American Hospital Association

J. ALEXANDER McMAHON
President

August 16, 1977

Dear John

In the fall of 1975, our Board of Trustees appointed a special committee to review the existing state of hospital regulation and make a series of recommendations to the Association on how hospital regulation could be made more effective. The committee, chaired by T. Stewart Hamilton, M.D., completed its report in April of this year and submitted its recommendations to the Board in May. The Board "accepted" the report and has referred each of the committee's 33 recommendations to the committees and councils of the Association for review and comment.

It would be extremely helpful to the American Hospital Association if, when the Board receives these comments from the internal policy bodies, it could also have the reactions of your organization. Would you please refer the report, which is enclosed, to the appropriate body or bodies in your organization for their review and comment by October of this year. Our Board is hoping to take final action on at least some of the committee's recommendations at its November meeting. As in the past, we would benefit greatly by your advice on this extremely important subject.

Sincerely yours

J. Alexander McMahon

enclosure

John A.D. Cooper, M.D., Ph.D.
President
Association of American Medical Colleges
1 Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

840 North Lake Shore Drive • Chicago, Illinois 60611 • 312 645-9400

COTH Member Experience Under Section 223 Regulations

To develop quantitative support for the Association's concerns regarding the impact on COTH members of the Medicare program's routine service cost limitations, postcard surveys of non-Federal COTH members were conducted in the Spring of 1976 and 1977. The surveys requested member hospitals to indicate: (1) the inclusive date of the hospital's cost reporting periods for the current and past year and (2) the Medicare cost ceiling for routine service costs for the past and current year as well as the past year's actual and current year's projected routine service costs. Thus, in the past two years, the Department of Teaching Hospitals has collected information on the Section 223 status of COTH members as follows:

(1) Fiscal Year 1975 Actual Status -- collected as past year data on the Spring 1976 survey.

(2) Fiscal Year 1976 Estimated -- collected as current year data on the Spring 1976 survey.

(3) Fiscal Year 1976 Actual -- collected as past year data on the Spring 1977 survey, and

(4) Fiscal Year 1977 Estimated -- collected as current year data on the Spring 1977 survey.

This report briefly summarizes and compares the survey findings for these time periods.

Response Rates

The 1976 survey of COTH member experience under Section 223 Regulations had a significantly higher response rate (83% returned, 279 responses from 329 hospitals) than the 1977 survey (66%, 218 responses from 331 hospitals). As a result, findings for fiscal years 1976 Actual and 1977 Estimated are less stable and subject to substantially greater errors when used as projections

than are those for fiscal years 1975 Actual and 1977 Estimated.

Findings

Table 1 shows the cost status of COTH members under the Section 223 limitations. In each period shown, roughly twenty percent of the responding hospitals had costs exceeding or expected to exceed the routine service cost limitation.

Table 2 is a year to year comparison of the Section 223 status of COTH hospitals. The Table shows that whether one compares 1975 Actual with 1976 Expected or 1976 Actual with 1977 Expected, a large majority of hospitals exceeding their Section 223 ceilings in one fiscal period also expect to exceed the ceiling in the subsequent fiscal period. In consecutive years, most COTH hospitals do not expect a change in their Section 223 status.

Table 3 is a percentage distribution of the responding hospitals which exceeded their routine service cost limitations. A substantial portion of those exceeding their ceiling imposed did so by less than $10.00 per day in each fiscal period. Nevertheless, the Table shows a continuing trend: hospitals exceeding the ceiling in the current year are generally over the ceiling by a larger amount than were those hospitals which exceeded the ceiling in past years.

If the Medicare classification system and cost limitations measured only inefficiency, there would be no reason to expect any particular group of COTH hospitals to exceed the ceilings. Table 4, however, indicates that the present scheme includes systematic biases: COTH hospitals exceeding the ceiling tend to be located in the west, university-owned, under 410 beds, controlled by a state or county, and spending over $7.75 per adjusted patient day for house staff stipends.

Table 1 -- Section 223 Status of COTH Hospitals

Percent of Responding Hospitals

Status	Fiscal Year 1975 Actual	1976 Estimated	1976 Actual	1977 Estimated
Ceiling exceeds Cost	74%	69%	75%	73%
Cost exceeds Ceiling	20	24	21	20
Not Ascertained	6	7	4	7
TOTAL	100%	100%	100%	100%
N	274	274	218	218

Table 2 -- Year to Year Comparisons of Section 223 Status
of COTH Hospitals Exceeding Medicare Routine Service Cost Ceilings

Ceiling Status	1975 Actual - 1976 Estimated		1976 Actual - 1977 Estimated	
	N	%	N	%
Over both Periods	45	59%	38	74%
Under to Over	21	28	5	10
Over to Under	10	13	8	16
TOTAL	76	100%	51	100%

Table 3 -- Percentage Distribution of Section 223 Status in Responding Hospitals where Costs Exceed Medicare Ceilings

Percent of Responding Hospitals

Amount by Which Cost Exceeds Ceiling	Fiscal Year 1975 Actual	1976 Estimated	1976 Actual	1977 Estimated
$ 0.00 - 4.99	37.5%	19.7%	28.3%	30.2%
5.00 - 9.99	19.6	19.7	13.0	20.9
10.00 - 14.99	12.5	15.2	13.0	7.0
15.00 - 19.99	10.7	12.1	19.6	4.7
20.00 - 24.99	5.4	10.6	2.2	7.0
25.00 - 29.99	3.6	6.1	6.5	16.3
30.00 - 34.99	5.4	3.0	2.2	0.0
35.00 - 39.99	0.0	4.5	8.7	4.7
40.00 - 44.99	3.6	3.0	2.2	2.2
45.00 - 49.99	0.0	3.0	0.0	0.0
50.00 - 54.99	0.0	0.0	0.0	2.2
55.00 - 59.99	0.0	0.0	2.2	0.0
60.00 - 64.99	1.8	0.0	0.0	2.2
65.00 - 69.99	0.0	3.0	0.0	0.0
70.00 - 74.99	0.0	0.0	2.2	0.0
75.00 - 79.99	0.0	0.0	0.0	2.2
TOTAL	100.1%	99.9%	100.1%	100.0%
N	56	66	46	43

Table 4 -- Characteristics of COTH Hospitals Which Disproportionately[1] Exceed Medicare Routine Service Cost Limitations

Category	Fiscal Year 1975 Actual	1976 Actual	1977 Estimated
Region[2]	--	West	West
Affiliations[3]	University-Owned	University-Owned	University-Owned
Bed Size[4]	410 Beds or Less	410 Beds or Less	410 Beds or Less
Control[5]	State, County, Church	State, County	State, County
House Staff Stipends[6]	$7.75 or More	$7.75 or More	$7.75 or More

[1]Categories in which the percentage of hospitals exceeding the ceiling is 1.5 times the percentage of all COTH hospitals exceeding the ceiling.

[2]Categories were Northeast, South, Midwest, West.

[3]Categories were university-owned, major affiliation, limited affiliation, unaffiliated.

[4]Categories were 410 beds or less, 411 to 520 beds, 521-745 beds, and 746 or more beds. This classification divides COTH members into quartiles.

[5]Categories were state, county, city, church, other, nonprofit and hospital district control.

[6]Categories were less than $3.25, $3.25 to $5.09, $5.10 to $7.74, and $7.75 and more per adjusted patient day. This classification divides COTH members into quartiles.

ANNUAL MEETING ACTIVITIES
OF SPECIAL INTEREST TO THE
COUNCIL OF TEACHING HOSPITALS

SUNDAY, NOVEMBER 6

7:30 p - 9:30 p

VA/COD JOINT PROGRAM

ANALYZING THE VETERANS ADMINISTRATION - MEDICAL SCHOOL RELATIONSHIP

Moderator: John A.D. Cooper

"A View From the General Accounting Office"

Murray Grant

"A View from the National Academy of Sciences Study"

Saul J. Farber

"The Veterans Administration Perspective"

Jack Chase

MONDAY, NOVEMBER 7

7:30 a - 9:00 a

COTH ADMINISTRATIVE BOARD BREAKFAST

9:00 a - Noon

PLENARY SESSION - ALAN GREGG MEMORIAL LECTURE

Presiding: Robert G. Petersdorf

"Historical Development of Specialization and Graduate Medical Education"

Rosemary Stevens

"The Hospital/Medical School Partnership"

Robert A. Derzon

"Options for Financing Graduate Medical Education"

James Kelly

ALAN GREGG MEMORIAL LECTURE:

"The Education of the Physician

Donald W. Seldin

ANNUAL MEETING ACTIVITIES (Continued)

MONDAY, NOVEMBER 7 (Continued)

12 Noon — COTH LUNCHEON

2:00 p - 4:30 p — COTH GENERAL SESSION

PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES

- As Viewed by the Department Chairman and Program Director

  Robert G. Petersdorf

- As Viewed by a Dean Turned Chief Executive Officer

  J. Robert Buchanan

- As Viewed by the Hospital Director

  Robert M. Heyssel

TUESDAY, NOVEMBER 8

9:00 a - Noon — PLENARY SESSION/ASSEMBLY

Presiding: Ivan L. Bennett, Jr.

Presentation of Awards

Chairman's Address: Ivan L. Bennet, Jr.

President Jimmy Carter
or
Joseph A. Califano, Jr., Secretary, HEW

Recess

Business Meeting of the AAMC Assembly

1:30 p - 4:00 p — COD/CAS/COTH JOINT PROGRAM

Session I - "Transition Between Undergraduate and Graduate Medical Education"

The Transition to Graduate Medical Education - A Student's Point of View

Thomas A. Rado

The Readiness of New M.D. Graduates to Enter Their GME-1 Year

Barbara Korsch

annual meeti
ANNUAL MEETING ACTIVITIES (Continued)

TUESDAY, NOVEMBER 8

1:30 p - 4:00 p

COD/CAS/COTH JOINT PROGRAM (Cont.)

SESSION I (Continued)

The Search for a Broad First Year

William Hamilton

SESSION II - "Quality of Graduate Medical Education"

The Evaluation of Residents' Performance

John A. Benson, Jr.

Supervisory Relationships in Graduate Medical Education

William P. Homan

The Program Director's Responsibility

Thomas K. Oliver

WEDNESDAY, NOVEMBER 9

9:00 a - 11:30 a

COD/CAS/COTH JOINT PROGRAM

SESSION III - "Influencing Specialty Distribution Through Graduate Medical Education"

The Coordinating Council on Medical Education Should Participate with the Federal Government to Regulate Opportunities for Specialty Training

The Private Sector Should Avoid Participating with the Federal Government

SESSION IV - "Institutional Responsibility for Graduate Medical Education - The McGaw Medical Center of Northwestern University Experience

ANNUAL MEETING ACTIVITIES (Continued)

WEDNESDAY, NOVEMBER 9 (Cont.)

9:00 a - 11:30 a — COD/CAS/COTH JOINT PROGRAM

SESSION IV (Continued)

The Concept and Its Development

James E. Eckenhoff

How It Operates

Jacob Suker

How it Affects the Program Director

Henry L. Nadler

Its Impact on the Teaching Hospital

David L. Everhart

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals
Minneapolis, Minnesota 55455

August 19, 1977

Dr. Richard M. Knapp
Director
C.O.T.H.
1 Dupont Circle N.W.
Washington, D. C. 20036

Dear Dick:

Enclosed is a copy of "Guidelines for the Application of Hospital Accreditation Program Standards in Survey University Hospitals."

With the exception noted on page 5, the guidelines were adopted by the Board of Commissioners on August 13.

While you will be receiving more formal notification from J.C.A.H., I thought you might be interested in this preliminary document. Thank you for all the time and effort you put in on the development of these guidelines.

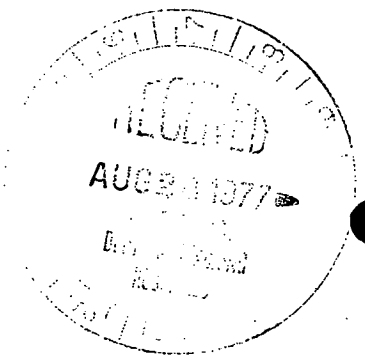
Sincerely yours,

John

John H. Westerman
General Director
University Hospitals
& Coordinator, Health Care Systems
Research & Development, Office of the
Vice President for Health Sciences Affairs

JHW/mh

cc: U.H.E.C. group



SUBJECT: Guidelines for the application of Hospital Accreditation Program Standards in Surveying University Hospitals

The unique characteristics, special needs and particular problems of university hospitals with respect to the standards and procedures of the JCAH accreditation process must be acknowledged. This involves recognition of the university hospital's threefold mission -- patient care, health science education and clinical research. There is concern that the rigid application of specific accreditation standards by JCAH will not acknowledge the teaching hospital's additional responsibility for innovation in the organization of health services and the training of health manpower. As in other types of hospitals, the reasonable application of JCAH standards includes provision for the principle of equivalency, wherein an equal or better way of complying with a standard's requirement has been demonstrated. The appropriate survey team member will describe in his report how the hospital has met such equivalent status and the acceptability of such information will be determined by the Hospital Accreditation Program (HAP).

Since the JCAH surveyor must be concerned with the "hospital" rather than the "university" aspect of the university hospital, and with the "quality of patient care" rather than the "teaching program" per se, it is appropriate to examine the relationship of hospital patient care to university academic programs. While the hospital responsibilities may include medical school objectives over and above patient care objectives, it is assessment of the latter on which the JCAH surveyor is expected to focus. Thus, it is necessary to distinguish between the roles of the physician acting as a member of the hospital's clinical staff and his role as a member of the medical school faculty. Two primary areas that require careful evaluation and the judicial application of the equivalency concept are governance and medical staff organization.

Governance The adequate fulfillment of governance/accountability functions are as important to the university hospital as to any other

hospital. Where the governing body is a university governing board, such as a Board of Regents, the multiple responsibilities of the university may not permit careful attention to the affairs of hospital governance. This can be a problem particularly in the board's responsibility for quality of care assurance, guaranteeing appropriate procedures for appointment to the medical staff, and assignment/approval of clinical privileges. The existence of an identifiable, accountable governance function is as important for the university hospital as the community hospital.

Where there is no evidence of the governing board fulfilling a trusteeship function, either directly or through clear delegation, there may be an actual problem of abdicated responsibility for the function, or there may be only a lack of corroborative documentation. Where the former exists, this problem may be resolved by the governing board's delegating in writing the authority for another body (group or individual), internal or external to the hospital, to act for it in whole or in part in critical clinically-associated areas, such as quality of care assurance, medical staff appointment, and the granting of privileges. Written documentation of such delegated authority should be available to the surveyor.

The JCAH requirements for broad community representation on the governing body must be approached realistically. The "community" is difficult to define where the hospital is a tertiary care referral center. The test of appropriate representation should be the ability to act objectively in conducting governing accountability. Basically, the JCAH accreditation process should address whether the essential process of governance is being adequately executed, regardless of the mechanism for accomplishing it. Recognition should be given to the variety of state legislative and executive review mechanisms other than the hospital governing board which assure the public accountability of publicly-owned teaching hospitals and which bring the varied interests of community members to bear upon hospital decision making.

Medical Staff The medical staff must have an organizational structure capable of addressing institution-wide health care delivery issues as well as being able to meet the responsibilities of any organized medical staff. As required of any hospital, the organization of the medical staff is reflected in its bylaws, rules and regulations which must address procedures for appointment and reappointment to the medical staff, the granting and delineation of clinical privileges, periodic reappraisal of the staff, and continuing medical education requirements.

Most university hospitals require medical or dental academic appointments as a prerequisite for clinical staff appointment. This usually includes all departmental faculty, both full-time and those appointed to the teaching staff who serve on a part-time basis. Although appointments may be fairly automatic upon recommendation by the head of the clinical department/service, the hospital credentialing process cannot be omitted. However, duplication of effort performed during the academic appointment is not required, provided the information is made available to the hospital for its files. It is recognized that the evaluation of professional competence must take into consideration that a physician's excellent credentials in the research/teaching field does not necessarily ensure excellence in patient care. Medical faculty reappraisal information required for periodic review of academic status, as it includes performance in patient care and hospital medical staff responsibilities, may also be used for the reappraisal of the medical staff of the hospital. The need for duplication is obviated if such "university" information is made available for "hospital" use and retention. The university faculty reappraisal is usually performed at regular intervals and thus also satisfies the JCAH requirement for the regular reporting by departmental chairmen on the clinical performance of medical staff members. While the "provisional" status of new staff members is also required in the university hospital, the degree to which it is implemented will be determined by the department/service chairmen. The tenure system relates to reappointment requirements for academic activities only.

Since the organization of the medical staff in the university hospital does not frequently follow the staff categories used in community hospitals, surveyors should expect categorization and nomenclature adopted to the needs of the particular institution.

In some university hospitals (or university-affiliated large teaching hospitals) there are teaching physicians, community physicians, and house staff physicians. It is in this type of setting that particular care must be taken to ensure there is not more than one standard of care permitted.

To varying degrees, house staff members function as students, teachers, and providers of care. If their role is not clearly defined within the organized medical staff, they may hold significant service responsibilities that are not subject to the rules and regulations that govern the medical staff. Thus, the mechanism of supervision of house staff members and their role in quality of care assurance and other departmental activities must be defined.

There must be privilege delineation for all members of the medical staff. Medical staff and medical faculty qualifications should be distinguished in the process of appointment to the medical staff and the assignment of privileges. The delineation of privileges is usually very well established within the department/service structure; however, it should be documented in writing.

It is required that there be an adequate review of the quality of care rendered in the facility. The university hospital has an intensive, prospective patient care review system conducted in conjunction with its educational programs. This is usually reflected in a heavy concentration of individual case review, often as the primary mode of assessment of quality of care. To provide a continuing evaluation of clinical judgment, a strong relationship of the quality of care activities to the teaching process is maintained. However, there is still a requirement for the university hospital to participate in retrospective outcome audits

as a measure of the quality of care rendered. The audit of cases through retrospective review can serve a function not met by individual case review. It is encumbent upon the JCAH surveyor to indicate to the medical staff where in the overall quality of care mechanism, audit can best serve its function. When retrospective audit is performed, care must be taken to ensure that the criteria used are applicable to all patients in the hospital to preclude the development and use of more than one standard of care in the same hospital.

In evaluating either an area of care provided or a continuous monitoring function of the medical staff, it may not be possible to obtain all required information from one individual as usually occurs in a small community hospital. For example, in evaluating respiratory care services in a large teaching hospital, it may be necessary for the surveyor to interview the director of pulmonary medicine, the director of a specific intensive care unit, the director of the pulmonary function laboratory, the individual who provides blood gas analyses, the chief respiratory therapist, and so forth. Similarly, in evaluating the infection control program, the surveyor may be required to consult with the chairman of the infection control program, the hospital epidemiologist, the chairman of a department of infectious diseases, the director of the microbiology or bacteriology laboratory section, surveillance nurses, and so forth. Where possible, a group interview of these individuals provides maximum information and clarifies the interrelationship of roles.

delete

~~The survey team should be very careful before making a recommendation relative to the lack of medical staff continuing education programs or its documentation.~~ Continuing education normally abounds at all levels in all divisions (department/service/section) of the university hospital, and indeed the hospital is itself the provider of the continuing education not only for its own staff but for many other physicians. There is a recognized but unwritten self-educational effort inherent in the teaching of others and in the publishing of professional papers.

III. WORKLOAD DATA	Medicare "Occasions of Service"	AHA "Visits"
Outpatient Clinics		
Ancillary Services for Outpatients		
TOTAL OUTPATIENT		
Emergency Clinics		
Ancillary Services for Emergency patients		
TOTAL EMERGENCY		
TOTAL AMBULATORY		

IV. Data reported for accounting period ending _____

Name of Hospital: _____

Individual to Whom Questions May Be Directed: _____

Area Code/Telephone Number: _____

Definitions

Medicare "Occasions of Service"
"An occasion of service should be recorded each time an outpatient receives an examination, a consultation, or a treatment in any of the services or facilities of the hospital."

AHA "Visit"
"An outpatient visit is a visit by a person who is not lodged in the hospital while receiving medical, dental, or other services. Include in the visit each appearance of an outpatient in each unit regardless of the number of diagnostics and/or therapeutic treatments that the patient received."

Attachment A

DRAFT

COTH General Membership Memorandum
No. _____
June ___, 1976
Subject: Survey of Ambulatory Service Charges and Expenses

The recently completed Institute of Medicine Report, Medicare - Medicaid Reimbursement Policies, "...recommended that financing mechanisms be changed to provide more equitable support for ambulatory care services..." It is the latest of several studies advocating increased ambulatory service support.

To date, in endorsing recommendations for increased ambulatory support, COTH/AAMC has been unable to present adequate data to show the magnitude of ambulatory service deficits in teaching hospitals. To rectify this situation, the COTH Administrative Board has requested that we initiate the attached "Survey of Ambulatory Financing" for fiscal year 1975. It is requested that you complete and return the Survey by ____ __, ____

We recognize that individual institutions use different procedures and definitions in accounting for ambulatory services. To facilitate completing the survey, while maintaining data comparability, a complete statement of definitions is included as part of the survey and Medicare Cost Report references are specified wherever appropriate. If you have any problems with the survey, call James D. Bentley, Ph.D., (202/466-5122) for assistance and clarification.

RICHARD M. KNAPP, Ph.D.
Director
Department of Teaching Hospitals

Association of American Medical Colleges/Council of Teaching Hospitals
Survey of Ambulatory Finances
Fiscal Year 1975

I. FINANCIAL DATA	TOTAL CHARGES	ALLOWANCES	UNCOLLECTIBLES	NET CHARGES	EXPENSES	GAIN OR (LOSS)
Outpatient Clinics	$	$	$	$	$	$
Ancillary Services for Outpatients						
TOTAL OUTPATIENT						
Emergency Clinic						
Ancillary Services for Emergency Patients						
TOTAL EMERGENCY						
TOTAL AMBULATORY						

II. Please indicate the estimated dollar value of physician ambulatory services which are provided by physicians who are not paid by the hospital, or a third party payor, or an individual patient for such services but who are compensated from sources such as university funds, research contracts, or foundation grants.

Outpatient Clinics: $_____

Emergency Clinics: $_____

Definitions and References

TOTAL CHARGES
Outpatient Clinics: Medicare Cost Report, Worksheet C, Column 1, Line 25b
Emergency Clinics: Medicare Cost Report, Worksheet C, Column 1, Line 26b
Ancillary Services: from the Medicare Cost Report, Worksheet C, add lines 2b-23b in Columns 7 and 9 to obtain total ambulatory ancillary service charges. Using available data or your best judgment, divide this total into the ancillary charges generated by the outpatient clinic patients and the ancillary charges generated by the emergency clinic patients

ALLOWANCES
For outpatient clinic charges, outpatient ancillary charges, emergency clinic charges, and emergency ancillary charges -- report the amount deducted as allowances to third party payors, employees, government contracts and others. If necessary, estimate.

UNCOLLECTIBLES
For outpatient clinic charges, outpatient ancillary charges, emergency clinic charges, and emergency ancillary charges -- enter the uncollectible amount used to develop the hospital's audited certified profit and loss statement.

NET CHARGES
For each line of the financial data, NET CHARGES = TOTAL CHARGES - (ALLOWANCE + UNCOLLECTIBLES)

EXPENSES
Outpatient Clinics: Medicare Cost Report, Worksheet C, Column 1, Line 25a.
Emergency Clinic: Medicare Cost Report, Worksheet C, Column 1, Line 26a.
Ancillary Services: from the Medicare Cost Report, Worksheet C, add Lines 2a-23a in Columns 7 and 9 to obtain total ambulatory ancillary service expenses. Using available data or your best judgment, divide this total into the ancillary expenses generated by outpatient clinic patients and the ancillary expenses generated by emergency clinic patients.

GAIN OR (LOSS)
For each line of the financial data, GAIN(LOSS) = NET CHARGES-EXPENSES

COTH Survey of Ambulatory Care Financing

Background

Last year, the COTH Administrative Board was interested in conducting a survey of Ambulatory Service Financing to determine the extent to which member hospitals were operating this service at a deficit. Following several drafts and the appointment of a technical advisory committee, the questionnaire shown in Attachment A was developed. This questionnaire was field tested in nine hospitals, six of which have sophisticated financial management capabilities. The hospitals with more sophisticated financial capabilities all stated problems with the qeustionnaire and its definitions. The other three hospitals raised no objections to the questionnaire. In this situation, activity on the survey was halted in the Fall of 1976.

Issue

1 - Interest in a survey of ambulatory program operations and financing remains high among some COTH members. Past efforts have demonstrated that a broadly focused, general questionnaire is less than satisfactory because of differences in clinic organization and financing among COTH members. Therefore, if a survey is to be initiated, the COTH Administrative Board needs to clearly define the survey's objective and its scope.

2 - The cost and financing of ambulatory services in the teaching setting is receiving increasing attention and scrutiny. A number of individuals have suggested that the philosophy of the Talmadge bill which removes house staff costs from inpatient routine service costs to provide more equitable hospital cost comparisons presents an opportunity to make a parallel suggestion with regard to the outpatient department costs. House staff costs could be removed and merged with inpatient house staff costs to create a combined "general education" burden. Should the staff be directed to set forth a fully developed position paper on this possibility?

6. What would be the estimated cost of additional plant and capital equipment expenditures, by project, if your hospital was required to immediately correct all J.C.A.H. deficiencies?

Project	Anticipated Cost
TOTAL	

7. Name and title of person completing survey:

_____

Please Return completed survey to: Council of Teaching Hospitals
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

COTH SURVEY OF
JCAH REQUIRED CAPITAL EXPENDITURES

1. Name of your hospital: _____

2. Address of your hospital: _____

_____

3. When was your hospital's last J.C.A.H. accreditation survey completed?

_____
(Month) (Year)

4. As a result of your hospital's most recent JCAH survey, was your hospital accredited for (check one):

_____ two years

_____ one year

_____ other, please specify _____

5. During your most recently completed fiscal year, what is the total dollar amount expended, by project, to bring your hospital's physical plant and capital equipment into compliance with J.C.A.H. standards?

Project	Dollars Expended
TOTAL	

DRAFT: 9/2/77

COTH General Membership Memorandum
No. 77-____
September ____, 1977
Subject: Capital Expenditures to Meet JCAH-Imposed Requirements

Titles I and II of President Carter's proposed cost containment program would severely restrict the funds available for capital expenditures. While Title I has received extensive criticism, Title II has received less criticism in House and Senate hearings than it deserves. In part, this lack of adequate criticism results from the absence of adequate data on recent and projected capital expenditures, especially on expenditures required to fulfill requirements imposed by parties external to the hospital. To help remedy this lack of data for teaching hospitals, I would appreciate your completing the enclosed questionnaire at the earliest possible date. For your convenience, a pre-addressed envelope has been enclosed for returning the questionnaire.

If you have any questions about this survey, please contact James Bentley, Ph.D., Assistant Director, Department of Teaching Hospitals. His telephone number is: (202) 466-5122.

Your assistance in completing this survey will enable us to demonstrate to Senate and House Committees the impact of this bill.

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

The AAMC strongly recommends that hospitals be permitted to increase their revenue limitations for the incremental costs of new services which are approved by local health planning agencies. As new treatment procedures are developed, physicians and patients expect hospitals to incorporate these advances. Becasue hospital revenues seldom exceed expenses by more than two or three percent and often do not even meet expenses, hospitals adding services must increase revenues when new services (and their expenses) are added. Where such services are added at times other than the beginning of a fiscal year, the hospital needs a pro-rated revenue adjustment the first year of the new service and a full revenue adjustment in subsequent years.

In addition to reducing the rate of increase in hospital revenues (or costs), a successful hospital cost containment program must be practical, equitable and administerable at both payor and provider levels. These AAMC recommendations would enhance present revenue limitation proposals by advancing these objectives.

additional revenues from third-party payors which alter their benefit structure to cover additional, previously unreimbursed, services. Thus, the payors can obtain unintended windfalls at the direct expense of the hospitals. (4) Unless hospitals abandon efforts to provide "one class" service and create separate and defined service units for different classes of payors, the proposal will necessitate four separate hospital control systems. (5) The class of purchaser limitation will have its most severe impact in a state such as New York where the state government has imposed stringent limitations on Medicaid and Blue Cross payments well below the 9% recommended by the Administration. These Medicaid/Blue Corss caps and the class of purchaser limitation, in New York, will result in an initial five to six percent cap in total revenues -- a limitation substantially below the initial limitation advocated by the Administration. At a minimum the use of a class of payor will increase the complexity of hospital operations; at worst it will render the institutions unmanageable.

The AAMC strongly recommends that a case-mix adjustment be included in the calculation of a hospital's payment limitation. The final regulations for Phase IV of the Economic Stabilization Program recognized that a limitation on hospital revenues would threaten the financial stability of hospitals unless they were permitted to adjust their revenues for changes in the diagnostic intensity of patients treated. As regionalization, health planning, and possible capital expenditure limitations continue to concentrate the more seriously ill and expensive patients in a limited number of hospitals, these hospitals need a case-miz adjustment to stay even financially. Otherwise, efforts to organize tertiary care services will result in the financial ruin of the hospitals which accept responsibility for the most seriously ill patients.

in revenues would decrease otherwise anticipated revenues by $36 billion across the next five years, a massive reduction in hospital revenues.

The AAMC strongly recommends that the hospital's base year in each accounting period be its immediately prior fiscal year. The Administration's proposal uses a 1976 based year for determining hospital's revenue limitations regardless of the tenure of the cost containment program. In addition to perpetuating the fiscal problems and spending patterns of 1976 on future fiscal years, the use of an increasingly irrelevant base year will necessitate annual increases in program staff to administer the increasing number of volume adjustments, exception requests, and special problems. This unnecessary rigidity and expense can be avoided by allowing a previously controlled fiscal year to serve as the basis for the present year.

The AAMC strongly recommends that the present limitation, established on a class of purchaser basis, be replaced by a limitation on total hospital revenues. The establishment of at least four separate payment categories for determining revenue limitations for Medicare, Medicaid, other cost-based, and charge-based payors does not recognize the payment characteristics of patients or the operational realities of hospitals: (1) Many patients have been and are supported by two or more of these four types of payors. It would be fiscally irresponsible to classify these multi-payor patients by any single payor, for hospitals could reap unintended windfall above current revenues or highly punitive limitations that are lower than present revenues. (2) the classification of patients by payor assumes each patient may be categorized prior to or upon admission. This is frequently not true for patients supported by Medicaid, workmen's compensation, automobile liability insurance, etc. Thus the hospital would have to accept patients with no knowledge of their eventual revenues to be realized. (3) With per admission revenues limited by class of payor, hospitals will be unable to obtain

Thus, the hospital limited to increasing its gross charges has no assurance that its net revenues will actually increase or even remain constant. The Administration has declared that it wishes to cut the rate of increase in hospital revenue. By using gross revenues rather than net revenues, the Administration's proposal could actually reduce hospital revenues below their present levels.

The AAMC strongly recommends that the formula approach for determining allowable revenue increases be replaced by a 10% ceiling on revenue increases. The formula proposed for determining revenue increases is based on an inappropriate measure of inflation, misleads those who use a single percentage to describe the proposal's impact, and adds unnecessary complexity at hospital and payor levels: (1) The GNP deflator reflects both price and commodity changes in the economy. As the Department of Commerce has stated, "it should not be used to measure only price movements." In spite of this strong statement by those who created and calculate the deflator, the Administration has proposed using it. (2) The Administration has argued that their proposal will result in a nine percent increase in revenues. The Congressional Budget Office has estimated that the proposed formula will result in the following revenue increases: FY78 = 8.7%, FY79 = 9.3%, FY80 = 7.6%, FY81 = 7.1%, and FY82 = 7.0%. By 1980, revenue increases will barely exceed inflation and service improvements will cease. (3) To reduce revenue increases below the otherwise anticipated 14-15%, hospitals must immediately begin to alter their operations to conform to available revenues. This alteration will be made more complex by the constantly diminishing increase in revenues provided by the GNP based formula. Hospital and payors could design and initiate more stable plans if a flat percentage increase in revenues were used which permitted accurate revenue projections. A 10% annual increase

In April, the Carter Administration proposed a federally-initiated hospital cost containment program which included using a fixed percentage to limit hospital revenue increases. In testifying before House and Senate Committees, the AAMC has opposed this proposal because a percentage limitation on revenues is arbitrary and inequitable in the short-term and because it is unreasonable in the long-term. Nevertheless, the concept of using a percentage cap to limit hospital revenues is gaining some Congressional support. While the AAMC and its constituents remain opposed to a cost containment program based on this concept, the AAMC offers the following six recommendations for modifying the Administration's proposal to ensure that a percentage cap approach does not undermine the nation's hospitals and their essential services.

The AAMC strongly recommends that the present limitation on gross revenues be replaced by a limitation on net revenues. The Administration's proposal uses gross revenues because of their computational convenience for hospital payors. However, the use of gross revenues will increase the complexity of hospital operations and add significant uncertainties to revenue projections: (1) Cost-based payors frequently do not make a final determination of payment until two to four years following an accounting period. Thus, the hospital does not have an accurate gross revenue base to determine its limitation for cost-based payors. (2) If cost-based payors alter the provisions of their deductions for contractural allowances, a gross revenue limitation could result in an increase or decrease in net revenues that it is inconsistent with the Administration's intention. (3) The average charge imposed for charge-based payors has no consistent relationship to the amount of monies received by the hospital since the volume of charity care and the bad debts experience are constantly changing.

COMPARISON OF MEDIAN MANAGERIAL SALARIES

AS RELATED TO ADMINISTRATOR--ALL REGIONS, ALL SIZES

↓ your survey (increased by 1/2 % per month from date of data collection)

TITLE OR DEPARTMENT	HOSPITAL COMPENSATION SERVICE National		National	
	%	$	%	$
Administrator	100	45,774	100	50,175
Associate Administrator	68	31,068	73	36,795
Controller	59	27,198	58	28,990
Data Processing	44	20,339	45	22,422
Dietary	42	19,221	47	23,329
Engineering	48	21,780	51	25,422
Housekeeping	33	15,265	37	18,786
Inhalation	38	17,222	35	17,639
Laboratories	41	18,598	40	20,138
Laundry	31	14,276	33	16,765
Medical Records	34	15,566	38	18,855
Nursing School	45	20,576	46	22,941
Nursing Services	49	22,618	57	28,338
Personnel	51	23,392	51	25,645
Pharmacy	49	22,403	50	25,135
Physical Therapy	41	18,770	38	19,178
Public Relations	43	19,651	44	21,986
Purchasing	40	18,125	43	21,359
Social Service	39	18,039	46	22,866
Volunteers	29	13,309	--	----
X-Ray	40	18,189	37	18,398

APPLIED LEADERSHIP TECHNOLOGIES, INC.

554 BLOOMFIELD AVENUE
BLOOMFIELD, N.J. 07003

COMPARISON OF AVERAGE MANAGERIAL SALARIES

AS RELATED TO DIRECTOR OF NURSING

RANK ORDER BY PERCENTAGE--AVERAGE OF FIVE STUDIES (Two state associations, one urban center, HCS, + COTH)

DIRECTOR/CHIEF OF:	1977	1975
Finance	114%	113%
Nursing	100	100
Engineering	92	92
Personnel	92	91
Data Processing	91	--
Pharmacy	90	91
Dietary	82	--
Social Service	80	81
Laboratory	79	--
Purchasing	76	77
X-Ray	74	74
Physical Therapy	73	--
Respiratory	72	--
Housekeeping	68	68
Medical Records	68	--
Volunteers	56	55

554 BLOOMFIELD AVENUE
BLOOMFIELD, N.J. 07003

summary report to all health care groups we work with, again focussing on interrelationships more than dollars--the samples demonstrate the approach; and, in a paper for publication in a national journal such as Hospitals, where we've had publication before. As an additional protection for COTH, I'm suggesting use of your 1975-76 survey updated conservatively by ½% per month to July 1977. By the way, in tracking this data I find close consistency in percents between your earlier surveys and 1975-76.

I sincerely hope that on the basis of our ethicality in asking permission, our experience in this field and cautious use of any such data, the increasing openness of information-sharing informally among hospitals, and especially our goal of fostering a more systematic, and fully competitive view of executive compensation in health care, that you will grant our request to identify your information. If this were not possible, we would like permission to use the data without identifying the source other than as a "national hospital association".

May I hear from you as quickly as possible? If you have any questions, please don't hesitate to call me. I would certainly appreciate your reactions to the project.

Very truly yours,

Theresa L. Seloe

Mrs. Theresa L. Seloe, CMC
Vice President

TLS:jho
enc:

APPLIED LEADERSHIP
TECHNOLOGIES, INC.

MANAGEMENT CONSULTANTS

554 BLOOMFIELD AVENUE • BLOOMFIELD, N.J. 07003

TELEPHONE: 201-429-9499

July 1, 1977

Richard M. Knapp, PhD, Director
Council of Teaching Hospitals of the
Association of American Medical Colleges
1 DuPont Circle, NW
Washington, D.C. 20036

Dear Dr. Knapp:

In a phone conversation with your office on June 30, 1977, I made a formal request to utilize the COTH survey data of 1975-76 in a special study of salary interrelationships among senior hospital positions. We realize it is not your policy to permit non-members access to the data, a stance with which we would agree in principal; in practice, it has been our experience as well as yours, I'm sure, that such information is often used by other than members, without permission.

In our own case, as consultants to many hospitals including COTH survey participants, your reports have been shared with us as we advise on executive compensation; we utilize more than one such resource, of course--from state hospital association surveys to our own area surveys, both of which your members participate in. As I'm sure you know, there are very few national surveys in health care--I'm aware of only two regular ones, in fact. The paucity of trustworthy data, readily available, causes much repetitive survey work by individual hospitals and lack of trust of results by Boards. (They often see Association surveys as credible but direct surveys as self-serving). The use to which we would put your information is primarily to make percentage comparisons against "benchmark" jobs. Rough as such comparisons must be, and accepting lack of commonality from survey to survey re dates of collection, regional and bed-size breakouts, jobs surveyed, job content, etc., we believe that even such broad-based information can be helpful to hospitals, most particularly in establishing credibility with Boards of Trustees, who, as people from other disciplines have familiarity with similar measurements outside of health care. I think our study is a pathmark one; I know of no articles that show attempts to make such analyses.

I'm enclosing samples from the draft of our study to date. (The other national survey source has given permission to identify, so it has been named. Their study encompasses a very sizeable number of hospitals--over 1100.)

We would hope to use our study in three different ways, none of which would cause embarrassment, I believe, to members who participate in your study: with individual hospital clients, and our health care associations (three state hospital associations, one national) mainly using percentages to audit internal relationships within established salary structures; as a

PRINCIPALS: LAWRENCE C. BASSETT • THERESA L. SELCOE • ALBERT N. WEBSTER

aamc association of american medical colleges

July 15, 1977

Mrs. Theresa L. Selcoe, CMC
Vice President
Applied Leadership Technologies, Inc.
554 Bloomfield Avenue
Bloomfield, New Jersey 07003

Dear Mrs. Selcoe:

As indicated in my letter of July 6, I have discussed your request of July 1 with the officers of the Council of Teaching Hospitals. Their unanimous opinion is that permission to cite the COTH survey data of 1975-76 should not be granted since we indicate in our questionnaire that the information submitted ". . . will be handled with confidentiality."

There is agreement that you may use the data without identifying the source other than as "a major national organization."

Sincerely,

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

RMK/pgg

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

DEPARTMENTAL EXECUTIVES - SALARY

TABLE OF CONTENTS

COTH Survey of Executive Salaries

Background

Since 1969, the Council of Teaching Hospitals has surveyed its members annually to determine salaries and compensation programs for chief executive officers, senior administrative staffs, and department heads. Attachment A is the Table of Contents from the most recent survey. In the tables, no individually identifiable data is published -- only aggregate information such as means, medians and percentiles are published. By tradition, the survey publication has been furnished on a "personal and confidential" basis to the chief executive officers of member hospitals and requests for copies by others have been denied.

Recently some COTH hospital executives have questioned the practice of making the Executive Salary Survey a confidential document. Some have found it somewhat embarrassing to know of a study they cannot share with colleagues; others are concerned that our testimony on cost containment calls for financial disclosure but our practices preclude it. It should be noted that the COTH practice is identical to that of the Council of Deans for their compensation survey and contrasts to the Medical Faculty Salary Survey which is a public document available to anyone.

Issue

The 1977 Executive Salary questionnaire is scheduled to be mailed in October. The Administrative Board needs to determine whether the findings will be publicly or confidentially published so that respondents can be informed of this policy prior to completing the questionnaire.

JACOB K. JAVITS
NEW YORK

COMMITTEES:
LABOR AND PUBLIC WELFARE
FOREIGN RELATIONS
GOVERNMENT OPERATIONS
JOINT ECONOMIC
SMALL BUSINESS

United States Senate

WASHINGTON, D.C. 20510

August 18, 1977

Ernest R. Jaffe, M.D.
Office of the Dean
Albert Einstein College of Medicine
1300 Morris Park Avenue
Bronx, New York 10461

Dear Dr. Jaffe:

Thank you for your recent communication concerning a proposed amendment to the National Labor Relations Act to include hospital interns and residents with the definition of "employee". The legislation would overrule recent decisions by the National Labor Relations Board which held that such house staff are students and therefore not permitted to bargain collectively over wages, hours and other conditions of employment.

In general, I have long advocated broad coverage of employees under the NLRA in order to permit the collective bargaining process, as regulated by the Act, to achieve the proper balance of employer and employee interests on the job. I recognize that the issue of extending coverage to house staff of hospitals involves some unusal circumstances. While certain aspects of the relationship between hospitals and their house staff are virtually indentical to that of employer and employee; (interns and residents receive wages and perform services to hospitals, the value of which is clearly recognized in third party reimbursement for those services) the house staff are still engaged in medical education, hence in fact they may and in fact not be amenable to collective bargaining.

I recognize that if coverage were to be enacted (or if the NLRB's decision were judicially overruled) there may well be a need for a carefully drawn limitation on the scope of collective bargaining between hospitals and house staff.

The Human Resources Committee, on which I serve as the ranking minority member, is examining the feasibility of covering hospital interns and residents under the NLRA. The Committee will review the experience of those jurisdictions where there has been such collective bargaining, and will examine the desirability of limiting the scope of collective bargaining in order to protect the integrity of the educational process at teaching hospitals as well as the legitimate concerns of those individuals as employees.

I appreciate receiving your views on this matter which I will keep in mind when this legislation is considered by the Senate.

With best wishes,

Sincerely,

Jacob K. Javits, U.S.S.

JKJ:hl

Although we are not in full agreement on this matter, I trust that our different views will not affect the respect and agreement that we share in other areas of mutual interest.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston

ALAN CRANSTON
CALIFORNIA

United States Senate

WASHINGTON, D.C. 20510

August 26, 1977

John A. D. Cooper, M.D.
President, Association of American
Medical Colleges
Suite 200, One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Cooper,

Thanks so much for writing of your concern regarding the coverage of hospital house staff under the National Labor Relations Act (NLRA).

During the 93rd Congress, I authored legislation which extended NLRA coverage of hospital employees to employees of community, nonprofit hospitals. At that time, it was Congress' intent to include house staff in that coverage. In fact, in my statement when the legislation was adopted on the Senate floor, I specifically referred to the long hours and low rates of pay of residents.

As you know, in a few cases, the National Labor Relations Board has ruled that residents are students, not employees, and that, they are not covered under the NLRA. Thus, it seems necessary to resolve this question legislatively.

To clarify the original intent of Congress, I have cosponsored Senator Riegle's legislation, S. 1884, which would amend the NLRA to clarify that house staff are covered by its provisions.

I can appreciate your reservations about the feasibility of making distinctions between a resident's responsibilities with respect to training and those with respect to providing services to patients. I believe that these concepts can be clarified when testimony is received on the legislation. Moreover, as far as I am aware, in states where housestaff can bargain collectively, the quality of training programs has not been reduced.

DONALD W. RIEGLE, JR.
MICHIGAN

COMMITTEES:
BANKING, HOUSING, AND URBAN AFFAIRS
COMMERCE, SCIENCE AND TRANSPORTATION
HUMAN RESOURCES

United States Senate

WASHINGTON, D.C. 20510

July 28, 1977

Dr. Robert D. Coye
Wayne State Univ.
540 E. Canfield
Detroit, MI 48201

Dear Dr. Coye:

Thank you for contacting me about H.R. 2222, introduced by Representative Thompson. This bill would classify medical interns, residents and fellows as hospital employees to permit collective bargaining.

This proposal has stirred a great deal of controversy, but after hearing from hospital administrators, medical school faculty members, the AMA and the Housestaff association, I have decided to introduce and work for passage of a Senate version of H.R. 2222.

Collective bargaining usually centers on issues such as working hours, pay, vacations etc. I do not believe that collective bargaining on these issues will adversely affect the educational training of doctors. Working excessive hours without consultation over salary does not improve either medical education or health care services. When housestaffs are given a collective voice in working conditions, educational and service functions will improve.

Again, thank you for letting me know your views on H.R. 2222. This legislation is still a long way from its final form. Please be assured that your views will be kept in mind throughout the legislative process.

Sincerely,

Don Riegle

Donald W. Riegle, Jr.
United States Senator

DWR/ccc

IN WITNESS WHEREOF, the parties have set their hands the day and year first hereinabove written.

UNIVERSITY OF SOUTHERN CALIFORNIA

By _____

Its

ORTHOPAEDIC HOSPITAL

By _____

Its President

By _____

Its Chairman of the Board

bility for one of the trauma admitting services of University at the Los Angeles County-University of Southern California Medical Center for not less than one (1) day each week during the period of this Affiliation Agreement.

6. Faculty Appointments

Hospital shall advise University of the names, responsibilities and functions of those members of the Hospital's full-time and volunteer medical staffs who participate in the teaching program of University or Hospital, whether at Hospital, University, or other location designated by University and shall make recommendations to University regarding offering faculty appointments to such persons by University. University shall consider the recommendations of Hospital in selecting those persons to whom faculty appointments will be offered by University.

7. Term and Termination

This Affiliation Agreement shall continue in effect for an indefinite period of time; provided, however, that it may be terminated by either party as of June 30 of any year by the giving of written notice to the other party to that effect not less than nine (9) months prior to said date.

Department of Orthopaedics, when such a department is established, shall be the chairman of the Residency Committee.

3.3 Commencing on January 1, 1975 the Residency Committee shall:

A. Select the resident orthopaedic physicians of University who are to participate in the orthopaedic residency program at University, at Hospital and at other hospitals affiliated with University in the field of orthopaedics;

B. Make the assignments of the resident orthopaedic physicians to University, to Hospital and to the other hospitals affiliated with University in the field of orthopaedics; and

C. Develop guidelines for the program of instruction of resident orthopaedic physicians at University, at Hospital and other hospitals affiliated with University in the field of orthopaedics.

3.4 The program for instruction and supervision of the resident orthopaedic physicians of the integrated residency program while at Hospital shall be developed, controlled and administered by Hospital.

4. Appointment to Hospital's Medical Staff

Appointments to Hospital's medical staff shall be made exclusively by Hospital as, in its sole discretion, it may determine are in the best interests of Hospital.

5. Trauma Admitting Service

Hospital shall provide at no cost to University the necessary qualified doctors to supervise and assume responsi-

2.7 Hospital and University intend that the affiliation will not affect the integrity or internal affairs of either organization.

2.8 Hospital and University intend that the costs incurred as a result of the affiliation shall be assumed by the parties as they shall mutually agree before the costs are incurred. Neither Hospital nor University may financially obligate the other.

2.9 Hospital and University intend that University shall work towards, and Hospital shall assist University in, the establishment of a department of orthopaedics at University.

3. Program for Resident Orthopaedic Physicians

3.1 The orthopaedic residency programs of University and Hospital shall ultimately be unified into a single residency program. However, full unification shall occur no earlier than June 30, 1978, and Hospital shall maintain a fully approved and separate residency program of its own at least until that date.

3.2 On or before January 1, 1975, a committee (hereinafter referred to as "Residency Committee") shall be established which shall be composed of representatives appointed by University, Hospital and other hospitals affiliated with University in the field of orthopaedics. The proportion of representatives from each institution shall be determined as mutually agreed upon; provided, however, that in no event shall any single hospital affiliated with University have greater representation on the Residency Committee than Hospital. The head of University's orthopaedic section of its Department of Surgery, or the head of University's

November 12, 1973

AFFILIATION AGREEMENT

1. Identification

This Agreement is entered into as of the 7 day of January, 1974 ~~1973~~ between the UNIVERSITY OF SOUTHERN CALIFORNIA, a California corporation (hereinafter referred to as "University") and ORTHOPAEDIC HOSPITAL, a California non-profit corporation (hereinafter referred to as "Hospital").

2. Recitals

2.1 Hospital is and is recognized as an outstanding orthopaedic medical center.

2.2 University has, and is recognized to have, outstanding schools and departments, including a medical school.

2.3 Hospital and University are located in close proximity to one another and have worked together for many years in their common interests.

2.4 While the primary objective of Hospital is patient care in the field of orthopaedic medicine and the primary objective of University is education, education is the major secondary purpose of the Hospital and the University has a major concern for patient care.

2.5 Affiliation between Hospital and University is mutually desirable.

2.6 Hospital and University intend that the affiliation be a dynamic process and a joint sharing of goals which will benefit both institutions and the community that supports both institutions.

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School of Medicine
Office of the Dean
(213) 226-3601

21 June 1977

Association of American Medical Colleges
Council of Teaching Hospitals
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Gentlemen:

I recommend Orthopaedic Hospital's acceptance to membership in the Council of Teaching Hospitals.

As a teaching hospital, Orthopaedic Hospital is important to the University of Southern California School of Medicine's training program because it provides more intensive training for resident physicians specializing in orthopaedics than is possible in a general hospital. As a private hospital, it also broadens the resident physicians' experience in patient care in the private sector as opposed to their exposure in a public institution.

The University's affiliation with Orthopaedic Hospital also enables us to expand our teaching staff through the appointment of qualified members of the Hospital's Medical Staff to the faculty of the University.

Sincerely yours,

Allen W. Mathies, Jr., M.D.
Dean, School of Medicine

AWM/drn

University of Southern California 2025 Zonal Avenue, Los Angeles, California 90033

II. PROGRAM DESCRIPTION

Orthopaedic Hospital is approved for twelve residents in orthopaedics (four years). In addition to the training they receive at the Hospital, they rotate to Harbor General Hospital, Los Angeles County Hospital and Veterans' Administration-Sepulveda.

The Hospital also has three Fellows (fifth year). In addition, resident physicians from Harbor General Hospital, the University of California at Los Angeles and Veterans' Administration receive a part of their training at Orthopaedic Hospital.

At the present time, Orthopaedic Hospital offers three-week orthopaedic clerkships for third and fourth year medical students. These are primarily for University of Southern California students, but special arrangements are made for students from the University of California at Los Angeles, etc. Five would be the maximum number the Hospital could accommodate, at least three are filled at all times.

As a specialty Hospital, Orthopaedic Hospital does not have chiefs of service. It does have a Director of Medical Education and two Associate Directors of Medical Education, all of whom are on the faculty of the University of Southern California. Recruitment is under way for a Medical Director, and the Director of Medical Education position will be eliminated.

For its fiscal year ending October 31, 1977, Orthopaedic Hospital budgeted $281,979 for salaries and fringe benefits for its resident physicians, Director of Medical Education and Associate Directors of Medical Education. The total amount budgeted for salaries was $7,889,001. The amount budgeted for medical education salaries is 3.6% of total budgeted salaries. In addition, operating expenses of $410,219 are budgeted for medical education.

Orthopaedic Hospital has no formal financial agreement with the University of Southern California. The Hospital's financial commitments to the University are negotiated on an individual program basis. An extensive research program is being established at the Hospital which is co-sponsored by the University of Southern California.

Many of the University of Southern California's faculty members are members of the Hospital's Medical Staff, participate in conferences sponsored by the Hospital and, where appropriate, serve on Medical Staff committees. Also, many members of the Hospital's Medical Staff are members of the faculty at the University of Southern California. The Dean of the Medical School is a member of the Hospital's Board of Trustees.

APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E. [1] Positions Offered	F.T.E. [1] Total Positions Filled by U.S. And Canadian Grads	F.T.E. [1] Total Positions Filled by FMG's
Medicine				
Surgery				
Ob-Gyn				
Pediatrics				
Psychiatry				
Family Practice				
Other (List):				
Orthopaedic	February, 1932		12	

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specifici reference to the following questions.

A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).

D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristids and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles, California 90033

Name of Dean: Allen W. Mathies, Jr., M.D.

Information Submitted by:

James C. Heidenreich — NAME

Executive Vice President/Administrator — TITLE OF PERSON SUBMITTING DATA

6-[illegible] — DATE

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

(a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

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

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

Orthopaedic Hospital
HOSPITAL NAME

2400 South Flower Street — Los Angeles
STREET — CITY

California — 90007 — 747-4481
STATE — ZIP CODE — TELEPHONE NUMBER

Chief Executive Officer: James C. Heidenreich
NAME

Executive Vice President/Administrator
TITLE

Date hospital was established: December 21, 1923

APPROVED FIRST POST-GRADUATE YEAR

TYPE[2]	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Flexible				
Categorical				
Categorical*				

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.

2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program directpr; Categorical*-graduate program under supervision of single program director but content is flexible.)

(4) development of state and regional rate or budget review authorities versus federal ones;

(5) strengthening regional capital control through strengthening of P.L. 93-641 and application of Certificate of Need to all providers and strengthening of review by extending it to all patients; and

(6) full financial disclosure (uniform reporting, not uniform accounting).

Mr. Everhart wondered whether it is possible to present the ideas and philosophies of over 400 constituents.

Mr. Robinson presented the AHA's view on cost control legislation. He said that AHA was basically in agreement with AAMC's position; or rather not in disagreement. He said that the AHA has no alternative to the short term legislation proposed and will not attempt to find one for FY 1978. He pointed out that the AHA estimated that there would be about $3 billion worth of damage to the hospital industry if the Administration's bill is enacted. In the long term however, he felt that some action should be taken to reduce the rate of increase and to bring it somewhere in line with the increase in the GNP. Mr. Robinson believed the key was control of input (a system of rationing or disincentives for use).

Mr. Womer did not think that the concept of a "cap" on the Carter proposal should be dismissed. Mr. Nelson believed that the answer lies on the demand side and noted that the AHA Board has discussed the possibility of a short-term moratorium on new beds. Dr. Thompson asked the Board for suggestions on what should be done over the summer with regard to cost control legislation. General opinion was that everything that has been done supported the Talmadge Bill and there should be a continued effort to work for at least a compromise of the Administration's bill and the Talmadge Bill. Dr. Thompson also suggested that the Ad Hoc study group might be reconvened at some later date.

NEW BUSINESS

No new business was discussed.

XI. Adjournment

The meeting was adjourned at 1:00 P.M.

Dr. Knapp expressed the belief that BHI and SSA had seriously considered these issues and that the decision was not made by mid-level bureaucrats. He also noted that the reason this topic was on the agenda was because it was felt the Board members should be informed about it, and to provide guidance on what level of activity ought to be initiated on this issue.

Dr. Bentley then reviewed a memorandum which he'd written for the record regarding a meeting he attended at the office of Duke's lawyers where the Duke situation was discussed with other impacted university representatives (a copy of this memorandum is attached as Appendix A to these minutes). Dr. Bentley also described the factors surrounding the Indiana University and University of California cases. Dr. Heyssel stated that it seemed to him that BHI decides to look at the university/hospital relationship every few years. Mr. EverHart wondered whether the decision in the Duke case would establish a precedent that would have serious implications for other similar hospitals that have gone the commercial route of raising capital funds. Mr. Marylander felt that some preventive measures should be considered. Dr. Knapp thought that it might not be the appropriate time to take action. After further discussion, the Board decided to wait for further developments before taking any sort of action.

X. Report of the Ad Hoc Committee on the Administration's Hospital Cost Control Program

Dr. Thompson reviewed the AAMC's activities regarding Cost Containment legislation for the board and reported on the latest meeting with Jay Constantine (June 18) on this subject.

Mr. Everhart, Chairman of the Ad Hoc Committee, felt that the staff had done an excellent job in preparation for testimony on Cost Containment legislation and expressed appreciation for the staff support. He then reported on the meetings of the Ad Hoc Committee on Administration's Cost Control Program whose purpose was to help formulate and discuss testimony to be presented on that legislation.

At the end of the second meeting which concentrated on the Talmadge bill, the committee had reached no conclusion as to alternate directions to take. However, it was felt that any proposed legislation should include the following:

(1) a system based on full economic costs;

(2) has to have better built-in incentives;

(3) has to control the input - reduce the amount of medical care in order to control costs;

LCGME is now totally dependent on the AMA (which provides the LCGME with approximately half its budget) for staff work and money for site visits. He also noted that each site visit costs about $600-700, while the charge to the institution or program is between $300-450, and should be considerably more to do it right. Thus, Dr. Heyssel explained, if the LCGME is going to maintain its credibility as an accrediting body, it needs to be determined what it would take to do the job properly and how and where to obtain adequate qualified staff and sufficient funding to carry it out.

Dr. Heyssel stated that this issue is intensified by the possibility of legislation or government regulation to limit the number of accredited programs. As the only accrediting body for graduate medical education, the LCGME would be forced to decide (value judgments) which residency programs would receive accreditation and which wouldn't and may have to start ranking programs. If the LCGME does this based on its current review processes, it can expect a multitude of lawsuits from institutions failing to receive accreditation.

Dr. Heyssel suggested that another concept that should be considered by the LCGME would be "institutional accreditation" (similar to the way medical schools are accredited) which would cut down tremendously on the number of site visits required because review committees would no longer have to go into each department on the basis of each program's specialty but could accredit the institution as a whole.

In closing, Dr. Heyssel expressed that LCGME activities are "proceeding reasonably well," given the circumstances, but stated his concern for the future.

IX. Medicare Payment of Interest Expense

Dr. Knapp reported that the AAMC has not yet done anything with regard to this issue, but provided background information. He stated that there appeared to be three basic issues concerning this matter:

(1) when the university forwards working capital or loans money to a hospital (which is under common ownership with the university) and charges interest on it, is that interest reimbursable on the Medicare cost report? (Indiana University took this question to the BCA Appeals Board and lost and is taking the question to the PRRB on August 9; Duke now has this problem as well);

(2) what kind of unrestricted funds does the hospital have call on where there is common ownership between the university and the hospital?; and

(3) it has been determined by the Social Security Commissioner to be erroneous to allow interest expense on external borrowing when existing funds are available within the corporate entity from unrestricted endowment.

pointed out that no future programs on behalf of COTH were scheduled and that there was a funding issue involved which he believed was surmountable. He suggested a tuition charge of $250. In addition, Dr. Rabkin suggested that MAP graduates get together at the annual meeting to follow-up on the program.

Mr. Womer described the MAP seminar as a "highly rewarding, worthwhile experience that could also benefit Department Chairmen greatly." He and Messrs. Everhart and Reinertsen encouraged the participation of both Deans and Department Chairmen in the MAP program.

Concern was expressed about which 5 days during the week were used for the seminar. Mr. Ensign and Dr. Thompson favored starting the seminar on Friday night, going though the weekend, and ending on Wednesday. Their reasoning was that some people would be more amenable to this schedule since it would not require five "working" days. Mr. Nelson felt that five days was a lot of time to block off at one time and asked whether it would be possible to shorten the seminar to three days or hold it in more than one session. Mr. Everhart explained that there is a dynamic that grows in the group and builds over the five-day period and he couldn't see any way to cut it back. Mr. Womer agreed, pointing out that the pace at which the material was presented at the seminar was good and that the program would be endangered if the pace were to be changed now. Mr. Womer also expressed that much of the group dynamics would be lost if the session was split up, and the potential to have the same group both times would be lower. Mr. Randall felt that meaningful results from the session began on the third day. Dr. Rabkin also thought that the intensity of the session was too great to cut it any shorter.

Dr. Knapp explained the costs involved in conducting the seminar and Mr. Womer stated that a $500-600 tuition would come closer to what was actually needed to continue the program.

Mr. Everhart stated that he would convey the Board's sentiments to the MAP Steering Committee.

VIII. Report on LCGME Activities

Dr. Heyssel provided the Board with an update on LCGME activities. He expressed his astonishment at the lack of quality in and standards for the accreditation reviews conducted on behalf of the Liaison Committee by the Residency Review Committees (RRCs), who themselves are appreciating the problems they are facing. Dr. Heyssel stressed that the underlying problem in this situation was the issue of insufficient staffing and funding to carry out site visit reviews in the manner in which they should be done. He pointed out that the

ACTION: It was moved, seconded, and carried that the recommendation that the Executive Council consider the appointment of a small working group to produce a policy statement on the withholding of professional services by physicians be passively approved.

VI. Specialty Recognition of Emergency Medicine

The Administrative Board reviewed a memorandum from the AAMC Ad hoc Group on Emergency Medicine which recommended that the Association support the establishment of a Conjoint Board in Emergency Medicine with mandatory representation of the following primary boards: Family Practice; Internal Medicine; Pediatrics; and Surgery; and representation from the following areas: Emergency Medicine; Psychiatry, and Obstetrics and Gynecology. Mr. Womer, having participated as a member of the Ad hoc Group, stated that of the various alternatives considered the Group believed the conjoint board was the most viable and adaptable to existing structures. Drs. Rabkin and Heyssel and Mr. Everhart questioned the exclusion of such areas as OB/GYN and Psychiatry as mandatory representatives of the Conjoint Board. Mr. Womer explained that the Ad hoc Group felt the amount of emergency room practice in these areas was limited and insufficient to warrant mandatory representation on the Board. He also explained that the Group thought that the four specialties recommended for mandatory representation was all it could hope to get together. Mr. Marylander wondered what representation on the Conjoint Board really meant. Mr. Womer responded by stating that mandatory representatives had voting rights on the Conjoint Board, while non-mandatory members had no voting power. He also provided data on the number of existing graduate programs in emergency medicine, the number of residents now participating in these programs, and the number of those who have already graduated from such programs. Mr. Womer then moved to recommend support for the establishment of the Board as prescribed by the Ad hoc Group.

ACTION: It was moved, seconded, and carried that the report and recommendations of the Ad Hoc Group on Emergency Medicine be approved by the Executive Council.

DISCUSSION ITEMS

VII. Report of the Management Advancement Program for COTH Executives (held June 6-11)

Copies of an evaluation session summary of the second MAP Executive Development Seminar for Council of Teaching Hospitals representatives were distributed among the Administrative Board members. Dr. Rabkin reported that it was the consensus of the group that attended the seminar that it had been a very successful meeting. Calling it an "outstanding program," Dr. Rabkin recommended that it be continued. He also felt that the facility (La Coquille Club) - its atmosphere, food and service - was excellent. Dr. Rabkin

Dr. Kennedy reported that Dr. Cooper had made suggestions to the Committee regarding the CCME's prospective role. Dr. Cooper recommended that CCME accept the responsibility to explore physician distribution, but not act as regulators as the GAO report suggests. He explained to the Committee that the CCME will have to do expensive detailed studies and that acceptance of government funds to conduct these studies would not make the CCME a quasi-governmental organization as long as it didn't function as a regulating body as well. Dr. Cooper also formally recommended that the Graduate Medical Education National Advisory Committee (GMENAC) be abolished if the CCME accepted the proposed role because there would be a great deal of overlap between the functions performed by the two bodies.

Following general discussion, a motion was made which led to the following action:

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to review the position of the AAMC on the question of private sector regulation of the numbers of specialists trained by graduate medical education programs and carry out the five recommendations listed on page 34 of the Executive Council agenda.

V. AAMC Position on the Withholding of Professional Services by Physicians

Dr. Thompson expressed his uncertainty as to why or how the AAMC got involved with this issue. Dr. Knapp provided background on the topic, explaining that Dr. Julius Krevans, Chairman of the Council of Deans, has been greatly concerned over such situations as the withholding of services by doctors to Champus patients in Texas, the treatment of Medicaid patients in some areas of the country, and the malpractice situation in California and would like to see a small working group created to examine the ethical side of the issue.

Mr. Marylander described several Southern California experiences involving the withholding of professional services by physicians. Mr. Womer questioned whether an AAMC policy statement on the issue would matter to anyone anyway. Dr. Thompson expressed uncertainty as to whether the AAMC was the appropriate organization to deal with this issue. Mr. Marylander pointed out, however, that the AAMC could serve as the vehicle to get the appropriate body, perhaps the AMA, to address the problem. Dr. Heyssel pointed out that the AMA has expressed its support of collective bargaining and the right to strike and might not be the organization to deal with the issue. Mr. Womer reiterated that he didn't see the necessity for the AAMC to address the issue, but believed that if the other AAMC councils favored it then the COTH should have representation on the working group appointed. Most Board members appeared to agree, questioning the necessity but passively approving.

I. Call to Order:

Dr. Thompson called the meeting to order at 9:00 A.M. in the Kalorama Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

The minutes of the March 31, 1977 COTH Administrative Board meeting were unanimously approved.

III. Membership Application:

The Board reviewed the application of Ranchos Los Amigos Hospital in Downey, California for membership in the Council of Teaching Hospitals of the AAMC and, by a vote of 11-to-1, took the following action:

ACTION: It was moved, seconded and carried to recommend approval of Ranchos Los Amigos Hospital for regular membership in the Council of Teaching Hospitals.

ACTION ITEMS

IV. Draft Response to the GAO Report

Dr. Kennedy presented an overview of the General Accounting Office's draft report on "Problems in Training an Appropriate Mix of Physician Specialists." He pointed out that although the results were unspectacular, the report did end up with one major long-term recommendation which would require the Secretary of HEW to go to the Coordinating Council on Medical Education (CCME) and ask that body to assume responsibility for study and development of a system to ensure that graduate medical education will be brought into line so that sufficient numbers of specialists and generalists for the country will be trained. If the CCME declines this role, the report states that the issue should go to Congress for action. Dr. Kennedy noted that the GAO opinion is similar to that held in the AAMC-supported Senate bill, S.992, introduced in 1975.

Dr. Thompson reviewed the report as a member of the Committee on Physician Distribution of the CCME. He felt that the summary in the Executive Council Agenda was adequate and that the report was as good as it could be under existing circumstances, and probably the best available on the subject. He pointed out that the aspect of geographic distribution of physicians was not addressed due to the difficulty in knowing how to deal with it. The CCME Committee felt it was important for the CCME to be actively involved on the issue of physician specialty distribution, but not as regulators, according to Dr. Thompson. They wanted a distinction made between providing the information to make decisions on physician distribution and actually establishing the numbers in various specialties and implementing the program.

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
June 23, 1977

MINUTES

PRESENT:

David D. Thompson, M.D., Chairman
David L. Everhart, Chairman-Elect
Charles B. Womer, Immediate Past Chairman
John Reinertsen, Secretary
Jerome R. Dolezal
James M. Ensign
Robert M. Heyssel, M.D., Ex Officio Member
Stuart Marylander
Stanley R. Nelson
Mitchell T. Rabkin, M.D.
Malcolm Randall
William T. Robinson, AHA Representative

ABSENT:

John W. Colloton
Baldwin G. Lamson, M.D.
Robert E. Toomey

STAFF:

James D. Bentley, Ph.D.
Armand Checker
Gail Gross
James I. Hudson, M.D.
Joseph C. Isaacs
Thomas J. Kennedy, M.D.
Richard M. Knapp, Ph.D.

aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 14-15, 1977
Washington Hilton Hotel
Washington, D.C.

Wednesday, September 14

6:00 P.M.	COTH Administrative Board Meeting	Hamilton Room
7:00 P.M.	Cocktails	Independence Room
8:00 P.M.	Dinner	Hamilton Room

Thursday, September 15

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Independence Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Conservatory Room
	Executive Council Business Meeting	
4:00 P.M.	Adjournment	

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