

COTH ADMINISTRATIVE BOARD  
Sunday, November 4, 1973  
Washington Hilton Hotel  
Chevy Chase Room  
2:30 p.m.-5:00 p.m.

AGENDA

- |       |   |       |
|-------|---|-------|
| I.    | Call to Order   |       |
| II.   | Approval of Minutes   | TAB A |
| III.  | Membership Applications   | TAB B |
|       | 1. Veterans Administration Hospital<br>White River Junction, New Jersey |       |
|       | 2. Norwalk Hospital<br>Norwalk, Connecticut                             |       |
|       | 3. Muhlenberg Hospital<br>Plainfield, New Jersey                        |       |
| IV.   | Review of the Compucare Decision  | TAB C |
| V.    | Current Status of AHA Special Section<br>for Teaching Hospitals         | TAB D |
| VI.   | Economic Stabilization Program  | TAB E |
| VII.  | Report of the COTH Nominating Committee                                 |       |
| VIII. | New Business  |       |
| IX.   | Information Items   | TAB F |
| X.    | Adjournment   |       |

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH Administrative Board Meeting  
September 13, 1973  
Washington, D.C.

MINUTES

PRESENT:

Leonard W. Cronkhite, Jr., M.D., Chairman  
Robert A. Derzon, Chairman-Elect  
Daniel W. Capps  
David H. Hitt  
Arthur J. Klippen, M.D.  
Sidney Lewine  
Herluf V. Olsen, Jr.  
Eugene L. Staples  
David D. Thompson, M.D.  
Charles B. Womer

ABSENT:

George E. Cartmill  
Stuart M. Sessoms, M.D.  
John H. Westerman

STAFF:

John A.D. Cooper, M.D.  
Richard M. Knapp, Ph.D.  
Dennis D. Pointer, Ph.D.  
Grace W. Beirne  
Catharine A. Rivera

I. Call to Order:

Dr. Cronkhite called the meeting to order at 9:00 a.m. in the Gallery Room of the Dupont Plaza Hotel.

II. Consideration of Minutes:

The minutes of the Administrative Board meeting of August 19, 1973 were approved as distributed.

III. Sprague Committee Report:

Dr. Cooper recapped the major points of a discussion that was held the previous evening with the three administrative boards regarding the final report of the Committee on Financing Medical Education. He indicated that during the last several months major modification had been initiated regarding both the methodology of cost estimation and the manner of presenting the resulting data. Specific attention has been focused upon developing an alternative approach to estimating the contribution of the "environmental cost component" to the total cost of undergraduate M.D. education. Dr. Cooper indicated that if the constituent administrative boards and the Executive Council of the AAMC approve the distributed draft report, work would begin immediately on preparing the companion financing report. Dr. Cooper expressed the desire of having a completed financing document before hearings begin on the Comprehensive Health Manpower Education Act during this session of Congress.

After an extensive discussion of the revised draft the following action was taken:

ACTION 1

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD APPROVE THE SEPTEMBER, 1973 DRAFT OF THE REPORT OF THE COMMITTEE ON FINANCING OF MEDICAL EDUCATION ENTITLED, "UNDERGRADUATE MEDICAL EDUCATION: ELEMENTS-OBJECTIVES-COSTS," WITH THE FOLLOWING RECOMMENDED REVISIONS: 1) OMISSION OF THE FOOTNOTE ON PAGE 17 REGARDING THE EFFECTS OF MEDICAL EDUCATION UPON PATIENT CARE COSTS: 2) A REPLACEMENT OF THE LABEL "ENVIRONMENTAL COSTS" BY THE TERM "NECESSARY SUPPORT COSTS" THROUGHOUT THE REPORT.

IV. Deliberation of the Cost of Living Council Health Industry Advisory Committee:

Dr. Cronkhite provided a narrative regarding the deliberation of the Health Industry Advisory Committee of the Cost of Living Council. He indicated that the American Hospital Association introduced a proposal regarding Phase IV hospital controls at the last meeting. Essentially the proposal suggests that facility revenue be partitioned by cost center, and that units of service applicable to each center be identified. Each cost center's revenue would then be divided by the

appropriate number of service units and then aggregated for the facility as a whole. Price increases of between 5 and 6 percent would be allowed for both increases in intensity and new services. Dr. Cronkhite stated this approach would necessitate each individual hospital estimate for the forthcoming accounting period: occupancy rate, length of stay, intensity of care provided and costs associated with increasing the scope of services provided. It appears that new regulations regarding a Phase IV for hospitals will be forthcoming within two months. However, Dr. Cronkhite expressed the opinion that such regulations would be retroactive to October 1, 1973 and have a life span of approximately 18 months.

Following Dr. Cronkhite's presentation there was a general discussion by the Board of the implications of such actions on teaching hospitals. There was general agreement that patient mix alternation in the absence of providing any specifically delineated new services was the primary concern of the Council of Teaching Hospitals. Given the anticipated structure of forthcoming Phase IV guidelines, it appears that hospitals experiencing changes in case mix in the absence of new technology would be forced to seek specific exception from the COLC. Members of the Board also expressed concern regarding the coordination of control mechanisms at various levels of government. Price controls, capital controls, PSRO's, certificate of need and rate review mechanisms conflict with each other and often negate the possibility of compliance across specific programs.

There was general feeling by the Board that staff should continue to monitor developments in the control arena and that the AAMC should develop a policy position in this area no later than the fall of 1973.

V. Senior Membership in the AAMC:

Dr. Knapp discussed changes in the AAMC By-Laws regarding distinguished membership in the Association. Guidelines regarding distinguished membership in the Association can be found in Appendix A.

ACTION 2

IT WAS MOVED, SECONDED AND CARRIED THAT GUIDELINES REGARDING DISTINGUISHED MEMBERSHIP IN THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES BE APPROVED.

ACTION 3

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING INDIVIDUALS BE RECOMMENDED TO THE EXECUTIVE COUNCIL FOR ELECTION AS DISTINGUISHED MEMBERS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES:

ACTION 3...

DONALD J. CASELEY, M.D.  
JOHN H. KNOWLES, M.D.  
RUSSELL A. NELSON, M.D.  
MATTHEW F. McNULTY, JR.  
ALBERT W. SNOKE, M.D.

VI. COTH Participation in JCAH Guideline Revision:

Dr. Knapp discussed a letter he received from John D. Porterfield, M.D., Director of the Joint Commission on Accreditation of Hospitals regarding COTH Participation in updating the 1970 Accreditation Manual for Hospitals. (The letter from Dr. Porterfield appears as Appendix B.) Discussion of Dr. Porterfield's request centered around the fact that accreditation manual review would entail a considerable amount of effort by both a subcommittee of the membership and staff. Questions were raised regarding the advisability of allocating staff time to this effort given the nature and urgency of other issues facing COTH. Several members pointed out that Dr. Porterfield's request gives the Council of Teaching Hospitals an excellent opportunity to become involved in adjusting those portions of the guidelines that do affect teaching hospitals in a significant manner.

ACTION 4

IT WAS MOVED, SECONDED AND CARRIED THAT A COMMITTEE BE APPOINTED TO REVIEW THE ACCREDITATION MANUAL FOR HOSPITALS, 1970 AND FORWARD ANY RECOMMENDATIONS IT DEEMS PROPER TO THE JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS.

VII. AAMC Policy on Labor Legislation:

On August 13, 1973 Dr. Cooper received a letter from Leo J. Gehrig, M.D., Vice President of the American Hospital Association requesting that the Association of American Medical Colleges support the AHA in its stand regarding current legislative attempts to include non-profit voluntary hospitals under the National Labor Relations Act. Presently there are two classes of bills under consideration by the Congress in this session: (1) The Thompson-Javitts bill which proposes to include non-profit voluntary hospitals under the National Labor Relations Act as presently constituted; and (2) the Taft Proposal (S. 2292) which would include non-profit voluntary hospitals under the National Labor Relations Act while incorporating certain modifications that would implement impasse resolution mechanisms and limit the number of bargaining units in health care facilities as well as incorporating other reforms. Dr. Gehrig's letter requested that the Association forward letters to members of both the House Committee on Education and Labor and to the Senate Committee on Labor and Public Welfare. In addition, he requested that the Association ask that its comments be included in the formal record associated with hearings on S. 2292.

It was noted that neither of the two proposals to include voluntary hospitals under the NLRA affect teaching hospitals in a unique way. Dr. Knapp indicated he had discussed the advisability of the AAMC becoming involved in this matter with several members of the Administrative Board earlier this year and the consensus was that the industry was evenly divided regarding the issue, thus the Association should not take a stand. Dr. Knapp also indicated that considerations stimulating approval of Dr. Gehrig's proposal was the fact that the American Hospital Association has been highly supportive of the AAMC's efforts regarding Section 227 of P.L. 92-603. Mr. Lewine indicated that since the introduction of S. 2292, divergence in the field regarding the merits of including voluntary hospital employees under the act has narrowed considerably.

ACTION 5

IT WAS MOVED, SECONDED AND CARRIED THAT THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORT THE AMERICAN HOSPITAL ASSOCIATION IN ITS STAND REGARDING THE INCLUSION OF VOLUNTARY NON-PROFIT HOSPITALS UNDER THE NATIONAL LABOR RELATIONS ACT.

VIII. Compucare Proposal:

On July 27, 1973 Dr. Knapp received a letter from Compucare, Inc., a firm specializing in systems and computer services for the health care field. In its letter to Dr. Knapp, Compucare proposed that with the Association's support and participation it would undertake an effort to provide background data and analysis to assess the current status of computer capability and information systems in university owned teaching hospitals. Compucare proposed to survey university owned teaching hospitals regarding the organization, structure, staffing, cost effectiveness, productivity and development of their computer system.

On August 29, Dr. Knapp met with a subcommittee of the membership to discuss Compucare's proposal. It was the subcommittee's opinion that the budget estimate of forty to fifty thousand dollars developed by Compucare to execute the study was too high and that alternative proposals should be sought both from Compucare and other firms capable of executing such a project. It was the opinion of the subcommittee that the project is worthwhile and should be pursued.

It was the opinion of the Administrative Board that Compucare's subsequent alternative offer of \$6,000 to execute a limited study in this area was reasonable, however, there was considerable feeling that it should not appear that COTH is giving a franchise to any specific firm

to execute a particular study. Although there was no formal action regarding this matter, it was the general consensus of the Administrative Board that staff should solicit similar proposals from other firms engaged in the health services computer systems field and make a selection based upon the bids received.

IX. Adjournment:

There being no further business the meeting adjourned at 11:00 a.m.

SENIOR MEMBERSHIP IN THE AAMC

At the June meeting of the Council of Deans Administrative Board, the AAMC staff was asked to explore the possibility of utilizing the Senior membership category to provide continued participation of individuals once active in the Association who no longer are members of any Council. The Executive Council, meeting the following day, considered this matter and approved a motion to:

1. direct the staff to prepare a proposal based on the recommendations discussed;
2. place this item on the agenda of the three administrative boards at their September meetings.

In accordance with the Executive Council directive, AAMC staff has developed the following Guidelines:

1. Senior members shall henceforth be called Distinguished Members.
2. Distinguished Members shall be elected by the Assembly on recommendation of the Executive Council and one of the constituent Councils.
3. The principal criterion for selection of Distinguished Members shall be active and meritorious participation in AAMC affairs while a member of one of the AAMC Councils. Additional criteria may be established by the Executive Council or constituent Councils responsible for nominating Distinguished Members.
4. Each Distinguished Member shall have honorary membership status on the Council which recommended his/her election, i.e., he/she would be invited to all meetings and would have the privileges of the floor without vote.
5. Distinguished Members shall meet as a group once a year at the Annual Meeting and elect a Chairman and/or Chairman-Elect.
6. Distinguished Members shall be eligible for Emeritus Membership at age 65; Emeritus Membership would be mandatory at age 70.
7. AAMC Bylaws shall be modified to incorporate these changes and to provide Distinguished Members with voting representation on the Executive Council through a 21st member of that Council. This position shall be filled by the Chairman of the Distinguished Members.

Bylaws changes necessary to meet the requirements listed above are under review by the Association's legal counsel and will be available for consideration by the September meetings. A copy of the current AAMC Bylaws appears on the following pages.

RECOMMENDATION

It is recommended that the Executive Council:

1. recommend to the Assembly approval of the Bylaws revisions proposed;
2. approve the proposed Guidelines for Distinguished Membership, to become effective if the Assembly approves the necessary Bylaws revisions.

PROPOSED AAMC BYLAWS REVISIONS

1. Some change may be necessary in Article 7 of the Articles of Incorporation. Is this subject to change? Does the single vote on the Executive Council justify or require any modification of the statement, "Other classes of members shall have no right to vote and no action of theirs shall be necessary for any corporate action?"

2. Title I, Section 2, Paragraph B:

Delete the existing paragraph B and insert:

- B. Distinguished Members - Distinguished Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.

3. Title I, Section 3

Add Paragraph E:

- E. Distinguished members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

4. Title VI, Section 2

Add the words, "and the Chairman of the Distinguished Members," on line 4 after the word, "Representatives".

**Joint  
Commission** 875 North Michigan Avenue Chicago, Illinois 60611  
*on Accreditation of Hospitals*

July 25, 1973

John D. Porterfield, M.D.

Director (312) 642-6061

Richard M. Knapp, Ph.D.  
Director  
Division of Teaching Hospitals  
Association of American Medical Colleges  
Suite 200, One Dupont Circle  
Washington, D.C. 20036

Dear Dr. Knapp:

When the Board of Commissioners of the Joint Commission on Accreditation of Hospitals adopted the new hospital accreditation standards in December, 1970, it had already determined certain characteristics that should be maintained. These included a flexibility which would provide for continuing timeliness of the standards. Advances in clinical knowledge, improvements in the "state of the art," and developments of new methodologies to enhance and preserve the quality of patient care, all call for regular review and appropriate amendment of the standards if they are to continue to reflect both the optimum and the achievable in hospital organization and practice.

To maintain this characteristic, the Board had adopted a resolution that it would at least biennially formally seek the counsel of those associations and groups with knowledge and experience in what hospitals are and what they ought to be. Certain amendments and expansions in the standards have already been adopted as they were earlier indicated, but it is now the time for the first comprehensive review.

The Joint Commission wishes to extend an invitation to your organization to create, or to identify, an existing committee which will review the Accreditation Manual for Hospitals (1970) critically and forward any recommendations for change it deems proper. Reports should be forwarded to Dr. Walter W. Carroll, Associate Director, Research and Standards, who enjoys the responsibility of collating all material for consideration by the Standards Committee of the Board. There is no deadline for receipt of recommendations, but we will be grateful for your response at as early a date as is reasonable.

Your organization's contribution can be substantial and the Joint Commission is appreciative of your valued advice.

Sincerely,



John D. Porterfield, M.D.  
Director

JDP:jm  
enclosure

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership  
in the  
Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Hospital

White River Jct. Street  
City 05001  
Vermont Zip Code  
State

Principle Administrative Officer: W. A. Yasinski  
Name  
Director  
Title

Date Hospital was Established 1938

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating			
Straight Medical	<u>3/14/73</u>	<u>19</u>	<u>19</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>11/25/46</u>	<u>26</u>	<u>26</u>
Neurology	<u>5/5/72</u>	<u>2</u>	<u>2</u>
Surgery	<u>10/29/47</u>	<u>21</u>	<u>21</u>
<del>Pathology</del>	<u>5/20/70</u>	<u>8</u>	<u>8</u>
<del>Radiology</del>	<u>8/3/71</u>	<u>6</u>	<u>6</u>
Psychiatry	<u>4/21/71</u>	<u>18</u>	<u>18</u>
Other Neurosurgery	<u>12/6/46</u>	<u>4</u>	<u>4</u>
Orthopedic Surgery	<u>3/13/57</u>	<u>6</u>	<u>6</u>
Urology	<u>11/2/49</u>	<u>3</u>	<u>3</u>

Information Submitted By: NOTE: Educational programs listed above are combined for the VA Hospital, White River Jct., Vt. and the Mary Hitchcock Memorial Hospital, Hanover, N.H. (Dartmouth Affiliated Hospitals.

W. A. Yasinski Director  
Name Title of Hospital Chief Executive  
10/9/73 W.A. Yasinski  
Date Signature of Hospital Chief Executive

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

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**Instructions:**

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

**Membership in the Council of Teaching Hospitals:**

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

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

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine Dartmouth Medical School  
Name of Dean James C. Strickler, M.D.  
Address of School of Medicine Hanover, New Hampshire 03755

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Date _____	Approved _____ Disapproved _____ Pending _____
Remarks _____	
_____	
_____	
_____	
Invoiced _____	Remittance Received _____

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership  
in the  
Council of Teaching Hospitals

(Please type)

Hospital: The Norwalk Hospital  
Norwalk 24 Stevens Street  
City Street  
Connecticut 06856  
State Zip Code

Principle Administrative Officer: Norman A. Brady  
Name  
President and Chief Executive Officer  
Title

Date Hospital was Established 1892

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	May 14, 1949	14*	14
Medicine	July 2, 1973	6	2
Straight Surgery	December 14, 1972	2	2

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	12/48-1 yr. approval; dis- approved '65; reapproved 1/31/71- 3 yr. program.	17	16
Surgery	12/48-1 yr. program; 12/4/70- 4 yr. program.	8	9
OB-Gyn	---	---	---
Pediatrics	11/62 - Group II Program	5	5
Psychiatry	---	---	---
Other	Pathology - 8/47 - 4 yr. approval	4	4

\*This figure drops to 10 as of 7/1/74 when other 4 slots  
in Straight Medicine are filled.

Information Submitted By:

Mr. Roland E. Larson, Vice  
President for Administration  
Name  
September 13, 1973  
Date

President and Chief Executive Officer  
Title of Hospital Chief Executive  
N. A. Brady  
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

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- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
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The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

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

Name of School of Medicine \_\_\_\_\_

Name of Dean \_\_\_\_\_

Address of School of Medicine \_\_\_\_\_

\_\_\_\_\_

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

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## PRELIMINARY AFFILIATION

Yale University School of Medicine [the School]  
and NORWALK Hospital [the Hospital]

### I. INTRODUCTION

The primary purpose of a medical school-community hospital affiliation is to achieve common objectives with an understanding of separate individual responsibilities. The greatest contribution to a successful relationship between a community hospital and a medical school is the understanding and sincerity of both in the recognition of interdependence of their shared goals.

### II. OBJECTIVES

Affiliations between the medical center and community hospitals have four major objectives;

1. Proper care of the patient
2. Effective medical education
3. Clinical and health care research on a continuing basis
4. Close cooperation between the medical school and community hospitals for joint development of a network of regional partnerships.

### III. CONCEPTS

#### A. Patient Care

The hospital has its customary responsibility for providing patient care services and will use the available special resources of the school as deemed necessary, not only for individual patients, but also to evaluate services at the hospital and to assess community needs. The school will provide clinical consultation as specifically arranged by each department.

#### B. Education

The hospital will maintain a continuing education program for physicians and will seek assistance from the school as necessary.

The school will continue to make available to the hospital physicians, clinical rounds and conferences in different specialties at Yale-New Haven Medical Center.

#### C. Clinical and Health Care Research

The hospital will identify research topics of concern to its service area, will seek appropriate help from the school in developing research activity, and will work with the school to bring the research to its conclusion. The school

will help in establishing priorities, and will provide technical and professional consultations as needed and available.

D. Cooperation toward development of a network of regional partnerships

The value of regionalization in Connecticut, and its logic, have been accepted and endorsed by both the hospital and the school, and both institutions support CRMP as a catalyst of regionalization.

E. Community Faculty

A necessary step toward a closer affiliation relationship is the appointment of a full-time Chief of Staff or Chief of Service in one or more of the major specialties at the hospital. The conditions of appointment outlined in the "Guide to Yale University School of Medicine - Community Hospital Affiliations", are understood and endorsed by both the hospital and the school.

F. Termination And Renewal

This agreement is for a period of one-year, at the end of which time, it is subject to renewal or modification by consent of both parties. This agreement does not bind either institution in any way that has not been specified above.

G. Authorization and Effective Date

In witness thereof, the parties have caused this Agreement to be executed by their responsible contracting officials this 8th day of September 1972.



School of Medicine  
Yale University



Norman A. Brady, President  
Norwalk Hospital Association

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Part I  
AFFILIATION AGREEMENT  
between

\_\_\_\_\_

and

Yale University School of Medicine

This AFFILIATION AGREEMENT (hereinafter called "this agreement")  
made on the \_\_\_\_\_ day of \_\_\_\_\_, 1972, by and  
between the \_\_\_\_\_ ("The Hospital") and Yale University  
("Yale"), both being Connecticut Corporations with the \_\_\_\_\_  
being located in the (city) (town) of \_\_\_\_\_ and Yale  
University being located in the City of New Haven.

WITNESSETH THAT:

1. Objectives. The common objectives of the parties to this  
Affiliation are the promotion of:
  - Proper care of patients,
  - Effective medical education,
  - Productive clinical and health care research, and
  - Such patient care, education and research among hospitals and  
other health care institutions in the region supporting the affil-  
iated institutions.
2. Cooperative Spirit. The Hospital and Yale recognize that although  
an agreement like this one is necessary for a successful affiliation, it is  
also necessary that understanding and sincerity control the many actions  
large and small taken from day to day if the parties are to achieve not  
only the common objectives of this affiliation but also the institutional  
goals of each party. These goals are consistent with the common objectives.

3. Hospital's Goals. The institutional goals of the Hospital in connection with this affiliation are as follows:

Maintenance of high standards of patient care. This would include the availability of clinical consultation services and easy access to specialized services at Yale.

Maintenance of high quality education for physicians, house staff members, students and paramedical personnel.

To obtain maximum quality of house staff and hospital services;

Expansion of Hospital services, such as service in connection with laboratory medicine; and

Stimulation of clinical research.

4. School's Goals. This Agreement will be performed for Yale by its School of Medicine ("the School"). The School has the following institutional goals which might be achieved through this affiliation:

Increase of good quality clinical facilities available for the training of medical students;

Exposure of medical students to a wider variety of patients and a broader spectrum of patient care;

Increase in the numbers of the clinical faculty of the School in certain specialties, and provisions for effective participation by them in the teaching program of the School;

Creation of opportunity to render service to a larger number of patients in connection with the educational and clinical research work of the School;

Support of complex, integrated professional services, such as organ transplantation and dialysis, with a broader base of patients and faculty members;

Improvement of the graduate training programs of the School in certain specialties by means of rotation of residents and fellows;

Improvement of communication and cooperation between the School and medical staff of the Hospital; and

Advancement in the creation of a regional network of cooperative arrangements among health care institutions, both official and voluntary, looking toward improved education, research, patient care, and community service.

5. Minimum Requirements for Affiliation. The minimum requirements by the School are as follows:

To have at least one full-time staff member who will be either chief of staff, chief of medicine or chief of surgery. These appointments should be made in accordance with the procedure outlined in this Agreement (see item #9, Part I).

To express a commitment to work toward full-time chiefs of services in its major departments.

To maintain strong supporting clinical and laboratory services.

To maintain a continuing education program for physicians and other health professionals. This includes a satisfactory system of peer review in each of the admitting clinical services.

To cooperate with other community health care institutions for improved education, research, patient care and community service.

To develop and maintain open communication with the medical school administration and departmental leadership.

6. Joint Affiliation Committee.

(a) There shall be a Joint Affiliation Committee (hereinafter called the "JAC"). The JAC shall consist of eight (8) members. The Administrator of the Hospital and the School's Associate Dean for Regional Activities (hereinafter referred to as "Associate Dean") shall be members ex officio. Three (3) additional members shall be appointed by the Hospital and three (3) additional members shall be appointed by Yale from the membership of the Committee on Regional Activities (CORA). Unless otherwise determined by the Hospital, the Hospital members, and their successors, shall be appointed by the Administrator of the Hospital. Unless otherwise determined by the School, the School's members, and their successors, shall be appointed by the Chairman of CORA. The representatives to the Committee from both the Hospital and the School should be designated in writing at the commencement of each academic year followed by exchange of this information between the institutions. Changes in appointments throughout the academic year should be handled in a similar fashion.

The first Chairman of JAC shall be the Administrator of the Hospital, ex officio, and he shall serve for one year. The next Chairman shall be the Associate Dean, ex officio, and he shall serve for one year, after which the Administrator and Associate Dean shall alternate as Chairman, ex officio, each for a term of one year. When the Administrator is Chairman, the Associate Dean shall designate a Secretary from among the Hospital members.

(b) Neither the Hospital nor the School by virtue of this Agreement confers upon the JAC any authority to make decisions binding upon the Hospital or the School. However, the JAC will in effect have such authority from time to time as is held by the Hospital members of the JAC in their capacities as officials of the Hospital, or specially conferred upon them by the Hospital and School members in their capacities as members of the faculty or administration of the School, or specially conferred upon them by the School. The JAC may take final action within the scope of such designated authority. The JAC, however, is authorized by this Agreement from time to time to make recommendations to the Hospital and to the School in respect of matters of common concern to the Hospital and the School. In making such recommendations there shall be two votes only, one by the Hospital members and one by School members, and each recommendation shall therefore be unanimous. In case of disagreement among the Hospital members the disagreement shall be resolved in such manner as the Hospital shall determine. In case of disagreement among the Yale members the disagreement shall be resolved in such manner as the School shall determine. Such recommendations on matters of common concern shall be considered to have been duly adopted when approved by the Hospital and the School and incorporated in a writing executed and delivered by each. Each party shall determine for itself the procedure for the approval or disapproval of such recommendations and the designation of the authority who shall execute and deliver the writing;

in case of approval.

(c) For the purposes of this Agreement a matter of common concern is one which any member of the JAC designates as such by requesting the Secretary to include it on the agenda of the JAC. The Secretary shall honor all such requests and the JAC shall consider them at its next meeting.

(d) Meetings of the JAC shall be held in a building of the Hospital at such time and place as shall be specified by the Chairman. The Chairman shall call a meeting of the JAC to be held whenever in his judgment it is desirable that there be a meeting, or whenever any member of the JAC requests that a meeting is held, or according to any schedule of regular meetings which the JAC may adopt. A minimum of one annual meeting of the JAC shall be held for purposes of review of the terms of the Affiliation Agreement, progress of existing programs and either the adaption of new joint programs or modifications of old ones.

(e) The Hospital shall determine the terms of membership of each of the three members of the JAC appointed by the Hospital. The Chairman of CORA shall determine the terms of membership of each of the three members of the JAC which he has appointed.

(f) This Agreement does not establish a partnership or joint venture between the Hospital and the School, and neither has any authority to act for the other by virtue of this Agreement.

7. Basic Principles and Understandings. In the administration of the work of the Hospital and the School in this affiliation, and in the consideration of matters of common concern by the JAC, the following principles and understandings shall control:

(a) Participation by medical students in the provision of medical care is an integral part of medical education and therefore of this Affiliation. Programs for the participation of Yale Medical students in teaching programs at the Hospital, however, will not be undertaken except in accordance with a written agreement as described in Part II of this Affiliation Agreement. The activities of medical students should include: taking patients' histories, conducting complete physical examinations, stating tentative diagnoses, proposing diagnostic and therapeutic procedures and measures, and making recommendations for patient disposition upon discharge.

The work of medical students should be critically reviewed with the student by the house staff and/or faculty members. Diagnostic and therapeutic procedures should be approved and ordered by the responsible physician. When possible, students should participate in performing the approved procedures. The patients' records should include, at least for the duration of the patients' current admissions, the students' histories, records of physical examination, proposals for diagnostic and therapeutic procedures, and disposition. Medical students should be encouraged to follow their patients through their in-patient stay, out-patient visits, and at nursing homes, as well as at extended care or long-stay care facilities, and in the homes of the patients.

Interns and residents, whenever possible, should participate to some extent in the education of medical students.

Adequate space and facilities for students participating in the educational program should be provided as mutually agreed upon by the Hospital and School. This will include lockers for clothes and equipment, access to the library or other study space, access to the cafeteria, etc.

(b) Interns, residents and fellows who rotate in their assignments have both moral and legal responsibilities to the hospital to which they are

assigned. Their education and supervision are the responsibility of the Staff of the Hospital when they are in the Hospital and of the Faculty of the School when they are in the School. Programs for interchange of interns and residents between Yale-New Haven Hospital, Inc. and the Hospital will not be undertaken except in accordance with a written agreement between those hospitals. Primary responsibility for the initiation of such programs rests with the Chief of Service at the Hospital and Chairman of the appropriate clinical department at the School. The details of house officer exchange or rotation programs between the Hospital and Yale are described in Part II of this Agreement.

(c) Appropriate participation in work under this Affiliation by para-professional, public health and other graduate students is appropriate as an integral part of their education. Such participation shall be the joint responsibility of the Hospital and the School. The details of any programs of this type are described in Part II of this Agreement.

(d) Patients admitted to the Hospital will be admitted with the understanding that they will participate in the teaching program.

(e) Research should be an essential element of this Affiliation, and may include laboratory studies, clinical investigation, therapeutic trials, epidemiological investigations, studies in the organization, administration and delivery of medical and hospital services and other related investigations. The Hospital has the responsibility to make sure that due regard is given to personal rights, safety, and understanding of the patients involved in clinical research, and the School shall assist the Hospital in fulfilling this obligation. All joint clinical research projects will be approved by the Clinical Research Committees at both the Hospital and the School before the research program is initiated. It is understood that the School assumes no legal responsibility for clinical research being con-

ducted at the Hospital. All research programs involving the School and Hospital joint participation in effect at the time this Agreement was signed are referred to in Part II of this Agreement.

8. Work to be Directed by Chiefs and Chairmen, Administrator and Dean.

(a) The Hospital and the School are organized in services and departments and for each Hospital service there is a corresponding School department. The work of the Hospital and the School in respect of each department or service in carrying out the common objectives of this Affiliation shall be directed, within their respective spheres of authority as conferred by each institution outside the provisions of this Agreement, by the Chief of the Service at the Hospital and the Chairmen of the Department at the School.

(b) Whenever a decision concerning the affiliation work is beyond the authority of the Chief of Service at the Hospital and the Chairman of the Department at the School, these officers shall consult, respectively, the Administrator of the Hospital and the Dean of the School, and the matter shall be determined by the Administrator and the Dean, each acting within the scope of the authority granted to him by his own institution outside the provisions of this Agreement.

(c) Whenever the decision concerning the affiliated work is outside the authority of the Chairman and the Dean, or whenever they disagree, or whenever they elect to refer the decision to the JAC, the decision shall be referred to the JAC as a question of common concern for recommendation, in appropriate cases, by the JAC to the Hospital and the School.

9. Appointment of Chief of Service.

(a) The Hospital agrees that it will not appoint any full-time chief for a clinical service at the Hospital except after receiving the recommendation of a search committee appointed by either the Board of Trustees or the Administrator of the Hospital as the Hospital may determine.

Two members of the search committee shall be persons nominated by the Associate Dean and appointed by the Board of Trustees of the Hospital, or the Administrator, as the case may be, and one of these two shall be the Chairman of the Corresponding Department of the School. The search committee shall search for and evaluate candidates and shall make recommendations to the Administrator of the Hospital in regard to the appointment. The compensation and terms of employment of such chiefs of service shall be provided by and determined by the Hospital.

(b) Each full-time chief of service selected in accordance with the provisions outlined above (9a) will receive a clinical faculty appointment with rank commensurate with his experience and accomplishments. Continuation of the appointment shall be determined by the School in accordance with its standard procedures in such cases in effect from time to time. The Chairman of the corresponding Department of the School shall consult with the prospective chief of service of the Hospital concerning faculty responsibilities, privileges, and rank. The faculty appointment in the School of the full-time chief of service at the Hospital shall be co-terminus with his Hospital appointment. Simultaneous clinical appointment at one or more medical schools is acceptable providing the other appointment responsibilities do not interfere with the duties of the School's appointment.

10. Appointment of Staff to Faculty. From time to time a chief of service at the Hospital may recommend to the Chairman of the corresponding Department of the School the appointment of a member of the Hospital Staff to the clinical faculty of the School. In the consideration of such recommendations credit will be given by the School for participation in the education at the Hospital of students in the School. Such appointments shall be made according to the policies and procedures of the School in effect from time to time in respect of appointments to the clinical faculty.

11. Appointment of Faculty to Staff. From time to time the Chairman of a Department at the School may recommend to the Hospital the appointment of a member of the faculty of the School to the Staff of the Hospital. The decision upon such recommendations shall be made by the Hospital according to policies and procedures in effect from time to time in respect of the making of such appointments generally except as the Hospital may decide to modify them in order to adapt them to the appointment of full-time members of the faculty of the School. Nothing in this paragraph shall limit the authority of the Hospital in regard to the appointment of members of its Staff who do not participate in the affiliated work of the hospital and the School under this Agreement.

12. Postgraduate education programs. All regularly scheduled postgraduate teaching exercises involving faculty members of the School will be arranged through the Postgraduate Education Office at Yale. Copies of letters requesting the participation of School faculty in postgraduate teaching at the Hospital which are not regularly scheduled will be sent to the School's Postgraduate Education Office. Specific requests for School faculty participation in postgraduate education are described in Part II of this Agreement.

13. Cooperative fellowship programs. School-affiliated Hospital fellowship programs must be approved by both the Hospital administration and appropriate departmental chairman at the School. Responsibility for the establishment and conduct of such fellowships is the responsibility of the appropriate full time faculty members at the School and Hospital based preceptors. Arrangements for these fellowships and their level of recognition by the School are to be in accord with established School policy. The expense of these programs will be borne by the Hospital involved in the fellowship program. Ongoing cooperative fellowship programs at the Hospital at the time of the signing of this Agreement are described in more detail in Part II of this Agreement.

14. Expenses. All expenses arising out of or related to the patient care, educational and research programs conducted at the Hospital under this Agreement shall be paid by the Hospital. Approval by the Hospital Administrator or the duly authorized delegate of the Hospital Administrator shall be obtained in advance of any expenditures.

15. Malpractice Liability Insurance. Each of the School and the Hospital shall procure, and each at its own expense shall maintain a full force and effect while this Agreement remains in effect, a policy or policies of malpractice insurance in such coverages and amounts as the Hospital and the School may from time to time mutually agree upon, in writing, provided, however, that in the absence of any further written agreement the total coverage afforded by each policy shall be substantially in the same form now carried by each and shall have limits of not less than \$500,000 for each person and \$1,000,000 for each occurrence.

16. Other Affiliations of the School. The School is affiliated with Yale-New Haven Hospital, Inc. as its primary teaching hospital. This Agreement is subject to the agreement as amended which provides for that affiliation. The School is also affiliated with other hospitals and nothing in this Agreement shall preclude the School from time to time from taking up new affiliations or discontinuing old ones with other hospitals. However, no new affiliation shall be undertaken which in the School's judgment would interfere substantially with this Affiliation while this Affiliation remains in effect.

17. License for Access. The Hospital hereby grants to the faculty, administration, and students of the School a license for entry upon and egress from the land and buildings of the Hospital and for use of the facilities and equipment of the Hospital all for the purpose of carrying on the affiliated work under this Agreement and all subject to such rules and regulations as are now in effect or may hereafter be promulgated by the Hospital.

18. Level of this Affiliation. The extent of this affiliation in terms of AMA classification, letterheads, advertising, etc. shall be specifically stated in Part II of this Agreement.

19. Term of this Agreement; Termination. This Agreement shall remain in effect for a term expiring 5 years following its signing. Thereafter it shall be extended from time to time for such extended terms as shall be mutually agreed by the School and the Hospital in a writing, one for each extension, executed and delivered before the expiration of the original or any extended term. The usual period of extension is 5 years. This Agreement may be terminated during the original or any extended term by either party acting in its sole discretion, by delivering to the other party a notice does thereby terminate this Agreement and stating the effective date of such termination, which effective date shall not be earlier than one year after the date of the giving of the notice of termination. Without imposing a legal obligation so to do it is understood that if either party at any time desires not be extend this Agreement, it should inform the other of such desire, preferably not less than one year before the end of the current term.

In Witness Whereof the Hospital and the School have causes this Agreement to be executed and delivered in duplicate at New Haven, Connecticut, the day and year first above stated.

Attest:

THE HOSPITAL  
\_\_\_\_\_

\_\_\_\_\_  
Hospital Administrator

By

\_\_\_\_\_  
Its  
hereunto duly authorized

Attest:

YALE UNIVERSITY SCHOOL OF MEDICINE  
\_\_\_\_\_

\_\_\_\_\_  
Dean of the School of Medicine

\_\_\_\_\_  
Its  
hereunto duly authorized

PART II

AFFILIATION AGREEMENT

between

---

and

Yale University School of Medicine

A. Introduction

The purpose of this portion of the Affiliation Agreement is to describe in some detail the specifics of ongoing or proposed programs arranged between the Hospital and the School. This section should be revised on an annual basis and approved by both the Hospital and CORA. All programs are subject to the general guidelines outlined in Part I of this Agreement.

The extent to which programs are described in this section will define the "level" of affiliation without reference to specific classification.

B. Description of Specific Programs

1. Medical student teaching programs.
2. House officer rotations.
3. Public health and graduate student programs.
4. Clinical Research Programs.
5. Postgraduate Education Programs.

6. Cooperative Fellowship Programs.

7. Other Programs.

C. Designation of Affiliation

1. AMA designation.

(This is one possibility) The parties agree that this Affiliation shall be proposed by them for designation, in the annual directory of approved internships and residencies published by the American Medical Association, as "M", i.e. an affiliation between a hospital and a medical school in which students serve clinical clerkships regularly on two or more major in-patient services under the direct supervision of members of the faculty. This designation shall be made annually and jointly by mutual agreement, and shall be subject to annual review by each party.

2. House Officer Certification.

3. Letterheads and other Printed Materials.

This is to certify that Part II of this Agreement has been reviewed and approved by CORA and the Hospital within three (3) months of this date. The Hospital and the School now agree that this version of Part II supercedes all others as part of the Affiliation Agreement between \_\_\_\_\_ and Yale which was signed on \_\_\_\_\_.

Attest:

THE HOSPITAL \_\_\_\_\_

\_\_\_\_\_  
Hospital Administrator

Attest:

YALE UNIVERSITY SCHOOL OF MEDICINE

\_\_\_\_\_  
Dean of School of Medicine

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership  
in the  
Council of Teaching Hospitals

(Please type)

Hospital:

MUHLENBERG HOSPITAL

<u>Plainfield</u>	Name	<u>Park Avenue and Randolph Road</u>
<u>City</u>		<u>Street</u>
<u>New Jersey</u>		<u>07061</u>
<u>State</u>		<u>Zip Code</u>

Principle Administrative Officer: Edward J. Dailey, Jr.

Name  
Director

Title

Date Hospital was Established 1877

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1957</u>	<u>14</u>	<u>12</u>
(Med.)	<u>1968</u>	<u>4</u>	<u>4</u>
Straight: Path	<u>1970</u>	<u>1</u>	<u>1</u>
(Peds)	<u>1968</u>	<u>3</u>	<u>3</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1963</u>	<u>8</u>	<u>8</u>
Surgery			
OB-Gyn	<u>1972</u>	<u>6</u>	<u>3</u>
Pediatrics	<u>1963</u>	<u>6</u>	<u>6</u>
Psychiatry			
Other			
Colon & Rectal Surgery	<u>1970</u>	<u>2</u>	<u>1</u>
Pathology	<u>1963</u>	<u>7</u>	<u>4</u>

Information Submitted By:

Edward J. Dailey, Jr.

Name

Director

Title of Hospital Chief Executive

4 September 1973

Date

*Edward J. Dailey, Jr.*  
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

**Instructions:**

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

**Membership in the Council of Teaching Hospitals:**

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

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

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine New Jersey College of Medicine and Dentistry--Rutgers Medical School  
Name of Dean James W. Mackenzie, M.D., Dean  
Address of School of Medicine P.O. Box 2100, New Brunswick, New Jersey 08901

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

STATE OF NEW JERSEY

Department of the Treasury  
Division of Purchase and Property  
Purchase Bureau  
State House  
Trenton, New Jersey 08625

CONTRACT #2P-210  
Waiver #K-188

This Agreement made and entered into this Fourth Day of May 1972, between the STATE OF NEW JERSEY, acting by and through the DIRECTOR OF THE DIVISION OF PURCHASE AND PROPERTY in the Department of the Treasury, for and on behalf of THE MUHLENBERG HOSPITAL hereinafter referred to as the HOSPITAL and THE COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY, a body corporate and politic in the Department of Higher Education, State of New Jersey hereinafter referred to as the COLLEGE.

WITNESSETH THAT:

WHEREAS, the College and the Hospital are desirous of cooperating in use of their respective facilities and staffs to develop high quality medical educational programs, and (a) whereby students of the Rutgers Medical School of the College can participate in the care of patients of the Hospital as an integral part of their medical education, and (b) whereby quality internships and residency programs can be developed for graduate education and clinical training, and

WHEREAS, the College and the Hospital are desirous of using their facilities and staffs jointly to provide the highest possible quality patient care for the community served by the College and the Hospital, and

WHEREAS, the College and the Hospital are desirous of providing on a cooperative basis programs of community service designed to sustain and improve the delivery of good medical care and to develop programs of preventive medicine; and

WHEREAS, the College and the Hospital are desirous of using the combined resources of their respective facilities and staff in joint programs of biomedical and clinical research, within the limitations of their existing respecting facilities; and

WHEREAS, to implement the foregoing, the College and the Hospital desire to enter into an affiliation agreement,

NOW THEREFORE, in consideration of the mutual promises, covenants and agreements hereinafter contained, the parties hereto do hereby covenant and agree as follows:

(continued)

## ARTICLE I

A. The members of the Hospital's medical staff who, in accordance with the standards and procedures prescribed by the Rutgers Medical School of the College for appointment to the College, qualify by training and performance will be given appropriate appointments to the Rutgers Medical School of the College's faculty of medicine as described below. Physicians who are members of the Hospital staff as of the date of this Agreement who do not so qualify by training and/or performance for an appointment to the College's faculty or who by choice prefer not to be so appointed, will continue as members of the Hospital staff, without loss of rank or privilege. Full-time Hospital staff members will receive clinical titles at the Rutgers Medical School of the College and have the same rights and privileges as clinical appointees of the faculty of the Rutgers Medical School of the College.

B. Full-time Hospital staff appointments will be renewed in accordance with the customary practices of the Hospital. Relative to those physicians covered in Article II, Section A, salary arrangements, appointments, and reappointments will be made directly by the Hospital's Board of Governors in accordance with its bylaws and with the knowledge of the Dean of the Rutgers Medical School of the College. The Board of Governors of the Hospital shall review with the Dean of Medicine of the Rutgers Medical School of the College, before any action is taken, any decision to rescind a contract or failure to renew the appointment of any full-time Hospital staff member holding a clinical appointment to the College faculty. Qualified voluntary members of the Hospital medical staff, who so desire, will receive clinical appointments to the faculty of the Rutgers Medical School of the College for a term of one year, subject to renewal, on the approval of the Hospital and the College through the usual appointment mechanisms of both the Hospital and the College.

C. After the effective date of this Agreement, all physicians newly appointed to the Hospital staff shall qualify for simultaneous appointment to the faculty of the Rutgers Medical School of the College in accordance with standards jointly prescribed by the College and the Hospital. Exceptions to this rule may be made for general and/or family practitioners, emergency service physicians, and for physicians in specialties who do not have counterparts on the College's faculty. In addition, other exceptions may be made upon the recommendation of the affiliation review committee. All nominations for appointment and for staff advancement shall originate in the Hospital in accordance with the regular procedures of the Hospital and professional staff. Before final approval of any nomination for appointment is given by the Hospital, the nomination or recommendation shall be submitted to the Rutgers Medical School of the College through the Dean of the School, who shall process the appointment through the School's and College's regular appointment mechanisms. It is expected that ordinarily these appointments will be approved or disapproved within 45 days after credentials are complete. No physicians who are members of the Hospital staff as of the date of this Agreement or subsequently may lose such membership except in accordance with the action of the Hospital's Board of Governors.

D. The Hospital agrees to employ full-time Hospital-based chiefs-of-service of, at least, the following services: medicine, pediatrics, radiology, pathology and obstetrics and gynecology, the latter within two years of the date of this Agreement. In addition, the Hospital agrees to employ full-time chiefs in

(continued) ARTICLE I

surgery, psychiatry, and family practice, when, in the sole discretion of the Hospital, it is feasible to do so. The Rutgers Medical School of the College agrees to assist the Hospital, if requested, in recruiting qualified personnel to be appointed as chiefs of the designated services. Final appointment of full-time chiefs-of-services shall be subject to the approval of the Dean of the Rutgers Medical School of the College, who shall refer such appointments through the School's and College's regular appointments mechanisms. The appointment of the Hospital's Chief of Staff shall be subject to the approval of the Dean of the Rutgers Medical School of the College, the President of the College, and the Board of Trustees of the College, as well as the Hospital's Board of Governors.

E. An affiliation review committee will be formed to consist of the Dean of the Rutgers Medical School of the College (or his representative, whom he may designate) and two representatives from the faculty of the Rutgers Medical School of the College, the Chief of Staff of the Hospital (or his representative) and a major department chief designated by the Board of Governors and a representative of the Hospital's Administration. This committee will have the authority to review and recommend educational programs and policies developed for purposes of this affiliation. It will also serve as an appeals committee in the event of individual disagreements as to questions of academic or educational character. It will be asked to formulate and present matters of policy for consultation by the respective governing bodies. It will meet annually or more often as is necessary. At each annual meeting, progress of the affiliation will be discussed and future plans will be developed, discussed, and approved. The Chairmanship of this committee will alternate between the Dean and the Chief of Staff of the respective institutions or their delegates.

F. The Dean of the Rutgers Medical School of the College or his regularly appointed delegate will sit on the Medical Executive Committee of the Hospital ex officio, with full voting power. The Chief of Staff of the Hospital, or his regularly appointed delegate, will sit on the Executive Committee of the Faculty of the Rutgers Medical School of the College ex officio with full voting power.

G. All patients admitted to the affiliated departments of the Hospital for medical care shall be admitted with the understanding of the patients that they will participate in the teaching program for the hospital house staff and medical students of the College under the guidance of the appropriate service chief and his teaching staff. Professional responsibility for the care and management of all patients will remain with the Hospital's Medical Staff. Patients may be excluded from participating in the teaching programs only if the attending physician determines that such participation might be harmful to the patient or if the patient declines to participate. Patients excluded from the medical student training program may also be excluded from receiving services of hospital house staff members as determined by the chief of the appropriate department except in cases of medical emergency. Any member of the teaching staff of the Hospital, excluding excess of ten (10) percent of his patients in any twelve (12) month period from the teaching program shall have all such excluded cases reviewed before his annual staff appointment is renewed.

H. The Hospital will accept, and the College will provide, students of the Rutgers Medical School of the College for primary clerkships in those services where the Hospital has appointed a full-time chief of service. These students shall abide by all of the policies, rules and regulations of the Hospital. The Hospital may continue to provide elective or advance clerkships in accordance with its existing commitments. The number of students to be assigned and retained to such primary clerkships in any year or fraction thereof shall be determined by the Rutgers Medical School of the College and the Hospital. The College agrees to transfer any student from the Hospital at the reasonable request of the Hospital. In such instances students may appeal to the affiliation review committee through the Dean of the Rutgers Medical School of the College. Each Hospital service chief shall be responsible for the supervision of those students assigned to his service. The student's association with patients of the Hospital shall be through their participation with the House Staff and assigned teaching attending physicians holding appointments on the faculty of the College. Student clerks shall participate in patient care by taking medical histories, doing physical examinations, recording differential diagnosis, making recommendations for diagnostic and therapeutic procedures, making recommendations for disposition of patients after discharge from the Hospital, and in participation in other activities as requested by the Hospital Service Chiefs. All students participating in the Hospital teaching program, shall record patient's histories, physical examinations and other notes in the patient's hospital records. Such entries shall be made for teaching purposes only and shall not be considered a part of the hospital's record. These entries shall be made on a separate sheet of paper and shall be identified by the student's signature and college class, and shall be reviewed and countersigned by a supervising resident or attending physician.

I. Subject to mutual agreement between the Director of the Hospital and the Dean of the Rutgers Medical School of the College, the Hospital will provide necessary educational facilities for all College students serving clerkships and electives within the Hospital.

J. The members of the Hospital House Staff shall participate under the direction of the appropriate Hospital service chief in the teaching program to be carried on at the Hospital. Students assigned to the Hospital will be working directly under members of the House Staff.

K. Attending staff members participating under this Agreement in the educational program shall not accept any appointment in another medical school without the approval of the Dean of the Rutgers Medical School of the College.

L. Subject to the approval of the governing board of the Hospital, the Hospital may appoint to its staff, with appropriate privileges, members of the College faculty.

M. The College shall assist the Hospital in developing quality internship and residency programs and assist in recruiting interns and residents.

## ARTICLE I (continued)

N. The Hospital agrees that it shall not enter into any affiliation agreement other than Agreements now in effect or renewals thereof with any other medical school without the prior approval of the Rutgers Medical School of the College. The Hospital also agrees to phase out any affiliations it may have with other medical schools as comparable replacement programs are developed by the College.

O. It is understood that the Rutgers Medical School of the College will require affiliations with other hospitals to carry out its purposes and that the College alone shall determine the number and content of such affiliations. However, the College agrees to refrain from contracting any affiliation which would interfere with the College's obligations under this Agreement without agreement of the affiliation review committee and the knowledge of the Board of Governors of the Hospital.

P. Under this Agreement both the College and the Hospital shall continue to be autonomous and shall be governed independently by the respective governing bodies and administrations except insofar as this Agreement specifically states to the contrary.

Q. This Agreement may be modified or amended by mutual consent of the parties and shall be subject to annual review.

## ARTICLE II

A. In full consideration of all services to be performed under this Agreement, the College agrees to pay the Hospital One Hundred Twenty-five Thousand (\$125,000) Dollars per year.

B. Payment shall be made in equal monthly installments of Ten Thousand, Four Hundred Sixteen (\$10,416) Dollars.

C. The amount to be paid by the College shall be reviewed and agreed upon annually prior to September 1 of each year. This amount shall be expended by the Hospital for the employment of five qualified medical educators to be apportioned among the clinical services as best meets the needs of the Hospital in providing for this education program. It is specifically understood and agreed that the College shall not make payment of any portion of the annual agreed-upon amount of compensation unless the individuals required to perform the services specified in this Agreement have been appointed and have assumed their duties at the Hospital. Appointment of these medical educators shall be processed in accordance with the staff appointment mechanism outlined above. The College recognizes the need to and shall permit the Hospital to supplement the salaries of these educators through other sources of funds. However, in no case may the total income for professional activities of any of these educators whose salary is supported by Rutgers Medical School of the College be greater than the maximum income paid to the highest paid member of the faculty of the Rutgers Medical School of the College by the College.

## ARTICLE III

A. This Agreement shall commence as of May 4, 1972, and continue in full force and effect until May 4, 1974.

### ARTICLE III (continued)

B. The DIRECTOR, DIVISION OF PURCHASE AND PROPERTY may extend the term of this Agreement for additional periods of one year each. Such extensions shall be made by the DIRECTOR, DIVISION OF PURCHASE AND PROPERTY in writing not less than 90 days prior to termination of the initial term of the Agreement or any subsequent term. In the event the Agreement is extended, all of the original terms will remain in effect for the extended period. Acceptance of any extensions by the Hospital is to be in writing and must be on file in the DIRECTOR, DIVISION OF PURCHASE AND PROPERTY's Office not less than 15 days before the expiration date of the original Agreement or any extension thereof.

C. The DIRECTOR, DIVISION OF PURCHASE AND PROPERTY at the request of the President, College of Medicine and Dentistry may terminate this Agreement at any time by giving one year written notice of termination sent to the Hospital at the address set forth in Article V. The Hospital may terminate this Agreement at any time by giving one year written notice of termination sent to the President of the College of Medicine and Dentistry, at the address set forth in Article V. In the event of the termination of this Agreement, as provided herein, the Hospital shall furnish to the President, College of Medicine and Dentistry such report or reports as they may require, based upon work completed under the provisions of this Agreement. The Hospital shall not be compensated for the time necessary to prepare such reports as may be required under this provision.

### ARTICLE IV

A. The Hospital's status shall be that of any independent principal and not as agent or employe of the STATE.

B. The Hospital agrees not to assign this Agreement or any monies due hereunder without the prior written approval of the STATE.

C. This Agreement shall be governed and construed and the rights and obligations of the parties hereto shall be determined in accordance with the laws of the STATE OF NEW JERSEY.

E. If it becomes necessary for the Hospital, either as principal or by agent or employee, to enter upon the premises or property of the State in order to construct, erect, inspect, make delivery or remove property hereunder, the Hospital hereby covenants and agrees to take, use, provide and make all proper, necessary and sufficient precautions, safeguards and protections against the occurrence of happenings of accidents, injuries, damages or hurt to any person or property during the progress of the work herein covered, and to be responsible for, and to indemnify and save harmless the State from the payment of all sums of money by reason of all, or any, such accidents, injuries, damages or hurt that may happen or occur upon or about such work and all fines, penalties and loss incurred for or by reason of the violation of any city or borough ordinance, regulation, or the laws of the State, or the United States, while the said work is in progress.

#### ARTICLE IV (continued)

E. There shall be no discrimination against any employee engaged in the work required to produce the services covered by the Agreement, or against any applicant for such employment because of race, creed, color, national origin or ancestry. This provision shall include, but not be limited to the following: employment upgrading, demotion, transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Hospital shall insert a similar provision in all subcontracts.

F. The New Jersey Prevailing Wage Act, P.L. 1963, Chapter 150, is hereby made a part of every contract entered into on behalf of the State of New Jersey through the Division of Purchase and Property, except those contracts which are not within the contemplation of the Act.

G. The parties to this contract do hereby agree that the provisions of N.J.S.A. 10:2-1 through 10:2-4, dealing with discrimination in employment on public contracts, and the Rules and Regulations promulgated pursuant thereto, are hereby made a part of this contract and are binding upon them.

#### ARTICLE V

The addresses given below shall be the addresses of the representative parties to which all notices and reports required by this Agreement shall be sent by mail:

Stanley S. Bergen, President  
College of Medicine and Dentistry of New Jersey  
100 Bergen Street  
Newark, New Jersey 07103

Rutgers Medical School  
University Heights Campus  
Post Office Box 2100  
New Brunswick, New Jersey 08903

Muhlenberg Hospital  
Park Avenue and Randolph Road  
Plainfield, New Jersey 07061

#### WARRANTIES:

A. The undersigned does hereby warrant and represent that this Agreement has not been solicited or secured, directly or indirectly, in a manner contrary to the laws of the STATE OF NEW JERSEY and that said laws have not been violated and shall not be violated as they relate to the procurement or the performance of this Agreement by any conduct, including the paying or giving of any fee, commission, compensation, gift, gratuity or consideration of any kind, directly or indirectly, to any State employee, officer or official.

B. The Hospital does hereby warrant and represent that it is qualified by training and experience to perform the required services in the manner and on the terms and conditions set forth herein.

IN WITNESS WHEREOF, the CONTRACTOR has duly signed and sealed this Agreement;

And, the STATE OF NEW JERSEY, has likewise caused this Agreement to be signed and sealed by its authorized officer this 16th day of June 1972

Witness:

*Ernest M. ...*  
Assistant Secretary

BOARD OF GOVERNORS  
HARRISONBERG HOSPITAL

*F. Edgar Davis*  
F. Edgar Davis, President

Witness:

*Elizabeth P. ...*

STATE OF NEW JERSEY  
DEPARTMENT OF THE TREASURY  
DIVISION OF PURCHASES AND PROPERTY

*James B. ...*

Reviewed and Approved:

COLLEGE OF MEDICINE AND DENTISTRY  
OF NEW JERSEY

*Stanley S. Bergen*  
Stanley S. Bergen, President

Approved as to form only:

ATTORNEY GENERAL, STATE OF NEW JERSEY

By: *Arthur S. Duffy Jr.*  
Deputy Attorney General

September 10, 1973

Richard M. Knapp, Ph.D.  
Director  
Department of Teaching Hospitals  
Association of American Medical Colleges  
One DuPont Circle  
Washington, D.C. 20036

Dear Dick:

Thank you very much for the opportunity to present this revised proposal to you. We appreciated the time that you and the committee devoted to in depth discussions of our initial proposal to you. Such discussions were both useful and productive.

We were pleased that the committee shared our belief that there is a need to develop and evaluate comparable data for University Owned Teaching Hospital (UOTH) computer programs and to help highlight factors impacting success of UOTH computer programs. We were also gratified that the committee concluded that Compucare assistance would be helpful in designing a survey instrument for use by the AAMC Department of Teaching Hospitals for gathering data.

Compucare initially proposed to undertake a study which would include a number of steps summarized as follows:

- . Construct a survey instrument to gather data to permit comparisons to be made for UOTH computer programs.
- . Analyze and evaluate survey responses to permit conclusions to be drawn by Compucare and survey participants.
- . Make recommendations to UOTH on how to make future computer efforts more effective.
- . Summarize these observations in a written report to each hospital.

It was felt by you and the committee that Compucare assistance would be required to design the survey instrument but that the analysis, evaluation, recommendations and report preparation activities were not required at this time. Therefore, it was suggested that Compucare undertake the preparation of a comprehensive survey instrument to accomplish your initial objectives.

#### PROPOSAL

Compucare will perform the following activities to assist the Department of Teaching Hospitals to accomplish its data gathering objectives.

1. Prepare an extensive survey instrument to gather data in the following areas of UOTH computer and systems improvement program:
  - . Organizational relationships
  - . User satisfaction and/or concern
  - . Staff size and allocation of effort
  - . Budgets
  - . Status of present program
  - . Cost effectiveness of on-going activities
  - . Productivity of investment in systems development
  - . Status of present and planned development effort
  - . Management goals and future plans
2. Prepare detailed instructions for completing the survey instrument.
3. Submit preliminary questionnaire and instructions to the Department of Teaching Hospitals for review, comment and approval.
4. Distribute survey instrument to the six committee member hospitals for completion.
5. After completion of the preliminary questionnaire, meet with each of the hospitals to review the questionnaire, assess comparability of data and obtain suggestions for improvement.

September 10, 1973

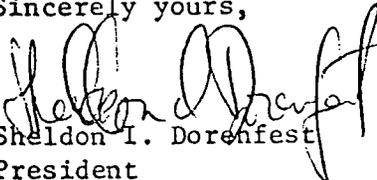
6. Revise the survey instrument and instructions for completion.
7. Submit the revised questionnaire to the Department of Teaching Hospitals for approval, printing and mailing.
8. Assist the Department of Teaching Hospitals to review and interpret responses to the survey and make adequate telephone follow-up to respondents to assure that data received is made comparable.
9. Define for your staff a suggested format for the tabulation and summarization of the survey responses by the Department of Teaching Hospitals.

PROPOSED FEE AND BASIS THEREOF

Compucare normally charges for its professional services on the basis of time devoted to the client assignment by members of the project team. Each staff member has a standard billing rate that covers the price of his services and the cost of the firm's services in support of the team. To these professional charges are added reimbursable expenses for such items as transportation, living costs of team members while away from their base cities, graphics, communications, special statistical tabulations and report production. We estimate the time to complete the tasks described above will approximate 400 hours. The fee for the professional charges at our standard rates would approximate \$14,000 plus reimbursable expenses, estimated at \$1,200. Thus, the aggregate price of the study would be \$15,200.

It was proposed by the committee that the study be undertaken by Compucare at no cost to the AAMC. Because of Compucare's modest size in relation to the scope of the study, this would not be possible. However, we do desire to participate in this very important problem area. As a result we propose undertaking the project at our direct salary plus out of pocket cost (excluding company overhead) of performing the tasks outlined above with reimbursement of our costs not to exceed \$6,000. We believe the result of the survey proposed to be undertaken by the Department of Teaching Hospitals will be of great value to all University Owned Teaching Hospitals and look forward to our participation in preparing the survey instrument.

Sincerely yours,

  
Sheldon I. Dorenfest  
President

SID:kk

compucare

## INTER-OFFICE MEMO

Retain - 6 mos.

1 yr.

5 yrs.

Permanently  
Follow-up DateDATE May 23, 1973

TO: John A. D. Cooper, M.D., Ph.D.

FROM: Richard M. Knapp, Dennis D. Pointer

SUBJECT: Medical School-Community Hospital Affiliations

Increasingly, the non university owned and/or non university affiliated (community based) teaching hospital is becoming more involved in providing clinical exposure settings for undergraduate medical education. This appears to be the result of two somewhat parallel developments. First, planned or developing medical schools are finding it increasingly difficult to secure the necessary funding to build and subsequently operate a university owned hospital facility. Second, established medical schools are increasingly looking toward community based hospital facilities to provide clinical settings whereby class size can be increased and/or a broader clinical exposure can be provided physicians in training. It appears reasonable to assume that both of these trends will continue in the future.

While affiliation arrangement between medical schools and community based hospitals have many benefits for both participants to the relationship as well as for the patient populations involved, such affiliations are complex to initiate and subsequently administer. This complexity is compounded by the almost complete lack of published material addressing the process and problems of medical school - community hospital affiliation. Additionally, there is no forum where institutions engaging or anticipating to engage in such relationships, can share common experiences.

Given the above, it appears that AAMC-COTH could make a significant contribution by initiating a mechanism whereby the issues surrounding medical school - community hospital affiliation arrangements could be addressed in detail by a broad range of participants. Although many options are available for this type of engagement, the following plan is suggested as a point of departure.

We propose that AAMC-COTH approach a funding organization to finance both the planning and execution of a workshop (and associated undertakings) focused on medical school -

COPIES TO:

John A. D. Cooper, M.D., Ph.D.

Page Two

May 23, 1973

community hospital affiliation arrangements to provide clinical settings for undergraduate medical education. It is suggested that the project be undertaken in four phases:

Phase I: Assemble a group of medical school and hospital representatives who have had experience in initiating and administering affiliation arrangements to outline pertinent issues and to design a workshop.

Phase II: Conduct Workshop(s)

Phase III: Assemble publishable documents

Phase IV: Evaluate completed effort and plan future activities.

We would like to receive the benefit of your thoughts regarding the value of this proposal. Quite possibly this idea could be discussed at the next COTH Administrative Board meeting on June 21.

# ECONOMIC STABILIZATION PROGRAM



BULLETIN 10

October 12, 1973

This bulletin describes the Cost of Living Council Health Staff's proposal for Phase 4 hospital revenue and expense controls. The bulletin is being sent in three separate mailings. The first mailing is going to AHA Type IA\* institutional members with a special cover letter urging those institutions to complete a copy of the enclosed questionnaire for return to us so that we may analyze the potential impact of the COLC Health Staff's proposal for Phase 4 controls prior to the Board of Trustees meeting on November 14-16, and prior to the expected publication of the proposed Phase 4 regulations around November 15. This initial description of the Phase 4 control program should be helpful for institutional members whose next fiscal year begins on January 1, 1974, because it can serve as a tentative basis for their fiscal planning. The second mailing is to the rest of our regular member mailing list, and the third is a special mailing by the Hospital Financial Management Association to all of its members.

As another part of our efforts to assure full understanding of the COLC proposal, we have arranged for John D. Twiname, executive director, Health Staff, Cost of Living Council, to brief representatives of the state hospital associations later this month when more detailed information becomes available. The discussion of the COLC proposal in the remainder of this bulletin is of necessity incomplete in many respects, because final decisions have not yet been made. This bulletin will, however, permit our members to begin to explore the implications of this revenue and expense per admission control system. As you study the proposal, I urge all of you to send us your written reactions, and ask the Type IA members to please return the enclosed questionnaire as promptly as possible.

## The Basic System

The Health Staff's proposal treats separately outpatient and inpatient activities. Those outpatient procedures that are not common to inpatient services, e.g. a visit to an outpatient clinic or an emergency room, are subject to a price control system without adjustment for volume changes. Price increases for these distinct outpatient procedures may be calculated on either a unit (a control on the price of each unit of service) or a weighted average basis. If the weighted average approach is used, the weights are established by each procedure's dollar share of last year's gross outpatient revenue for all of these distinct procedures. The latest COLC proposal calls for a 5 per cent limit on these price increases.

Financial controls on inpatient activities must meet two tests: (1) a limit on increases in gross inpatient revenue per admission, and (2) a limit on increases in total inpatient expense per admission. If one assumes that the number of admissions and the length of stay will remain constant from the current year to the next, the COLC staff is considering a 7 per cent allowable increase in both gross revenue per admission and a 7 per cent increase in expense per admission, although this percentage may be increased to 8 per cent before the proposal is made final.

For purposes of illustration in this bulletin, we have used a 7 per cent figure. For example, if an institution's gross inpatient revenue and total inpatient expense per admission were \$1000 and \$900 respectively in 1973 and the number of admissions in 1974 remains the same, the institution would be permitted to earn gross revenues per admission of \$1070 and incur expenses of \$963 per admission.

It is clear, however, that most, if not all, institutions will experience some change in number of admissions and/or in length of stay. The COLC Health Staff is cognizant of this fact and proposes to recognize volume changes based on two premises:

First, the Health Staff has concluded that 60 per cent of the hospital's costs are fixed costs and 40 per cent are variable. They reason that added admissions affect only variable costs and not fixed costs. Conversely, reduced admissions will affect a reduction in the variable costs only, and the fixed costs must be spread over fewer admissions.

Second, the Health Staff understands that virtually no hospital can predict a year or more in advance the exact number of admissions or patient days it will experience. Further, the Health Staff understands that year-to-year variations in use are likely to be more pronounced in small hospitals (those with less than \$2,000,000 in gross revenues) than they are in larger ones.

\*The specific COLC proposal being discussed is applicable only to Type IA members, acute hospitals. Long-term care facilities and nursing homes will not be controlled on an admissions basis, but will probably be controlled on a gross charges and total expense per diem basis.

Therefore, "corridors" have been proposed to allow for variance in use that could not be predicted. For large hospitals (those with gross revenues exceeding \$2,000,000 per year), the "corridor" might be plus or minus 3 per cent in the number of admissions. If, for example, a hospital experienced a 3 per cent increase in admissions, it would still be allowed a 7 per cent increase in revenue per admission. If it experienced a 3 per cent decrease, the 7 per cent revenue figure would still hold. If admissions varied by more than plus or minus 3 per cent, the fixed cost-variable cost reasoning would be applied and allowable revenue increases would be adjusted accordingly. For a clear illustration, see the table on page 4 of the attachment. (Both models I and II are under discussion and can be used for illustration.) The "corridor" for smaller hospitals will probably be greater than the "corridor" for large hospitals, because, as stated, smaller hospitals are subject to wider variations in the number of admissions.

If a hospital's changes in revenue and expense per admission comply with the limits, there will be no internal cost limits, except for the application of the national wage policy on wage rates; no cost justification requirement; and no profit margin test.

Association studies of annual survey data cast significant doubt on the reasonableness of the 60/40 fixed-variable cost assumption in predicting the cost behavior of all health care institutions. We are also urging the use of an 8 per cent base figure for both revenues and expenses. Your prompt return of the survey questionnaire will be of critical importance in helping us with these issues.

One other significant volume factor, not explicitly dealt with in the COLC proposal, is the institution's average length of stay. Our analysis indicates that if an institution can prospectively influence its average length of stay, this will significantly affect the institution's ability to meet the compliance limits. One of the basic policy issues debated in the Health Industry Advisory Committee deliberations on this proposal was the question of whether or not institutions could significantly alter their lengths of stay during a short-term control program. I said that the external factors, such as the randomness of illness, changing demographic conditions, changing case mix, etc., were important causal factors in determining changes in lengths of stay and that the institution is limited in its ability to influence its average length of stay. Consequently, there is doubt that any control system based on the premise that incentives for the institution to substantially change its length of stay could achieve the desired result.

Our analysis of the extreme randomness of both changes in admissions and an institution's average length of stay suggest that there will be a large number of exception requests. Your appraisal of how your institution might come to grips with, for example, decreasing lengths of stay, may in large part determine how well your institution can operate under the Phase 4 program.

#### Exceptions

Because of the possibility that a large number of institutions may require exceptions to the basic inpatient control system, our staff is concentrating its efforts on the development of guidelines for exception review which, thus far, have not been fully developed by the COLC staff. Our Council on Financing, at its meeting last week, concluded that without detailed guidelines for exception review at the same time the general regulations are promulgated, hospitals will be unable to plan their operations under Phase 4.

Thus far, we have only a general framework for the exceptions process. The COLC hopes that many states will be able to develop the necessary administrative capability to operate the exceptions review program, as well as assume the responsibility for the monitoring of compliance. In the event that such capability is not demonstrated, the COLC in Washington will perform these functions.

Special emphasis will be placed on the need for exceptions to meet the financial requirements of new programs, new services, and modernization and renovation of plant and capital equipment facilities. Exceptions to finance these requirements will require the approval of the designated state planning agency as prescribed in Section 221 of P.L. 92-603. This planning review may, however, at the option of the institution, be extended to include projects having capital and operating requirements in excess of \$100,000 annually rather than the \$100,000 capital expenditure limit employed in P.L. 92-603. In evaluating these projects, the operating and capital requirements for a three-year period will probably be considered. The COLC intends to monitor closely the increase in the total number of beds in any state and suggests that a net addition to the supply of beds will require COLC approval.

In addition to the capital review, exceptions consideration will be given to such factors as significant changes in patient mix that require a more expensive or higher level of care, adjustment of charges if they are currently less than cost in order to comply with Section 233 of P.L. 92-603, and legislated and other increases in costs beyond the control of the individual hospital such as taxes or regulatory changes requiring improvements in standards. It is proposed that new hospitals will be exempted from the program for their first three years of operation so long as they establish prices "comparable" to other facilities in the community.

October 12, 1973

ESP Bulletin No. 10/3

States may seek exemption from the program if they can demonstrate an effective hospital control program meeting federal standards. These federal standards have not been developed as yet.

Let me repeat again that the purpose of this bulletin is to keep you up to date on the latest Phase 4 developments. AHA will continue to advocate a control system based on increases in aggregate annual revenue due to prices, but we must also analyze alternative control proposals and weigh their advantages and disadvantages. A final appraisal of Phase 4 controls must await publication of the draft regulations, and we then anticipate a period in which we can submit specific suggestions or objections. Your assistance in responding to this bulletin is crucial to our analysis of the proposal described herein.

John Alexander McMahon  
President

attachment

The attached form and schedule of increase limits were designed by AHA to simulate the Cost of Living Council's Phase IV control system on your hospital. Basic data requirements for completing this form are: total admissions (excluding newborn patients), inpatient expenses and inpatient revenue.

### Instructions

Two columns are provided on the form. Column A is the base fiscal year and column B is the control fiscal year. Enter the ending date of fiscal years selected in the appropriate space. In specifying the years, it would be best if the base year (Col. A) was your current fiscal year and the control year (Col. B) would reflect estimates for your next fiscal year. If this is not possible, the control year (Col. B) should represent the most recent fiscal year for which information (estimated or actual) is available. The base year (Col. A) will then be your preceding fiscal year.

Item 1 - Enter your hospital's gross inpatient revenue for the base year, column A, and the control year, column B.

Item 2 - Enter total inpatient expenses for the base year, column A, and the control year, column B.

Item 3 - Enter total inpatient admissions (excluding newborn patients) for the base year, column A, and the control year, column B.

Item 4 - Calculate inpatient revenue per admission for the base year (divide item 1, column A, by item 3, column A). Enter result in item 4, column A.

Similarly, calculate inpatient revenue per admission for the control year (divide item 1, column B, by item 3, column B). Enter result in item 4, column B.

Item 5 - Calculate inpatient expenses per admission for the base year (divide item 2, column A, by item 3, column A). Enter result in item 5, column A.

Similarly calculate inpatient expenses per admission for the control year (divide item 2, column B, by item 3, column B). Enter result in item 5, column B.

Item 6 - Determine the percentage change in admissions between the control year and the base year (divide item 3, column B, by item 3, column A). Since this calculation yields a decimal factor, subtract 1 from the result to convert to a percentage.

Example of decimal to percentage conversion:

	<u>Column A</u>	<u>Column B</u>
	<u>Base Year</u>	<u>Control Year</u>
Item 3 admissions	8,000	10,000

$$\frac{10,000}{8,000} = 1.25;$$

$$1.25 - 1 = .25 = 25\% \text{ increase}$$

Item 7 - Calculate the percentage change in inpatient revenue per admission between the control year and the base year (divide item 4, column B, by item 4, column A). Make the necessary decimal to percentage conversion by subtracting one from the result.

continued

Item 8 - Calculate the percentage change in inpatient expenses per admission between the control year and the base year (divide item 5, column B, by item 5, column A). Convert the result to a percentage.

Use the attached schedule to determine whether your hospital is within compliance limits of the proposed system.

Find the admission change number on the schedule which corresponds to the result in item 6 of the form. The adjacent figures are the compliance limits.

Two models are proposed. Model I has varying compliance limits for inpatient revenue per admission and inpatient expenses per admission. Thus, once you have found the appropriate percentage change in admissions figure, your hospital must meet the adjacent limits on both revenue and expenses per admission. The limits are checked against items 7 and 8 of the form. For example, if your hospital experienced a 5 per cent increase in admissions, Model I increase limits are 6.2 per cent for inpatient revenue per admission and 3.2 per cent for inpatient expenses per admission. If your hospital exceeded either limit, it would be out of compliance.

Model II is a suggested modification. Compliance limits for inpatient revenue per admission and inpatient expenses per admission are the same at any given admissions change. For example, if your hospital had a 5 per cent increase in admissions, your compliance increase limits for both inpatient revenue per admission and inpatient expenses per admission would be 6.2 per cent.

Note: If the admissions change percentage determined in item 6 falls within the values given in the schedule you should interpolate the appropriate increase limits. For example, a -10.5 per cent change in admissions will yield limits under Model I, of +10.0 per cent for inpatient revenue per admission and +14 per cent for inpatient expenses per admission. Under Model II, the same admission change will yield a +14 per cent limit on both inpatient revenue per admission and inpatient expenses per admission.

If your admissions change percentage determined in item 6 falls outside the values on the schedule you should extrapolate the appropriate increase limits. For example, a -30 per cent change in admissions yields for Model I, a +17.8 per cent limit on inpatient revenue per admission and +20.8 per cent limit for inpatient expenses per admission. Under Model II, a similar admissions change yields a +20.8 per cent increase limit for both inpatient revenue per admission and inpatient expenses per admission.

Duplicate forms are provided in this packet. The form designated as HOSPITAL WORK COPY is for your files, while the other form should be completed and returned to AHA in the enclosed envelope. Thank you for your cooperation.

HOSPITAL WORK COPY

Hospital Name \_\_\_\_\_ Date \_\_\_\_\_

City and State \_\_\_\_\_

Number of staffed for use beds \_\_\_\_\_.

ITEM	Enter appropriate dates	Col. A	Col. B
		Base Fiscal Year Ending ( __ Mo. __ Yr.)	Control Fiscal Year Ending ( __ Mo. __ Yr.)
1) Gross Inpatient Revenue		_____	_____
2) Total Inpatient Expenses		_____	_____
3) Total Inpatient Admissions		_____	_____
4) Inpatient Revenue per Admission (divide Item 1 by Item 3)		_____	_____
5) Inpatient Expenses per Admission (divide Item 2 by Item 3)		_____	_____
6) Per Cent Change in Admissions (divide Item 3, Col. B by Item 3, Col. A -- Subtract 1)			_____
7) Per Cent Change in Inpatient Revenue per Admission (divide Item 4, Col. B by Item 4, Col. A -- Subtract 1)			_____
8) Per Cent Change in Inpatient Expenses per Admission (divide Item 5, Col. B by Item 5, Col. A -- Subtract 1)			_____

To determine compliance, see attached schedule.

In your control fiscal year will your hospital have capital expenditures in excess of \$100,000?

Yes  No

Proposed Limits  
Model II

Per Cent Change in  
Admission  
(See Item 6)

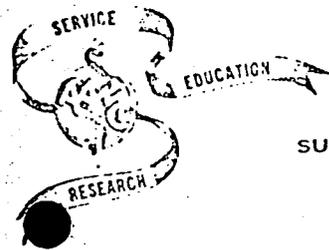
Proposed Limits  
Model I

Inpatient Revenue  
per Admission      Inpatient Expense  
per Admission

Inpatient Revenue  
per Admission and  
Inpatient Expense  
per Admission

-25.0%	15.8	18.8	18.8
-24.0	15.4	18.4	18.4
-23.0	15.0	18.0	18.0
-22.0	14.6	17.4	17.6
-21.0	14.2	17.2	17.2
-20.0	13.8	16.8	16.8
-19.0	13.4	16.4	16.4
-18.0	13.0	16.0	16.0
-17.0	12.6	15.6	15.6
-16.0	12.2	15.2	15.2
-15.0	11.8	14.8	14.8
-14.0	11.4	14.4	14.4
-13.0	11.0	14.0	14.0
-12.0	10.6	13.6	13.6
-11.0	10.2	13.2	13.2
-10.0	9.8	12.8	12.8
- 9.0	9.4	12.4	12.4
- 8.0	9.0	12.0	12.0
- 7.0	8.6	11.6	11.6
- 6.0	8.2	11.2	11.2
- 5.0	7.8	10.8	10.8
- 4.0	7.4	10.4	10.4
- 3.0	7.0	10.0	10.0
- 2.0	7.0	9.0	9.0
- 1.0	7.0	8.0	8.0
0.0	7.0	7.0	7.0
+ 1.0	7.0	6.0	7.0
+ 2.0	7.0	5.0	7.0
+ 3.0	7.0	4.0	7.0
+ 4.0	6.6	3.6	6.6
+ 5.0	6.2	3.2	6.2
+ 6.0	5.8	2.8	5.8
+ 7.0	5.4	2.4	5.4
+ 8.0	5.0	2.0	5.0
+ 9.0	4.6	1.6	4.6
+10.0	4.2	1.2	4.2
+11.0	3.8	.8	3.8
+12.0	3.4	.4	3.4
+13.0	3.0	0.0	3.0
+14.0	2.6	-.4	2.6
+15.0	2.2	-.8	2.2
+16.0	1.8	-1.2	1.8
+17.0	1.4	-1.6	1.4
+18.0	1.0	-2.0	1.0
+19.0	.6	-2.4	.6
+20.0	.2	-2.8	.2
+21.0	-.2	-3.2	-.2
+22.0	-.6	-3.6	-.6
+23.0	-1.0	-4.0	-1.0
+24.0	-1.4	-4.4	-1.4
+25.0	-1.8	-4.8	-1.8

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

October 5, 1973

Irwin Wolkstein  
Deputy Director  
Program Policy  
Social Security Administration  
East Building, Room 191  
Security Boulevard  
Baltimore, Maryland 21235

Dear Mr. Wolkstein:

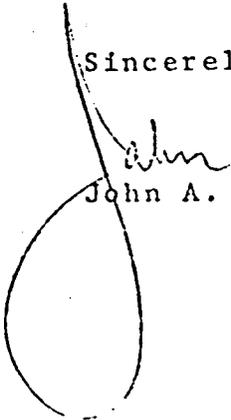
I believe there are certain unresolved issues related to the methodology for cost reimbursement under Section 227 of P.L. 92-603. The resolution of these problems is reaching a critical stage since the payment of Medicare fees has already been suspended at a number of medical centers throughout the country.

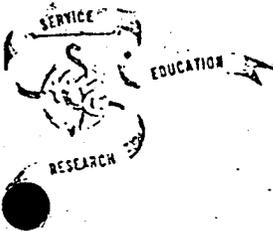
As you know, earlier in the year we had numerous meetings with Social Security Administration staff members concerning the implementation of Section 227. However, repeated efforts to engage in a meaningful discussion of the cost methodology were unsuccessful. The results at that time were draft guidelines which did not include some of the most difficult, but important, issues.

Further, the proposed regulations as published in the July 19 Federal Register do not adequately cover the subject of cost reimbursement and have created confusion for medical center administrators and hospital controllers.

In view of the serious nature of these issues as well as the shortness of time, I respectfully request a meeting with you to discuss the cost reimbursement issue. I would bring no more than five individuals to the meeting who are well acquainted with the issue. This is an urgent matter, and I believe a meeting is necessary immediately.

Sincerely,

  
John A. D. Cooper, M.D.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.  
PRESIDENT

WASHINGTON: 202: 466-5175

October 12, 1973

Mr. James B. Cardwell  
Commissioner  
Social Security Administration  
Department of Health, Education  
and Welfare  
Fourth and Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Mr. Cardwell:

The purpose of this letter is to request a sixty day extension of the comment period to proposed regulations implementing Section 233 of Public Law 92-603 as published in the September 13, 1973 Federal Register.

The Association of American Medical Colleges fully supports the concerns expressed by the American Hospital Association in their similar request. We intend to work closely with the American Hospital Association in an effort to determine the impact of these regulations if they are implemented as proposed. These regulations will have a particularly severe effect on public hospitals and on the operation of teaching hospital outpatient departments in general.

The following points are of definite concern and importance.

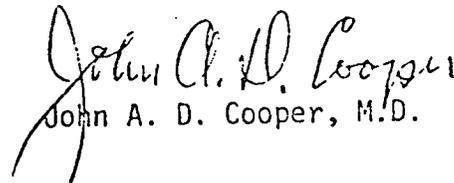
- The legislative history of this section of the amendments clearly demonstrates an intent to provide special protection for public hospitals. I believe an analysis of the facts will reveal that this protection is not provided in the proposed regulations.
- The proposed regulations fail to recognize that voluntary non-profit hospitals, particularly teaching hospitals, make substantial contributions to the community by providing ambulatory services to medically indigent patients at charges which are less than cost. Thus, the proposal

to separate the cost or charge determinations into Part A and Part B components presents an unnecessary restriction. The net results of the proposed regulations under the above circumstances would be a higher outpatient charge to those least able to pay, a disincentive to provide ambulatory services, and a disincentive for private hospitals to provide services to the poor and near-poor.

- Assurances must be provided that the Cost of Living Council will relax the constraints on hospitals' ability to raise charges to meet cost increases. In this regard, it should be recognized that during the period in which the Economic Stabilization Program has been in operation, hospitals have not been able to raise charges at a rate commensurate with cost increases, thus intensifying the impact of these proposed regulations.
- Specific portions of the proposed regulations require more definitive clarification. Under § 405.455(b) the phrases "patients liable for payment" and "reasonable efforts to collect" must be given clearer definition.
- Finally, in paragraph (d)(2), provisions are granted for new providers to carry forward for five successive periods, costs attributable to program beneficiaries which are not reimbursed, with respect to a cost reporting period which begins after December 31, 1972, and ends on or before the last day of its third year of operation. In effect, a new hospital which has been in operation more than three years does not receive the benefit of this provision. A three year period is not long enough for most teaching hospitals to pass through the unusual financial conditions that arise during its "start-up." Consideration should be given to extending this three year period to at least five years.

Based upon the serious implications that I believe would result from implementing the proposed regulations as published, I request that the period provided for submitting written comments, suggestions or objections be extended at least an additional sixty days so that we may offer constructive proposals regarding the regulations and their implementation.

Sincerely,

  
John A. D. Cooper, M.D.

cc: Honorable Caspar W. Weinberger

Charles C. Edwards, M.D.