



# association of american medical colleges

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

June 13-14, 1979  
Washington Hilton Hotel  
Washington, D.C.

Wednesday, June 13

6:30 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Cocktails and Dinner	Thoroughbred Room
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Thursday, June 14

8:30 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Hamilton Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Hemisphere Room
2:30 P.M.	Executive Council Business Meeting	Military Room

Council of Teaching Hospitals  
Administrative Board

June 14, 1979  
Washington Hilton Hotel

8:30 a.m. - 1:00 p.m.

A G E N D A

- I. Call to Order
- II. Consideration of Minutes Page 1
- III. Membership: Information And Discussion Items
- A. Dues Increase Page 11
- B. Membership Termination Page 13
- C. Corresponding Membership Page 14
- D. Membership Application Page 15
- Saint Mary's Health Center  
St. Louis, Missouri
- IV. JCAH Activities Page 29
- V. Regulations Issued for 1122 And Certificate Of Need  
Reviews of CT Scanners Page 36
- VI. Medicare Routine Service Cost And Malpractice  
Reimbursement Regulations Page 42  
& Separate Attachment
- VII. COTH Spring Meeting
- A. Evaluation of Kansas City Meeting Page 52
- B. Date And Location of 1980 Meeting Page 57
- C. Discussion of Spring Meeting Paper:  
"Toward a More Contemporary Public  
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& Separate Attachments
- D. Recommendations from the Spring Meeting  
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& Separate Attachment
- VIII. CAS Resolution on Manpower Executive Council Agenda  
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- IX. Final Report of the Working Group on  
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| X. Clinical Laboratory Improvement Act   | Executive Council Agenda<br>Page 59 |
| XI. Educational Commission for Foreign<br>Medical Graduates                              | Executive Council Agenda<br>Page 64 |
| XII. Report of the Ad Hoc Committee on<br>Continuing Medical Education                   | Executive Council Agenda<br>Page 72 |
| XIII. Health Sciences Promotion Act of 1979  | Executive Council Agenda<br>Page 82 |
| XIV. Regulations for Section 227   | Executive Council Agenda<br>Page 85 |
| XV. Nonrefundable Deposits   | Executive Council Agenda<br>Page 86 |
| XVI. Review of AAMC Position on Health<br>Planning Legislation                           | Executive Council Agenda<br>Page 91 |
| XVII. Interim Report of the Graduate<br>Medical Education National<br>Advisory Committee | Executive Council Agenda<br>Page 99 |
| XVIII. New Business  |                                     |
| XIX. Adjournment   |                                     |

Association of American Medical Colleges  
COTH Administrative Board Meeting

Washington Hilton Hotel  
Washington, D.C.  
March 29, 1979

M I N U T E S

PRESENT:

Robert M. Heyssel, M.D., Chairman  
John W. Colloton, Chairman Elect  
David L. Everhart, Immediate Past Chairman  
John Reinertsen, Secretary  
Dennis R. Barry  
James Bartlett, M.D.  
James M. Ensign  
Kevin Hickey, AHA Representative  
Stuart Marylander  
Robert K. Match, M.D.  
Malcom Randall  
Elliott C. Roberts

ABSENT:

Jerome R. Dolezal  
Mark S. Levitan  
Mitchell T. Rabkin, M.D.

GUESTS:

Paul A. Lavigne

STAFF:

James D. Bentley, Ph.D.  
Peter Butler  
John A.D. Cooper, M.D.  
Kat Dolan  
Gail Gross  
James I. Hudson, M.D.  
Joseph Isaacs  
Paul Jolly, Ph.D.  
Richard M. Knapp, Ph.D.  
John F. Sherman, Ph.D.  
Emanuel Suter, Ph.D.  
August G. Swanson, M.D.

I. Call to Order

Dr. Heyssel called the meeting to order at 9:00 a.m. in the Kalorama Room of the Washington Hilton Hotel. He informed the Board that he had testified on cost containment before Representative Rangel's Ways and Means Subcommittee on Health on March 23 and that Dr. Thompson testified for the AAMC on the hospital cost containment bill before the Subcommittee on Health of the Senate Finance Committee on March 14, 1979. Because of extenuating circumstances, Dr. Thompson agreed to appear at the last moment as a substitute, and Dr. Heyssel expressed his appreciation on behalf of the Board.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve unanimously the minutes of the January 18 COTH Administrative Board Meeting.

III. Membership Applications

Dr. Bentley reviewed the four applications for COTH membership. Staff recommendations and Board discussion which followed resulted in the following actions:

ACTION: It was moved, seconded and carried to approve Health Sciences Center Hospital, Lubbock, Texas, for COTH full membership

ACTION: It was moved, seconded and carried to approve New Rochelle Medical Center, New Rochelle, New Jersey, for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve St. Luke's Hospital, Milwaukee, Wisconsin, for COTH full membership

ACTION: It was moved, seconded and carried to approve Mount Auburn Hospital, Cambridge, Massachusetts, for COTH full membership.

Status Report on Compensation of Human Subjects Involved In Research

Dr. Heyssel invited Dr. Sherman to report on the probable HEW requirement for compensation coverage of injured biomedical and behavioral research subjects. Dr. Sherman indicated that a status report had been prepared and would be circulated to the Board members. He explained that the problem is essentially that DHEW intends to issue a notice of proposed rule making requiring that each institution conducting research on human subjects under HEW grants or contracts must have some compensatory mechanism to cover the care and loss of wages for those subjects injured during the course of the research. A task force (composed exclusively of HEW staff) established two years ago by Secretary Califano has maintained that such coverage should be mandated by HEW regulation and that legislation should be sought to ensure the same coverage for individuals conducting research in federal institutions.

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Dr. Sherman noted that earlier this year, HEW sponsored a meeting to explore, with representatives from institutions and other groups such as the AAMC, the problems and feasibility of such coverage. The AAMC urged HEW to have a meeting with insurance industry representatives to explore this. In the meantime, a meeting has been scheduled by the AAMC for April 2 with insurance industry representatives and others from the academic community to consider options for recommendation to HEW. The major immediate concern is that HEW could proceed with publication of the Notice of Proposed Rulemaking at any time, when as far as AAMC staff can determine, most institutions will not be a position to comply.

#### Introduction of Paul Lavigne

Dr. Knapp introduced and welcomed Paul Lavigne who had been working with COTH staff on several projects as part of a work experience requirement of his post-masters program in health care administration at George Washington University. He noted that Mr. Lavigne has eight years of collective experience as a management consultant, manager of an industrial engineering department, and Assistant Director of Rochester General Hospital for two years. Dr. Knapp also pointed out that the staff would soon be interviewing a prospective administrative resident who would serve a one year residency.

#### IV. Staff Report on the COTH Spring Meeting

Dr. Knapp reviewed plans for the Spring Meeting. He reminded the Board that the preliminary program had been sent out and that the topics for the concurrent sessions scheduled for Thursday afternoon, May 17, had since been determined. They are: Veterans Administration session with Al Gavazzi; the MAXICAP Experience with Paul Hanson; The "Voluntary Effort" with Paul Earle and Howard Berman; and a session on the role of state health planning and development agencies in specialty distribution and manpower development with Dr. Henry Zaretsky and Dr. Robert Tranquada. Dr. Knapp indicated that leaders for the Thursday morning discussion groups were still to be selected. He anticipated that the final program for the meeting would be mailed out along with registration materials by the first week in May. He said that an evaluation form would be available at the meeting since this had proven helpful in assessing last year's meeting. Dr. Knapp then distributed a list of current registrants and indicated that 65 were Chief Executive Officers including five Veterans Administration CEO's and that 20 were additional staff accompanying the CEO's.

Dr. Knapp reported that he had received a call from Dr. Arther Friedell, Medical Director of St. Vincent's Hospital in Worcester, Massachusetts. Dr. Friedell felt very strongly that he be allowed to attend the meeting despite the fact that the CEO of St. Vincent's would be unable to attend. Dr. Friedell followed with a letter elaborating on his concerns. Dr. Knapp distributed copies of the letter to the Board, along with a letter from Dr. Rabkin (responding to Dr. Knapp's request for his opinion) who suggested that it be assumed that the CEO registered and then cancelled. Following brief discussion, Mr. Marylander suggested that Dr. Knapp be permitted to use his own discretion in determining exceptions in individual cases. The Board generally agreed.

V. System for Hospital Uniform Reporting

Dr. Bentley reviewed this issue for the Board, recalling that at the last board meeting the Board had decided that the AAMC should actively oppose SHUR in a manner consistent with the stance taken by the AHA. He explained that staff recommends that the major arguments made in the Ernst & Ernst position paper not be followed by the AAMC because the requirement for the reporting system appears legitimately founded in the legislation.

Dr. Bentley then drew Board attention to the AHA Statement on "Proposed Uniform Reporting Systems for Health Services Facilities and Organizations" which was a separate attachment to the COTH Agenda. He indicated that staff proposes to prepare the AAMC response in the context of the positions set forth in the AHA document and asked whether the Board disagreed with anything contained in the AHA document, whether there were additional items that should be identified, or whether there was total opposition to this approach.

Dr. Match commented that elements in the AHA report indicate that a system of uniform accounting should be developed by HEW. He wondered if this conflicted with the Board's position. Mr. Hickey pointed out that the AHA was simply stating that, should an accounting system become imperative, anything that went beyond a simple and relatively easy system would be unacceptable. Dr. Match suggested that five new employees would have to be hired at his hospital to address SHUR. Dr. Heyssel indicated that in terms of an AAMC position, reference to an accounting system should be avoided and that development of a reporting system simpler than SHUR be supported.

Dr. Heyssel invited discussion on possible courses of action. Summarizing the Board's views, he stated that the AAMC oppose SHUR (along the lines taken by the AHA), suggest technical amendments if it is implemented, and coordinate efforts with the AHA in seeking legislative relief from SHUR.

Responding to a question from Dennis Barry, Mr. Hickey indicated that efforts for legislative repeal have yet to be made an immediate priority by the AHA, but that the AHA has been corresponding with legislators to keep them receptive and sympathetic. Dr. Knapp suggested that it would be better to follow AHA policy on the issue of repeal since a joint effort would be more effective.

The Board generally agreed to maintain its opposition, with staff developing a critique of the SHUR document which generally coordinates with the AHA position. It was agreed that the official response would oppose SHUR, but include recommendations for changes. Further, it was decided to coordinate strategy on legislative repeal with the AHA at a later date. Dr. Knapp invited the assistance of any board members, or their staff, who might be working on this issue on their own.

VI. Medicare Proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs

Dr. Bentley reviewed this item for the board, drawing attention to the General Membership Memorandum on the subject (page 68 of the COTH Agenda) which sets forth the problems which staff had identified regarding the proposed schedule. He indicated that direction from the Board was needed with regard to how comments to HCFA should be structured and welcomed discussion of the three alternative responses presented on page 67 of the COTH Agenda.

At Dr. Heyssel's request, Dr. Bentley reported on a related issue involving payment of malpractice insurance premiums by HEW for Medicare recipients. He explained that HEW had conducted a weak study which demonstrated that although Medicare reimburses about 21% of malpractice premiums, in fact only 12% of malpractice dollar awards are made to Medicare beneficiaries. Therefore, HEW has proposed to pay that particular expenditure on a direct cost basis rather than on an average cost basis. Dr. Bentley indicated that this had been incorporated into a recommended Senate legislative proposal, along with the removal of the 8½% nursing differential. He requested the Board's comments and direction on the stance to be taken in reaction to the HEW proposal concerning malpractice costs.

Dr. Heyssel returned the discussion to the topic of the proposed Medicare schedule of limitations. Mr. Colloton illustrated how it would cost his hospital approximately 3.8 million dollars under the Administration's proposed payment limits. He maintained that the Board should opt for #2 of the alternative responses on page 67 of the COTH Agenda, with the stipulation that HEW be directed to rework the wage adjustments and the labor component of the market basket approach. He also believed it was time to push for an appropriate classification for hospitals which are the primary affiliates of medical schools -- a scheme that would address the intensity factor.

Mr. Marylander offered a different point of view. He contended that given Secretary Califano's objectives, it would be difficult to devise a classification system which would be acceptable to HEW. Support of #2 would mean support of the concept if certain exemptions would be allowed. He felt it would be better to oppose the present concept and offer a different one, rather than work from the HEW proposal.

Mr. Everhart wondered how to determine the primacy of the teaching hospital to a medical school, relative to Mr. Colloton's earlier proposition. Dr. Heyssel stated that while educational costs related to "teaching" status constitute an important variable for consideration, costs are more logically the result of the tertiary care nature of the services provided at teaching hospitals. Mr. Colloton maintained that it might be the time to point out that HEW should recognize that there are approximately 100 tertiary care centers,



most of which are the prime teaching hospital for their schools of medicine, and that criteria should be established by which other hospitals could qualify for this group. He emphasized that the general approach currently proposed would allow classification only on the basis of education, without regard for the intensity factor (which the AHA has quantified at 4%). He felt the AAMC response should call for: 1) classification of hospitals relative to medical school affiliation, 2) an adjustment in the salary differentials, and 3) an adequate intensity factor (greater than 4% for tertiary care facilities). Dr. Bentley pointed out that if a tertiary care category were established, the HEW proposed limitation would essentially guarantee that 20% of the hospitals so classified would be over the limit. Dr. HeysseI allowed that this was a danger but felt it might still be a viable approach.

Dr. Match wondered if one would then have to establish criteria to define tertiary care. He believed the basic problem is the yardstick that has been accepted as an industry measure - comparing daily per diem costs rather than discharge data on the basis of diagnostic case mix. Mr. Colloton allowed that, over a period of time, such criteria would have to be developed. However, he noted that for the time being the basic criteria would be that of being the primary teaching hospital of a school of medicine. Dr. Match pointed out that there could be more than one primary teaching hospital for a medical school.

Mr. Marylander agreed that the response should press for recognition of the intensity factor and a more realistic factor for inflation, and felt that these ought to be the primary objectives. Mr. Barry agreed that the argument would be better if framed in a tertiary care mode, rather than on the basis of medical school affiliation. Mr. Reinertsen and Dr. Match voiced concern about the preliminary definition of tertiary care center proposed by Mr. Colloton and expressed the need for better terminology.

Dr. HeysseI reviewed two possible courses of action in response to the HEW regulations: (1) give general approval, with insistence that recognition be given to a separate classification of hospitals which are the primary affiliates of schools of medicine or (2) totally oppose the proposal until there is clear legislative intent expressed by Congress regarding a cost containment program (e.g., the Talmadge bill). Dr. Knapp stated that the AAMC's existing position on Section 223 is clear and that the Association could now commend HEW on the positive steps it has taken, but clearly express our concerns about the inadequacy of the revised limitations generally. Dr. HeysseI questioned whether COTH should create a committee on these issues, besides directing discussion on the topic at the Spring Meeting.

Mr. Marylander felt that the Board should oppose the limitations totally and concentrate on development of a valid classification system that would withstand the attacks it would certainly receive. He felt

that opposition had to be on the basis of the equity of the costs that are incurred by differing hospitals and the validity of those costs. He favored endeavoring to accomplish another kind of mechanism to deal with this issue that would be more productive than creating a classification of hospitals. Dr. Match expressed the belief that there was general agreement that there does exist a group of hospitals which, because of the activities in which they're involved, legitimately generate higher costs. He felt the issue was basically whether to try to identify those costs and justify them as being either related to educational activities (which creates one set of problems) or to the kind of cases that are attracted to such institutions. He noted that the latter course requires a much more complicated mechanism and doesn't provide the short-term relief that some hospitals need. Dr. Cooper asked the Board whether it could support recommendation #2 along with a stipulation for consideration of diagnostic case mix.

Dr. Knapp indicated he would send out a draft of the Association's comments for the Board's review prior to their submission. He felt that the major problem would remain the definition of an appropriate classification system.

Mr. Colloton reviewed his motion and following some minor modification the following action was taken by the Board:

ACTION: It was moved, seconded and carried to respond to the "Proposed Medicare Limitations for General Routine Operating Costs" by: 1) applauding HEW's move in the direction of recognizing the unique costs in teaching hospitals through recognition of the educational component; 2) stipulating that this concept should be further modified by establishing a separate classification for tertiary level teaching hospitals which would be identified as primary affiliates of schools of medicine and others who may qualify under criteria to be established for this group; 3) requesting that this separate classification of teaching hospitals contain an intensity factor which is estimated at 4% based on current data; and 4) offering to collaborate with appropriate Department officials to appropriately define the criteria for the classification system that will more precisely identify all of the hospitals that merit separate consideration on the basis of intensity.

XIV. Proposed Revision of the General Requirements in the Essentials of Accredited Residencies

Dr. Heyssel briefly reviewed this item and invited discussion. Mr. Colloton allowed that the revision was consistent with the Association's position on institutional responsibility for graduate medical

education, and pointed out two areas for possible modification. He took exception to the detailed plan requirements in item 1.1.2 on page 10 of the "Essentials," stating that institutional resources should be allocated on the basis of the hospital mission rather than specifically on the costs of its educational programs. He objected to the latter basis because it would require an institution to choose one segment of the budget (educational costs) for negotiation and approval (thereby identifying costs for HEW investigation) and he believed this to be too rigid and incompatible with sound management practice and the need for administrative flexibility. He suggested the deletion of this entire section or its revision to read, "A plan which sets forth the allocation of resources devoted to graduate medical education and the methodology by which the plan was formulated," and so moved the substitute language.

Dr. Swanson pointed out that the intent of Section 1.1.2 was not to put an inflexible system into place, but to create a greater concern and awareness by program directors of programs other than their own. It was decided that a plan to clearly demonstrate the allocation of resources would achieve this.

Dr. Match agreed with Mr. Colloton's proposed change. He felt that the proposed activity was already in essence being carried out. Mr. Everhart pointed out that every teaching hospital has or should have an institutional plan setting forth its objectives and mission, a part of which includes its commitment to teaching and learning. He felt it was entirely appropriate for LCGME to expect evidence of this. He did not interpret the specificity of the language as did Mr. Colloton, but would support the proposed language substitution.

Mr. Marylander did not see the difference in interpretation of Mr. Colloton's proposed language and the original language. He suggested that deletion of the word "detailed" would address Mr. Colloton's objections. Mr. Colloton agreed to change his motion somewhat and subsequent discussion by the Board with Dr. Swanson resulted in the following action:

ACTION: It was moved, seconded and carried to substitute "A plan which sets forth the process by which institutional resources are organized and distributed for educational purposes:" for the underlined portion of section 1.1.2 of The Essentials of Accredited Residencies in Graduate Medical Education" and to delete the first two sentences of the supportive language of section 1.1.2 retaining only the last sentence.

Reviewing section 1.1.3 and 1.1.4 of the "Essentials," Dr. Heysel objected to the specificity of language that he interpreted to require that a new policies and procedures manual would have to be produced to provide information obtainable from other sources. In light of Dr. Heysel's concerns, Mr. Everhart moved to change the language in section 1.1.3 to "...provide evidence of operational systems for:" on page 10 of the "Essentials" and to delete the words "...incorporated in a manual of policies and procedures..." in the first supporting

sentence in Section 1.1.3 on page 11. Indicating that he felt a manual was necessary, Dr. Swanson drew attention to lines 14-17 of the last page of the document where it indicates that the LCGME intends to develop a phased program to provide sufficient time to permit institutions to adapt to these requirements.

Mr. Colloton also proposed to delete the clause in the same sentence which reads "and reviewed and approved by the governing board." Following Board discussion Mr. Everhart modified his motion and the following action resulted:

ACTION: It was moved, seconded and carried to change the underlined language of section 1.1.3 of "The Essentials of Accredited Residencies In Graduate Medical Education" to read "Provide evidence of operational systems, based on institutional policies, establishing how the sponsored programs provide for:" and to replace the sentence on lines 5-8 on page 11 of the "Essentials" with a sentence which reads "These policies should have appropriate institutional approval."

Dr. Swanson informed the Board that on page 11 under section 1.1.3 an item g) "Supervision of Residents" had been added.

In reviewing section 1.1.4, Dr. Heyssel reviewed line 21 which states that "there should be evidence that these analyses are effective." Dr. Swanson indicated that this basically addresses the institutional self-study.

Mr. Barry questioned lines 12 and 13 of section 1.2 on page 12 of the "Essentials" which states "...Documentary evidence of agreements, approved by institutional governing boards,..." Dr. Swanson proposed to change the language to read "...Documentary evidence of agreements, approved by the institution."

Dr. Swanson pointed out that under item d) of section 1.2.1 on line 7 of page 13 the Council of Academic Societies' Administrative Board had changed the clause to read "by each institution, should be agreed to and based upon the educational needs of the residents as determined by the program directors." The Board generally agreed with Mr. Everhart who opposed approval of this modification. Dr. Heyssel indicated that COTH Executive Council representatives would take appropriate action when this item was discussed.

Dr. Swanson then pointed out that on page 26, line 7 under item 5.3.7, the phrase "such as a reduced schedule or educational opportunities" was deleted by the CAS discussion group. Mr. Colloton expressed preference for the term "stipends" in place of the word "compensation" in relation to payment of residents.

VI. (Continued) Medicare Malpractice Reimbursement

Dr. Heyssel then returned Board attention to an earlier discussion of the malpractice premiums issue. Dr. Knapp wanted guidance for wording as to the apportionment argument that would not jeopardize the nursing differential. Mr. Hickey indicated that the AHA will recommend that HEW not go in this direction unless it is prepared to examine each cost center. Dr. Heyssel suggested responding that it's a bad idea and proceed to ask a lot of questions demanding that the whole issue be examined.

Mr. Colloton distributed an analysis of President Carter's Cost Containment Act of 1979 by the University of Iowa Hospitals and Clinics attorney and financial staff and proceeded to highlight and review it for the Board. On the basis of this analysis, Mr. Colloton suggested that the Administration's proposed program is misleading at best, and borders on fraud.

Dr. Heyssel closed by indicating that any agenda items not formally discussed in the meeting would be left to the wisdom of the COTH representatives to the Executive Council.

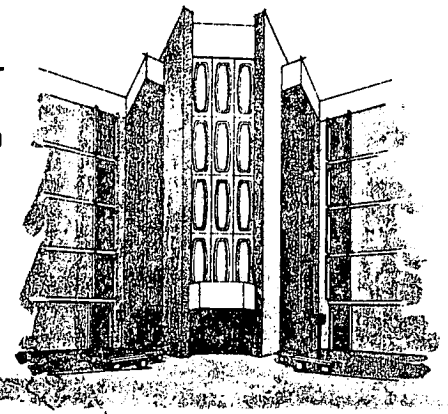
Adjournment

The meeting was adjourned at 12:50 p.m.

# Wesley Medical Center

550 North Hillside / Wichita, Kansas 67214 / (316) 685-2151

May 10, 1979



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



Subject: Annual Dues - \$1,500

Dear Dr. Cooper:

I received the statement for our billing for the period of July 1, 1979 - June 30, 1980, in the amount of \$1,500, an increase of exactly 50% over the billing for last year.

I know you are aware of the cost containment efforts, and the pressures that we have.

I do not recall having received an analysis of why this increase is so heavy and would appreciate very much having this, so that I can refer it to our budgeting committee. The increase of \$500 is unbudgeted as far as we are concerned, and I must have a supporting rationale to be consistent with our other cost containment efforts here at Wesley Medical Center.

I am appreciative of the services of the AAMC and we certainly wish to continue our membership, but this increase of 50% has been challenged appropriately internally, thus this request to you.

Very truly yours,

Roy C. House  
President & Chief  
Executive Officer

RCH:dr

May 29, 1979

Mr. Roy C. House  
President and Chief Executive Officer  
Wesley Medical Center  
550 North Hillside  
Wichita, Kansas 67214

Dear Mr. House:

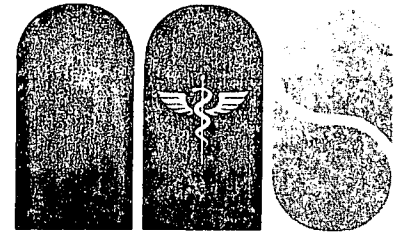
In your letter of May 10th, you express concern that COTH dues have been raised from \$1,000 to \$1,500 per year effective July 1, 1979. I regret that this dues increase came as a surprise to you for the AAMC made several efforts to inform members of this development. The need for a dues increase was originally discussed at the 1977 Annual Meeting. Following significant staff and member evaluation of Association activities, all Administrative Boards approved the dues increase at their March, 1978 meeting, the COTH members unanimously approved the dues increase at their 1978 Spring Meeting, the AAMC Executive Council approved the dues increases at its June meeting, and the AAMC Assembly provided final approval at the Annual Meeting in New Orleans. These actions were reported in the May 9th and October 31st issues of my Weekly Report to the AAMC membership and in the May issue of the COTH Report.

To provide you with background information on the need for a dues increase and the approved increases for all members, I have enclosed a copy of the Finance Committee Report from the Agenda of the 1978 AAMC Assembly. Of particular significance, you will note that COTH dues have not increased since 1973, medical school dues have not increased since 1969, and academic society dues have not increased since 1975. While membership growth did provide some additional revenues to offset some of the impacts of inflation, membership has now stabilized and a significant outside contract has been terminated. As a result, membership dues must now be increased to support essential membership services.

I hope this letter and Finance Committee Report provide the essential information needed by your cost containment committee. If not, please contact me again.

Sincerely,

John A. D. Cooper, M.D.



May 18, 1979

Richard Knapp, Ph.D.  
Council of Teaching Hospitals  
Association of American Medical Colleges  
1 Dupont Circle NW  
Washington, D.C. 20036

Dear Dick:

I regret to advise you that Mount Sinai Hospital has made a decision not to renew its membership in COCH. The dues increase was only the straw that broke the camel's back. For some time I have had to honestly question the benefit received from COCH for a hospital like Mount Sinai. We are small and have a number of small affiliations with the University, but our main mission is not medical education. With the press of cost containment programs, it just seems to me that this is not an expense that our patients should continue to bear.

In no way does this reflect on the hospital's or my personal feelings about AAMC or COCH. I think you and your colleagues perform an important service to medical education and teaching hospitals. I hope to maintain my personal interest in this area and in your activities. I wish the Association the best in the future.

Sincerely yours,

Peter H. Sammond  
President and  
Chief Executive Officer

dj





MEDICAL EDUCATION

SOUTHWESTERN MICHIGAN AREA HEALTH EDUCATION CENTER  
252 East Lovell Street  
Kalamazoo, Michigan 49006

(616) 383-7896

Robert M. Nicholson, M.D.  
Executive Director

May 1, 1979

James D. Bentley, Ph.D.  
Assistant Director  
Department of Teaching Hospital's  
Association of American Medical Colleges  
1 Dupont Circle NW  
Suite 200  
Washington, D.C. 20036

Dear Dr. Bentley:

I have just received and reviewed my copy of the COTH Directory 1979 Educational Programs and Services. I am deeply disappointed and dismayed after searching diligently in vain, seeking to find a listing of our organization and its address.

I am aware that as a corresponding member of a little over a year's duration we are a "second class citizen" of sorts in COTH, but it seems to me that it wouldn't take much effort, would cost very little, and require very little space to simply list the name, address and telephone number of the corresponding members somewhere in the directory. Truly this seems little to ask. It would certainly be helpful to us, and perhaps useful to others that might wish to contact us relative to some matter of mutual interest and concern.

I would once again raise the issue as to whether or not we as an organization are not really entitled to a regular Teaching Hospital membership. Certainly we fulfill all criteria as listed except for the fact that we are an unusual and relatively new entity, or a "new breed of cat" so to speak. If we were to use a different name such as the Harper-Grace Hospitals of Detroit and call ourselves instead the Borgess-Bronson Hospitals and then establish divisions such as they have and call ourselves the Borgess Hospital Division, Borgess-Bronson Hospitals and the Bronson Hospital Division, Borgess-Bronson Hospitals would that really make us any different and therefore more eligible for Teaching Hospital membership rather than Corresponding membership.

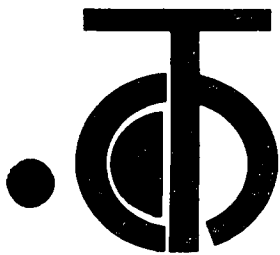
I would ask that you seriously review the entire situation and consider the possibility of modifying the COTH position with respect to, and in light of, the issues that I have raised. I shall look forward to a reply at your earliest convenience.

Very truly yours,

Robert M. Nicholson, M.D.

RMN/cg

cc: W. Donald Weston, M.D.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Saint Mary's Health Center  
Hospital Address: (Street) 6420 Clayton Road  
(City) St. Louis (State) Missouri (Zip) 63117  
(Area Code)/Telephone Number: ( 314 ) 644-3000  
Name of Hospital's Chief Executive Officer: Sister Betty Brucker, S.S.M.  
Title of Hospital's Chief Executive Officer: Executive Director

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>568</u>	Admissions:	<u>18,880</u> plus <u>2,301 newborns</u>
Average Daily Census:	<u>471.6</u>	Visits: Emergency Room:	<u>16,369</u>
Total Live Births:	<u>2,301</u>	Visits: Outpatient or Clinic:	<u>5,921</u>

B. Financial Data

Total Operating Expenses: \$ 33,134,651.00

Total Payroll Expenses: \$ 17,576,127.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 806,093.00  
Supervising Faculty: \$ 198,167.00

C. Staffing Data

Number of Personnel: Full-Time: 1,299  
Part-Time: 592

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 189  
With Medical School Faculty Appointments: 163

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Internal Medicine    Nuclear Medicine    OB/GYN  
\* Pathology        \* Radiology        \* Anesthesiology  
\*Full Time but remuneration other than salary.  
Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education (All undergraduates come from St. Louis University School of Medicine through our major affiliation with them).

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	15 each 6 wks.	9 av.	4th yr.-elective 3rd yr.-required
Surgery	5 " 6 wks.	4 av.	4th yr.-elective
Ob-Gyn	10 " 8 wks.	10 av.	3rd yr.-required
Pediatrics	N/A		
Family Practice	N/A		
Psychiatry	N/A		
Other: <u>Orthopedic Surgery</u>	1 each 6 wks.	1 av.	4th yr.-elective

There are seniors who elect to come out to Saint Mary's Health Center on Pathology, Urology, Radiology and Anesthesiology but not on a regular basis.

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u> at Saint Mary's Health Center	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	N/A			
Medicine (SMHC own program)	30	19	7	1964
+ Surgery	4			
+ Ob-Gyn	7			
+ Pediatrics	1 (High Risk Nursery)			
Family Practice	N/A			
Psychiatry	N/A			
Other:				
+ Ortho.Surgery	1			
+ Pathology	3			
+ Urology	1			

+ These positions are staffed by graduate physicians in training at St. Louis University Medical School (through our major affiliation agreement) and these departments are approved as an integral part of the University Services.

<sup>1</sup>As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical\* and Categorical programs should be reported under the clinical service of the supervising program director.

<sup>2</sup>As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

(Attached)

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement. (Attached)
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs. (Attached)

Name of Affiliated Medical School: St. Louis University School of Medicine

Dean of Affiliated Medical School: David R. Challoner, M.D., Dean

---

Information Submitted by: (Name) John A. Nuetzel, M.D.

(Title) Medical Director

Signature of Hospital's Chief Executive Officer:

Sister Betty Brucker, S.S.M. (Date) 5-22-79

Sister Betty Brucker, S.S.M.  
Executive Director

IV. SUPPLEMENTARY INFORMATION

See Statement attached.

Association of American Medical Colleges  
Department on Teaching Hospitals  
Council of Teaching Hospitals  
Suite 200, 1 DuPont Circle NW  
Washington, D. C. 20036

Supplemental Information for Application for Membership to Council on  
Teaching Hospitals, Saint Mary's Health Center - - - See Section IV.

Saint Mary's Health Center has been affiliated in medical education with the St. Louis University School of Medicine since 1924. This association was reaffirmed in 1962 and is covered by the enclosed contract signed at that time. There is a close collaborative relationship between the institutions and the great majority of staff members at Saint Mary's are University faculty members.

On many services house officers from departments at St. Louis University School of Medicine rotate through Saint Mary's Health Center as a part of their graduate training. This rotation is constant on Obstetrics and Gynecology, General Surgery, Orthopedic Surgery, Urology and Pathology. In Radiology such rotation has taken place in the past and will be resumed in the near future.

Although there is affiliation in Internal Medicine the graduate education program is recruited independently at Saint Mary's Health Center and is fully approved for thirty residents over four years of graduate training.

Students receive training in physical diagnosis, in junior clerkships and in senior year electives at Saint Mary's in many areas but principally in Internal Medicine, Obstetrics and Gynecology and General Surgery.

Saint Mary's has no Pediatric Service other than newborn. This is part of a high risk perinatal center for which a full time neonatologist is at present being recruited by the School of Medicine. There is no Family Practice program at Saint Mary's Health Center.

It should be noted that the entire Active and Associate Staffs of Saint Mary's Health Center are Board certified or at least have attained training sufficient to qualify for Board examination in their specialty.

There are active research programs conducted at Saint Mary's in a number of specialties. There is a full time section of biochemical research. ("Laboratory for Biochemical Research")

Saint Mary's is a community teaching hospital. Its long time dedication to teaching medical students, graduate students and allied health professionals as well as its activities in continuing medical education is felt to warrant its consideration for membership in the Council of Teaching Hospitals.

V. SUPPORTING DOCUMENTS

A. Affiliation Agreements

AFFILIATION AGREEMENT  
BETWEEN  
ST. LOUIS UNIVERSITY AND SISTERS OF ST. MARY  
IN THE MATTER OF  
COOPERATION OF ST. LOUIS UNIVERSITY SCHOOL OF  
MEDICINE AND ST. MARY'S HOSPITAL IN ST. LOUIS COUNTY

THIS AGREEMENT made and entered into by and between St. Louis University, a Missouri corporation, hereinafter referred to as the "SCHOOL OF MEDICINE" and Sisters of St. Mary, a Missouri corporation, hereinafter referred to as the "HOSPITAL",

WITNESSETH, that

WHEREAS, the parties to this agreement respectively own and operate the St. Louis University School of Medicine and the St. Mary's Hospital in St. Louis County, Missouri, and

WHEREAS, the parties have been affiliated since 1924 in the operation of their individual functions, and

WHEREAS, the parties deemed it advisable to re-evaluate their cooperative efforts in the light of present conditions so that the cause of hospital administration and medical education may be forwarded by a new affiliation agreement, and

WHEREAS, the Hospital recognizes as its chief objective the care of patients, but accepts teaching and research as legitimate functions second only to the function of services to the patient, and

WHEREAS, the School of Medicine accepts as its primary objective the training of skillful physicians and medical scientists, and recognizes that clinical instruction in hospitals involves the care of patients and other procedures which must be coordinated with the administrative policies of the hospitals in which such programs are conducted, and

WHEREAS, both parties agree that means must be provided to insure communication between the School of Medicine and the Hospital regarding current policies which may affect the operation

of instructional programs by the School of Medicine and the conduct and administration of patient care by the Hospital, and

WHEREAS, both the Hospital and the School of Medicine, in the pursuit of their objectives, hold that their jurisdictional authority over their respective programs must be recognized and safeguarded in the implementation of any affiliation agreement, and

WHEREAS, it is conceded that the Hospital retains all jurisdictional power incident to separate ownership, including power to determine general and fiscal policies for the Hospital; that it retains the right to appoint, under the terms of this agreement, as hereinafter set forth, its administrative officers, medical staff, chiefs of services and other personnel; that it has the right and duty to define the method of application for hospital staff appointment, and the right of approval or disapproval of such application, whether the application is from a faculty member of the School of Medicine or otherwise; that it has the further right and duty to decide upon the duties and the duration of hospital staff appointments and to define the method of selection and appointment of chiefs of clinical services in the Hospital and the duration of such appointments, and

WHEREAS, the Hospital recognizes that provision of essential teaching facilities in its physical plant is necessary for the conduct of instructional programs, and that such patients that consent thereto must be made available for clinical and bedside instruction of residents, internes and students of the School of Medicine, and

WHEREAS, the Hospital as operator of the hospital has responsibility for all expenses for hospitalization of patients, for all costs of supporting and maintaining personnel required to provide hospital services, for paying the salaries of certain administrative personnel, such as the Medical Director of the Hospital and of the chiefs of the major clinical services (except by specific individual agreement this obligation does not



extend to supporting teaching personnel), and

WHEREAS, while recognizing that all teaching programs of the School of Medicine shall be carried out by members of the Hospital staff who must be members of the faculty of the School of Medicine, the Hospital, nevertheless, reserves the right to organize and administer teaching programs under such regulations as it may establish on clinical services for which the School of Medicine does not assume responsibility, but only for those services, and

WHEREAS, the School of Medicine retains the authority to establish and control the educational programs used in the instruction of its students, whether at undergraduate or post-graduate levels, which authority over these educational programs it delegates to departmental directors whom it appoints in each field of clinical medicine, and

WHEREAS, the School of Medicine holds that it has the right to select and appoint the departmental directors who shall, in turn, select the members of their respective departments who will be assigned to teaching duties in hospital instructional programs; that all teaching in the instructional programs for which the School of Medicine assumes responsibility must be carried out by members of the faculty of the School of Medicine; that the School of Medicine shall define the procedure of application for faculty membership and recommend to the President of the University, the appointment of those applicants who are given approval; that the School of Medicine will define the duties of faculty members and the duration of appointment; that since the Hospital retains the right to reject applications for staff membership from members of the faculty, the School of Medicine will not require that faculty members be members of the staff of St. Mary's Hospital; that the School of Medicine must have full authority to control the number and type of students assigned to the clinical services in each teaching hospital; that the School of Medicine must be able to decide upon the adequacy of the teaching material

available on each service; that through its departmental directors it must have full control of research activities conducted by members of the University faculty; that applications for research grants and contracts made in the name of the University or any department of the University must have the approval of the respective departmental director, the Dean of the School of Medicine and the University Director of Research Grants and Contracts; that where the Hospital applies in its name for a research grant or contract which involves a faculty member of the School of Medicine, that in that event the School of Medicine reserves the right to define in its faculty regulations the conditions under which participation in such a project could be approved; that faculty regulations also will define the circumstances under which publications may be made by a faculty member in which his faculty status is indicated in the publication; that it is the fiscal policy of the School of Medicine that the costs of instructional programs in affiliated hospitals be borne, in large part, by the hospital in which those programs are conducted, and

WHEREAS, the Hospital recognizes that an agreement of the nature herein contemplated should facilitate the obtaining of professional personnel for optimum patient care, and

WHEREAS, the parties feel that the above policies must govern the proper administration of this affiliation agreement

NOW, THEREFORE, in consideration of the premises and of the mutual benefits inuring to the parties hereto, it is agreed as follows:

1. All previous agreements and amendments thereto between St. Louis University and Sisters of St. Mary pertaining to an affiliation between the School of Medicine and the Hospital are hereby abrogated and declared to be of no further force and effect, to be null and void and to be superseded by this agreement.

2. Each party to this agreement will respect the

administrative prerogatives of the other as set forth herein.

3. The Hospital will select and appoint a Medical Director who will act as liaison officer between the Hospital administration and the School of Medicine.

4. Further liaison between the School of Medicine and the Hospital will be provided by meetings between the President of St. Louis University or a Vice President of St. Louis University placed in charge of School of Medicine affairs and the Mother General of Sisters of St. Mary or her appointed representative.

5. The Hospital will include in its administrative organization, a Medical Advisory Committee of which the Medical Director will be chairman, and which will consist of the Medical Director, the chief of each clinical service in the Hospital and such other persons as may be provided for in the By Laws of the Staff of St. Mary's Hospital, the Administrator of St. Mary's Hospital and the Dean of the School of Medicine or his authorized representative.

6. The appointment of chiefs of clinical services at St. Mary's Hospital ordinarily will be on nomination by the School of Medicine and approval of the Hospital administration. In case of inability to agree on a mutually acceptable appointee, the School of Medicine will have the right to choose a faculty member who shall be in charge of teaching on that clinical service and the Hospital administration may appoint an interim administrative head of the service, who shall serve until such time that agreement is attained. The School of Medicine, however, reserves the right to judge the effectiveness of the teaching program under these circumstances. If this is deemed unsatisfactory, it may elect not to establish a teaching program on that service at the time the initial agreement is put into operation, or if the change occurs after a program is in operation, to discontinue that program at the termination of the scholastic year for the undergraduate

students on that service. The School of Medicine, however, will assume the responsibility of carrying to completion the educational programs of any internes or residents on such a service where discontinuance of undergraduate teaching occurs prior to completion of their period of service, provided, that the Hospital will agree to the continuation on that service of the instructional personnel which the School has assigned to that program.

7. The School of Medicine agrees to submit the administrative policies of the Hospital as herein set forth to the departmental directors of the clinical departments of the School of Medicine. After due consideration of these policies, each departmental director will decide whether he can assume responsibility for conducting an instructional program in the corresponding clinical service at St. Mary's Hospital. The departmental directors who decide that they can assume responsibility for an instructional program at St. Mary's Hospital, will prepare and present to the Dean of the School of Medicine, a statement of their plans for operation of the service. This will include information regarding the conduct of undergraduate teaching, if any, and the program of interne and resident training. Each departmental director will indicate the faculty member who will be assigned as chief of the teaching service at St. Mary's Hospital, and the relationship of this individual to the administrative organization of the staff of that Hospital. The departmental directors will also select the faculty members in their departments who will participate in the instructional program under the chief of service and will recommend the financial arrangements for remuneration of those individuals where salaries are involved. On services where undergraduate instruction will be given, the approximate number of students assigned to the service will be indicated, and also whether junior or senior students will be assigned.

8. After approval of the proposed programs by the

administration of the School of Medicine, the Dean or his authorized representative will then present the plan of operation to the Medical Director of the Hospital, who, will, in turn, present it to the Medical Advisory Committee and then to the Hospital administration along with the recommendations of the Medical Advisory Committee.

9. If and when approved by the Hospital administration, the Dean of the School of Medicine will then recommend to the President of the University, that an affiliation agreement involving those services for which departmental directors will assume responsibility be approved and a formal agreement made to put this into effect. It is also agreed that on other services where initially a departmental director does not feel that conditions permit the establishment of a satisfactory teaching service, consideration will be given to the establishment of instructional services whenever the situation becomes conducive to carrying out the objectives of the respective departmental educational program.

10. On those clinical services where an instructional program is not established by the corresponding department of the School of Medicine, it is agreed that the Hospital may establish its own instructional program without restriction as to participation of faculty members of the School of Medicine. On those services where the Hospital establishes its own program, it is agreed that the Hospital may apply to the Council on Medical Education and Hospitals of the American Medical Association for separate approval of internship and residency appointments on those services.

11. On services where a department of the School of Medicine agrees to conduct an internship and/or residency program, the recruitment of house officers for the service will be conducted and the schedules will be administered by the Dean of the School of Medicine, or his authorized representative acting in conjunction with the corresponding departmental directors of the School of

Medicine. It is agreed that such recruitment shall be carried out in the name of "The St. Louis University Group of Hospitals".

These internships and residencies will be listed in the official brochure of the St. Louis University School of Medicine, in the Interne Matching Plan and with the Council on Medical Education and Hospitals of the American Medical Association under the title just mentioned.

12. Remuneration of internes and residents shall be made by the Hospital in which the individual house officer is at that time in residence.

13. It is agreed that the staff privileges of staff members at St. Mary's Hospital shall be subject to annual review and reappointment by the Hospital, and that the School of Medicine likewise may review and reappoint faculty members and define the obligations of faculty membership in accordance with regulations established by the administration of the School of Medicine and the University.

14. In the case of a chief of service or a faculty member engaged in teaching at St. Mary's Hospital, it is agreed that, in the interest of insuring the stability of educational programs, a period of as long as twelve months be allowed before a change in status is made effective, unless otherwise agreed to mutually by the School of Medicine and the Hospital.

15. It is agreed that a review of this agreement may be requested annually by either party for elaboration or amendment of the articles contained therein. It may be abrogated on twelve months notice by either party.

IN WITNESS WHEREOF the Parties to this Agreement have caused the same to be executed by their proper officers as of this 14th \_\_\_\_\_ day of June . 1962. Executed in duplicate.

ST. LOUIS UNIVERSITY, a corporation

ATTEST: BY \_\_\_\_\_  
President

\_\_\_\_\_  
Asst. Secretary

SISTERS OF ST. MARY, a corporation

ATTEST: BY \_\_\_\_\_  
President

\_\_\_\_\_  
Secretary



St. Louis University  
Medical Center

V. SUPPORTING DOCUMENTS

- B. Letter of recommendation from Dean of the affiliated medical school.

School of Medicine

1402 S. Grand Blvd., St. Louis, Mo. 63104  
314/664-9800

Office of the Dean

February 6, 1979

John A. Nuetzel, M.D.  
Medical Director  
Saint Mary's Health Center  
6420 Clayton Road  
St. Louis, Missouri 63117

Dear John:

I am delighted to hear that Saint Mary's Health Center wishes to become a member of the Council of Teaching Hospitals of the Association of American Medical Colleges. It is a most appropriate and important action based on our current arrangements and joint future plans for the School of Medicine and the Saint Mary's Health Center.

In view of the fact that we have teaching affiliations at the residency and/or student level on almost all services, your role in our teaching programs is the most important and historic among all those at private community hospitals in the St. Louis Metropolitan Area. Of greater importance is the fact that we now have made Saint Mary's Hospital the academic "home base" for the obstetrics division of our Department of Obstetrics and Gynecology. The joint development by the University and Saint Mary's of the maternal-fetal medicine unit at Saint Mary's is an important step for both institutions and one that clearly enrolls Saint Mary's as a legitimate participant in the activities of the Council of Teaching Hospitals.

Kindest regards.

Yours truly,

David R. Challoner, M.D.  
Dean

DRC:jb

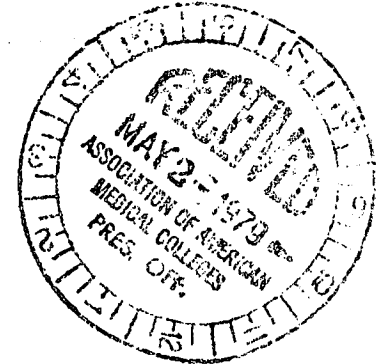
# Joint Commission

875 North Michigan Avenue Chicago, Illinois 60611  
on Accreditation of Hospitals (312) 642-6061

John E. Affeldt, M.D.  
President

April 23, 1979

John A. Cooper, M.D.  
President  
Association of American Medical Colleges  
Council of Teaching Hospitals  
1 DuPont Circle, N.W.  
Washington, D.C. 20036



Dear Dr. Cooper:

As you may be aware, the Board of Commissioners of the Joint Commission on Accreditation of Hospitals took action at a special meeting on October 28, 1978 authorizing the implementation of a major reorganization of the corporation. The actions taken at this meeting were the culmination of a comprehensive study of the organization and operations of the Joint Commission which was conducted by the Board's Planning and Organization Committee, in conjunction with a team of selected consultants.

A major portion of the reorganization focused on the operation and administration of the JCAH accreditation programs. As a result, the Board recognized that the participation of the various constituencies of the accreditation programs in the JCAH is vital to its growth and success. Consequently, the Board voted to establish Professional and Technical Advisory Committees (PTACs) for the purpose of advising the various JCAH accreditation programs on standards, survey procedures and related matters concerning each program. The PTACs will replace the Accreditation Councils which have contributed greatly to the development and growth of the accreditation programs and the extension of voluntary accreditation to ambulatory health care, long term care, psychiatric facilities, and services for mentally retarded and other developmentally disabled persons.

The Board of Commissioners considered the membership of the PTACs at its April 7, 1979 meeting, and on behalf of the Board, I am inviting the Association of American Medical Colleges Council of Teaching Hospitals to become a participating organization of the Professional and Technical Advisory Committee for the Hospital Accreditation Program of the Joint Commission. While it was the consensus of the Board that PTACs be instituted expeditiously, the Board also limited membership on the PTACs at this time in order to facilitate a smooth transition in the implementation of the reorganization. Therefore, other organizations will be reviewed by the Board throughout this year for participating membership on the PTACs.

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Member Organizations

American College of Physicians    American College of Surgeons  
American Hospital Association    American Medical Association



John A. Cooper, M.D.  
Page 2

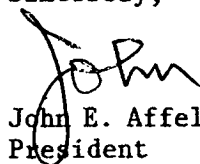
Please notify me as soon as possible of your organization's decision. If your organization chooses to accept this invitation, you are requested to nominate a candidate to represent your organization on the PTAC as specified above.

Attached is a statement of the functions and procedures governing the PTACs. Additional information concerning meeting dates and agenda items will be forwarded to you upon acceptance of this invitation.

I would like to add that I believe that the organizational changes authorized by the Board will improve and strengthen the services the Joint Commission provides to the professions and publics it serves. This invitation is recognition by JCAH that the specialized knowledge and experience possessed by your organization will significantly strengthen our efforts to foster high standards of care in today's multifaceted health care system.

I look forward to hearing from you in the near future. Please do not hesitate to contact me if you have questions concerning this matter.

Sincerely,



John E. Affeldt, M.D.  
President

JEA/wpc

Att.

PROFESSIONAL AND TECHNICAL ADVISORY COMMITTEES

STATEMENT OF FUNCTIONS AND PROCEDURES

FUNCTIONS

Each accreditation program's Professional and Technical Advisory Committee (PTAC) will

- advise and make recommendations to the Program Director regarding standards, survey documents, and survey procedures;
- serve as a resource for appointments to accreditation decision appeal hearing panels; and
- review all exceptional accreditation recommendations and those accreditation decisions in which unanimous agreement is not reached by staff, and make recommendations concerning such decisions to the Accreditation Committee of the Board.

PTAC functions will be periodically reviewed and revised as necessary by the Board of Commissioners.

COMMUNICATIONS

Each PTAC will have direct representation on the Board's Accreditation Committee, Standards-Survey Procedures Committee (S-SP), and the Policy Advisory Committee (PAC).

- Each PTAC will elect a representative to serve as a non-voting member of the Board's Accreditation Committee.
- Each PTAC will elect a representative to the Board's S-SP Committee. PTAC representatives on the S-SP Committee may vote on all matters being recommended to staff, but they may not vote on matters constituting a final action of the S-SP Committee when it acts on behalf of the Board.
- Each PTAC will elect a representative to serve as a full voting member of the Policy Advisory Committee to the Board of Commissioners.

The President of the Joint Commission will direct all communications between the Board and PTACs. The President shall receive all minutes, reports, and recommendations from PTACs and shall determine which issues warrant consideration by the Board or PAC.

Professional and Technical Advisory Committees  
Page 2

MEMBERSHIP

Membership on each PTAC will total no more than 15 and will include organizational representatives and selected individual at-large members.

Organizational Membership

Terms of office for organizational members will be for one year, subject to annual review and reappointment by the Board. Although the number of terms served by an organization are not limited, the Board will review the total composition and size of each PTAC annually and will revise and rotate membership as deemed necessary to insure that the professional and technical expertise provided by the PTAC meets the needs of the accreditation program served. Maximum tenure for any person appointed as an organizational representative will not exceed six consecutive years.

Selected Individual At-Large Membership

Terms of office for selected individual at-large members will be for one year, subject to annual review and reappointment by the Board. Maximum tenure for an individual at-large member will not exceed six consecutive years.

PTAC membership is currently limited to organizations. However, the Board's Planning and Organization Committee and Executive Committee and the President of the Joint Commission will be considering additional membership proposals from numerous sources having specialized knowledge in each area and from organizations or agencies who are interested in joining the PTACs and whose qualifications warrant consideration.

RULES AND PROCEDURES

Rules and procedures governing PTACs will be developed by the Vice-President for Accreditation and approved by the Board of Commissioners. Provisions for the election of officers and the establishment of ad hoc committees, appointment procedures, and attendance and quorum requirements will be included in the rules and procedures.

EXPENSES

Expenses for meetings will be reimbursed by the Joint Commission in accordance with its general administrative policies and procedures. This includes travel and maintenance of all PTAC representatives.

(Approved by the Board of Commissioners October 28, 1978)

**Joint  
Commission**

875 North Michigan Avenue Chicago, Illinois 60611  
on Accreditation of Hospitals (312) 642-6061

John E. Affeldt, M.D.  
President

May 22, 1979

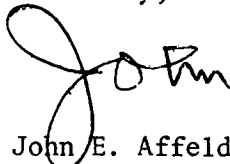
John A.D. Cooper, M.D.  
President  
Association of American Medical  
Colleges  
Suite 200  
One, Dupont Circle, N.W.  
Washington, D.C. 20036

Dear John:

Your acceptance on behalf of the Association of American Medical Colleges to become a participating organization of the Professional and Technical Advisory Committee for the Hospital Accreditation Program was received with pleasure.

Plans for the first meeting of the PTAC are currently being developed. A letter informing you of the details of such preparation will be forthcoming. Please notify me as to the Council's representative selected to serve on the PTAC as soon as possible following its Board meeting of June 14.

Sincerely,



John E. Affeldt, M.D.  
President

JEA:mls

cc: John Milton  
Donald C. Smith, M.D.

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# Joint Commission

875 North Michigan Avenue Chicago, Illinois 60611  
on Accreditation of Hospitals (312) 642-6061

John E. Affeldt, M.D.  
President

May 16, 1979

John A. D. Cooper, M.D.  
President  
Association of Medical Colleges  
1 Dupont Circle, N.W.  
Washington, DC 20036

Dear ~~Dr.~~ <sup>John</sup> Cooper:

It is my strong belief that we are currently facing a significant period of change in the approach to quality assurance through voluntary accreditation. Consumer awareness, advancing technology, government influence, and cost considerations are playing major roles in changing the methods of delivering health care to the American people. As the patterns of health care delivery change, so must there be a change in the approach to assessing the quality of the care delivered.

One of the areas undergoing the most dynamic change is the field of ambulatory health care. The incentives for change in this field are strong. The national commitment to reduce unnecessary health care expenditures strongly implies that where appropriate and feasible the focus may be shifted from inpatient hospital care. The health maintenance organization movement is gaining momentum with pressures for reduction of federal restrictions and with increasing support from private investors. Primary care initiatives are leading to hospital and community-based ambulatory care programs that emphasize continuity of care, health maintenance and prevention, and public and patient education.

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals has taken action to ensure that its accreditation programs are responsive to and reflective of the changing patterns of the total health care delivery system. It is the Board's intent to move toward a comprehensive system approach to accreditation in contrast to the categorical accreditation programs of the past.

As this system approach to accreditation becomes better defined, the mechanisms for conducting accreditation activities will become more integrated. The increasing intersection of ambulatory care with all areas of the total delivery system will enhance this emerging approach to accreditation.

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Member Organizations

American College of Physicians  
American Hospital Association

American College of Surgeons  
American Medical Association

May 16, 1979

Page Two

As JCAH moves forward, emphasis will be given to ambulatory care in developing and applying the broader principle of system accreditation. In the system approach, accreditation is not limited to assessing the degree of compliance with defined standards but, rather, takes on a more consultative and educational role.

I am pleased to report that through our new Division of Accreditation we are moving aggressively toward a stronger program of accreditation for ambulatory health care. By consolidating our current accreditation standards and integrating the strengths of our survey procedures, we can move quickly into an expanded role in ambulatory accreditation. Our new organizational structure provides us with the advice and assistance of a much broader range of national, professional and specialty organizations than ever before.

Both Donald C. Smith, M.D., Vice-President for Accreditation, and I would welcome any comments or suggestions you might have concerning our new direction and expanded role in the ambulatory health care field. We are confident that with strong national support, the voluntary efforts of the private sector will bring improved health care to the American people.

Sincerely,



John E. Affeldt, M.D.  
President

JEA/wpc

REGULATIONS ISSUED FOR 1122 AND CERTIFICATE OF  
NEED REVIEWS OF CT SCANNERS

In the April 25 Federal Register, the Public Health Service issued interim regulations regarding reviews of proposed expenditures for computed tomographic (CT) scanner services under the capital expenditure review program in Section 1122 of the Social Security Act and in satisfactory certificate of need (CON) programs under Title XV of the Public Health Service Act.

With regard to the Section 1122 regulations, the new rules essentially incorporate the provisions of a program policy notice (#78-15) on this matter which was issued by the Health Resources Administration on February 3, 1978. COTH Administrative Board members may recall that concern about the implications of this memorandum was brought to their attention by Mitch Rabkin at an earlier Board meeting. Accordingly, the regulations are amended so that the acquisition of a CT Scanner costing \$100,000 or less will be governed by the following principles:

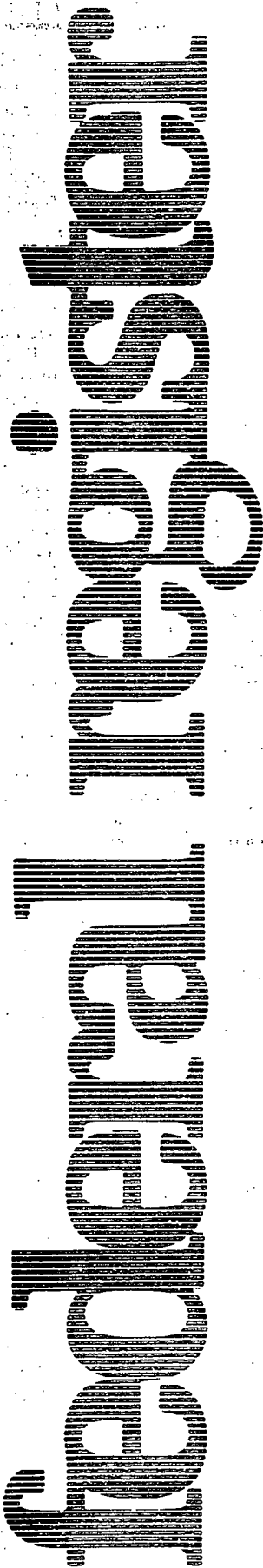
- A. The purchase of a CT scanner by or on behalf of a health care facility involving a capital expenditure less than \$100,000 is subject to review if it results in the addition of a new diagnostic service.
- B. Such a purchase involving a capital expenditure of less than \$100,000 is considered to be the addition of a new diagnostic service unless the CT scanner is in addition to or replaces an existing CT scanner.
- C. If a health care facility proposes to purchase a CT full-body scanner to replace an existing CT head scanner, or to purchase equipment to upgrade an existing head scanner to a full-body scanner, this purchase is considered to result in a new diagnostic service for the facility and, therefore is subject to section 1122 review.
- D. If a health care facility proposes to offer the services of a mobile CT scanner, this is considered the addition of a new diagnostic service unless it is in addition to or replaces an existing fixed or mobile CT scanner of the same type (head or full-body scanner).
- E. The lease (or acquisition through a comparable arrangement) or the donation of a CT scanner by or on behalf of a health care facility is also subject to section 1122 review if its purchase, under the principles noted above, would have required review.
- F. Any capital costs associated with installing a CT scanner, as well as the costs of any renovations to accommodate its installation or use, are to be included in the estimated cost of the proposed capital expenditure under the section 1122 review program.

Relative to the requirements for satisfactory state CON programs, the regulation amendments would require review of "radiological diagnostic health services which are proposed to be offered in, at, through, by, or on behalf of a health care facility or health maintenance organization (HMO), which are to be provided by fixed or mobile computed tomographic scanning equipment

whether or not an addition to or replacement of these services is offered." Therefore, these interim regulations require review of all CT scanning services proposed to be performed in space leased or made available to any person by a health care facility or HMO, as well as any mobile scanning services offered by such institutions.

Comments have been invited by the Bureau of Health Planning on both of these interim regulations, which became effective with their publication on April 25. Such comments must be submitted by June 25. The AAMC seeks the Board's guidance concerning the need to submit comments on the regulations; and, if deemed necessary, what line of argument should be pursued.





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Wednesday  
April 25, 1979

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**Part III**

**Department of  
Health, Education,  
and Welfare**

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**Public Health Service**

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**Inclusion of Computed Tomographic  
Scanning Services**

DEPARTMENT OF HEALTH,  
EDUCATION, AND WELFARE

## Public Health Service

## 42 CFR Part 100

Inclusion of Computed Tomographic  
Scanning Services

AGENCY: Public Health Service, HEW.

ACTION: Interim regulations.

**SUMMARY:** This notice sets forth interim rules regarding reviews of proposed capital expenditures for computed tomographic (CT) scanner services under the capital expenditure review program of section 1122 of the Social Security Act. These rules incorporate into the section 1122 regulations, with minor revisions, a policy notice on this matter which has already been issued by the Department. Interested persons are invited to submit written comments and suggestions concerning these interim rules.

**DATES:** These regulations are effective on April 25, 1979. Comments must be received on or before June 25, 1979.

**ADDRESS:** Interested persons may submit written comments on these interim regulations to the Acting Director, Bureau of Health Planning, Health Resources Administration, Center Building, Room 6-22, 3700 East-West Highway, Hyattsville, Md. 20782. The comments will be available for public inspection at the above address between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

**FOR FURTHER INFORMATION CONTACT:** Colin C. Rorrie, Jr., Ph. D., Acting Director, Bureau of Health Planning, 3700 East-West Highway, Center Building, Room 6-22, Hyattsville, Md. 20782, 301-436-6850.

**SUPPLEMENTARY INFORMATION:** Section 1122 of the Social Security Act (42 U.S.C. 1320a-1) provides for a program for reviews of certain proposed capital expenditures by designated planning agencies (DPAs) in participating States to determine their conformity with applicable health plans, standards and criteria. Subject to certain procedural requirements, the Department will not provide reimbursements, under the Medicare, Medicaid, and Maternal and Child Health programs for expenses related to capital expenditures found by DPAs to be out of conformity with these plans, standards, and criteria. Section 1122(g) of the Social Security Act defines a capital expenditure subject to review as one which under generally accepted accounting principles is not

properly chargeable as an expense of operation and maintenance, and which (1) exceeds \$100,000 or (2) changes the bed capacity of the facility with respect to which the expenditure is made, or (3) substantially changes the services of the facility with respect to which the expenditure is made. The third of these categories is further defined in the regulations under section 1122 (42 CFR Part 100) as including an expenditure "which results in the addition of a clinically related (i.e., diagnostic, curative, or rehabilitative) service not previously provided in the facility \* \* \*" (42 CFR 100.103(a)(2)(iv)).

On February 3, 1978, the Department issued Section 1122 Notice 78-05 to clarify the requirements of section 1122 with respect to CT scanner services. The purpose of these interim regulations is to incorporate that policy notice, with minor revisions, into the section 1122 regulations, to the extent it is not already a part of these regulations.

The Department recognizes that the existing regulations do not explicitly include all aspects of the February 3 notice and accordingly amends the regulations so that they will, subject to the following revisions. First, because the Health Maintenance Organization Amendments of 1978 (Pub. L. 95-559) deleted from section 1122 all references to HMOs, expenditures by or on behalf of an HMO are no longer subject to review, unless they are also on behalf of a health care facility which is subject to review. Thus, if an HMO proposes to purchase a CT scanner on behalf of a hospital, the proposed expenditure is subject to review. Second, the regulations specify that the proposed expenditure for a CT scanner by or on behalf of a health care facility is subject to review, whether it is for a fixed or a mobile CT scanner. Third, the purchase of an additional CT head scanner by or on behalf of a facility which already has such a scanner is not subject to review if it costs less than \$100,000, because this is a service which was "previously provided in the facility". See the present § 100.103(a)(2)(iv).

Accordingly, the regulations are amended as set forth below, so that the acquisition of a CT scanner costing \$100,000 or less will be governed by the following principles:

A. The purchase of a CT scanner by or on behalf of a health care facility involving a capital expenditure less than \$100,000 is subject to review if it results in the addition of a new diagnostic service.

B. Such a purchase involving a capital expenditure of less than \$100,000 is

considered to be the addition of a new diagnostic service unless the CT scanner is in addition to or replaces an existing CT scanner.

C. If a health care facility proposes to purchase a CT full-body scanner to replace an existing CT head scanner, or to purchase equipment to upgrade an existing head scanner to a full-body scanner, this purchase is considered to result in a new diagnostic service for the facility and, therefore, is subject to section 1122 review.

D. If a health care facility proposes to offer the services of a mobile CT scanner, this is considered the addition of a new diagnostic service unless it is in addition to or replaces an existing fixed or mobile CT scanner of the same type (head or full-body scanner).

E. The lease (or acquisition through a comparable arrangement) or the donation of a CT scanner by or on behalf of a health care facility is also subject to section 1122 review if its purchase, under the principles noted above, would have required review. (See 42 CFR 100.103(b)).

F. Any capital costs associated with installing a CT scanner, as well as the costs of any renovations to accommodate its installation or use, are to be included in the estimated cost of the proposed capital expenditure under the section 1122 review program.

In relation to these regulations, attention is called to another interim regulation, also being issued in this edition of the *Federal Register*, which amends 42 CFR Parts 122 and 123 to require review of fixed and mobile computed tomographic scanners in satisfactory certificate of need programs under Title XV of the Public Health Service Act.

For the reasons set forth below, the Secretary has determined that public participation in rulemaking before issuance of these regulations and a delay in their effective date would be impracticable, unnecessary and contrary to the public interest. First, this is in large part simply a clarification of the Department's interpretation of the existing regulations. Second, given the recent proliferation of CT scanners, a delay in implementing these revisions and clarifications would likely result in the purchase or other acquisition of scanners which are not needed. Third, because these amended regulations complement amendments to regulations governing certificate of need reviews under Title XV of the PHS Act, and because those regulations are being issued on an interim basis to give those States needing revised legislative authority the maximum time possible to

obtain it, proper coordination of reviews requires that these regulations also be effective upon publication. As noted above, however, the public is invited to submit comments on these amended regulations during the next sixty days, and the Secretary will revise the regulations further as warranted by his evaluation of the comments received.

The Assistant Secretary for Health, with the approval of the Secretary of Health, Education, and Welfare, amends 42 CFR Part 100 as set forth below.

Dated: January 30, 1979.

Julius B. Richmond,  
Assistant Secretary for Health.

Approved: April 16, 1979.

Joseph A. Califano, Jr.,  
Secretary

Section 100.103(a)(2)(iv) is amended by adding at its end the following sentences:

**§ 100.103 Expenditures covered**

(a) \* \* \*

(2) \* \* \*

(iv) \* \* \*. The addition of computed tomographic (CT) scanner services not previously provided in or through the facility is a substantial change of services within the meaning of this subparagraph, whether these services are provided through a fixed or mobile CT scanner. The addition of CT full-body scanner services is included in the previous sentence if it is added to or replaces existing CT head scanner services.

(Sec. 1122, Social Security Act, 86 Stat. 1386 (42 U.S.C. 1320a-1); Sec. 1102, Social Security Act, 49 Stat. 647, as amended (42 U.S.C. 1302).)

[FR Doc. 79-12637 Filed 4-24-79; 8:45 am]  
BILLING CODE 4110-83-M

**42 CFR Parts 122 and 123**

**Inclusion of Computed Tomographic Scanning Services**

**AGENCY:** Public Health Service, HEW.  
**ACTION:** Interim regulations.

**SUMMARY:** The Assistant Secretary for Health, with the approval of the Secretary of Health, Education, and Welfare, proposes to amend the regulations governing reviews of proposed new institutional health services by State Health Planning and Development Agencies (SHPDAs) and Health Systems Agencies (HSAs). These regulations set forth requirements for satisfactory State certificate of need programs. The amendments would require review of radiological diagnostic

health services which are proposed to be offered in, at, through, by, or on behalf of a health care facility or health maintenance organization, which are to be provided by fixed or mobile computed tomographic scanning equipment whether or not an addition to or replacement of these services offered by fixed or mobile computed tomographic equipment. Interested parties are invited to submit written comments and suggestions concerning these proposed amendments.

**DATES:** These regulations are effective on April 25, 1979, subject to the discussion set forth under the "Supplementary Information" heading below. Comments received on or before June 25, 1979, will be considered.

**ADDRESS:** Interested persons may submit written comments on the interim regulations to the Acting Director, Bureau of Health Planning, Health Resources Administration, Center Building, Room 6-22, 3700 East-West Highway, Hyattsville, Md. 20782. The comments will be available for public inspection at the above address between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

**FOR FURTHER INFORMATION CONTACT:** Colin C. Rorrie, Jr., Ph. D., Acting Director, Bureau of Health Planning, 3700 East-West Highway, Center Building, Room 6-22, Hyattsville, Md. 20782, 301-436-6850.

**SUPPLEMENTARY INFORMATION:** Section 1523(a)(4)(B) of the Public Health Service Act ("the Act") requires each fully designated SHPDA to "administer a State certificate of need program which applies to new institutional health services proposed to be offered or developed within the State and which is satisfactory to the Secretary" of Health, Education, and Welfare. Section 1523(a)(5) of the Act requires each SHPDA to make findings as to the need for proposed new institutional health services, after consideration of recommendations submitted by HSAs. Section 1513(f) requires HSAs to assist SHPDAs by reviewing and making recommendations concerning the need for proposed new institutional health services. Institutional health services are defined in section 1531(5) of the Act, and at § 122.301 and § 123.401 of Title 42, Code of Federal Regulations. Sections 122.304 and 123.404 establish thresholds for review of institutional health services. The amendments add an additional threshold: radiological diagnostic health services provided by fixed or mobile computed tomographic scanning equipment.

The Secretary, wishing to contain the rising costs of health care, is concerned with the high cost of computed tomographic scanning, both as to the initial cost of the equipment and its subsequent operating expenses. These amendments require review of computed tomographic scanning services proposed to be performed in space leased or made available to any person by a health care facility or HMO. As to mobile scanners, although it is realized that there may be cost saving, since a number of institutions may share the same equipment, the offering by a health care facility or HMO of services of mobile scanners is also subjected to review by health planning agencies.

The Secretary notes that the amendments do not necessarily require changes in any State's statutes or regulations or in any lists of services which may be embodied therein. The amendments require simply that, for a State certificate of need program to be satisfactory, the proposed services be required to be reviewed, and those services not be offered or developed without a prior determination of need and issuance of a certificate of need.

In relation to these amendments, the Secretary calls attention to another interim regulation, also in this edition of the Federal Register, which amends the regulations for review of proposed capital expenditures under section 1122 of the Social Security Act to clarify the coverage of computed tomographic scanners under that program.

*Effective date provisions.*—For the reasons set forth below, the Secretary has determined that public participation in rulemaking before issuance of these regulations and a delay in their effective date would be impractical and contrary to the public interest. First, given the recent proliferation of CT scanners, a delay in implementing these regulations would likely result in the purchase or other acquisition of scanners which are not needed. This is especially true with regard to mobile CT scanners. Hospitals can now receive reimbursement through Medicare for fixed scanners, but not for scans from mobile scanners. Medicare, however, will soon begin reimbursing hospitals for scans from mobile scanners as well. As a result, it is expected that sales of mobile scanners will increase significantly. Second, in order to give those States which need revised legislative authority to implement these amendments the maximum time possible to obtain it, these regulations should be effective immediately.

As noted above, however, the public is invited to submit comments on these

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amended regulations during the next sixty days, and the Secretary will revise the regulations further as warranted by his evaluation of the comments received.

As noted above, these regulations are effective upon publication in the Federal Register. However, because the question of when the Secretary will determine whether a State's certificate of need program is satisfactory is not addressed in the regulations themselves, the Secretary has decided as follows.

Initially, the Secretary notes the relevant statutory provisions. Under section 1521(b)(2)(B) of the Act, the term of a conditional designation agreement of a SHPDA may not exceed 36 months. A fully designated SHPDA must, under section 1521(b)(3), be capable of performing all of the functions specified in section 1523, including certificate of need reviews, during its first year of full designation. If on September 30, 1980, a designation agreement under section 1521 is not in effect in a State, the Secretary is prohibited by section 1521(d) from paying certain Federal funds for the development, expansion, or support of health resources in that State.

Accordingly, in determining whether a SHPDA is capable of administering a satisfactory certificate of need program (which is a necessary element in establishing eligibility for full designation), the Secretary will require compliance with these revised regulations as follows:

(1) For States in which SHPDAs do not require additional legislative authority to implement the revisions to these regulations, the Secretary will require their implementation within six months after publication of this document in the Federal Register, and in accord with other SHPDA designation requirements.

(2) For those States in which the SHPDAs do require additional legislative authority to implement the revisions to these regulations, the Secretary will require their implementation within six months after the end of the earliest legislative session in which legislation to permit this implementation may be introduced and acted upon, and in accord with other SHPDA designation requirements.

After consulting with their legal counsel, SHPDAs should contact the appropriate DHEW Regional Office to determine into which of these categories they fall.

Accordingly, 42 CFR Part 122, Subpart D, and 42 CFR Part 123, Subpart E, are amended in the manner set forth below.

Dated: April 13, 1979.

Julius B. Richmond,  
Assistant Secretary for Health.

Approved: April 16, 1979.

Joseph A. Califano, Jr.,  
Secretary.

1. Section 122.304 of Part 122 of Title 42 is amended by adding to it a new paragraph (a)(5), to read as follows:

**§ 122.304 New institutional health services subject to review**

(a) \* \* \*

(5) Radiological diagnostic health services which are offered in, at, through, by or on behalf of a health care facility or HMO (including services offered in space leased or made available to any person by the health care facility or HMO), which are provided by fixed or mobile computed tomographic (CT) scanning equipment, except where these services are an addition to or replacement of the same service offered in, at, through, by, or on behalf of the health care facility or HMO. For purposes of this subparagraph, a CT head scanner and a CT body scanner, do not provide the same service, and a CT fixed scanner and a CT mobile scanner do not provide the same service.

2. Section 123.404 of Part 123 of Title 42 is amended by adding to it a new paragraph (a)(5), to read as follows:

**§ 123.404 New institutional health services subject to review.**

(a) \* \* \*

(5) Radiological diagnostic health services which are offered in, at, through, by or on behalf of a health care facility or HMO (including services offered in space leased or made available to any person by the health care facility or HMO), which are provided by fixed or mobile computed tomographic (CT) scanning equipment, except where these services are an addition to or replacement of the same service offered in, at, through, by, or on behalf of the health care facility or HMO. For purposes of this subparagraph, a CT head scanner and a CT body scanner do not provide the same service, and a CT fixed scanner and a CT mobile scanner do not provide the same service.

(Sec. 215 of the Public Health Service Act, 58 Stat. 690 (42 U.S.C. 216); sections 1501-1536 of the Public Health Service Act, 88 Stat. 2225-57 (42 U.S.C. 300k-1-300n-5).)

[FR Doc. 79-12836 Filed 4-24-79; 8:45 am]

BILLING CODE 4110-83-M

Proposed Routine Service Limitations:  
A Survey of COTH Member Impact

Background

Section 223 of the 1972 Social Security Amendemnts authorized Medicare to impose limitations on the costs paid for services provided under the program's Part A coverage. Since 1974, Medicare has annually promulgated limitations on routine service costs based on a hospital's bed size, its geographic location, and the per capita income of its surrounding community. On March 1st, Medicare published a schedule of proposed limitations which differs significantly from the limitations proposed in prior years:

- The present limitation on inpatient routine service costs would be replaced by a limitation on general routine operating costs. To obtain general routine operating costs, capital and medical education costs are subtracted from the present inpatient routine service costs.
- The hospital classification system would be reduced from thirty-five categories to seven categories by deleting the variable of per capita income and using only bed size and rural/urban location.
- A wage index derived from service industry wages would be used to adjust the proportion of the limitations which represent wages paid.
- A "market basket" price index would be used to update historical data and to set projected ceilings. The market basket index is designed to measure and adjust for price changes in the goods and services purchased by hospitals.

At its March meeting, the COTH Administrative Board reviewed the proposed regulations for Section 223 and adopted the following notion: the AAMC would respond to the regulations by (1) applauding HEW's move in the direction of recognizing the unique costs in teaching hospitals through recognition of the educational component; (2) stipulating that this concept should be further modified by establishing a separate classification

for tertiary level teaching hospitals which would be identified as primary affiliates of schools of medicine and others who may qualify under criteria to be established for this group; (3) requesting that this separate classification of teaching hospitals contain an intensity factor which is estimated at 4% based on current data and (4) offering to collaborate with appropriate Department officials to appropriately define the criteria for the classification system that will more precisely identify all of the hospitals that merit separate consideration on the basis of intensity.

After the Board meeting and staff preparation of a draft letter of comment, staff developed serious reservations about the position of a tertiary care category adopted in March. This reservation had five bases: even where there is a clear choice of the primary affiliate, there is significant variation in the size and economic setting of these hospitals; at some medical schools it is difficult to identify a single primary affiliate; at other medical schools the primary affiliate is not a provider of tertiary care; some obviously tertiary care hospitals would not be captured by a reliance upon the affiliation criteria; and having the dean select the primary affiliate would symbolically emphasize educational rather than case mix costs. In light of these concerns, the Board was asked via memorandum to reconsider its position. In responding to this staff request, some Board members requested AAMC to survey COTH members to assess the likely impact of the draft regulations. These Board members believed HCFA data was highly erroneous. This report summarizes the survey conducted by staff.

### Data Collection

With approximately ten days remaining between the decision to undertake the member survey and the final date for submitting comments on the proposed regulation, a relatively simple Mailgram survey was designed and mailed to 325 non-Federal, COTH members. Hospitals were asked to return the completed mailgram within two working days. As might be expected, many hospitals were unable to meet this return deadline. With only sixty responses returned by the date for submitting comments on the proposed regulations, the data could not be used in the AAMC comment letter. The data were retained, however, and by May 30th, 207 hospitals (64%) had returned usable survey responses.

The Mailgram survey appears to have provided a satisfactory questionnaire for most members. One possible weakness of the questionnaire does deserve attention. In preparing the Mailgram questionnaire, staff failed to explicitly identify the 8½% nursing differential. While it was expected that financial officials would include the 8½% factor in estimating per diem costs, the fact that several hospitals called seeking guidance on this matter means that results should be viewed with caution: some hospitals reporting costs below the proposed limitation may have excluded the nursing differential and, thereby, understated their costs.

### Findings

With a 64% self-selected response rate, substantial estimating errors may be included in reported findings and caution should be exercised in extending any survey findings to all non-Federal COTH members. Table 1 shows a frequency distribution of responding hospitals by the difference between the hospital's estimated costs and HCFA's proposed payment

limitation. Four conclusions may be drawn from this frequency distribution:

- The proposed limitation has highly varying impacts on COTH members. While one hospital is penalized over ninety dollars per patient day, two hospitals are operating more than seventy dollars below their limitation.
- While the frequency distribution is not the classical normal curve, there is a clear bell shape with forty-six percent of responding hospitals falling within  $\pm$  \$20.00 of their payment limitation.
- Given the tendency of responding hospitals to have costs close to their payment limitation, relatively small changes in the limitation can significantly change the number of hospitals or the types of hospitals penalized.
- COTH members are disproportionately penalized by the proposed limitation even though medical education and capital costs are removed. With twenty percent of all hospitals expected to exceed the ceiling, thirty-three percent (68/207) of the responding COTH hospitals are penalized. While this percentage might increase or decrease somewhat with additional returns, it would be statistically impossible for less than twenty-one percent of COTH members to be penalized (68 penalized responses divided by 325 mailed questionnaires).

Table 2 presents a summary of responding and surveyed hospitals by geographic region. The response rates were amazingly similar with the highest rate being 70% (36 of 52) in the South and the lowest rate 59% (24 of 41) in the West. The responses clearly demonstrate that COTH members in the West are penalized more frequently than those in the Northeast or Midwest while those in the South are harmed least. Clearly, the proposed limitation incorporates geographic bias.

In preparing his memorandum to the Board in a proposed AAMC response, Dr. Knapp prepared a list of hospitals that would "almost certainly" be primary affiliates and those who would possibly be primary affiliates.

Table 3 compares the impact of the proposed regulations on COTH members by the primacy of the affiliation relationship using Dr. Knapp's list. The table demonstrates that any conclusion about the primary affiliates is left uncertain because of differing response rates: of those responding, the percentage of "possible" primary affiliates exceeding the limitation



is greater than the percentage of "probably" primary affiliates; however, this finding could change if all surveyed hospitals responded. It is clear that both categories of primary affiliates exceed the limitation more frequently than hospitals which are secondary affiliates.

Table 4 lists the twelve responding hospitals over and under their respective limitations by the largest amounts. The hospitals with costs most over their limitation are essentially primary affiliates and specialty hospitals. Significantly, several of the hospitals with costs most below their ceilings are also primary affiliates. This observation is reinforced by Table 5 where all responding hospitals with general routine operating costs above \$175 per patient day and below \$85.00 per patient day are listed. Both the highest and lowest cost lists are dominated by primary affiliates. With primary affiliates having such a broad range of actual costs, it appears that a special category for determining payment limitations for primary affiliates could have an overall harmful effect.

#### Discussion

COTH members provide "routine" hospital services at highly varying costs. This variation exists for all types of teaching hospitals: primary affiliates, possible primary affiliates, and secondary affiliates. These variations do not appear to be accommodated by the HCFA's March 1st proposal for general routine operating payment limits: COTH members are penalized more often than community hospitals generally, specialty hospitals are disproportionately penalized, and hospitals in the West are often penalized. It is most unlikely that these systematic patterns reflect corresponding variations in hospital efficiency. More likely, the proposed scheme is simply biased.

Table 1 -- Frequency Distribution of the Difference Between Estimated Hospital Costs and Proposed Payment Limitations

<u>Costs &gt; Limitation</u>	<u>Costs &lt; Limitation</u>	<u>Number of Responding Hospitals</u>
\$90-99.99		1
80-89.99		1
70-79.99		1
60-69.99		2
50-59.99		3
40-49.99		4
30-39.99		5
20-29.99		17
15-19.99		6
10-14.99		7
5- 9.99		6
0- 4.99		<u>15</u>
TOTAL		<u>68</u>
	\$ 0- 4.99	19
	5- 9.99	18
	10-14.99	12
	15-19.99	13
	20-29.99	21
	30-39.99	24
	40-49.99	11
	50-59.99	8
	60-69.99	7
	70-79.99	5
	80-89.99	1
		<u>139</u>

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Table 2 -- Regional Impact of Proposed 223 Limitations on COTH Members

Region	Number of Hospitals			Percent of Respondents Penalized *	Minimum Percent of COTH Penalized **
	Surveyed	Responding	Penalized		
Northeast	143	89	31	34.8%	21.7%
South	52	36	6	16.7	11.5
Midwest	89	58	20	34.5	22.5
West	<u>41</u>	<u>24</u>	<u>11</u>	<u>45.8</u>	<u>26.8</u>
TOTAL	325	207	68	32.9%	20.9%

\* Penalized Hospitals/Responding Hospitals

\*\* Penalized Hospitals/Surveyed Hospitals

Table 3 -- Impact of Proposed 223 Limitations by Primacy of Affiliation

<u>Primacy of Affiliation</u>	<u>Number of Hospitals</u>			<u>Percent of Respondents Penalized *</u>	<u>Minimum Percent of COTH Penalized **</u>
	<u>Surveyed</u>	<u>Responding</u>	<u>Penalized</u>		
Probable Primary Affiliates	108	79	29	36.7%	26.9%
Possible Primary Affiliates	48	27	11	40.7	22.9
Secondary Affiliates	<u>169</u>	<u>101</u>	<u>28</u>	<u>27.7</u>	<u>16.6</u>
TOTAL	325	207	68	32.9%	20.9%

\* Penalized hospitals/Responding hospitals  
 \*\* Penalized hospitals/Surveyed hospitals

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Table 4 -- Responding Hospitals with the Largest Differences between Costs and their 223 Limitations, as Proposed

<u>Hospital</u>	<u>Cost Exceeds Limitation</u>	<u>Cost Below Limitation</u>
Methodist Hospital at Dallas	\$90.48	
University of Massachusetts Hospital	85.47	
UCLA Hospital and Clinics	78.17	
Truman Medical Center, Kansas City	66.58	
Milwaukee County Medical Center	63.08	
Stamford University Hospital	56.56	
Children's Memorial Hospital, Chicago	55.45	
Memorial Hospital for Cancer	55.07	
McLean Hospital	47.00	
Children's Hospital National Medical Center	46.50	
University of Iowa Hospitals and Clinics	43.07	
Children's Hospital Medical Center	40.34	
Memorial Hospital Medical Center, Long Beach		\$62.15
Christ Hospital, Cincinnati		64.20
Mt. Sinai, Miami		64.91
St. Mary's, Rochester, Minnesota		68.35
Baylor Medical Center		69.30
Barnes Hospital		69.70
Greenville Hospital System		72.60
Albany Medical Center Hospital		72.86
Grady Memorial Hospital, Atlanta		74.72
St. Francis, Peoria		75.82
Parkland Memorial, Dallas		79.78
Wesley Medical Center, Wichita		85.54

Table 5 -- Responding Hospitals with the Highest and Lowest Costs for  
General Routine Operating Services

<u>Hospital</u>	<u>Estimated Cost, FY '80</u>
<u>Costs for Routine Services</u>	
<u>Above \$175 per patient day</u>	
Cedars-Sinai Medical Center, LA	\$211.67
U.C.L.A. Hospital & Clinics, LA	210.63
Methodist Hospital of Dallas	209.63
Cook County Hospital, Chicago	209.54
Memorial Hospital for Cancer and Allied Diseases, New York	197.44
University of Massachusetts Hospital	196.43
Truman Medical Center, Kansas City, MO	192.83
Stanford University Hospital, CA	189.65
The Children's Memorial Hospital, Chicago	186.26
Henry Ford Hospital, Detroit	184.72
The Mount Sinai Hospital, New York	183.88 (not penalized)
Children's Hospital National Medical Center, D.C.	183.33
Milwaukee County Medical Complex	179.76
St. Vincent's Medical Center of Richmond, NY	178.81 (not penalized)
University Hospitals of Cleveland	177.34
The Brooklyn Hospital, NY	176.77
<u>Costs for Routine Services</u>	
<u>Below \$85 per patient day</u>	
Iowa Methodist Medical Center	\$ 84.41
St. Paul Hospital, Dallas	83.91
Latter Day Saints Hospital, Salt Lake City, UT	83.74
Greenville Hospital System	83.58
St. Joseph's Hospital and Medical Center, Phoenix	82.91
Parkland Memorial Hospital	82.88
St. Thomas Hospital, Nashville, TN	82.78
St. Francis Hospital, Peoria, IL	81.00
University of South Alabama Medical Center Hospitals and Clinics	80.84
Albert B. Chandler Medical Center, KY	74.29
Louisville General Hospital	73.48
John Dempsey Hospital, Farmington, CT	68.20
Montefiore Hospital Association of Western PA, Pittsburgh	68.00
University of Mississippi Medical Center	67.77
Louisiana State University Medical Center at Shreveport	63.37
York Hospital, York, PA	57.61

Summary of 1979 Spring Meeting Evaluation Responses

	<u>Very Interesting</u>	<u>Somewhat Interesting</u>	<u>Not Interesting</u>	<u>Very Useful</u>	<u>Somewhat Useful</u>	<u>Not Useful</u>
<u>Staff Paper</u>	27	8	0	21	4	0
<u>Concurrent Sessions</u>						
Maxicap	8	5	0	1	6	0
Manpower	4	2	1	3	3	0
Voluntary Effort	1	3	1	0	3	1
VA	4	1	1	2	2	1
<u>State Rate Review</u>						
Kues	27	6	0	20	4	0
McFadden	25	6	0	15	6	0
Hitt	18	6	0	12	7	1
Goldberg	<u>22</u>	<u>3</u>	<u>0</u>	<u>12</u>	<u>7</u>	<u>0</u>
TOTAL	135	40	3	86	42	3

Should the Format for Meeting Be Continued?	<u>Definitely Yes</u> 30	<u>Yes, but not every year</u> 8	<u>No</u> 1
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	<u>Yes</u>	<u>No</u>
Were discussion sessions interesting?	33	3
Were discussion leaders' reports beneficial?	27	8

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Overall Evaluation	11	23	1	0

	<u>City</u>	<u>Resort</u>	<u>University Conference Center</u>
Location Preference	22	7	3

	<u>Yes</u>	<u>No</u>
Should meeting include time for recreational activities?	10	22

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## Suggested Topics for Future Meetings

Studies on Affiliations, Variations in Patterns

Responsibility for financing: (a) fellowships; (b) full-time physicians (faculty) Reimbursement? Fee/svcs vs. salary. Fund-raising? Specific "special" services for special hospitals?

The teaching hospital - further definition plus public education.

Who will be a teaching hospital in the next 5 years? From Federal point of view, university-medical school point of view, from accrediting body point of view, etc.

Future roles - marketing, strategic planning: manpower requirements in future and how to respond.

The partnership relationship of the medical faculty and hospital administration

Won't suggest topics, but do suggest that your workshop leaders have highly structured objectives to attain (i.e., position statement on specific questions, etc.)

How can we work together more unitedly?

Techniques for Maximizing Funding

What does rate regulation, etc. dictate about governance structure of the academic medical center/teaching hospital?

Strategies for expanded leadership by COTH hospitals, regionally.

Let's see what's up next year.

Continue work on defining common denominators of COTH hospitals.

At least part should be a further step on this year's topic.

### How would you have prepared the paper differently?

Show present criteria so you can evaluate paper against others

I thought that I had had a part in its preparation

This paper was an outstanding piece of work. Will use back home with our trustees and medical staff.

I would observe that teaching hospitals share the common goal of preparing doctors for tomorrow. The goal that unifies them also divides them as they prepare doctors for different roles- academic, research, and patient care; patient care at primary, secondary tertiary levels. Patient care in Manhattan and North Dakota present some different requirements.

I would have narrowed the definition of teaching hospitals (not to the "one hospital" because that in effect, places the dean in control) so that COTH does not bog down in trying to represent all. (assume the paper will be updated regularly as part of evolution.

Paper is excellent - it opened many very good questions for discussion and follow-up.

In general, very helpful but the section on "multiple objectives as a unifying force" is very strained - I can't buy it.

I thought it was pretty well done - I do like the idea of categories.

Didn't receive it in advance -couldn't say. Knapp's oral presentation for me could have highlighted it more. Would hit the case mix issue harder.

More extensive discussion of the role of research in the teaching hospital. Discussion of governance similarities and differences in more detail. Outline the role(s) we play in indigent care.

Emphasize what is similar between "teaching hospitals" and other , rather than reverse. Avoid categorization and work toward definition that assess reimbursement regardless of label.

Not certain at this time except more emphasis probably would be placed upon how we should be cooperating more.



How would you have prepared the paper differently? (cont.)

Not very much. Perhaps a clearer separation of types of hospitals within COTH, and a stronger and clearer definition of "academic" "teaching" hospital. Would also like to have seen (did I miss it) a restatement of present criteria for COTH membership.

More time should be devoted to presentation and discussion of papers in larger sessions. Staff views and recommendations could be more pronounced.

Hopefully, it would be more definitive in definition of a teaching hospital thus containing results of "study" membership suggested at this meeting.

No significant change. Suggest paper be mailed to all 206 HSA and SHCC Executives.

The paper was well done - I intend to use it extensively - provides an excellent base for understanding.

The only thing I would have done differently is to assume two approaches - total national health insurance through Federal tax base, and National Health Control but through different mechanisms for insurance - has different results.

Needed a section speculating on the future roles and perspectives of teaching hospitals.

Well done - no suggestions.

Didn't receive paper prior to meeting, so have not read it carefully - but it looks good and my own would probably not differ.

Comments on Discussion Groups

None.

No.

More time - somehow - for chairmen to prepare summary of discussion.

Not really.

While an acceptable technique, our group's report ended up hearing the personal thoughts advanced by Spike Foreman. Our group might have hammered out a set of conclusions if we had had another hour or so.

Recommendations for detailed analysis of teaching hospital data excellent.

Smaller size.

As noted previously, group leaders should have general consensus points or objectives for conclusions - this in order to help focus discussion somewhat in the otherwise heterogeneous group.

Successful methods of increasing revenue.

Align topics in advance. Use a couple of rounds of Delphi technique before the meeting.

We had two groups in one room. Not a good situation.

Provide questions to discuss on groups to aid in giving more focus to the discussion.

It was very good. Perhaps the discussion group leaders might keep bringing participants back to the matter of formulating "action items" either for COTH or for individual institutions.

Smaller Groups.

Perhaps pre-assignment and lighter agenda with pre-distributed material including examination of alternatives for COTH with evaluation of each.

Discussion groups were the weakest and least beneficial and least interesting portion of the program.

Provide some structure.

Keep the numbers to 10 or less.

Although I felt chairman had a preconceived notion of the result he wanted - with which, incidently, I agreed.

Page Three

Comments on Discussion Groups (cont.)

Less prepared positions from group leader.  
Moderators should not prepare their conclusions before the sessions.

Comments on Discussion groups' reports

Differences in each hospital - their interests were so diverse - no evidence of coalescence.

Too general.

Would have not been beneficial except for action which was taken to undertake and finance the study. This action justified the entire meeting - in my judgment. Topics were such that we couldn't get a handle on solutions, so a summary wasn't useful, or perhaps the expectation wasn't high enough in terms of time committed - might have been better to tackle fewer topics in more depth - unless your objective was not to secure direction, but understanding of the complexity of the lobbying task.

Not for the time spent.

Could have been better down by written summaries, using time for other subjects. Much of the meeting was a reiteration of the group discussions - less time could have been allowed for this session with additional small group sessions scheduled to react to reports from other groups.

Diversity of opinion was obvious.

Generalities - perhaps useful to COTH staff and Board but not me.

But, summaries are generalized. Two of them reflected discernable bias of presentors.

A staff summary, distributed promptly after the meeting, might better describe the content and provide a better follow-up reference.

Might have been better if group leaders had more time to prepare and members had some time to review the reports before discussion - thus giving more time for discussion.

Not really. All seemed to waltz around a "hot" potato. More substance should be explored for greater cooperational efforts in my opinion.

Good opportunity to get to know others, listen to problems and viewpoints of others, have one's own perceptions challenged or refined.

Tended to be rather long in return for the benefits. Conclusion reached about the need for data and the willingness by institutions to support financially such an undertaking was significant.

Needed to be much more concise - spent too much time on this.

Summary reports are not as effective as hearing/participating in the discussions.

What suggestions would you make for future meetings?

Meeting new and old friends is useful as well as enjoyable. These opportunities should be fostered or stimulated. The more casual (resort?) approach and setting might achieve this end.

Continue same format.

This meeting was well organized - however, I would suggest that the report from the work sessions be delayed longer than over lunch to enable group leaders to better organize their presentations to the assembly.

What suggestions would you make for future meetings?

In terms of trends for the future, I think one should consider: (1) Role of HMOs in Teaching Hospitals; (2) Consequences of reduced enrollments in under graduate and graduate medical education; (3) consequence to teaching hospitals as a result of specialists trained by centers now siphoning off referrals previously going to Centers. Kansas City was tops.

Consider program topic which would have represented HEW or one of key congressional committees. Also, each year consider inviting someone from another professional school (optional, nursing, allied health, dentistry, etc) to meet with us and participants.

COTH Administrative Board should define major issues before it and use them as basis for future Spring Meetings. Positions beginning to evolve out of Spring Meetings should form basis for some aspects of COTH program and sessions for Fall AAMC meeting. Keep the opportunity for small group interaction.

Probably more concurrent groups with greater range of topics with recap sessions would be more helpful. We should tell our story to the local HSAs more in person.

Make them at least oriented to individual institutions, rather than Association concerns.

Throw the VA into the open discussions more; don't isolate them in their own sessions.

Be careful of small groups - if purpose is to educate really very helpful to make everyone feel better by ventilating - ok.

Focus on how to get money into the system for the education of medical students and primary care (including family practice) residents in hospitals that are not receiving money from medical schools. (would appreciate a no-smoking section in meetings).

Continue and expand the small discussion and reaction group concept.

The second day was superb - very informative and provocative. Format would have been good for first day issues.

Select the current issue topics closer to the meeting time as opposed to the year ahead.

How a community hospital deals with medical school to avoid financial rape.

Why this continuing push for affiliation? We need good non-affiliated programs but feel like 2nd class citizens.

A session on case mix, and intensity methodology, strengths and weaknesses, state of art, and new directions.

Friday session excellent - showed both sides of issues.

Guarded.

## DATE AND LOCATION OF 1980 SPRING MEETING

Based on this year's experience, particularly for booking hotel space, it is the staff's recommendation that the date and location of the 1980 meeting be determined by the COTH Board at the June, 1979 meeting.

### DATE

Meetings already known to be scheduled in the spring of 1980 are as follows:

Dean's spring meeting	April 9-12 <u>or</u> April 30-May 3
Duke Forum	May 8-10
AHA Board Meeting	May 14-16

The staff recommends the dates of May 21-23 with May 7-9 or May 14-16 as alternates depending on whether or not the conflict with the AHA Board meeting or the Duke Forum are viewed as major problems.

### LOCATION

A number of individuals have recommended in casual conversation that Denver, Colorado be considered as a site for the 1980 meeting. Coincidentally the marketing staff of the Fairmont Hotel to be opened in Denver in October, 1979 recently visited the AAMC business affairs office. The accommodations and meeting space appear to be excellent.

Roger Hunt, Director, Indiana University Hospitals has called twice to suggest that the meeting be held in Indianapolis at the Hyatt Regency Hotel and has gone so far as to determine that hotel space is available in May. He has stated that arrangements could be made to watch either "time trials" or "practice runs" for the Indianapolis 500, and other types of tours of the facility. The May 21-23 dates could be a problem for Indianapolis.

Other suggestions are welcome.

DISCUSSION OF SPRING MEETING PAPER:  
"Toward A More Contemporary Public  
Understanding Of The Teaching Hospital"

The staff would very much appreciate any suggestions for improving the paper. A number of individuals have suggested distribution of the paper to various groups, including the COTH membership. Guidance is also requested on this matter. A copy of the paper is enclosed as a separate attachment to the Agenda.

## 1979 Spring Meeting: Workshop Recommendations

### Background

At the 1979 COTH Spring Meeting, a workshop examining the definition of the term teaching hospital was conducted. Prior to the meeting, attendees were provided with a thirty page paper, "Toward a More Contemporary Understanding of the Teaching Hospital" (see Attachment B), which summarized the evolution of the teaching hospital, the characteristics which fundamentally distinguish teaching from non-teaching hospitals, and the diversity among those teaching hospitals. The workshop began with Dr. Knapp reviewing the planning committee's objectives for the workshop and presenting some personal observations and perspectives on the topic of defining a teaching hospital (Attachment A).

Following Dr. Knapp's presentation, attendees were divided into four discussion groups to review the paper and discuss its implications for health planning, reimbursement, and national health insurance (Attachment C lists the discussion groups and their group leaders). Following the individual discussion sessions, a plenary session was held with each group presenting its recommendations.

### Workshop Recommendations

While the individual workshops were organized around three separate topics (health planning, reimbursement, and national health insurance), there was a remarkable consistency to the recommendations developed by three of the four workshops. Essentially each workshop concluded that the problems facing teaching hospitals in the future resulted from three factors: atypical service costs resulting from the complexity or intensity of care provided patients, atypical institutional costs resulting from educational

program activities, and a wide variation in each of these costs among teaching hospitals. Because of the variation among teaching hospitals, each discussion group recognized methodologies were needed to quantify intensity and educational costs so that teaching hospitals could be classified into homogeneous groups or scaled into continuous distributions. Therefore, each discussion group recommended that the AAMC/COTH sponsor or conduct a study to quantify the intensity of patient care and the costs of educational programs. The discussion groups felt such a study could be used (1) to familiarize planning agencies and the general public with the unique requirements of teaching hospitals, (2) to propose new approaches for hospital reimbursement schemes or payment limitations, and (3) to evaluate proposed reimbursement and limitation schemes. In making the recommendation for a study at least one of the workshops explicitly acknowledged a willingness to support a special dues assessment to finance the activity.

The fourth discussion group, which addressed national health insurance in two subgroups, took positions somewhat contrary to the previously discussed study recommendation. One of the subgroups expressed severe reservations about quantifying case mix as the basis for determining hospital payments. This subgroup included two CEOs from New Jersey where case mix reimbursement is being used experimentally, and both CEOs stated that the experiment was not providing adequate reimbursement for teaching/tertiary care hospitals (see attached letter from Edward Dailey). The second subgroup took the position that COTH should not clearly separate hospital educational and patient care roles, should not categorize members into homogeneous subgroups, but should pursue a study of case mix reimbursement.

Staff Assessment

The AAMC does not presently have a comprehensive document detailing the current state-of-the-art for determining either hospital education or case mix costs. To maximize the productivity and likely success of the member-recommended study, staff believe the effort should begin with a comprehensive assessment of the state-of-the-art in both areas. These assessments should be conducted in two phases: a literature review -- designed to answer what is known, who's active in the area, and what is unfinished in major lines in inquiry -- and visits with those major actors in the field designed to assess the current state of work and proposals in progress. Using the case mix topic as an example, the literature review would examine the following areas: diagnostic and procedural coding systems; nursing service intensity; accuracy of diagnostic coding; manpower assignment systems; hospital classification studies, including reimbursement and rate review; hospital output measures; and hospital cost studies. Visits would initially be conducted with the following: Clif Gaus - DHEW; John Thompson/Bob Fetter - Yale; Hal Cohen/Jack Cooke - Maryland; N.J. Health Department and Hospital Association; United Hospital Fund researchers; Bill Dowling - Washington State; Sylvester Berki/Paul Feldstein - Michigan; Martin Feldstein - Harvard; Stuart Altman - Brandeis; and, Al Williams - Rand Corporation. When the literature reviews and visits have been completed, staff would prepare reports on the state-of-the art in determining educational costs and case mix costs and develop recommendations for further pursuit of the issues.



Recommendations

It is recommended that the COTH Administrative Board:

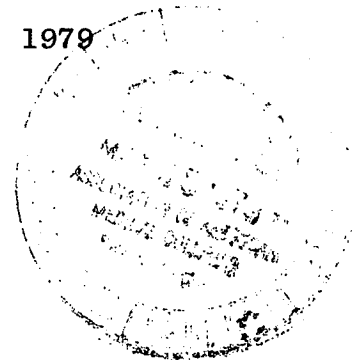
- adopt the position that the educational and case mix study should begin with state-of-the art assessments to be prepared by staff for the September Board meeting;
- direct the staff to prepare recommendations to the COTH Board at its September meeting for further pursuit of the issues based on the state-of-the-art assessments; and
- request AAMC Executive Council endorsement of this approach to initiating activities on these studies.



MUHLENBERG HOSPITAL  
PLAINFIELD,  
NEW JERSEY 07061  
201-668-2220

OFFICE OF THE DIRECTOR  
EDWARD J. DAILEY, JR.

May 22, 1979



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

Dear Dr. Cooper:

I am writing you for two reasons.

The first reason is to tell you I appreciated the COTH meeting last week in Kansas City: it was one of the most instructive sessions I have attended in a long while. It does much to fill in gaps and information lags.

Secondly, I want to urge that COTH not be carried away with "high regard for the DRG experiment in New Jersey." The DRG system fails to address the uniqueness of each hospital in terms of demography, patient population, intensity of service and the scope of available health care services. It is untested and to date the twenty odd hospitals participating in the experiment as a group are unwilling to endorse the program or to suggest a state-wide application. The DRG program can be a disaster to the teaching hospital, especially the private sector teaching hospital, with its high educational overhead and its multiple objectives.

I did sense at Kansas City, in several sessions, a feeling that the DRG program is a savior - such a belief may well be a serious error.

Thank you again for the meeting, it was much enjoyed.

Very truly yours,

Edward J. Dailey, Jr.

dj

cc: Robert L. Evans, M.D., Cooper Medical Center



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## THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

DEPARTMENT OF PUBLIC HEALTH

May 22, 1979

Robert Blendon, Sc.D.  
Vice President, Planning  
and Development  
The Robert Wood Johnson  
Foundation  
Box 2316  
Princeton, NJ 08540

Dear Dr. Blendon:

I recently met with Dr. Richard Knapp and briefly discussed some ideas with him for a study of teaching and non-teaching hospitals. Dr. Knapp indicated the need for such an analysis and suggested that I contact you to ascertain the Foundation's interest in supporting such a project. Dr. Knapp's letter to you dated April 9, 1979 indicates the AAMC's interest in and support of research in this area.

Our proposed project has two specific objectives. First, we seek to analyze the medical, operating, and financial attributes of teaching and non-teaching hospitals. Among the research questions we seek to address are:

- Do teaching and non-teaching hospitals provide similar care output?
- Are teaching hospital costs greater than non-teaching hospital costs for a similar product mix?
- Is the quality of patient care rendered in a teaching hospital setting higher than in a non-teaching hospital setting?



The second study objective entails an analysis of teaching hospital characteristics and seeks to derive a meaningful taxonomy of teaching hospitals. Classification systems currently in use are based on either certification for postgraduate medical education, scope of teaching activities, or intensity of teaching activities. From both a research and policy perspective, such classifications are far from adequate.

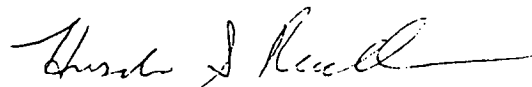
A thorough review of the literature indicates both the widespread recognition of the need for an indepth analysis of teaching and non-teaching hospitals and the absence of a single, comprehensive study addressing the issues posed in the preceding paragraph.

The rich data base being assembled by the Office of Health Systems Management, State of New York, provides much of the data required for an analysis of hospital activity. Mr. Richard Berman, Director of the Office of Health Systems Management, is interested in our study and has indicated that hospital data reported to his office, including case-mix data, would be made available to us for use in this project. While individual hospital authorization will be required to release the case-mix data, we are confident that the authorizations will be obtained. Although much of New York State's new hospital data base will not be fully constructed until the early 1980's, sufficient data will be available by the fall of 1979 to support a pilot study in our area of interest.

I will be joined in this study by three colleagues. They are George G. Reader, M.D., Livingston Farrand Professor of Public Health, Mary E. W. Goss, Professor of Sociology in Public Health, and David D. Thompson, Professor of Medicine and Director, The New York Hospital.

Dr. Goss and I would appreciate the opportunity to visit with you and explore the Foundation's interest in our proposed research.

Sincerely,



Hirsch S. Ruchlin, Ph.D.  
Professor of Economics  
in Public Health

HSR:af

# **STUDY TO QUANTIFY THE UNIQUENESS OF CHILDREN'S HOSPITALS**

## **SUMMARY OF MAJOR FINDINGS**

**STUDY CONDUCTED FOR  
THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS, INC.**

**1978**

Conducted by the Associated Firms of:

Arthur Andersen Company  
Philadelphia, Pennsylvania

Arthur D. Little, Inc.  
Cambridge, Massachusetts

E. D. Rosenfeld Associates, Inc.  
White Plains, New York

Turner Construction Company  
New York, New York

## ACKNOWLEDGEMENTS

A project of the magnitude of this study is concluded successfully only with the interest, dedication, and effort of many individuals. All involved are best rewarded by their knowledge that a challenge undertaken has been completed satisfactorily. Particular note should be made of the effort by the members of the Study Steering Committee and the Specialty Advisory Task Force, named herein.

Two individuals, who successively chaired the Study Steering Committee, made an exceptional contribution of time and talent:

Mr. David S. Weiner  
and  
Ned W. Smull, M.D.

The Committee, in its task, was provided invaluable support by Marvin J. Bostin, Ph.D., Project Director for the associated firms.

\* \* \*

Funding for the development and conduct of the study was provided to the Association by Children's Hospitals and their supporters, who recognized the importance of this undertaking to children.

\* \* \*

Funding to assist in the publishing and dissemination of the Report of the Study was provided by:

FANNIE E. RIPPEL FOUNDATION  
SCHERING-PLOUGH FOUNDATION

who through this support have enabled the Association to bring to a wider audience than otherwise possible, knowledge of its contents, and have thereby made a substantial contribution to the understanding of child health care.

## NOTICE

This is the summary of the final report of the associated firms of a study contracted by the Association and conducted pursuant to a protocol developed at the request of the Association.

The firms selected to work in association were chosen for recognized competence and experience, each to bring to the study conduct particular analytical skills, knowledge, and the balance of disciplines appropriate to the project. Although the Association, through its Study Steering Committee, met periodically during the course of the study with the associated firms to facilitate its conduct and to receive progress reports, the findings and conclusions of the report are those of the associated firms.

The summary was prepared by Marvin J. Bostin, Ph.D., Project Director for the associated firms.

## SUMMARY OF MAJOR FINDINGS

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## 1. STUDY PURPOSE AND OBJECTIVES

Children's hospitals as a group constitute an invaluable national resource in the delivery of health care to the pediatric and adolescent populations of the United States. The staff, facilities and other resources required to effectively carry out the programs and services of children's hospitals, represent unique operational and capital costs requirements. It is believed that children's hospitals incur financial hardships in their operations as a result of inadequate financing programs for pediatric health care, and the problems of operational under-financing are believed to be related to insufficient numbers of patients who have voluntary and/or governmental health insurance coverage, inadequate levels of reimbursement by governmental and voluntary health insurance carriers to compensate for the higher costs of pediatric care, and the imposition of reimbursement "ceilings" which inappropriately relate children's hospitals' costs to the costs in comparably bed-sized general care institutions.

The study was conducted to identify and quantify the unique operating and capital cost characteristics of children's hospitals which vary from comparable costs in similarly bed-sized general hospitals and, to the extent feasible, to determine the causative factors underlying such cost variances.

The study was organized to measure the unique cost-contributing factors in "comprehensive child health care centers" in which the greatest number and extent of such factors exist. To the extent that other institutional settings experience similar cost-contributing differentials, it is expected that the study's findings will be applicable in defining those unique cost implications in the pediatric divisions of major university-based teaching medical centers, in the pediatric units of community general hospitals, in children's long-term and rehabilitation care centers, and in children's psychiatric care facilities.

The study identifies and quantifies the cost differentials between children's hospitals and comparably-sized general hospitals as related to the following major areas:

- Intensity of care including specialized services, specialized intensive care beds and occupancy, diagnostic mix, and patient origin.
- Occupancy.
- Nurse staffing.
- Ancillary and support services staffing.
- Interns and residents, education, research, and community service costs.
- Occupancy, fiscal, administrative, and non-payroll variable costs.
- Sources of payment and levels of non-compensated (free) care.
- Space allocations and construction costs.

## 2. STUDY APPROACH AND METHODOLOGY

Data was collected from one children's hospital and one general hospital of similar bed size in the same general geographic area, in each of the nine census regions of the country. The children's hospitals in the study group range from 157 beds to 343 beds in size; the general hospitals in the study group range from 212 to 452 beds in size. Three of the nine general hospitals in the study group maintain AMA-approved residency training programs and two of them are medical school affiliated. No conscious effort was made to exclude general hospitals with intern-resident training programs or with medical school affiliation.

There may be some question regarding the validity of comparing children's hospitals with active teaching programs, with non-teaching general hospitals. The choice of children's hospitals with active teaching programs is justified: (a) in order to demonstrate the costs of teaching and research activities; and (b) since these are representative of



children's hospitals (90% of children's hospitals' beds in the U.S. are provided in medical school affiliated teaching institutions). Thus, the additional costs of education are generally applicable to children's hospitals; the inclusion of three of nine general hospitals with graduate medical education programs, for comparison purposes, actually overstates the level of such activity in general hospitals of comparable bed size.

A key criterion for the comparison groups of children's and general hospitals was bed size — a comparison criterion imposed by the policies and practices of regulatory agencies and third-party payers. A primary hypothesis for the study is that the two groups of hospitals are so dissimilar in nature (with teaching being only one element of dissimilarity) that cost comparisons on the basis of bed size alone are inappropriate.

The data collection was by questionnaire, by on-site visits and interviews, by access to automated discharge abstract systems (such as PAS, CHAMP, etc.), by specially conducted data sampling techniques, by on site work sampling and observation, by examination of statistical and financial documents of record, and by examination of architectural plans and documents. A "dry run" of the study protocol and data collection methods was conducted in one pair of hospitals, and modifications made in the protocol and methodology as warranted. Every reasonable effort has been made to assure that comparisons are drawn on a uniform and consistent basis.

The study was conducted by four national consulting organizations in association: Arthur Andersen Co., Arthur D. Little, Inc., E. D. Rosenfeld Associates, Inc., and Turner Construction Company. The consultants' efforts and the conduct of the study were supervised by a specially appointed Steering Committee of NACHRI's Board of Trustees. To provide a perspective on the relationship of the study's findings to specialized children's health care, a Specialty Advisory Task Force of experts in the pediatric subspecialties was convened to review the study findings and to comment on their applicability to the programs of specialized children's health care centers.

### 3. MAJOR STUDY FINDINGS

#### 3.1 Intensity of Care

The on-site provision of 51 selected facilities or services was studied in the group of nine children's and nine general hospitals. The entire group of hospitals had a mean value of 25.28 facilities or

services; the mean value for the children's hospitals was forty percent greater than the mean value for the general hospitals.\* Dowling's Costliness Weights were applied to 38 facilities or services for which they had been developed. The mean Dowling Index for the entire group of hospitals was 54.56; the mean Index for the children's hospitals was almost twenty percent greater than the mean Index for the general hospitals.\* These studies demonstrate that the children's hospitals studied maintain more specialized facilities and services than the comparably sized general hospitals.

Specialized intensive care beds, available bed days, and occupied bed days were studied as a percentage of all beds, available bed days, and occupied bed days (excluding bassinets) in both the children's hospitals and the general hospitals. The composite data for all hospitals of each class are summarized as follows:

INTENSIVE CARE AS A PERCENTAGE OF ALL CARE	CHILDREN'S HOSPITALS	GENERAL HOSPITALS
Beds (year end)	24.1%	10.2%
Available bed days	23.0%	9.6%
Days of care	23.3%	9.4%

The data demonstrate that the children's hospitals commit a substantially greater percentage of beds, available bed days, and days of care to specialized intensive care than do the general hospitals.\*\*

The diagnostic mix in the children's hospitals was compared with pediatric discharges from the general hospitals in the study group, and with a sample of over two million pediatric discharges reported to the Professional Activities Study (PAS) of the Commission on Professional and Hospital Activities for 1975. Primary discharge diagnoses were classified into 27 mutually exclusive diagnostic categories, as listed below:

#### Group A

Respiratory Diseases, except T&A  
T&A  
Otitis Media

\*The greater value in the children's hospitals was statistically significant by paired t statistic testing with a probability of less than .02.

\*\*This two to three fold difference was found statistically significant by Chi Square testing with a probability much less than .001.

Trauma (fractures and injuries)  
 Intestinal Infections  
 Bladder and Urethral Disease  
 Uncomplicated Appendicitis and Inguinal  
 Hernia

**Group B**

Congenital Anomalies  
 Other Gastrointestinal Diseases  
 Nutritional and Metabolic Disorders  
 Malignant Neoplasms  
 Organic Lesions of the Nervous System  
 Perinatal Conditions  
 Hematologic Disorders  
 Cardiac and Arterial Diseases

**Group C**

Eye and Ear, except Otitis Media  
 Bone and Joint Diseases, except fractures  
 Other Infectious Disease  
 Kidney and Ureteral Diseases  
 Benign Neoplasms  
 Psychiatric Conditions  
 Venous and Lymphatic Conditions  
 Prostate and Male Genital Disease  
 Gynecologic Conditions

**Miscellaneous Diseases**

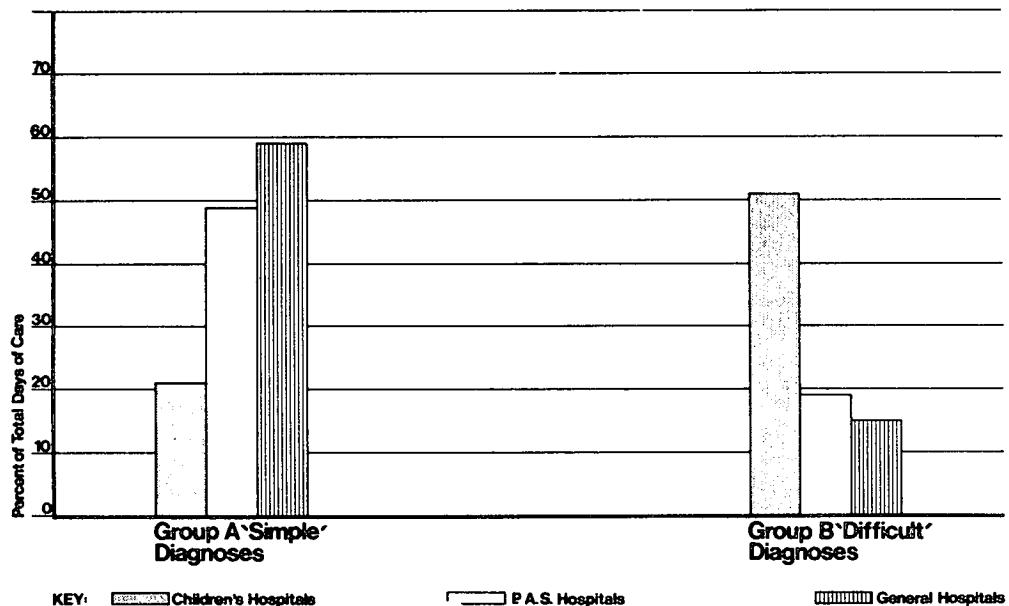
Obstetrics  
 Signs and Symptoms Referrable to  
 Different Systems  
 Ill-Defined Conditions

Group A conditions occur with greater relative frequency in the general hospitals as compared with the PAS sample, and account for most pediatric discharges from the general hospitals; these are common conditions which require relatively simple hospital care. Group B conditions occur with greater relative frequency in the children's hospitals as compared with the PAS sample; these are uncommon conditions which frequently require complex intensive hospital care. Group C and Miscellaneous conditions occur with approximately comparable frequency in the children's hospitals, the general hospitals, and the PAS sample. Discharges and days of care for Group A and Group B conditions, as a percentage of all discharges and days of care, are given below for each class of hospital:

DISCHARGES	CHILDREN'S HOSPITALS	PAS	GENERAL HOSPITALS
Group A (simple)	33.2	54.8	66.6
Group B (difficult)	34.8	13.8	9.7

DAYS OF CARE	CHILDREN'S HOSPITALS	PAS	GENERAL HOSPITALS
Group A (simple)	20.5	48.6	59.0
Group B (difficult)	51.1	19.4	14.9

**'Simple' vs 'Difficult' Diagnoses  
 Days of Care Rendered**



Average length of stay for each diagnostic category in the PAS sample was used to develop severity weights. Hypertrophy of tonsils and adenoids had the shortest average length of stay (1.79 days). This was set at 1.0 and all other average lengths of stay were divided by 1.79 to determine a relative severity weight for each diagnostic category. The class average for Group A conditions is 1.94 (range 1.00 to 2.89). The class average for Group B conditions is 4.47 (range 2.02 to 9.05) confirming that the latter are more difficult diagnoses to manage in the hospital.

Severity weights for each of the 27 diagnostic categories were applied to the distribution of discharges in each class of hospital. The total severity weight is 278.08 in the children's hospitals, and 238.55 in the PAS sample, and 220.46 in the general hospitals in the study. By this technique, the children's hospitals are found to be about 26% more intense than the paired general hospitals and about 17% more intense than the national PAS sample.

Patient home origin, as defined by postal zip codes, was available for all of the children's hospitals and for 7 of the 9 general hospitals. The number of zip codes required to account for 25%, 50%, and 90% of all discharges, regardless of diagnosis, was determined for each hospital. Class averages for all the children's and all the general hospitals are given below:

ZIP CODES REQUIRED TO ACCOUNT FOR	RATIO CHILDREN'S		
	CHILDREN'S HOSP.	GEN'L. HOSP.	HOSP. TO GEN'L. HOSP.
25% of all discharges	10.2	2.0	5.1
50% of all discharges	33.9	6.0	5.6
90% of all discharges	201.2	32.0	6.3

These data demonstrate that the children's hospitals serve a much greater regional population base than do the general hospitals.

The primary service area for each hospital was defined alternately as those zip codes accounting for 50% and 75% of all discharges in the simple Group A category.\* The percentage of all difficult Group B patients resident in this internally defined primary service area was then determined for each hospital. The class averages for the nine children's hospitals and for the seven general hospitals are as follows:

\*Since the zip code required to reach each percentage of discharges was included, the actual percentage of discharges covered varied slightly from 50% and 75%.

	CHILDREN'S GENERAL HOSPITALS HOSPITALS	
Percent of Group A discharges to define primary service area	50.69	52.74
Percent of Group B discharges from these zip codes	30.52	47.03
Percent of difficult Group B patients from outside of primary service area	40.00	11.00
Percent of Group A discharges used to define primary service area	75.30	76.00
Percent of Group B discharges from these zip codes	51.81	68.65
Percent of difficult Group B patients from outside of primary service area	31.00	10.00

These data demonstrate that the children's hospitals selectively draw more difficult patients from a larger geographic area by serving as referral resources for more distant general hospitals.

\* \* \*

An important portion of the high cost of maintaining the children's hospitals relates to the intensity of the level of care required for the sicker patients served by the children's hospitals. The completed studies confirm all of the initial hypotheses concerning the intensity of care in the children's hospitals:

(1) The children's hospitals maintain more specialized facilities and services because of the characteristics of children and the unique mix of sick patients served.

(2) A larger percentage of beds and days of care in the children's hospitals are dedicated to specialized intensive care to meet the needs of sicker patients.

(3) The diagnostic mix in the children's hospitals includes fewer patients with simple conditions and more patients with complex conditions than in the comparably sized general hospitals in the national PAS sample.

(4) The children's hospitals provide service to a larger geographic area than their matched general hospitals and particularly draw complicated patients from outside of their primary service areas.

### 3.2 Occupancy

Weekly occupancy rates, and average annual occupancy rates, for one year, were computed and analyzed for the medical surgical services of the children's hospitals and the general hospitals, and for the pediatric services of the general hospitals. Daily occupancy rates, for one sample month, were similarly analyzed.

The overall annual average occupancy rate of the children's hospitals (75%) is lower than the annual average occupancy rate of the medical-surgical care units of the general hospitals (84%) and higher than the pediatric care units of the general hospitals (40%). The weekly occupancy pattern of the children's hospitals more closely follows the cyclic (seasonal) variations of adult medical-surgical services than of pediatric services in the general hospitals. The pediatrics and adult medical-surgical services of the general hospitals, and the medical-surgical services of the children's hospitals, all experience significant occupancy drops in the latter part of December corresponding to the Christmas and New Year holiday season. This reduction in occupancy is more short-lived in the children's hospitals and in the adult medical-surgical services of the general hospitals, and is more prolonged in the pediatrics services of the general hospitals. The occupancy rate in the pediatric services of the general hospitals experiences a greater reduction during the summer

school vacation period than does the occupancy of the children's hospitals.

Comparing the weekly occupancy Mean Positive and Mean Negative Deviations from average annual occupancy, indicates that the children's hospitals experience a narrower range of "peaks and valleys" of occupancy than the medical-surgical or the pediatric services of the general hospitals.

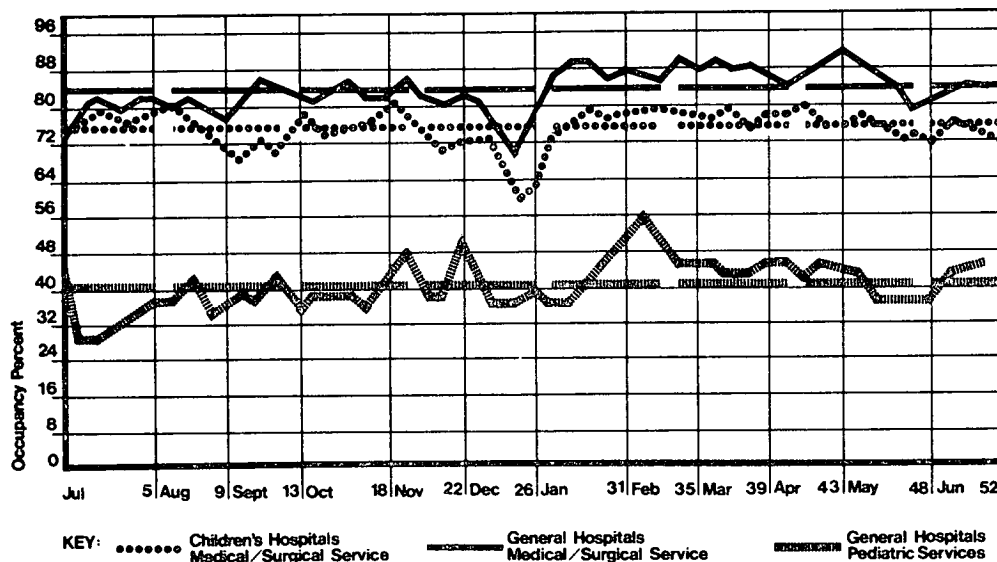
Average length of stay (ALOS) for medical-surgical services is uniformly higher in the general hospitals than in the children's hospitals. However, a statistical linear regression analysis for correlation of occupancy rates and ALOS indicates that average length of stay is not the major contributing factor affecting occupancy rate differentials between the children's hospitals and the general hospitals.

The children's hospitals have a greater percentage (64%) of non-emergent (elective) admissions to their medical-surgical services than do the general hospitals (58%) and there is no significant difference in the percentage of non-emergency admissions between the children's hospitals and the pediatric services of the general hospitals. The children's hospitals have a substantially higher "elective turnover rate" (i.e., number of elective admissions per bed per year) than the pediatric or medical surgical services of the general hospitals.

The average occupancy of specialty intensive care beds is slightly higher in the children's hospitals (76%) than in the general hospitals (74%), but the children's hospitals devote a substantially higher

### Weekly Occupancy Rate—Children's & General Hospitals

July 1, 1976 - June 30, 1977



proportion of beds and inpatient care days to such "dedicated" beds than do the general hospitals.

\* \* \*

Although the average occupancy rates of specialty intensive care beds are similar in the children's hospitals and in the general hospitals, the substantially higher proportion of such specialty intensive care beds in the children's hospitals affects their overall average occupancy rates. The limited assignment flexibility of dedicated specialty care beds, utilized at a lower occupancy rate than general medical-surgical care beds, and the proportion of such dedicated specialty care beds, is believed to be the most significant contributing factor to the overall differences in medical-surgical occupancy rates between the children's hospitals and the general hospitals of similar bed size. Data previously summarized demonstrates the more intensive nature of the care and services provided in the children's hospitals as compared with the general hospitals; such specialty intensive care beds in the children's hospitals operate at a higher average occupancy rate than similar beds in the general hospitals and appears to justify the proportion of such specialty care beds maintained in the children's hospitals.

### 3.3 Nurse Staffing

A major contributing factor to the higher per diem costs of the children's hospitals as compared with those of the comparably sized general hospitals is that the children's hospitals require more personnel per bed or inpatient care day. Since the largest single component of hospital personnel is represented by the nursing service department, special attention is devoted to analyzing nursing staff requirements of the children's hospitals as compared with requirements of the general hospitals. This phase of the study was designed to determine:

- The number of nursing staff in the children's hospitals as compared with those of the general hospitals, required for both inpatient and out-patient care.
- The levels of nursing personnel (registered professional nurses, licensed practical nurses, nurse aides, etc.) in the two groups of hospitals.
- The allocation of nursing staff by function (direct care, administration, and inservice/orientation training, etc.) in the children's hospitals as compared with the general hospitals.

- The allocation of effort and time to various medical and nursing procedures for pediatric patients as compared with adult patients.
- The time required to carry out specific nursing procedures with pediatric patients as compared with adult patients.

The study involved three basic types of investigation:

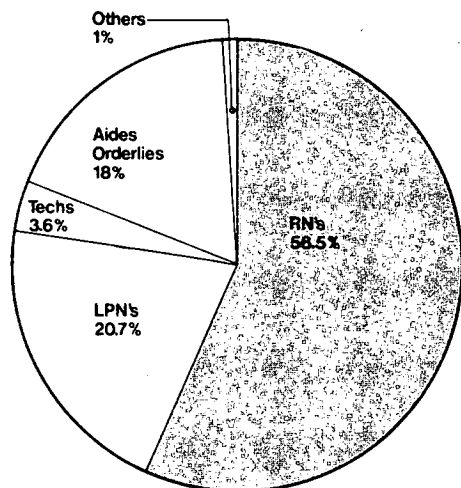
- Collection and analysis of data on nurse staffing patterns in the nine children's hospitals and the nine paired comparison general hospitals of similar bed size.
- Work sampling observations by specially trained observers in a limited sample of two pairs of children's and general hospitals. Units studied included a surgical unit, a medical unit, and an intensive care unit in each of the two children's hospitals, and a surgical unit, a pediatric unit, and an intensive care unit in each of the two general hospitals. A total of 17,000 observations were made of the time devoted to specific activities by the assigned nursing staff, and by non-assigned hospital staff, and by outside people (principally parents) when the latter were actively involved in emotional/social support or direct care.
- Direct observation of the time required to carry out four specific nursing procedures: feeding assistance, instituting intravenous therapy (IVs), administering medications, and obtaining vital signs. These observations were made in the same two pairs of children's and general hospitals.

The most significant conclusions of the analyses are:

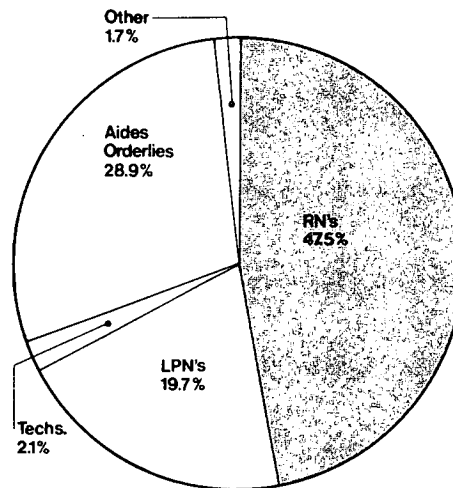
#### NURSE STAFFING ANALYSIS

Patients in the children's hospitals require a significantly higher and more intensive level of nursing care than adult patients in the general hospitals. Patients in the children's hospital medical-surgical units require on the average 60% more direct care nursing hours per patient day than adult patients in similar units in the general hospitals. The difference in requirements is less pronounced in intensive care units; patients in the children's hospital intensive care units require on the average 8% more nursing hours per patient day than patients in adult intensive care units in the general hospitals. The overall difference in requirements is 68% (9.4 hours versus 5.6 hours per patient day) due to the higher proportion of intensive care beds in the children's hospitals.

## Distribution of Direct Care Nursing Staff



Children's Hospitals



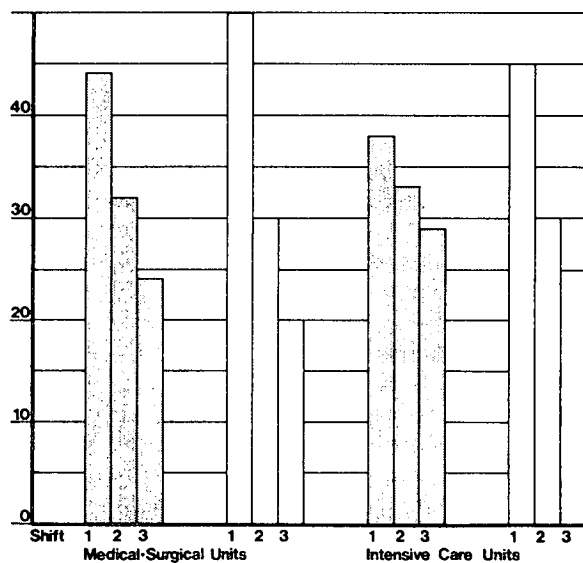
General Hospitals

The children's hospitals' nursing departments have proportionally more highest level staff (RNs) and fewer lower level staff (LPNs and aides) than do the general hospitals.

The distribution of shift staffing in the children's hospitals is more uniform than in the general hospitals. While the general hospitals have a 50%, 30%, and 20% distribution of nursing staff on the first, second, and third shifts respectively in medical-

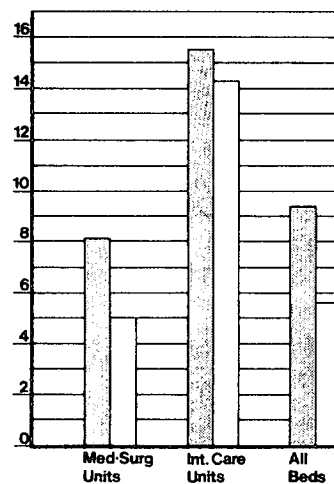
surgical units, in the children's hospitals the shift distribution is 44%, 32%, and 24%; similar to the more even distribution of nursing staff in adult intensive care units (45%, 30%, and 25%). The shift distribution of nursing staff in the children's hospitals' intensive care units has an even more uniform distribution (38%, 33%, and 29%) than the adult intensive care units of the general hospitals. These results are consistent with the findings (developed in Chapter 2)

### Nurse Staffing-Distribution by Shift of Duty



KEY: Children's Hospitals General Hospitals

### Nurse Staffing-Inpatient Hours per Patient Day



that patients in the children's hospitals are generally more ill and therefore require a more intensive and more uniform level of nursing care throughout the 24-hour day, as compared with adult patients in the general hospitals.

The children's hospitals have much larger outpatient departments than the general hospitals; the former have proportionally almost five times as many outpatient visits as the general hospitals. The average number of nursing staff utilized by the children's hospitals per 1,000 outpatient visits (0.45 FTEs per 1,000 visits) is approximately 25% less than that of the general hospitals (0.61 FTEs per 1,000 visits).

Aside from having a greater proportion of nursing staff in the children's hospitals assigned to outpatient activities (11% in the children's hospitals as compared with 5% in the general hospitals), the percent allocation of nursing staff to functional areas, such as for inpatient care, unit management/clerical, inservice orientation and training, and nursing administration, is very similar to that of the general hospitals, despite the greater complexity of care of the children's hospitals.

### WORK SAMPLING RESULTS

Patients in the children's hospitals' medical-surgical and intensive care units require both more total hours and more "Patient Direct Care Related" hours per inpatient care day than do adult patients in the general hospitals' units. The additional time spent by the nursing staff is devoted to the complete spectrum of nursing care activities, both direct care and indirect care related. Due to the intensive care requirements, the additional hours are not associated with time spent explicitly on emotional/social support activities; this support is provided in conjunction with other direct care nursing procedures and activities. In the children's hospital and the general hospital pediatric units, outside non-hospital people (i.e., non-staff, principally parents) provide a significant amount of time to such support activities, although in lesser amounts in the intensive care units due to the more severe illness of the children in such units. Presumably, even more nursing staff time would be required if this "volunteer time" were not available.

### SPECIFIC NURSING PROCEDURES

In both pairs of hospitals studied, all four nursing procedures studied (providing feeding assistance, instituting IV therapy, administering medications, and

taking of vital signs) take either significantly more staff minutes to carry out with patients in the children's hospitals as compared with adult patients in the general hospitals, or take the same amount of time. Instituting intravenous therapy and taking of vital signs require significantly more staff minutes in both of the children's hospitals than in the paired general hospitals. Administering medications takes significantly more time in one of the children's hospitals as compared with its paired general hospital and takes the same amount of time in the other pair of hospitals. While feeding assistance takes the same amount of time per patient in the children's and general hospitals, the proportion of patients requiring such feeding assistance is 2.5 and four times greater in the two children's hospitals as compared with their paired general hospitals. About twice as many patients require intravenous therapy in the children's hospitals as in the paired general hospitals.

\* \* \*

The overall conclusions, using several different methodologies, are consistent internally and with the conclusion that the average patient in the children's hospitals requires a more intensive and more uniform level of nursing care, by higher level staff, than adult patients in the paired general hospitals. The additional requirements total 60% to 70% more hours per inpatient care day in the children's hospitals than in adult units of the general hospitals. The difference in requirements is less pronounced in the intensive care units, but is still higher in the children's hospitals' intensive care units. The greater amount of care and nursing staff required by the children's hospital patients would be even greater, were it not for the significant amount of time provided by parents in the pediatric units. The number of nursing hours per inpatient care day provided in pediatric units of the general hospitals is similar to that of the medical surgical units in the children's hospitals, but this is related primarily to the smaller bed size and lower patient census of the general hospital pediatric units, requiring proportionally a greater nursing staff.

### 3.4 Ancillary and Support Services Staffing

Data was collected and analyzed on the number of full-time equivalent (FTE) employees in the study group of children's and general hospitals, for 14 selected ancillary services. The total number of FTE employees in each of the ancillary services is

analyzed as a ratio per 10,000 adjusted inpatient care days.\*

Of the 14 ancillary services selected for study, six services are excluded from the comparative analyses because only four or fewer of the nine pairs of hospitals reported FTE staffing data (representing less than 50% of the total sample). The six ancillary services thus excluded from the analyses are: clinical psychology, nuclear medicine, patient education, recreational therapy, and therapeutic radiology. For the remaining ancillary services studied, the analyses of FTE personnel per 10,000 adjusted inpatient care days are summarized as follows:

<b>FTE PERSONNEL PER 10,000 ADJUSTED INPATIENT CARE DAYS</b>		
	<b>CHILDREN'S HOSP.</b>	<b>GEN. HOSP.</b>
Electrocardiography (ECG)	0.6	0.6
Electroencephalography (EEG)	0.4	0.1
Laboratories	9.9	5.0
Pharmacy	2.2	1.3
Physical Therapy	1.2	0.9
Radiology, Diagnostic	3.9	2.8
Respiratory Therapy	2.4	1.9
Social Work	1.4	0.4

The children's hospitals average 1.3 FTE staff per 1,000 procedures, in the electrocardiography (ECG) service, as compared with 0.5 FTE's per 1,000 procedures for the general hospitals. In the electroencephalography (EEG) service, the children's hospitals average 1.9 FTE's per 1,000 procedures as compared with 1.4 FTE's for the general hospitals.

Correlations of FTE staffing to units of services (i.e., workload) could not be made for the other ancillary services because of obvious inconsistencies (between paired hospitals, among the children's hospitals, and among the general hospitals) in data recording and reporting methods (e.g., variations in counting "tests" or "procedures" or "exams").

The inadequacies in data reporting systems, and inconsistencies in methods of tabulating units of services rendered, preclude a valid comparison of the children's hospitals' and the general hospitals' ancillary services staffing for inpatient and outpatient care programs, and for staffing ratios related to volumes of services rendered. These apparent inconsistencies in methods of recording and repor-

\*For purposes of consistent comparisons, outpatient visits are defined as including visits to organized outpatient clinics, and emergency rooms, but excluding "referred" visits solely for diagnostic-therapeutic services; and the adjustment is made on the basis of 5 outpatient visits equivalency to one inpatient care day.

ting caseload volumes for ancillary services are not unique to this study nor to the study group of hospitals. It is a national problem which affects the planning of staffing, financing, and facilities for ancillary services of hospitals throughout the country. The problem is further compounded by the failure or inability of hospitals to accurately record units of ancillary services allocated to inpatients versus outpatients. In many cases, the data is aggregated or, when workloads are differentiated, the allocation is often made on the basis of arbitrary ratios.

\* \* \*

The children's hospitals in the aggregate have higher ratios of full time equivalent personnel in most ancillary services than do the general hospitals. The manhour effort required to perform diagnostic and therapeutic procedures on infants and children, and the higher incidence of high intensive specialty care services in the children's hospitals and the resultant demands upon ancillary diagnostic and therapeutic services, are believed to be major contributing factors to these staffing differentials.

On the average, the children's hospitals and the general hospitals utilize the same number of FTE dietary personnel per maintained bed (0.13 FTE) allocated to inpatient feeding services. The children's hospitals average 2.2 meals served to inpatients per inpatient care day as compared with 2.8 meals in the general hospitals; this finding correlates to the higher volume of intravenously fed patients in the children's hospitals (Section 3.3—Nurse Staffing) and to the volume of pediatric patients on formula feeding. The children's hospitals average 0.11 FTE dietary staff per maintained bed for staff and visitor feeding as compared with 0.06 FTE's in the general hospitals; the greater number of personnel in the children's hospitals is a contributing factor to this differential.

On the average, there are nearly twice as many FTE housekeeping employees per maintained bed in the children's hospitals as in the general hospitals. However, a correlation of housekeeping FTE's to gross building area demonstrates that the children's hospitals average 1.67 FTE's per 10,000 gross sq. ft. as compared with 2.13 FTE's in the general hospitals.

### **3.5 Interns and Residents, Education, Research, and Community Service Costs**

All of the children's hospitals in the study group reported having graduate medical education (interns and residents training) programs, as compared with only three of the nine general hospitals. The average



net cost (after related revenue) of these programs is about twice as great in the children's hospitals—averaging about \$17 per adjusted inpatient care day and almost 6% of total operating expenses as in the general hospitals.

All of the study group of hospitals reported having other education programs.\* The average net cost of such programs is about four times as great in the children's hospitals—averaging almost \$6 per adjusted inpatient care day and about 1.4% of total operating expenses as in the general hospitals.

Costs of organized research programs were reported by eight of the nine children's hospitals, but by only one of the general hospitals. In the eight children's hospitals reporting research program costs, the average net cost is about \$4 per adjusted

inpatient care day and represents about 1.25% of total operating expenses.

Only two of the general hospitals reported costs associated with community service programs\*\* as compared with seven of the nine children's hospitals. Among the hospitals reporting such programs, the average net cost in the children's hospitals is about 7 times greater—averaging about \$1 per adjusted inpatient care day—than in the general hospitals, and represents about 0.4% of total operating expenses in the children's hospitals.

In the aggregate, these cost elements are four to six times greater in the children's hospitals as in the general hospitals and demonstrate one of the major programmatic differences which distinguish children's hospitals from comparably bed-sized general hospitals.

### Average Net Cost Per Adjusted Patient Care Day

	General Hospitals	Children's Hospitals
Interns & Residents	\$6.76	\$17.12
Other Education	1.38	5.75
Research	0.11	3.70
Community Services	0.17	1.01

### 3.6 Occupancy, Fiscal, Administrative, and Non-Payroll Variable Costs

The average total occupancy costs (including housekeeping, plant operation, security, and related costs) are slightly less in the children's hospitals—averaging about 9.5% of total operating costs and about \$6.50 per gross square foot of building—than in the general hospitals.

The average total fiscal service costs (including general accounting, admitting, data processing, and related costs) are slightly lower in the children's hospitals as a ratio of total operating costs (5.5%), but slightly higher as a cost per thousand dollars of gross revenue (\$54), as compared with the general hospitals.

The average total administrative costs (including personnel, receiving and stores, purchasing, public relations, malpractice and other insurance, and

related costs) are about twice as high in the children's hospitals—averaging about 8% of total operating costs and about \$2 per adjusted inpatient care day—as in the general hospitals. Within this cost category, malpractice insurance costs per adjusted inpatient care day are over three times as high in the children's hospitals as in the general hospitals.

The aggregate average cost of occupancy, fiscal services, and administrative costs, represents only a slightly larger percentage of total operating expense in the children's hospitals (about 23%) than in the general hospitals (about 22%); these aggregate costs translate into an average cost per adjusted inpatient care day in the children's hospitals (about \$66), which is almost twice as much as in the general hospitals (about \$37).

Much of the differential in fiscal service costs between the two groups of hospitals arises from the higher costs of general accounting services and particularly data processing in the children's

\*Defined as formally organized or planned programs of study, including inservice training, but excluding programs included in "Interns and Residents."

\*\*Defined as programs or services rendered to the community, which are not directly related to inpatient or outpatient care, medical education, or research.

hospitals. Because the children's hospitals offer a broader range of patient care services and programs (as summarized in Section 3.1) they are likely to require more sophisticated data processing systems. In addition, the treatment of more medically complex cases in the children's hospitals is likely to be reflected in higher bills to third party payers for non-routine services; such bills are frequently questioned by third parties, which may require additional information and reprocessing efforts by both the accounting and data processing departments. The larger volume of outpatient visits in the children's hospitals also contributes to increased workload and costs in the areas of accounting and data processing.

The higher costs for administration functions in the children's hospitals may be partially explained by the larger number of management personnel required to manage and coordinate the broad spectrum of services and programs found in urban, teaching hospital referral centers.

Personnel costs are also understandably higher in that the children's hospitals have a higher staff to patient ratio as well as a greater percentage of higher level personnel, such as registered nurses. Therefore, the children's hospitals require larger personnel departments with programs directed at recruiting and maintaining highly skilled personnel.

There are several possible reasons for the higher cost of public relations in the children's hospitals. One is that the children's hospitals offer more community service programs; the nature of these programs must be communicated to the community periodically. Another factor is that children's hospitals need strong public relations to generate the non-operating funds to underwrite their operating deficits.

Some of the factors seen as being largely responsible for the significantly higher cost of malpractice insurance in the children's hospitals are:

- The "long tail" on claims reflects the rights of injured minors to defer bringing their claims to court until several years after they have attained their majority. Typically, the amount awarded on such claims are higher in that there are more years of a life which have already been, and will be, affected by the injury, and there is strong jury sympathy for children who have been injured. Additionally, the effects of inflation on future monetary settlements must be considered. All of these factors increase the degree of risk and uncertainty to the insurance company, which translates into higher premiums.
- Children's hospitals typically employ more salaried physicians, and the full costs of malpractice insurance premiums for these physicians are usually borne by the hospital.

- The research orientation of the children's hospitals, coupled with the tertiary care services they offer, produce higher risk than is usually found in comparably sized general hospitals.

Studies by insurance specialists have shown that there are fewer claims for pediatric patients, as a group, but that there have been no published studies concerning malpractice insurance claims specifically in children's hospitals. If there are also fewer claims for pediatric patients in children's hospitals, these hospitals may be unjustly penalized, in that there are no separate experience ratings for children's hospitals. They are rated the same as general hospitals and the resulting premium rating figure is revised upward to reflect what the underwriter may perceive to be an increased risk.

Non-payroll variable costs include the costs of medical-surgical supplies, intravenous solutions, food and formulas, linen, radiology and laboratory supplies, and drugs. In the aggregate, such non-payroll variable costs average about \$36 per adjusted inpatient care day in the children's hospitals, which is about 50% greater than in the general hospitals. The high intensity of patient care, and the highly specialized services in the children's hospitals are contributing factors to the higher non-payroll variable costs as compared with the general hospitals.

### **3.7 Sources of Payment and Levels of Non-Compensated (Free) Care**

On the average, the children's hospitals deliver a significantly higher percentage of non-compensated (free) care averaging about 17% of total gross charges than do the general hospitals. Considering revenue from all sources of payment (third-party reimbursers and self-pay patients), the children's hospitals recover only about 93% of operating costs as compared with slightly over 100% of operating costs recovered by the general hospitals.

Most of the major sources of payment for both the children's hospitals and the general hospitals use "allowable cost" as the basis for reimbursement for patient care services. Such "allowable cost" frequently excludes, for purposes of reimbursement, the costs associated with the teaching and research oriented activities found in much greater volume in the children's hospitals.

## Sources of Payment Recovery of Patient Care Costs

Source of Payment	Gross Charges as % of Total Revenue		% of Cost Recovered	
	General	Children's	General	Children's
Federal—Title 5	—	1.5	100.5	99.4
Federal—Title 18	36.9	1.2	97.2	85.0
State—Title 19	7.5	23.7	98.2	89.9
City & County	0.1	1.8	107.3	99.6
Blue Cross	20.2	24.7	110.2	106.1
Commercial Insurance	23.0	28.8	118.0	112.9
Self-Pay	11.3	16.3	57.0	49.3
Grants	—	0.7	—	103.6
Other	1.0	1.3	121.0	98.5
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>101.7%</b>	<b>93.1%</b>

The children's hospitals appear to be reimbursed more slowly than are the general hospitals; a greater proportion of the children's hospitals' total accounts receivable are found in the "over 60 days" categories. At least in part, the high proportion of "aged" accounts is related to the children's hospitals' greater dependency upon Medicaid (Title 19) reimbursement (about 24% of total revenue) which is traditionally very slow in making reimbursement. Furthermore, the amounts of charges for specialty care services rendered to the high-intensive care patients treated, frequently subjects the children's hospitals to billing audits, re-submissions, and resultant delays in receiving reimbursement.

In most of the hospitals studied, Blue Cross and Medicaid reimbursement (which together account for almost one-half of the children's hospitals' total revenue) are based on a cost or "cost plus" method for inpatient care. Cost reimbursement for the hospital services that are provided to program beneficiaries is based upon allowable costs and, therefore, may not fully recognize the costs of some of the specialized programs and services provided by the children's hospitals. More importantly, Medicaid and some of the other third-party payers generally exclude bad debts expense and non-compensated (free) care from reimbursement.

One possible way to recover these losses is to raise the level of gross charges. This approach shifts more of the burden to self-paying patients and to charge-based third-party payers (e.g., Commercial Insurance and Blue Cross, in some cases). The ultimate effect, however, is to increase the self-pay

component of revenue. However, the study data indicates that a significant percentage of such self-pay charges is likely to become bad debts and free care in the children's hospitals.

\* \* \*

These findings suggest that the children's hospitals, as a group, need to arrange with third-party payers more reasonable methods of reimbursement, which take into account the services and programs offered in children's hospitals.

A major conclusion deriving from the findings is that the children's hospitals have a great dependency upon non-operating revenue sources (endowments, charitable gifts, etc.) to bear their losses on non-compensated (free) care, bed debts, and third-party reimbursement allowances.

### 3.8 Capital Construction Costs

From architectural plans provided by each of the children's and general hospitals in the study group, detailed space allocations were made of all existing in-use areas to 63 standard "usage categories". These 63 categories were regrouped into 18 "functional groupings" including: inpatient services, outpatient services, ancillary (diagnostic and therapeutic) services, administrative services, general and supply services, plant operation, education and research, and other, with sub-groupings in many cases.

On the average, the children's hospitals have more than double the gross area per bed than the general hospitals. The major differences in gross area per bed are in inpatient care facilities, especially in intensive care (the children's hospitals have more than three times as much area per bed as the general hospitals); outpatient services (the children's hospitals have about 11 times as much area per bed as the general hospitals); and education and research (the children's hospitals have about 6½ times as much area per bed as the general hospitals). In all of the functional groupings, the children's hospitals exceed the general hospitals in area per bed.

On the basis of the average area per bed allocations derived, a "model" is projected for a "prototypical" 250-bed children's hospital and a 250-bed general hospital, to "average out" differences in building ages, in program variations, and in geographic/climatic factors affecting space needs. Unit costs per gross square foot are assigned to each of the functional groupings to allow for cost related differences in electro-mechanical systems, finishes, structure, fixed equipment, etc. By applying unit costs

per gross square foot to the derived space allocations per functional grouping, a "prototypical" capital construction cost is developed for each "model" 250-bed hospital. Uniform "other costs" (architect/engineer fees, movable equipment and furnishings, etc.) are applied as percentages of the construction costs, to derive project costs. The project cost so developed is about 2.4 times as high for the "model" 250-bed children's hospital as for the "model" 250-bed general hospital.

Applying uniform assumptions regarding project financing (amount and term of borrowing, interest rates, etc.), and based upon the study's findings regarding average inpatient occupancy rates and outpatient visit volumes, the project costs are translated to per diem costs per adjusted inpatient care day for project amortization (principal, interest, and depreciation) for the "prototype" 250-bed children's hospital and general hospital. This methodology indicates that the average annual cost per adjusted inpatient care day for depreciation and interest in the children's hospital (about \$48) is more than double the cost in the general hospital.

## Space Allocations

Sq. Ft. Per Bed (Average)

Inpatient Services	329	17.0	262	33.6
Outpatient Services	157	8.1	25	3.2
Ancillary D & T Services	331	17.1	133	17.0
Administrative Services	279	14.4	95	12.2
General & Supply Services	197	10.2	90	11.5
Plant Operation & Circulation	459	23.7	153	19.7
Education & Research	167	8.6	13	1.6
Other	17	0.9	9	1.2
<b>Total</b>	<b>1,936 Sq. Ft.</b>	<b>100%</b>	<b>781 Sq. Ft.</b>	<b>100%</b>
	<b>Children's Hospitals</b>		<b>General Hospitals</b>	

## 4. REPORT OF SPECIALTY ADVISORY TASK FORCE

Pursuant to the study protocol, a Specialty Advisory Task Force (Task Force) was convened. The purposes of the Task Force, as expressed in the study protocol, were to obtain a review and comment of the study's findings with respect to:

- The application of the study's findings and conclusions to the pediatric departments and services of major university-based teaching medical centers.
- The application of the study's findings and conclusions to specialized children's health care institutions.
- The appropriateness of the methodology and of the conclusion reached as supported by the findings and data analyses.

The Task Force members were provided with copies of the study protocol and of the complete study report. A one-day conference was held at which the Task Force discussed the entire study report in depth. The following constitutes a summary of their review and comments.

### GENERAL CONCLUSION

The NACHRI study represents a significant achievement in documenting the major characteristics which distinguish: pediatric care from adult care; and pediatric care in children's hospitals from pediatric care in general hospitals; and children's hospitals from general hospitals of comparable bed size.

The NACHRI study findings and the conclusions derived are applicable to the pediatric departments and services of major university teaching medical centers, especially with regard to differences in nurse staffing (nursing care needs and ratio of RN's), regional referral (patient origin) patterns, ancillary services staffing, cost reimbursement, occupancy patterns, and space needs, as compared with the adult medical surgical services within the same medical centers. The study findings and conclusions appear to be less applicable to differentials between pediatric and adult care services of major medical centers with regard to intensive care unit occupancies, intern and resident costs, other education costs, and certain components of intensity of care.

The NACHRI study findings and the conclusions derived are particularly applicable to the pediatric departments and services of major university teaching medical centers, in all respects, as compared with community general hospitals, especially with regard to differences in intensity of care, nurse staffing, regional referral patterns, levels of tertiary care specialty services and outpatient services, intern and resident and other education costs, research costs, levels of non-compensated (free) care, ancillary services staffing, non-payroll variable costs, and space needs and construction costs.

The NACHRI study findings and conclusions are applicable to pediatric specialty care institutions (rehabilitation and long term care, mental health and psychiatric, etc.) as compared with adult specialty care institutions of similar type, particularly with regard to differences in nurse staffing and ancillary services staffing, regional referral patterns, occupancy, intern and resident and other education costs, research costs, reimbursement, and space needs and construction costs.

### COMMENTS AND IMPRESSIONS

The NACHRI study findings and their applicability to the pediatric departments and services of major medical centers and to pediatric specialty care institutions demonstrate that much of the staffing and other cost differences are inherent in the nature of the care needs of children with complex illness.

Many of the factors underlying staffing and other cost differences are related to greater intensity of care and to the complexity of specialty services, provided by the children's hospitals, the pediatric specialty care institutions, and the pediatric departments of major medical centers. In this regard especially, the NACHRI study has provided invaluable information on the uniqueness of pediatric care needs and the cost implications thereof.

While the major thrust of the NACHRI study is to compare children's hospitals to general hospitals of similar bed size—a comparison currently imposed by the practices of reimbursement and regulatory agencies—it would be extremely informative to apply the NACHRI study methodology to a study group of pediatric services of major university-based teaching hospitals as a third comparison group.

The NACHRI study will be extremely helpful to

individual pediatric care institutions in demonstrating to their own governing boards and to outside agencies that they are not "out of step" with children's institutions throughout the country, as compared with similar sized general hospitals.

The dependency of children's hospitals on endowments, charitable contributions, and similar non-operating revenue sources demonstrates the fragile condition of the financing of child health services in particular. The continued inadequate funding of pediatric care will produce dire consequences for the health of children as a whole and not merely for pediatric care institutions, if solutions for adequate financing of children's health care are not found in the future.

Any national health insurance program for pediatric care should relate reimbursement to case mix and to intensity of care, or it will penalize the pediatric care referral centers and the pediatric care specialty institutions. Such a reimbursement scheme will necessitate uniform reporting systems in pediatric care institutions, recognizing the difficulties this may impose and notwithstanding the multiple reporting requirements imposed by different national and state regulatory and reimbursement agencies.

The invited members of Task Force were:

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| Barbara Bishop, R.N., M.N.<br>Editor                                   | <i>MCN, The American<br/>Journal of Maternal<br/>Child Nursing</i><br>New York, New York   |
| Burr H. Curtis, M.D.<br>Medical Director Emeritus                      | Newington Children's<br>Hospital<br>Newington, Connecticut   |
| Paul C. Laybourne, M.D.<br>Professor of Psychiatry<br>& Director       | Division of<br>Child Psychiatry<br>University of Kansas<br>College of Health Sciences<br>and Medical Center<br>Kansas City, Kansas |
| Jimmy L. Simon, M.D.<br>Professor &<br>Chairman                        | Dept. of Pediatrics<br>Bowman Gray School of Medicine<br>Wake Forest University<br>Winston-Salem, North Carolina                   |
| James L. Talbert, M.D.<br>Professor of Surgery and<br>Pediatrics Chief | Division of<br>Pediatric Surgery<br>College of Medicine<br>University of Florida<br>Gainesville, Florida                           |