and 19 members appointed by the Secretary, a majority of whom are to be representatives of health care consumers. The appointed members are to be selected from among leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery and financing of health care, officials in state and areawide health planning agencies, leaders in health care administration, or state or community or other public affairs, who are state or local officials, or representatives of consumers of health care. The Secretary is to be chairman of the Council, and it is to meet at least four times a year. Appointed members of the existing National Advisory Council on Comprehensive Health Planning Programs (which the new Council replaces) may serve at the Secretary's discretion as additional members of the new Council until their existing terms expire.

Title III

Other Amendments to the Public Health Service Act

Amend section 304(a) (research and demonstrations relating to health facilities and services) to provide a permanent, open-ended authorization for the National Center for Health Services Research and Development.

PROPOSED MEDICARE CHANGES

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Office of the Secretary
Washington, D. C. 20201

FOR RELEASE AT 12 NOON (EST) MONDAY, JANUARY 29, 1973

CAUTION: The attached document is based on the President's budget scheduled for delivery to the Congress on Monday, January 29, 1973, and is strictly embargoed until noon of that day.

It must be held in strict confidence. No portion, synopsis, or intimation of its contents may be published until release time, nor may any of its contents be paraphrased, alluded to, or hinted at in stories or commentary while the embargo is in effect.

The same caution applies to newspapers, radio and television commentators and news broadcasters, both in the United States and abroad.

PLEASE USE EXTREME CARE TO AVOID PREMATURE PUBLICATION OR ANNOUNCEMENT.

C O R R E C T I O N

PAGES 81-84 ARE INCORRECTLY NUMBERED AND PLACED. THEY SHOULD
BE INSERTED BETWEEN PAGES 72 AND 73.

Medicare

A number of significant administrative and legislative changes are included in the Medicare budget estimates for FY 1974. The Social Security Amendments of 1972 provide for a substantial broadening of the program by extending Medicare coverage to social security disability beneficiaries who have been entitled to disability benefits for two years or more. This new coverage, effective July 1, 1973, is expected to add 1.7 million disabled persons to the program and increase FY 1974 benefit outlays by \$1.7 billion.

The Amendments also contain a number of important cost and quality control provisions which are reflected in the estimates. These include limits on provider costs recognized as reasonable, provisions establishing reimbursement procedures for health maintenance organizations, limits on reimbursements for capital expenditures not approved by State health planning agencies, and, perhaps most important for the future, the establishment of a nationwide network of Professional Standards Review Organizations (PSRO). These are organizations through which practicing physicians will assume responsibility for reviewing, on a comprehensive and integrated basis, the necessity for and quality of institutional and outpatient services under Medicare and Medicaid. Funds totalling \$9 million in FY 1973 and \$34 million in FY 1974 are included in Medicare, Medicaid, and Departmental Management to finance the start-up of PSRO's throughout the country.

In FY 1973, an administrative change is being made to the present method of reimbursing providers in the hospital insurance program. At the beginning of the Medicare program in 1966, there was considerable concern that substantial numbers of institutional health care providers would decline to participate in the program until a fully satisfactory system of processing and paying Medicare claims was established and proved. To provide assurance against the possibility of long delays in routine reimbursements, a mechanism termed "current financing" was established. This device, in effect, provided special payments to providers concurrent with the time services were rendered. Now that the routine claims process has been established and the original concern over large backlogs eliminated, this particular procedure is no longer as important. Its termination will allow the recovery of approximately \$300 million in funds advanced under its provisions. If delays in payment occur in unusual cases, an accelerated payments procedure will still be available to providers if the need can be currently demonstrated.

New proposals to help control rising medical costs are also included in the Medicare budget. While the Phase III price controls on medical costs, coupled with an increased utilization review and pre-admission certification effort, will exercise a restraining influence on Medicare cost increases, we are also seeking to encourage greater cost consciousness and cost awareness on the part of the medical care consumer in order to minimize over-utilization of medical services. To this end, legislation will be proposed to become effective January 1, 1974, increasing cost sharing in both the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) components of the Medicare program. Were it not for the combined effect of these administrative actions and legislative proposals, the FY 1974 Medicare budget would be \$893 million higher. Savings from the legislative proposals will be

marginally offset by a \$44 million increase in Medicaid costs. The HI program currently contains an initial deductible amount the beneficiary must pay which is equal to the national average cost of one day's stay in a hospital (currently \$72). The beneficiary pays nothing further until the 61st through 90th days of hospital stay, during which time he is charged a daily amount equal to one-fourth of the initial deductible. If the beneficiary needs more than 90 days of hospital care in a benefit period, he has a lifetime reserve of 60 additional days. For each lifetime reserve day used, he pays one-half of the initial deductible. Thus, the current system provides for major cost sharing only at the end of a long hospital stay--when the beneficiary is least able to afford it--while doing little to counteract over-utilization at an earlier stage of hospitalization when it is most likely to occur. Moreover, the amount the beneficiary pays bears no relationship to actual costs incurred and services rendered in the course of his hospitalization.

Legislation to be proposed would replace the current HI cost-sharing system with a new system under which the beneficiary would pay daily amounts equal to ten percent of actual hospital, extended care facility, or home health agency charges for that day, after having met an initial hospital deductible amount equal to one day's actual room and board charges. Thus, the proposed system has the advantages of tying cost-sharing to actual charges and services used, instituting it at a point where it is likely to discourage over-utilization, and eliminating high cost-sharing at the end of a long hospital stay. It is intended to establish a cost awareness on the part of the medical care consumer which, besides its effect on over-utilization, should inhibit hospital price increases.

Two legislative changes also are proposed in the SMI program. The first increases the initial deductible to \$85 from its present \$60, while the second increases the percentage amount of subsequent bills which the beneficiary pays from 20 to 25 percent. Since the SMI program came into being in 1966, the deductible has increased only 20 percent, despite an increase in physicians' fees of close to 50 percent and an increase in cash benefits paid to Medicare beneficiaries of more than 70 percent. The proposed deductible has been increased by the same percentage that Social Security cash benefits have increased since the inception of the SMI program--and would increase in the future as cash benefits are raised. It would, in effect, keep pace with the beneficiary's ability to pay.

In FY 1974 about 23.1 million persons will be covered under the provisions of the Hospital Insurance program and 22.5 million under SMI. Medicare benefit outlays are expected to be \$11.9 billion under current law, an increase of \$2.8 billion over FY 1973. Including proposed legislation, FY 1974 benefit outlays are expected to be \$11.4 billion. Total Medicare outlays are estimated at \$12.1 billion.

§405.455. Amounts of Payments Where Customary Charges for Services Furnished Are Less Than Reasonable Cost.--(a) Principle.--Payments to providers of services are based on the lesser of the reasonable cost of covered services furnished to program beneficiaries or the customary charges to the general public for such services. However, public providers rendering services free of charge or at a nominal charge will be reimbursed an amount determined to represent fair compensation for covered services furnished to program beneficiaries. This provision is effective for services rendered by providers in cost reporting periods beginning after December 31, 1972.

(b) Definitions.--(1) Customary Charges.--Customary charges mean the charges most frequently assessed for services to patients who are liable for payment of such charges.

(2) Reasonable Cost.--For purposes of comparison between reasonable cost and customary charges, reasonable cost shall include (1) the routine nursing service salary cost differential, (ii) the allowance for a reasonable return on equity capital (in the case of proprietary providers), and (iii) payments made to a provider for the reasonable cost of services of teaching physicians; but shall not include (1) payments made to a provider as reimbursement for bad debts arising from noncollection of Medicare deductible and coinsurance amounts, (ii) amounts

which represent the recovery of excess depreciation resulting from termination or a decrease in Medicare utilization, (iii) payments to funds for the donated services of teaching physicians, and (iv) amounts attributable to depreciation, interest expense, return on equity capital, and other costs related to capital expenditures to be excluded pursuant to the limitation on capital expenditures.

(3) Public Provider.--A public provider means any provider owned, operated, or controlled by a Federal, State, county, city, or other local government agency or instrumentality.

(4) Nominal Charges.--A public provider's charges are considered nominal where they represent only token charges and are not intended to meet the cost of services rendered. Charges are considered nominal if, in the judgment of the intermediary, the aggregate charges are less than one-half of the actual cost of services or items represented by such charges.

(c) Application.--(1) It is appropriate that, on an aggregate basis, payments to a provider for covered services rendered beneficiaries under title XVIII should not exceed the customary charges made by the provider to the general public for such services. In determining payments on an aggregate basis, charges for items and services and the reasonable cost of such items and services will be considered separately for Part A and Part B of title XVIII. The principle established is to be applied after the provider's charges and costs have been adjusted in accordance with the requirements set forth in (b)(2) above and in

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sections 405.480-405.488 to exclude any amounts attributable to physicians' services (other than interns and residents) and any other noncovered services.

EXAMPLE: The reasonable cost of covered Part A services furnished to program beneficiaries by a provider for a cost reporting period is \$125,000. The customary charges to these beneficiaries for these services totaled \$110,000. The amount to be reimbursed this provider will be \$110,000 less deductible and coinsurance amounts to be borne by program beneficiaries.

(2) Providers of services whose charges are lower than costs in a given period--possibly due to miscalculation, or special circumstances of limited duration--are given an opportunity to recover any unreimbursed costs. Such recovery is accomplished by permitting the provider to carry forward for the two succeeding reporting periods any disallowed costs attributable to program beneficiaries which are unreimbursed by the operation of this regulation. If the two succeeding reporting periods are less than 24 months in duration, the provider may carry forward any reimbursable costs for three succeeding reporting periods. Where beneficiary charges exceed reasonable cost in such periods, the unreimbursed amount carried forward will be reimbursed to the provider up to the limit of the excess of current period charges over reasonable cost applicable to program beneficiaries. For the purpose of this provision, separate computations will be made for amounts reimbursed under Part A and Part B

trust funds. Thus, the carryover provision would permit recoupment of previously unreimbursed costs under one part to be recovered under that part only.

EXAMPLE: In the reporting period ending December 31, 1973, the provider's reimbursable costs attributable to covered Part A services furnished program beneficiaries were \$100,000. The provider's customary charges for these services were \$90,000. The provider will, therefore, be reimbursed \$90,000 less any deductible and coinsurance amounts but will be permitted to carry the unreimbursed \$10,000 forward for the next two succeeding reporting periods. If, in the reporting period ending December 31, 1974, beneficiary charges for covered Part A services exceeded the reimbursable reasonable costs of such services by \$10,000 or more, the provider could recover the entire \$10,000 previously not reimbursed. If, however, beneficiary charges exceeded costs by \$8,000, this amount would be added to the provider's reimbursable costs for this period. The balance of the unrecovered amount or \$2,000 would be carried over to the next reporting period.

(3) Public providers rendering services free of charge or at nominal charges, as defined in (b)(4) above, are not considered as having customary charges and the fair compensation for the services they furnish will be the reasonable costs of covered services, as defined in section 405.451(b).

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Regulations No. 5--Subpart ~~8~~ 9405.401(a)

Subpart D—Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Appeals by Provider

AUTHORITY: The provisions of this Subpart D issued under secs. 1102, 1814(b), 1833(a), 1861(v), and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 79 Stat. 302, 79 Stat. 322, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

§ 405.401 Introduction.

(a) Under the health insurance program for the aged, the amount paid to any provider of services—i.e., hospital, extended care facility, or home health agency—for the covered services furnished to beneficiaries is required by section 1814(b) and section 1833(a)(2) of the Social Security Act to be the "reasonable cost" of such services.

(b) These principles of reimbursement and the related policies described in this subpart establish the guidelines and procedures to be used by institutional providers, fiscal intermediaries, and the Social Security Administration in determining reasonable cost.

(c) The principles of reimbursement are to be applied on behalf of the program by public and private organizations and agencies acting as fiscal intermediaries in the payment of claims. These organizations and agencies are selected after nomination by groups or associations of hospitals. Extended care facilities and home health agencies may similarly nominate such intermediaries. The fiscal intermediaries are responsible for paying the bills of beneficiaries for covered services received in participating hospitals and other institutions under the Medicare program. A provider may deal directly with the Social Security Administration, in which case the same principles are to be used in making payment for services.

(d) In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points. They offer certain alternatives and options designed to fit individual circumstances and to allow time for those providers who do not already collect the statistical and financial data necessary for the reporting of costs to develop the necessary records.

(e) An important role of the fiscal intermediary, in addition to claims processing and payment, and other assigned

However, with respect to cost reporting periods beginning after December 31, 1972, payments to providers of services are based on the lesser of the reasonable cost of services or the customary charges to the general public for such services.

responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure them equitable payment under the program.

[51 F.R. 14863, Nov. 22, 1986]

§ 405.102 Cost reimbursement; general.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of that cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be

However, with respect to cost reporting periods beginning after December 31, 1979, payments to providers of services are based on the lesser of the reasonable cost of services or the customary charges to the general public for such services.

routine nursing salary cost (\$13.12 - \$12.50)	\$0.62
(ix) Portion of the per diem in- patient routine nursing salary cost differential included in the cost of routine service (\$12.50 - \$12.09)	\$0.41

(3) *Illustration of differential adjustment factor for a cost reporting period beginning before July 1, 1969 and ending after June 30, 1969.* Assume the same statistical and financial data in paragraph (c) (1) of this section and that the provider's cost reporting period was for a 12-month period ending March 31, 1970.

Potential routine nursing salary cost differential adjustment factor ap- plicable to beneficiaries for the re- porting period	\$2,381
Allowable routine nursing salary cost differential adjustment factor ap- plicable to beneficiaries for the re- porting period	$9/12 \times \$2,381 = \$1,786$

(36 F.R. 12606, July 2, 1971 as amended at 37 F.R. 10354, May 20, 1972)

§ 405.451 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the "reasonable cost" of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

(b) *Definitions*—(1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered

However, for cost reporting periods starting after December 31, 1972, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in §405.455.

COTH SUPPORT OF DOCTORAL RESEARCH: A PROPOSAL

One way in which the Department of Health Services and Teaching Hospitals can expand its investigative activities in the absence of acquiring additional staff is to provide modest support for ongoing doctoral research in areas of interest to the COTH membership. The following mechanism is proposed for consideration:

- (1) The establishment of two (2) COTH \$2500 research support grants to doctoral candidates in the organizational and/or behavioral sciences, e.g. Departments of Economics or Programs in Hospital and Health Administration. It is suggested that these awards be general in nature and not tied to any particular expenditures (data processing, travel, etc.)
- (2) The applicants should be full-time degree candidates who have passed their comprehensive examination and who have a formally approved dissertation proposal.
- (3) The subject matter area addressed in the research proposal should be directly related to the financing, organization and/or delivery of health services in an academic medical center environment. It is anticipated that the COTH administrative board would delineate specific areas it would be willing to support; some examples might be:
 - a) The effect of teaching programs on hospital cost dynamics,
 - b) Quantification of differential characteristics of teaching and non-teaching facilities (e.g., case mix, staffing patterns, organizational structure, etc.),
 - c) The design and implementation of innovative ambulatory care delivery models,
 - d) The effect of structural and functional arrangements of different delivery mechanisms upon the quality of care in a teaching setting.
- (4) It is suggested that promotion of the willingness of COTH to support certain types of research should be informal in nature. After specific areas of interest have been selected by the Administrative Board, a list of academic departments known to be sponsoring such research efforts would be contacted by letter. The chairman of each would be asked to encourage able students conducting relevant research to apply directly to COTH.
- (5) The applicants themselves and their research proposals would be screened by the staff; selection of award recipients would be made by the Administrative Board.



COTH Survey of House Staff Policy

March 1973

To Be Completed and Returned to:

COTH-AAMC, One Dupont Circle, N.W., Washington, D. C. 20036

HOSPITAL NAME: _____

A. INTERNS AND RESIDENTS

- How many house staff positions did you fill in 1972-1973?
- How many house staff positions are you offering for 1973-1974? (If you share house staff with another institution, please estimate the full-time equivalencies for your hospital)
- What is the minimum cash stipend per year?

Interns	Residents	Clinical Fellows
---------	-----------	------------------

_____	_____	_____
_____	_____	_____

1973-74 stipends are estimated:

Yes _____

No _____

Cannot Estimate _____

Interns:

1972-73	1973-74
\$ _____	\$ _____

Residents:

1st year	_____	_____
2nd year	_____	_____
3rd year	_____	_____
4th year	_____	_____
5th year	_____	_____
1st year	_____	_____
2nd year	_____	_____

Clinical Fellowships:

If minimum stipends vary by department, in which departments do they vary, and how much in 1972-73 was the difference for 1st year residents?

Departments

\$Amount

a. _____	+ _____
b. _____	+ _____
c. _____	+ _____
d. _____	+ _____

5. Do you have a dependency allowance? YES _____ NO _____

6. What is the estimated total dollars to be spent for intern and residents' stipends for 1972-73? \$ _____

7. What is the estimated cost of perquisites and/or fringe benefits (including insurance) to your institution for house staff during 1972-73? \$ _____

8. What percent of your 1972-73 operational budget is allocated to the costs of stipends and fringe benefits for house staff? _____ %

9. What sources are used to pay your costs (stipends and fringe benefits) for interns and residents? (i.e. hospital charges, federal grants, medical school funds)

Sources	\$	% of Contribution
a. _____	_____	_____ %
b. _____	_____	_____ %
c. _____	_____	_____ %

10. What sources are used to pay your costs for clinical fellowships?

Sources	\$	% of Contribution
a. _____	_____	_____ %
b. _____	_____	_____ %
c. _____	_____	_____ %

11. Will there be a change in the total number of funded house officer positions for July, 1973? Net Number Increased _____
 Net Number Decreased _____
 No Change _____

B. PERQUISITES

1. Please check the health insurance benefits for which you pay the full costs of the premiums to insure

	House Officers	Dependents
Hospitalization	_____	_____
Medical Surgical	_____	_____
Major Medical	_____	_____

2. Please indicate the perquisites which you furnish at reduced rates or at no cost to your house officers.

- | | |
|---|---|
| _____ Laundry | _____ Professional Meetings (travel, room or board) |
| _____ Duty Uniforms | _____ Housing (cash allowances or domicile) |
| _____ Parking | _____ Meals (other than on-call or snacks) |
| _____ Malpractice Insurance | |
| _____ Life Insurance: Face Value of Policy \$ _____ | |
| _____ Other: (please specify): _____ | |
| _____ None of the above mentioned | |

3. During the past year, which fringe benefits were:

Added?	Increased?	Eliminated?	Decreased?
_____	_____	_____	_____
_____	_____	_____	_____

C. HOUSE OFFICER EMPLOYMENT POLICIES

In addition to their regularly prescribed duties, are your house officers permitted to engage in the delivery of other medical services at your hospital, such as staffing your emergency room, for which they earn additional money (moonlighting)?

YES _____ NO _____

2. Does your hospital policy permit house officers to "moonlight" outside your institution?

YES _____ NO _____

3. If NO, is the policy strictly enforced?

YES _____ NO _____

4. Does your hospital ever hire house officers from other institutions to staff your emergency room or a similar service?

YES _____ NO _____

D. COLLECTIVE BARGAINING

1. Has your hospital, since January 1, 1972, received a request for collective bargaining recognition from any formally constituted group seeking to represent your house staff regarding wages, fringe benefits, and/or terms and conditions of employment?

YES _____ NO _____

2. Does your hospital now have a negotiated collective bargaining contract with any segment of your house staff regarding wages, fringe benefits, and/or terms and conditions of employment?

YES _____ NO _____

3. Has your hospital, since January 1, 1972, experienced any type of job action (e.g., work stoppage, strike, "admit-in," mass resignation, "sick-out," etc.) by any segment of your house staff?

YES _____ NO _____

4. Is any portion of your non-house staff personnel (full-time physician faculty, nurses, paramedical, non-professional) covered by a negotiated collective bargaining contract?

YES _____ NO _____

E. OTHER

What is the procedure in the following two departments for "nights on"?

a. In Medicine, 1st year residents are assigned a "night on" every _____ weekday and every _____ weekend.

b. In Surgery, 1st year residents are assigned a "night on" every _____ weekday and every _____ weekend.

Resume

DENNIS DALE POINTER, PH.D.

Present Position:

Assistant Director, Division of Teaching Hospitals, Association of American Medical Colleges (2/1/73 to date)

Past Positions:

Assistant Professor, Graduate Program in Health Care Administration, The City University of New York (2/1/71 to 2/1/73)

Assistant Professor (5/1/72 to 2/1/73) and Instructor (2/1/71 to 5/1/72), Department of Administrative Medicine, Mount Sinai School of Medicine

Instructor, Graduate Program in Hospital and Health Administration, the University of Iowa (1/1/70 to 2/1/71)

Research Fellow, National Institutes of Health Predoctoral Research Fellowship, Graduate Program in Hospital and Health Administration -- University of Iowa College of Medicine, the University of Iowa (1/1/69 to 1/1/70)

Administrative Assistant, University of Iowa Hospitals and Clinics; Iowa City, Iowa (1/1/68 to 1/1/69)

Education:

University Undergraduate-- Iowa State University; Ames, Iowa (Major: Psychometrics; Minors: Philosophy, History) B.Sc. Degree awarded June, 1967

University Graduate -- The University of Iowa; Iowa City, Iowa. Doctor of Philosophy Degree awarded January, 1971. Major: Hospital and Health Administration. Minor: Statistics. Tools: Computer Science, Research Methodology. Thesis: "Employee Organization in Health Care Facilities: An Exploratory Analysis and Evaluation"

Awards:

Dean's Scholar, Iowa State University (academic year 1966 through 1967)

Psi Chi Academic Psychology Honorary, Iowa State University (initiated June, 1967)

University of Iowa Graduate College Scholarship (awarded for academic year 1967-1968)

Resume

DENNIS DALE POINTER, PH.D.

Page 2

Association of University Programs in
Hospital Administration Research and
Educational Trust Award for Academic
Achievement (awarded February, 1968)

University of Iowa Graduate College
Scholarship (awarded for academic year
1968-1969)

National Institute of Health Predoctoral-
Research Fellowship Grant No. 1 FO1 HS
00002; awarded by the Division of
Health Services Research and Development
(1/1/69 to 1/1/70)

United States Public Health Service Study
Grant (HSM - 00 - 128) to participate
in Faculty Institute On Medical Care
Teaching; Ann Arbor, Michigan (June 12
through June 23, 1972)

Affiliations:

American Hospital Association
American Public Health Association
American Statistical Association
Industrial and Labor Relations Research
Association

Appointments:

Research Consultant, Division of
Research, Naval School of Health Care
Administration, National Naval Medical
Center; Bethesda, Maryland (Bureau of
Medicine and Surgery, United States Navy)

Affiliated Consultant (specialist in labor
relations) Health Associates International,
Inc.; Washington, D.C.

Associate Project Director, Health Research
Fellows Program, Contract No. HSM 110-71-140,
Health Service and Mental Health Adminis-
tration, U.S. Public Health Service

Statistical Consultant, "Nursing Homes
in Massachusetts: An Analysis of Costs
and Services" Contract No. HSM 100-69-413,
National Center for Health Services Research
and Development

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Ruchlin, Hirsch S., Dennis D. Pointer and Samuel Levey, "Health Administration Manpower Research: A Critique and A Proposal," pending publication, Hospital Administration.

Pointer, Dennis D., Robert L. White and James Bentley, "Work Load Measurement in Navy Hospitals: An Initial Discussion," pending publication, Military Medicine.

Ruchlin, Hirsch S., Dennis D. Pointer and Lloyd L. Cannedy, "Hospitals that Failed: An Analysis of Characteristics," pending publication, Modern Hospitals.

Ruchlin, Hirsch S., Dennis D. Pointer and Lloyd L. Cannedy, "Hospital Administration in a For-Profit and Non-Profit Environment: An Analysis of Perceptual Similarities and Differences," pending publication, Hospital Administration.

Pointer, Dennis D., Robert L. White and James Bentley, "The Composite Work Unit As A Resource Allocator: A Critical Analysis," pending publication, Military Medicine.

93^D CONGRESS
1ST SESSION

S. 1006

IN THE SENATE OF THE UNITED STATES

FEBRUARY 26, 1973

Mr. DOMINICK introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to extend the provisions of section 601 thereof and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 That (a) section 601 of the Public Health Service Act
4 (42 U.S.C. 201) is amended by striking the words "sec-
5 tion 600" and inserting in lieu thereof the words "this
6 title".

7 (b) Section 601 (a) of such Act is amended to read
8 as follows:

9 " (a) For the fiscal year ending June 30, 1974, and
10 each of the next two fiscal years—

11 " (1) \$25,000,000 for grants for the construction

1 of public or other nonprofit facilities for long-term care;

2 “(2) \$70,000,000 for grants for the construction
3 of public or other nonprofit outpatient facilities;

4 “(3) \$15,000,000 for grants for the construction
5 of public or other nonprofit rehabilitation facilities.”

6 (c) Section 601 (b) of such Act is amended by insert-
7 ing immediately after “1973” the following: “\$45,000,000
8 for the fiscal year ending June 30, 1974, and for the next
9 two fiscal years”. (grants for the construction of public or other
nonprofit hospitals and public health centers)

10 (d) Section 601 (c) of such Act is amended by insert-
11 ing immediately after “1973” the following: “, \$50,000,000
12 for the fiscal year ending June 30, 1974, and the next
13 two fiscal years”. (grants for modernization of above named facilities)

14 (e) Section 601 of such Act is further amended by add-
15 ing at the end thereof the following new subsection:

16 “(d) For the purposes of assisting facilities providing
17 services required under section 603 (c) (2), \$50,000,000
18 for the fiscal year ending June 30, 1974, and for the next
19 two fiscal years.” (availability of services for persons unable to pay)

20 SEC. 2. Section 602 (a) of such Act is amended by add-
21 ing at the end thereof the following new paragraph:

22 “(3) For each fiscal year the Secretary shall, in ac-
23 cordance with regulations, make allotments among the States
24 from the sums appropriated under section 601 (d), on the
25 basis of population, the financial need, and the extent of the

1 need for the services required under section 603 (c) (2), of
2 the respective States.”.

3 SEC. 3. Section 605 of such Act is amended by adding
4 at the end thereof the following new subsection:

5 “(f) No application for assistance under this title for a
6 project which would result in an increased number of hos-
7 pital beds in an area shall be approved unless such applica-
8 tion has been reviewed and approved by the appropriate
9 areawide health planning agency established pursuant to
10 section 314 (b) of such Act (or, if there is no such agency
11 in the area, then to such other public or private nonprofit
12 agency or organization, if any, which performs similar func-
13 tions), and only if such assistance will be provided in ac-
14 cordance with such plans as have been developed pursuant to
15 section 314 (a) of such Act.” (approval of projects for construction or
modernization)

16 SEC. 4. Section 625 of such Act is amended by adding
17 immediately after “1973,” the following: “and the next two
18 fiscal years,”. (limitation of amount of loans guaranteed or directly made -
\$1,500,000,000)

19 SEC. 5. Section 631 of such Act is amended by striking
20 the word “two”, and inserting in lieu thereof the word
21 “five”. (construction or modernization of emergency rooms)

1973 AAMC Annual Meeting

Format - With Sunday serving as the arrival date for most participants, Plenary Sessions would be held on Monday and Tuesday mornings, Business meeting of the Councils would be held on Monday afternoon and the Assembly on Tuesday afternoon. Wednesday morning would be reserved for a program of the Councils, similar to the joint COD-CAS program held this year. Sunday afternoon, Wednesday afternoon, and all day Thursday would be open for committee meetings and meeting of outside groups (including Academic Society meetings).

Nov. 4 Nov. 5 Nov. 6 Nov. 7 Nov. 8

	S	M	T	W	T
AM		Plenary	Plenary	Council Program	Misc
PM	Misc OSR	Council Business	Assembly Minority?	Misc	Misc

Council of Teaching Hospitals—AAMC

GENERAL SESSION SPEAKERS

Friday, November 3, 1972

THEME—External Fiscal Controls On
The Teaching Hospital

H. ROBERT CATHCART
President
Pennsylvania Hospital
Philadelphia, Pennsylvania



THE PHILADELPHIA
EXPERIENCE

THOMAS L. HAWKINS, JR.,
M.D.
Executive Vice President
and Director
Albany Medical Center
Hospital
Albany, New York



THE NEW YORK STATE
EXPERIENCE

COTH ACTIVITIES

Thursday, November 2, 1972

4:00-6:00 p.m. AAMC-VA Joint Session

Friday, November 3, 1972

12:00 p.m. COTH Annual Luncheon

1:30 p.m. COTH Annual Institutional
Membership Meeting

Presiding, GEORGE E. CARTMILL
Chairman, COTH, 1971-1972

2:30-5:00 p.m. COTH General Session
Presiding, LEONARD W. CRONKHITE, JR., M.D.
Chairman, COTH, 1972-1973

Saturday, November 4, 1972

1:30-4:00 p.m. AAMC Assembly Meeting
Chairman's Report

President's Address

Presentation Abraham Flexner
and Borden Awards

Election and Installation of AAMC Officers

6:00-7:30 p.m. AAMC CHAIRMAN'S RECEPTION

OTHER AAMC PROGRAM OPPORTUNITIES

THEME—From Medical School to Academic Health Center

PLENARY SESSION (FRIDAY MORNING, NOVEMBER 3)

Presiding: RUSSELL A. NELSON
President, The Johns Hopkins Hospital,
AAMC Chairman

The Challenge of Health Professions Education in the Seventies

EDWARD M. KENNEDY, *U.S. Senator, Massachusetts*

Health at the Crossroads: Which Road to Follow

PAUL G. ROGERS, *U. S. Representative, Florida*

Integration of Educational Programs for Health Professionals

JOHN R. HOGNESS, *President, Institute of Medicine*

The Continuum of Undergraduate and Graduate Medical Education

IVAN L. BENNETT, JR., *Director and Dean,*
New York University Medical Center

A Tiger by the Tail

PHILIP R. LEE, *Chancellor, University of California,*
San Francisco

PLENARY SESSION (SATURDAY MORNING, NOVEMBER 4)

Presiding: CHARLES C. SPRAGUE
Dean, University of Texas Southwestern Medical School
AAMC Chairman-Elect

ALAN GREGG MEMORIAL LECTURE:

Enlarging Human Capability: The Role of the Health Sciences

CLARK KERR, *Chairman, Carnegie Commission on*
Higher Education

Area Health Education Centers and the Regionalization of Academic Medicine

EDMUND D. PELLEGRINO, *Vice President for the Health*
Sciences, SUNY at Stony Brook

The Role of the Academic Health Center in Delivering Health Care

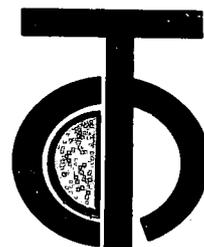
ARTHUR E. HESS, *Deputy Commissioner, Social*
Security Administration

Directions for Research in the Academic Health Center

HOWARD H. HIATT, *Dean, Harvard School of Public*
Health

SEE YOU IN MIAMI BEACH

Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W. Washington, D. C. 20036
(202) 466-5128

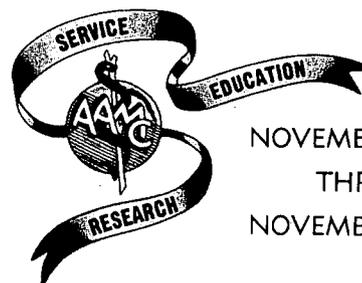


COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Annual Meeting Program

**HOTEL FONTAINEBLEAU
MIAMI BEACH, FLORIDA**



NOVEMBER 2, 1972
THROUGH
NOVEMBER 6, 1972

THE GRADUATE MEDICAL EDUCATION COMMITTEE

William G. Anlyan, M.D., CHAIRMAN
Vice President for Health Affairs
Duke University
School of Medicine

Sam L. Clark, Jr., M.D.
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Thomas D. Kinney, M.D.
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Christian Ramsey, M.D.
President
Institute for the Study of
Health and Society

Arnold S. Relman, M.D.
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University of Pennsylvania
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David B. Wilson, M.D.
Asst. Dir. of the Medical Center
(For Special Projects and Health
Care Planning)
University of Mississippi
School of Medicine

Dr. Dael L. Wolfle
Professor
University of Washington
Graduate School of Public Affairs

Prepared by:

August G. Swanson, M.D.
Director, Dept. of Academic Affairs
Association of American Medical Colleges

GUIDELINES FOR ACADEMIC MEDICAL CENTERS
PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY
FOR GRADUATE MEDICAL EDUCATION

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FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist faculties seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It was not intended that a single best solution be promulgated.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieving a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academics in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.¹ In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.² In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.^{3,4}

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialization in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the policies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must develop sufficient financial resources for supporting educational programs to ensure that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for patient services delivered in the teaching setting by both faculty and advanced residents is appropriate and essential. Funds so generated should be collected and managed in such fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

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FOREWORD

The Ad Hoc Committee on Continuing Medical Education was charged with advising the Association of American Medical Colleges regarding the role that the Association and its constituents should play in continuing education in the future. Implicit in that charge was the view that continuing education has not been effective in accomplishing its imputed purpose--to make physicians of all ages optimally effective in the performance of their professional duties.

Data on performance of physicians (including those holding full- and part-time academic appointments) are difficult to acquire, but the information available suggests that there are significant defects in performance. In the opinion of the committee, there are two main reasons for these deficiencies which are of importance to medical faculties.

The first is that the behaviors imparted during the academic years do not, apparently, persist long into the practice years. The pressures of practice envelop the physician before he has an opportunity to adapt to the discipline required to continue his learning.

Secondly, despite a complete lack of evidence of effectiveness, the "shotgun" approach continues to be the pattern of continuing education as provided by medical faculties and associations. The committee questions the effectiveness of short courses, audio-tapes, video-tapes, and even books and

journals when they are considered in the light of the documented behavioral changes experienced by the majority of physicians after they become involved in the delivery of health care.

Measurements of continuing education, such as certificates of attendance, recognition rewards, and possibly recertification and relicensure by examination, are not measurements of the end objective--improving patient care by changing the behavior of physicians--and have no greater correlation with this objective than do grades and class rankings in medical school with performance during clinical graduate training.

Therefore, it is the thesis of this committee that continuing education cannot and should not be separated from the initial formal education and that medical faculties must strive to incorporate into the basic and graduate training years those continuing education methods which have been shown to be effective.

The committee report develops this position and also emphasizes that the AAMC and its constituents must make plans for instituting educational policies which bear directly on the problem of making physicians continually responsive to the changing knowledge and technology of medicine in the context of their daily responsibilities for patient care.

INTRODUCTION

The committee determined that fulfilling its charge required that it consider continuing education not in the context of the past or present but in the context of future. There was a consensus that there will be increasing expectations by the public for professional accountability (that is, that high quality care be obtainable at reasonable cost).

A modified Delphi technique was utilized to obtain opinions of the entire committee regarding the trends and characteristics of the health care delivery system during the next 10 years.

In the aggregate the committee believes that:

1. Physicians will continue to have the major responsibility for patient care, although they will be increasingly associated with and assisted by other health professionals.
2. Group practice will increase until by the end of the decade at least 50%--and perhaps as high as 80%--of all physicians will be members of organized medical groups.
3. These groups will increasingly be associated with a specific hospital.
4. Forty to seventy percent of physicians will receive at least three-fourths of their professional incomes from salaries.
5. There will be systematized methods of assuring an acceptable quality of physician performance. The responsibility for defining accountability will be shared by:

- (a) practicing physicians and medical educators,
- (b) the federal government,
- (c) third-party insurance carriers, and
- (d) consumers.

The committee believes that the definition of the parameters of quality will be predominantly initiated by practicing physicians and medical educators.

6. Efforts to control quality of medical practice will include:

(a) Audit systems such as the Professional Standards Review Organizations already enacted into law.

(b) Relicensure and recertification with recertification being distinctly favored.

(c) Periodic updating as a condition for continued employment in both private and public clinics.

(d) Requirement for continuing education credit even though there is little evidence that this is effective in assuring that physicians will responsibly modify their practice as knowledge and technology advance.

7. With increased demand for public accountability, there will be an increasing emphasis on educational programs for physicians by hospitals and clinics.

The committee's recommendations must then be interpreted with the knowledge that medical practice in the future is expected to be conducted by physicians predominantly working in organized groups with the majority rewarded through a salary in a social system demanding accountability for control

of quality and with hospitals and professional organizations placing an increasing emphasis on staff education.

RECOMMENDATIONS

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to demonstrate that they are competent to deliver care to patients throughout their professional lives.*

The form in which students and physicians will be asked to demonstrate competence will vary as their careers evolve. Initially, written cognitive examinations will play an important part in evaluation; but these will become less frequent as skills, attitudes, and ability to deduce appropriate conclusions from given data are tested. In practice the quality of care actually being delivered may be the method by which physician competence is constantly monitored.

2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm.*

Before educational goals can be defined and plans laid, it is essential that the real educational needs of physicians be identified. Needs must relate to specified deficiencies

in knowledge, skills, attitudes, and medical care delivery organizational structures which are impairing optimal patient care. This effort cannot be unilateral. The academic staff must be as willing to examine and correct its own deficiencies in patient management as it is to criticize management by members of the nonacademic community of physicians. Students must see that their mentors are willing to participate in rigorous criticism of their own clinical activities. The development of positive and responsive attitudes of open dialogue among physicians must be imprinted as early as possible. Faculty examples of disregard of criticism may be a significant factor in imprinting and molding later regressive behaviors in physicians, impairing their willingness to participate in lifelong learning.

In developing criteria, both the processes of patient care and outcomes must be scrutinized. Although the patient population and the mission of academic hospitals vary from nonacademic hospitals, the committee urges that equivalent standards for ensuring optimal quality be required for all health providers in a community.

Initially, both the establishment of criteria and the development of a feedback system must be modest in scope, but ultimately criteria for all disciplines and subdisciplines of clinical medicine should have a systematized methodology. The areas where the efficacy of two or more approaches to the same problem is unresolved must be identified and flexible allowance made for differing professional opinions.

3. Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.

There is too often an undue preoccupation with form which obscures function in continuing education. The development of educational programs should be directed toward fulfilling the physician's own desire to improve his performance as rapidly and as effectively as possible. Consideration should be given to principles of adult education concerning variations of learning styles, objective-directed learning, and the necessity for interchange of ideas during the learning process. Where learning new skills requires an on-the-job setting, provisions should be made to bring physicians to the appropriate site for the needed period. This may require the provision of substitute personnel in the physician's practice; the academic centers are urged to work particularly with organized groups that have planned for this need.

4. Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice. Depend-

ence upon subjective evaluation of participants and/or cognitive evaluation may be spurious and misleading.

Experimental protocols and research applications failing to provide methods for data collection would not survive any current scientific review process. So too, with educational exercises at undergraduate, graduate, and continuing education levels, there should be methods for assessing objectively that specific desired learning outcomes have been achieved. As the student progresses in his professional education and career, these methods become increasingly sophisticated, time-consuming, and expensive but are, nevertheless, critical to the success of the educational system. Continuing education should be looked upon as a pragmatic effort to improve professional practice and can thus only be evaluated in the real practice setting. If the deficiencies toward which an educational program was directed persist, the content, mode of presentation, and motivational impetus for the learners must be re-examined.

Recommendations 1 through 4 set forth the broad principles upon which the committee believes the Association and its constituents should base their efforts in continuing education. The subsequent recommendations are directed toward specific areas of concern.

5. *Medical faculties should evolve auditable records.*

Assessment of both the process and outcomes of patient

management requires a written clinical record which clearly sets forth the problems identified and attacked, the logic of the diagnostic and therapeutic decisions made, and the outcomes of these decisions. Academic faculties are encouraged to evolve clinical record systems which meet these needs. Students should learn from their very first clinical experience how to develop such records and should grow to expect that their records will be reviewed throughout their professional lives. Faculty willingness to accept review and criticism from colleagues in their own and other disciplines is essential for inculcating responsible professional attitudes in the students whom their attitudes influence. A uniform patient record system involving all affiliated institutions in a center would greatly assist in education and in the measurement of the quality of patient care.

6. Medical faculties should endeavor to apply computer technology to patient record systems, diagnostic and therapeutic decision-making; and educational feedback systems.

Computers have undeveloped potential for clinical data management in a real time sense. Notable experiments are in process, and much can be learned from these. Resistance to the application of computers to clinical problems and adherence to the handwritten records of the past is a position which must be carefully reassessed. Because of high costs for both developmental and operational computer applications, resource sharing among centers will be essential.

7. *Educational planning and implementation should be carried out with the direct involvement of individuals skilled in educational methodologies.*

The development of systems for establishing patient management criteria and educational goals and objectives and for evaluating the impact of education on the learner require skills not necessarily inherent in all medical academicians. Both initial and continuing education require the assistance of individuals who may or may not be physicians but who have had the necessary training to develop and implement modern, goal-directed educational programs. The services of these individuals will do much to improve medical education throughout its continuum.

8. *Whenever appropriate, the members of a health team should be educated together.*

As the team concept of patient care grows, management and skills of delegation are becoming more important. Educational programs directed toward the improved attainment of team care should be developed and directed toward the activities of the entire team. Interdisciplinary development of criteria of quality of care is a method by which educational programs in which the team members learn together may be encouraged.

9. *Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.*

Continuing education must be financed from several sectors. Traditionally, these programs have been self-supporting. The process of evaluation of the efficacy of programs in terms of altered physician behavior and/or improved patient care is sophisticated, time-consuming, and expensive. As with any other sector of education, stable base funding from states, professional societies, and the federal government is essential in order to ensure the development of a skilled cadre of individuals to direct, lead, and evaluate such programs.

The committee believes that education of health professionals, and particularly their continuing education, must be directed toward the goal of the constant improvement of health care throughout the nation. Special funds, obtained on a competitive basis, are necessary in order to stimulate the development and implementation of new ideas in this area. Tuition derived from the students must also be continued in order to both provide support for ongoing programs of proven worth and to create an attitude of personal investment by the learner.

CONCLUSION

These nine recommendations do not represent extraordinary departures. All of them have been developed and implemented to varying degrees both in academic centers and in community hospitals. They do not set continuing education apart from the formal academic programs for students still in their

medical school or clinical graduate years but rather attempt to meld these years into the full professional life span.

The recommendations are pragmatic and are based upon defensible predictions of the characteristics of the health care system during the next decade. If the AAMC and the academic centers embark upon policy development which implements these recommendations in a spirit of cooperation with practicing physicians, much of the criticism currently being leveled at the health care system may be allayed.

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