aamc association of american medical colleges

# AGENDA

## FOR

# COUNCIL OF TEACHING HOSPITALS

# ADMINISTRATIVE BOARD MEETING

**SEPTEMBER 25, 1980**

**WASHINGTON HILTON HOTEL**

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

# MEETING SCHEDULE
# COUNCIL OF TEACHING HOSPITALS
# ADMINISTRATIVE BOARD

September 24-25, 1980
Washington Hilton Hotel
Washington, D.C.

## WEDNESDAY, September 24

| | | |
|---|---|---|
| 2:00pm | COTH Administative Board Discussion | Map Room |
| 3:30pm | Joint Board Discussion with COTH/ CAS/COD | Conservatory Room |
| 4:30pm | Joint Board Discussion with AAHC President John Hogness, MD | Conservatory Room |
| 6:00pm | COTH Administrative Board Meeting | Hamilton Room |
| 7:00pm | COTH Reception | Independence Room |
| 8:00pm | COTH Dinner | Hamilton Room |

## THURSDAY, September 25

| | | |
|---|---|---|
| 9:00am | COTH Administrative Board Business Meeting | Kalorama Room |
| 12:30pm | Joint Administrative Board Luncheon | Map Room |
| 2:00pm | Executive Council Business Meeting | Military Room |

COUNCIL OF TEACHING HOSPITALS
Administrative Board
Meeting

September 24-25, 1980
Washington Hilton Hotel

9:00 a.m. - 12:30 p.m.

# A G E N D A

| | | |
|---|---|---|
| I. | Call to Order | |
| II. | Consideration of Minutes | Page 1 |
| III. | Membership Application<br>National Jewish Hospital & Research Center - National Asthma Center | Page 13 |
| IV. | Progress Report on Case Mix Project | Mr. Levitan |
| V. | National Resident Matching Program Institution Agreement | Dr. Match<br>Page 23 |
| VI. | Review and Comment: Draft Report of the Ad Hoc Committee on Competition | Page 28 |
| VII. | Proposed AAMC Bylaw Change | Executive Council Agenda Page 27 |
| VIII. | Coordinating Council on Medical Education/ Council for Medical Affairs | Executive Council Agenda Page 28 |
| IX. | General Requirements of Accredited Residency Programs | Executive Council Agenda Page 33 |
| X. | LCGME Subspecialty Accreditation Report | Executive Council Agenda Page 34 |
| XI. | Medicare's "Moonlighting" Policy | Executive Council Agenda Page 35 |

| | | |
|---|---|---|
| XII. | Universal Application Form for Graduate Medical Education (form enclosed) | Executive Council Agenda Page 41 |
| XIII. | LCCME 1981 Budget | Executive Council Agenda Page 42 |
| XIV. | Report on the Commission on Professional and Hospital Activities | John Bassett, President, CPHA |
| XV. | Discussion Items | Executive Council Agenda Pages |
| | 1. Health Research Legislation | 46 |
| | 2. Health Manpower | 48 |
| | 3. Medical Sciences Knowledge Profile Program 1980 Experience | 50 |
| | 4. Graduate Medical Education National Advisory Committee | 52 |
| XVI. | Information Items | |
| | 1. Letter to Marc J. Roberts, PhD | Page 62 |
| | 2. COTH Membership Terminations as of January 1, 1980 | Page 64 |
| | 3. A Requiem for the University Hospital | Page 65 |
| | 4. University of Connecticut Certificate of Need Experience | Page 73 |
| XVII. | Adjournment | |

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
June 26, 1980

# M I N U T E S

PRESENT:

John W. Colloton
Stuart J. Marylander, Chairman-Elect
Robert M. Heyssel, M.D., Immediate Past Chairman
Mitchell T. Rabkin, M.D., Secretary
Dennis R. Barry
James W. Bartlett, M.D.
Robert E. Frank
Earl J. Frederick
Mark S. Levitan
Malcom Randall
John A. Reinertsen
Elliott C. Roberts, Sr.
Kevin Hickey, AHA Representative

ABSENT:

Fred J. Cowell
Robert K. Match, M.D.

GUEST:

Charles B. Womer

STAFF:

Peter W. Butler
James B. Erdmann, Ph.D.
James I. Hudson, M.D.
Joseph C. Isaacs
Thomas J. Kennedy, M.D.
Richard M. Knapp, Ph.D.
Thomas E. Morgan, M.D.
Penny Roberts
August G. Swanson, M.D.
Melissa H. Wubbold

I. Call to Order

Mr. Colloton called the meeting to order at 9:00 a.m. in the Edison Room of the Washington Hilton Hotel. He then introduced an unscheduled presentation by Dr. Morgan.

II. Disposal of Radioactive Wastes from Biomedical Institutions

Dr. Morgan distributed a self-explanatory position paper on this subject for the Administrative Board's information, discussion and comment. He provided background on the issue and reviewed the contents of the position paper, explaining that it (and the recommendations put forth) was a product of the efforts of a working group assembled under the auspices of the AAMC, the National Association of State Universities and Land Grant Colleges (NASULGC), and the Association of American Universities (AAU). The recommendations of the working group have been presented in testimony before the President's newly formed Radiation Policy Council. Dr. Morgan reported that the premise of the position paper, if not its basic recommendations, has been accepted by the Council. He believes the working group approached its charge in a cost-conscious manner. The American Hospital Association (AHA) has called for the deletion of Recommendation V which suggests that wastes generated by biomedical isotope and radiopharmaceutical manufacturers receive priority and preferential access to national waste disposal sites. The AHA believes that support of special treatment for these middle level radioactive waste products will serve to mask the low level problem of our biomedical institutions.

Dr. Rabkin believed the public needed to be educated on the issue of low level radiation. Dr. Heyssel thought the biggest issue is pyrolysis and incineration, and the public response to putting radiation into the air. He noted that the cost of shipping liquid scintillation vials to nuclear waste dump sites has grown sharply, doubling over the past few years, and reported that Hopkins is going to use incineration in the future. Dr. Morgan believed that the Hopkins decision was wise since the present laws permit low cost incineration, but hospitals continue to ship their low level wastes at significantly higher costs. Discussion ensued on the topics of educating the public, pyrolysis, and the "certificate of need" aspects of building new incinerators at hospitals.

III. Consideration of Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the March 20, 1980 COTH Administrative Board Meeting, subject to inclusion of Dr. Bartlett as present at that meeting.

IV. Membership Applications

Mr. Butler reviewed four applications for COTH membership. Based on staff recommendations, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve the Community Hospital of Indianapolis, Inc. for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve the Santa Clara Valley Medical Center for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve the University of Texas System Cancer Center (M.D. Anderson Hospital and Tumor Institute) for COTH full membership.

ACTION: It was moved, seconded and carried to approve the Veterans Administration Medical Center, Salem, Virginia for COTH corresponding membership.

V. Rumored Amendments to Senate Health Manpower Legislation

Dr. Kennedy reviewed this agenda item for the Board's consideration, noting that it is anticipated that Senate health manpower legislation (S. 2375) will contain provisions that would recognize chiropractic services and schools of chiropractic for eligibility for programs under the law, as described on page 39 of the Executive Council Agenda. He reported that a study of the supply and demand for chiropractic services was understood to have been contracted out to the Foundation for the Advancement of Chiropractic Tenets and will be published sometime soon. In addition, Dr. Kennedy noted that Clinical Psychology had been added to the list of eligible health professions in the Senate proposal. He then reviewed the staff's recommendation that the Executive Council adopt a formal position opposing the chiropractic-related amendments.

Mr. Randall wondered whether this issue was a "spin-off" of the discussion being heard in the VA system regarding the hiring of chiropractors. Mr. Colloton asked whether staff was calling for opposition to the chiropractic amendments on the basis of "cost" or "principle". Dr. Kennedy explained that the opposition was based on the "principle" of opposing recognition of a non-accepted scientific health profession until sufficient data and evidence has been compiled to support its treatment as an established bona fide scientific health profession. Until such evidence for approval is developed, it was felt that financial support should not be directed to chiropractic services and away from established health professions which are currently fighting for their funding. Dr. Heyssel opposed the staff

recommendation because he felt the AAMC would be too self-righteous philosophically in protecting the public from a service that it should have the "freedom of choice" to pursue. Dr. Rabkin believed that chiropractors were "technicians" and should not be treated equally with "practitioners" of established health professions. Subsequent to further discussion, the following action was taken on a vote of eleven "yeas" and one "no" by Dr. Heyssel.

ACTION: It was moved, seconded and carried to recommend that the Executive Council adopt a formal position opposing the chiropractic-related amendments in the Senate health manpower legislation.

VI. Discussion of COTH Annual Meeting Program and COTH Spring Meeting

Mr. Colloton provided an update on the "university teaching hospital study" proposed by the Consortium led by John Westerman and Jep Dalston. He stated that the AAMC's Executive Committee expressed interest in the study earlier this year and that a letter from Dr. Cooper to Mr. Westerman and Dr. Dalston indicated this. A meeting between the Executive Committee and representatives of the Consortium was held at the annual COD meeting in April, at which the Executive Committee delineated what it saw as the AAMC's role in relation to the study. The AAMC would: (1) appoint a steering committee to oversee the project; (2) try to secure financial support for the study; (3) serve as fiscal agent for the study; and (4) provide logistical support from the Department of Teaching Hospitals staff in undertaking and completing the study. It was recommended that these provisions be put in writing by the Consortium as part of the focus and structure for the study. The Consortium did not respond to this recommendation.

A meeting of the university-owned members of COTH was set up by Dr. Dalston at the COTH Spring Meeting in Denver, at which the study methodology and themes were discussed. After the meeting, the AAMC suggested that Dr. Dalston and Mr. Westerman develop a refined document on the organizational focus and structure for the proposed study. Since that time, three drafts of such a document have been proposed, each one moving closer to formal sponsorship by the AAMC, with a steering committee chairman chosen by the AAMC and at least one member from the AAHC Directors and at least one from the AAU presidents. In addition, the AAMC feels the study will have to be structured around a sub-group of COTH members, rather than the Consortium members as they had proposed. It is hoped that the next draft, expected in

September, will have completely incorporated the Executive Committee's concepts. According to the drafts already seen, the "focus" of the study will initially be on governance, mission and finance. Dr. Knapp hoped that after the organizational aspects of the study were settled, the Steering Committee could address the managerial prerogatives and operational problems that must be faced if the study objectives are to be achieved. Further discussion on potential managerial constraints and the role of the AAHC followed. Mr. Colloton reported on the joint AAMC/AAHC meeting held on April 18 in Chicago, which he called "constructive". He noted that representation of the COTH Chairman on their AAHC Committee of Presidents was favorably discussed.

The Board next discussed the 1980 Spring Meeting held in Denver. Mr. Colloton stated that the general consensus among those who attended the meeting was that it was definitely a good meeting. Dr. Knapp reported that there were approximately 165 registrants and that it was generally felt that the meeting went well in terms of attendance, location and, for the most part, speakers. Dr. Rabkin and Mr. Marylander commended the 1980 Planning Committee and staff on their efforts. Mr. Marylander then announced the 1981 COTH Spring Meeting Planning Committee would be chaired by Dr. Bartlett. Other Committee members include: J. Robert Buchanan, MD, President, Michael Reese Hospital; John E. Ives, Executive Director, Shands Teaching Hospital; Sheldon S. King, Director of the University of California-San Diego Hospital; and Al Zamberlan, Director of the VA Medical Center-Ann Arbor.

Dr. Knapp reported that staff recommended either Boston or Philadelphia as the site of the 1981 Spring Meeting. Mr. Hickey brought to the attention of the Board that the AHA's Annual Meeting would be held in Philadelphia in 1981. Boston was then informally approved by the Board as the next Spring Meeting site. Dr. Knapp stated that staff would follow-up on this, but warned that Boston hotels may already be booked. The question of a half-day joint COTH-CAS meeting at the Spring Meeting was also discussed. The Board's position was generally favorable. Dr. Heyssel suggested the topic of "departmental organization in the schools and hospitals" for the combined meeting and proposed a rotation wherein COTH would meet with CAS in 1981, COD in 1982, alone in 1983, CAS again in 1984, etc. if the topics for discussion between groups could remain of mutual interest and avoid hostility. A decision on a joint COTH-CAS meeting at the 1981 Spring Meeting was left to the discretion of the staff and Planning Committee. If and when such a meeting takes place, decisions on future joint council meetings would be made on the basis of this experience.

Dr. Knapp then turned the discussion to the 1980 COTH Annual Meeting and requested the Board's assistance on selecting topics

and securing speakers for the General Session. Mr. Marylander thought a session on "health care marketplace economics" would be current. Mr. Reinertsen suggested a session on "the relationship of programs in teaching hospitals to research as funds diminish for these purposes". Mr. Levitan recommended Irving Shapiro, Chairman of the Board at DuPont and a member of the University of Pennsylvania Hospital's Board of Trustees, as a potential speaker, Dr. Heyssel thought it might be worthwhile to examine the long list of top corporation executives in the Fairfield-Westchester County Council on Health up in the New York City area for possible speakers. He then suggested the topic of "high cost patients" and cited a recent article in the New England Journal of Medicine written by Doctor Moore and others on this subject. Following discussion, the staff was instructed to take action on Doctor Heyssel's suggested topic.

VII. Possible Meeting with National Commission on Research

Dr. Knapp explained that representatives and staff of the National Commission on Research (NCR) would like to meet with the Boards of the AAMC's Councils, either jointly or individually. CAS staff has suggested the evening of September 24 or the morning of September 25, just prior to the next Administrative Board meetings for the meeting. Most Board members felt a joint COTH/COD/CAS meeting with the NCR would be best, but left the final decision on the meeting to the discretion of the COTH Board Chairman in his discussions in the Executive Council session.

VIII. Relationships with the NBME

Dr. Swanson provided background on this agenda item and reviewed the 1976 AAMC response to the recommendations of the Goals and Priorities (GAP) Committee Report to the NBME, as presented on pages 59-60 of the Executive Council Agenda. Dr. Erdmann then discussed the most recent meeting of the NBME, at which a new prototype examination was unveiled and plans for its field testing were announced, failing to provide an opportunity for meaningful assessment from others. He noted that the new examination, the CQE (Certification Qualifying Examination), would have 700 test items (548 from the various parts of the current NBME examinations) and was heavily influenced in its development by the Federation of State Medical Boards, in an effort by the NBME to enhance its relationship with the Federation. Dr. Swanson expressed concern over the possibility of the Federation taking over control of the CQE, which would create a situation wherein licensing bodies would infringe on medical education. After listening to these presentations, the Board took the following action (as proposed

on page 52 of the Executive Council Agenda).

ACTION: It was moved, seconded and carried to recommend that the Executive Council appoint an ad hoc committee charged to examine these issues and recommend to the Council what actions are necessary to preserve and improve the relationship between the medical schools, their faculty, and the National Board of Medical Examiners and its examination programs.

IX. MSKP Program Ad Hoc Evaluation Committee

Dr. Swanson provided the background on this agenda item, explaining that the staff believes a small advisory committee should be formed to meet in the Fall for purposes of assessing the first year's experience with the Medical Sciences Knowledge Profile (MSKP) Program and recommending any necessary refinements. The Board was supportive of this proposal.

ACTION: It was moved, seconded and carried to recommend that the Executive Council approve the appointment of an ad hoc committee to evaluate the MSKP Program.

X. Distribution of Assembly Memoranda

Dr. Cooper reviewed this issue, expressing the belief that if AAMC pink memoranda are to be distributed to the Vice Presidents of academic health centers they should originate from the Association. The Board generally agreed.

ACTION: It was moved, seconded and carried to recommend that the AAMC distribute selected memoranda to the Vice Presidents of academic health centers.

XI. Senate Finance Committee Amendments to Reconciliation Legislation

Dr. Knapp reported that the Senate Finance Committee has submitted a number of Medicare-Medicaid amendments to the Budget Committee as its suggestions for areas of cost savings in the Congressional effort to reconcile the fiscal 1981 federal budget. Of particular concern, Dr. Knapp noted, was a provision included by Jay Constantine, Senate Finance Health Subcommittee Senior Staff member, that would give states discretion in arranging for care and services for Medicaid recipients through competitive bid contracts, thereby limiting the "freedom of choice" that Medicaid patients presently have in selecting providers. This amendment would purportedly save $97 million in fiscal year 1981. Recognizing the potential negative effects on teaching hospitals, Senator Ribicoff amended the provision so that states would be

required to avoid adversely impacting on access to hospitals with graduate medical education programs. Dr. Knapp stated that the AAMC, AHA and AMA have expressed opposition to the provision on the grounds that it would establish a two-class operating system for hospitals and hurt teaching hospitals particularly. He also noted that efforts to adopt such a provision in California, led by Beverlee Myers, Director of the State's Department of Health Services, had failed recently. In addition, he urged Board members to communicate with their respective legislators and convey their opposition to the amendment.

Dr. Heyssel felt that the amendment would establish "socially incorrect policy" which would make the assigned facilities "hospitals for the poor". Dr. Bartlett thought that in New York it might not be too bad to send poor patients elsewhere if equitability of reimbursement could be assured. Mr. Marylander believed that government rationing of health care was at issue and told of plans to visit with Representative Waxman. Dr. Knapp noted that Dr. Cooper would be meeting with Representative Tim Lee Carter on the issue.

XII. A Position Paper: The Expansion and Improvement of Health Insurance in the United States

Mr. Colloton reviewed this item for the Board, explaining that the paper was recently reviewed by the COD at its Spring Meeting in Fort Lauderdale, Florida. Only one minor wording change, from "propriety" to "appropriateness" on line 9 of page 24 in the Executive Council Agenda, was suggested. Mr. Marylander objected to the paper's failure to address the "financial commitment" necessary to undertake any major expansion of health insurance in this country. Mr. Colloton then directed attention to lines 17-25 on page 22 of the Executive Council Agenda which were added on this issue in response to earlier concerns expressed by Mr. Marylander. Mr. Levitan felt that the document was naively written, citing as an example the phrase "insurance companies should be requested to participate, as a social responsibility, in state or regional insurance pools..." (emphasis added). He thought the document was in need of more sophisticated wording. Dr. Cooper stated that compared to the Association's November 1975 policy statement, the current paper had come a long way toward expressing the AAMC's position in less nebulous, more definitive terms.

ACTION: It was moved, seconded and carried to recommend that the position paper on "The Expansion and Improvement of Health Insurance in the United States" be approved by the Executive Council as

the basis for AAMC policy on national health insurance. In addition, it is recommended that efforts continue to further refine the paper in the future.

The discussion then turned to Mr. Colloton's paper on "National Health Insurance and Its Implications for Academic Health Centers". A number of the Board members commended Mr. Colloton and his staff on producing an excellent paper. Mr. Colloton then talked about his April 21, 1980 presentation before the Assocation of American University presidents which was based on his paper. He noted the need to apprise the university presidents of the wide range of variability in financial support for, and personnel and other needs of, university teaching hospitals.

In light of potential enactment of some "competitive" approach to health care delivery or a national health insurance scheme, Mr. Colloton felt it was imperative to convey to the University presidents that the future financial difficulties of university hospitals and negative implications for graduate medical education and research could be devastating unless addressed now with their assistance. To demonstrate the wide ranging variability among university hospitals in various comparative statistical areas, Mr. Colloton distributed a table (see appendix A) on personnel per occupied bed figures for such hospitals as derived from the COTH Survey of University-Owned Hospitals' Financial and General Operating Data.
Mr. Colloton felt the federal government's concern for operating cost variability can be appreciated somewhat when the relative staffing ratios are compared. The variation was considerable and could prove too difficult to justify to third-party reimbursers, he warned. He stated that he had intended to advise that academic health centers conduct comprehensive analyses of hospital staff support to assist in determining if reallocations are indicated. However, he noted that the hand-out table was not distributed at the AAU presidents meeting in recognition of the sensitivity of the data and the presence of HHS Under Secretary Nathan Stark. He wondered whether he should now pursue his staffing analysis suggestion with the university presidents or just file the table away.

Further discussion on the hand-out table ensued. Mr. Levitan questioned the meaningfulness of the figures due to the failure to exclude outpatient personnel and contracted services from the calculations. Mr. Colloton emphasized that regardless of whether these figures are distorted, a wide ranging variance does exist and is worthy of further analysis. He then quoted Judith Lave of HCFA's Office of Research and Demonstrations who stated at the COTH Spring Meeting that, "Our preliminary studies indicate that even after accounting for proven case mix and educational components, there remains a great deal of variance among teaching hospitals in various statistical categories." Mr. Barry suggested that COTH might want to do a small sampling

of hospitals at the upper and lower ends of the range and carefully analyze with them their staffing ratios and the appropriate personnel adjustments that need to be made. With this data, he continued, a more accurate and realistic personnel per bed or occupied bed figure could be derived. Mr. Levitan suggested that personnel per admission data might even be more helpful. Dr. Knapp stated staff would examine ways of obtaining "cleaner" data in future "university-owned" surveys and look at other alternatives as well.

XIII. Reimbursement of Primary Care Residents Under Medicare Part B

Dr. Knapp reviewed this item, explaining that the Academy of Family Medicine has hired the services of Steve Lawton to help push a bill through Congress that would reimburse primary care residents under Medicare Part B. As originally drafted, the bill would allow residents in Family Practice, General Internal Medicine and Pediatrics to bill in their own names for physician services. He reported that he and Dr. Swanson had met with representatives from the Academy a number of times on the legislation and conveyed a negative position to them about the bill. They have since modified the bill to propose that Part B fees be allowed to be paid in the name of the clinic or program without identifying a physician or resident by name. Under this proposal, the Academy feels that hospital costs that are under Part B can be allocated to the outpatient department or clinic, having subtracted any salaries for supervisory physicians and residents. Though the salaries would not be reimbursable to the hospital, it would still be allowed other hospital costs through the clinic allocation under Part B. The reasoning behind the Academy's support of the legislation is essentially based on two premises: (1) that receipt of reimbursement of physicians' fees and the residents' share would be made easier by no longer requiring documented evidence of a supervising physician's presence and (2) greater revenue would be generated (however, Dr. Knapp noted, they have yet to provide figures demonstrating such a financial advantage).

Dr. Knapp then described his reasoning for opposing the bill. He was concerned that it would provide faculty a great deal of latitude to allow residents to do all of the work and return to a circumstance more prevalent eight or nine years ago -- a circumstance the Association has tried to reverse in an effort to encourage a single standard of care with faculty involvement across the board. In addition, he believed that to apply new rules in the primary care area would move others to ask why they should not apply them in other areas. If this occurred, Dr. Knapp thought that the faculty practice plans or physicians' fees would be asked to support resident stipends, a concept that practice plans would undoubtedly resist. He then reemphasized that he believed the disadvantages clearly outweighed the

advantages of the bill. Dr. Cooper then asked the Board to consider the issue and provide staff direction on whether the AAMC should support, not support, or remain neutral on the bill. After brief discussion, the Board took the following action:

ACTION: It was moved, seconded, and carried to recommend that the AAMC oppose the proposed legislation that would reimburse primary care residents under Part B of the Medicare program.

XIV. Tax Treatment of Residents' Stipends

Ms. Roberts provided background on this issue, as presented on page 40 of the Executive Council Agenda. She asked the Board to consider the possibility that now may be an appropriate time for the AAMC to seek a legislative clarification of the tax status of house staff stipends under the Internal Revenue Service Code. Dr. Heyssel asked why the issue was being brought before the Board now. Ms. Roberts cited the defeat of H.R. 2222, the publication of the AAMC Task Force Report on Graduate Medical Education, and the favorable Claims Court decision in Burstein vs. United States where the court ruled in favor of tax exemption on the basis of the "education" argument of the "education vs. service" dispute. She suggested that these occurrences may make legislation opportune at this time. After further discussion, the Board supported the following motion

ACTION: It was moved, seconded and carried to recommend that AAMC staff continue to monitor the issue of tax treatment of resident stipends prior to pursuing any definitive action.

XV. Required Residency Training Duration

Dr. Knapp explained that this item was placed on the Board's agenda in response to a letter from Dr. Harry Alvis, Director of Medical Education at Millard Fillmore Hospital in Buffalo, New York. Dr. Alvis requested guidelines on the treatment of house staff vacation time in relation to various certification requirements for a full"24 months of educational training". He noted that at Fillmore house staff currently would receive eight weeks or two months of paid vacation time during the required twenty four months of training. Dr. Knapp asked whether it would be best to refer Dr. Alvis to the LCGME for a response. After further discussion, the Board generally agreed that the issue was normally resolved on the basis of individual discretion and institutional prerogative, and that this view should be related to Dr. Alvis.

XVI. Adjournment

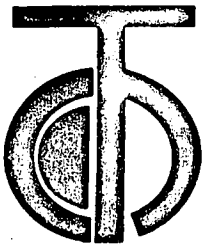
The meeting was adjourned at 12:20pm.

NATIONAL COUNCIL OF TEACHING HOSPITALS STUDY, PUBLISHED APRIL, 1980

COMPARATIVE NUMBER OF STAFF PER OCCUPIED BED
(Fiscal Year 1978)

| | Teaching Hospital | Personnel Per Occupied Bed (F.T.E.) |
|---|---|---|
| | **First Quartile** | |
| * 1. | Eugene Talmadge Memorial Hospital | ~~13.86~~ 6.63 |
| 2. | University of Massachusetts Hospital | 10.23 |
| 3. | University Hospital, University of Arkansas | 9.16 |
| 4. | University of California, Davis | 9.11 |
| 5. | Medical College of Pennsylvania and Hospital | 8.42 |
| 6. | U.C.L.A. Hospital and Clinics | 7.64 |
| 7. | University Hospital, University of Arizona | 7.01 |
| 8. | University of Texas Medical Branch at Galveston | 6.95 |
| 9. | North Carolina Memorial Hospital | 6.87 |
| 10. | University of California, Irvine Medical Center | 6.79 |
| 11. | University Hospital, University of California Medical Center, San Diego | 6.77 |
| 12. | Loma Linda University Medical Center | 6.71 |
| 13. | Confederate Memorial Medical Center, Louisiana State University | 6.69 |
| 14. | University of Missouri Medical Center | 6.40 |
| 15. | University of Kansas Medical Center | 6.37 |
| 16. | Medical University Hospital, Medical University of South Carolina | 6.25 |
| | **Second Quartile** | |
| 17. | University of Washington Hospitals | 6.13 |
| 18. | University of Connecticut Health Center - John Dempsey Hospital | 6.10 |
| 19. | Stanford University Medical Center | 6.05 |
| 20. | Rush-Presbyterian, St. Luke's Medical Center | 6.00 |
| 21. | Thomas Jefferson University Hospital | 5.97 |
| 22. | University of Chicago Hospitals and Clinics | 5.93 |
| 23. | University of Nebraska Medical Center | 5.87 |
| 24. | University of California Hospitals, San Francisco | 5.81 |
| 25. | University of Utah Hospital | 5.81 |
| 26. | University of Alabama Hospitals | 5.75 |
| 27. | Howard University Hospital | 5.69 |
| 28. | University of Minnesota Hospitals and Clinics | 5.68 |
| 29. | University of Illinois Hospital | 5.67 |
| 30. | University of Maryland Hospital | 5.66 |
| 31. | Martland Hospital CMDNJ | 5.61 |
| 32. | University Hospital, University of Michigan | 5.43 |
| | **Third Quartile** | |
| 33. | Indiana University Hospital | 5.38 |
| 34. | Vanderbilt University Hospital | 5.26 |
| 35. | Georgetown University Hospital | 5.18 |
| 36. | William A. Shands Teaching Hospital, University of Florida | 5.07 |
| 37. | State University Hospital of the Upstate Medical Center | 5.01 |
| 38. | Medical College of Virginia Medical Center | 5.00 |
| 39. | Cincinnati General Hospital | 4.88 |
| 40. | Hospital of the University of Pennsylvania | 4.87 |
| 41. | University of Wisconsin Hospitals | 4.80 |
| 42. | University Hospital, University of Oregon Health Sciences Center | 4.79 |
| 43. | The Milton S. Hershey Medical Center, Pennsylvania State University | 4.78 |
| 44. | Foster G. McGaw Hospital | 4.77 |
| 45. | Crawford W. Long Memorial Hospital | 4.70 |
| 46. | Ohio State University Hospitals | 4.68 |
| 47. | Medical College of Ohio Hospital | 4.63 |
| 48. | University Hospital, University of Mississippi | 4.66 |
| | **Fourth Quartile** | |
| 49. | State University Hospital, Downstate Medical Center | 4.62 |
| 50. | Duke University Hospital | 4.49 |
| 51. | University of Virginia Hospitals | 4.46 |
| 52. | Emory University Hospital | 4.45 |
| 53. | New York University Medical Center | 4.34 |
| 54. | Colorado General Hospital | 4.19 |
| 55. | West Virginia University Hospital | 4.18 |
| 56. | Temple University Hospital | 4.09 |
| 57. | University of Iowa Hospitals and Clinics | 4.05 |
| 58. | Albert B. Chandler Medical Center, University of Kentucky | 4.04 |
| 59. | Strong Memorial Hospital of the University of Rochester | 4.04 |
| 60. | University of South Alabama Medical Center Hospital | 3.89 |
| 61. | St. Louis University Hospital | 3.64 |
| 62. | George Washington University Hospital | 3.21 |

*NOTE: Subsequent to publication of the Fiscal Year 1978 COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data, Talmadge Memorial submitted revised F.T.E. personnel figures.



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: National Jewish Hospital & Research Center - National Asthma Center

Hospital Address: (Street) 3800 East Colfax Avenue

(City) Denver (State) Colorado (Zip) 80206

(Area Code)/Telephone Number: ( 303 ) 388-4461

Name of Hospital's Chief Executive Officer: Michael K. Schonbrun

Title of Hospital's Chief Executive Officer: Executive Vice President

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

### A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 200

Average Daily Census: 77

Total Live Births: --

Admissions: 955

Visits: Emergency Room: x

Visits: Outpatient or Clinic: 7,500

B. Financial Data

Total Operating Expenses: $22,000,000

Total Payroll Expenses: $13,200,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $750,000
Supervising Faculty: $ 80,000 (approx.)

C. Staffing Data

Number of Personnel: Full-Time: 800
Part-Time: 200

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 20
With Medical School Faculty Appointments: 20

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

Pediatrics

Medicine

Does the hospital have a full-time salaried Director of Medical Education?: No.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year: Not applicable

| Clinical Services Providing Clerkships | Number of Clerkships Offered | Number of Students Taking Clerkships | Are Clerkships Elective or Required |
|---|---|---|---|
| Medicine | | | |
| Surgery | | | |
| Ob-Gyn | | | |
| Pediatrics | | | |
| Family Practice | | | |
| Psychiatry | | | |
| Other: | | | |
| | | | |
| | | | |

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.

| Type of Residency[1] | Positions Offered | Positions Filled by U.S. & Canadian Grads | Positions Filled by Foreign Medical Graduates | Date of Initial Accreditation of the Program[2] |
|---|---|---|---|---|
| First Year Flexible | | | | |
| Medicine | 17 | 12 | 5 | Unknown |
| Surgery | | | | |
| Ob-Gyn | | | | |
| Pediatrics | 17 | 14 | 3 | Unknown |
| Family Practice | | | | |
| Psychiatry | | | | |
| Other: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

[1]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.

[2]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.

## V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

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.

Name of Affiliated Medical School: University of Colorado School of Medicine

Dean of Affiliated Medical School: Dr. Roy Schwarz

Information Submitted by: (Name) Don A. Evans

(Title) Director, Hospital and Clinical Services

Signature of Hospital's Chief Executive Officer:

Michael Schonbrun (Date) August 11, 1980

UNIVERSITY OF COLORADO
MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

April 2, 1973

OFFICE OF THE DEAN
SCHOOL OF MEDICINE

Attachment V A

Mr. Richard N. Bluestein
Executive Vice President
National Jewish Hospital and Research Center
3800 East Colfax Avenue
Denver, Colorado 80208

Dear Mr. Bluestein:

The purpose of this letter is to reaffirm the existing affiliation between the University of Colorado School of Medicine and the National Jewish Hospital. This affiliation, which bears a formal approval of the Board of Regents of the University and of the Executive Committee of the School of Medicine, provides for joint efforts in residency training, teaching, and research. A joint agreement is also provided for appointment of professional persons, including faculty appointments in the School of Medicine.

In addition, the University of Colorado Medical Center and National Jewish Hospital provides services for one another as needed and at the usual charge. Specifically, the Medical Center has been and will continue to provide surgery services for NJH patients as required, since NJH has phased out its own surgery program.

This affiliation is under the supervision of a joint committee, consisting of the chiefs of service at the National Jewish Hospital, the chairmen of the cognate departments in the School of Medicine, and is chaired by myself as the Dean of the School of Medicine, with you as Executive Director of the National Jewish Hospital serving as secretary of the committee.

We have been very pleased with this affiliation over the past many years and fully expect that additional collaborative programs will be initiated in the future.

Sincerely,

Harry P. Ward, M.D.
Dean, School of Medicine

HPW/da

# AFFILIATION

"Whereas the faculty and staffs of the University of Colorado School of Medicine (hereafter referred to as "School") and the National Jewish Hospital and Research Center (hereafter referred to as "Hospital") share a common concern for enhancing the quality of medical care and enriching medical education at all levels; and whereas both parties agree that these goals can be achieved more readily through a formal affiliation; therefore, by appropriate action of the Board of Regents of the School and the Board of Trustees of the Hospital, the Hospital is hereby affiliated formally with the School. It is agreed that affiliation includes, but is not necessarily limited to, the following procedures:

1. All appointments of M.D.'s or Ph.D.'s (hereafter referred to as "appointees") to the regular Clinical and Research staffs of the Hospital must have the advance approval of the School and will include a faculty appointment at the level to be determined by the School after consultation with the Hospital. Only full-time appointees to the staff are eligible for appointments at the rank of instructor, assistant professor, associate professor or professor.

2. Decision on promotion and tenure will be arrived at jointly. Academic tenure will be granted by the School. Financial tenure will be granted by the Hospital in accordance with its rules.

3. Salaries at the Hospital shall be based on recommendations made to the Dean of the School and the Executive Vice President of the Hospital by the appropriate Hospital Service Chief or Department Head and by the appropriate Medical School Department Chairman; in the event there is a failure to agree, the final decision will be made by the Hospital's Board of Trustees.

4. Appointments of Chief of Services or Department Heads at the Hospital shall be made by the Executive Vice President of the Hospital upon the recommendation of a search committee comprised of representatives of both institutions and with the agreement of the Chairman of the relevant Medical School Department.

## AFFILIATION

5. Appointees to the medical and research staffs shall be recommended by the individual Chiefs of Department Heads at the Hospital and shall have the approval of the Executive Vice President of the Hospital and the Chairman of the appropriate department at the School.

6. Fellows, Residents and other House Staff at the Hospital will be recruited through the joint efforts of both parties to this agreement, and will operate under a joint program of training approved by both parties and so certified to the respective specialty boards.

7. There shall be a Joint Committee of representatives of the School and the Hospital who shall meet on call to deal with questions of mutual interest. This Committee shall consist of:

| National Jewish Hospital | University of Colorado Medical School |
|---|---|
| Chief of Professional Services | Dean |
| Chief of Medicine | Chairman of Medicine |
| Chief of Pediatrics | Chairman of Pediatrics |
| Chief of Behavioral Sciences | Chairman of Psychiatry |
| Director of Division of Molecular and Cellular Biology | Chairman of Biophysics and Genetics |
| Executive Vice-President | Associate Dean, Director of Clinical Affairs |
| Administrator | Associate Dean for Graduate Medical Education |

**University of Colorado Health Sciences Center**

**Office of the Dean** School of Medicine

Campus Box C 290
4200 East Ninth Avenue
Denver, Colorado 80262
(303) 394-7565

Attachment IV B

August 8, 1980

Dr. Arthur Robinson, M.D
Vice President for Professional Services
National Jewish Hospital and Research Center
3800 East Colfax Avenue
Denver, Colorado 80206

Dear Art:

Enclosed please find a letter which I would be happy to have you incorporate in your application for membership in the Council of Teaching Hospitals (COTH). If you would have your secrectary type in the appropriate name, I would be most appreciative as I did not know to whom it should be addressed.

Trusting this will meet with your approval, I remain,

Sincerely,

M. Roy Schwarz, M.D
Dean

MRS/le

**University of Colorado Health Sciences Center**

**Office of the Dean** School of Medicine

Campus Box C 290
4200 East Ninth Avenue
Denver, Colorado 80262
(303) 394-7565



The purpose of this letter is to support the application of the National Jewish Hospital and Research Center in their quest for membership in the Council of Teaching Hospitals. This support is based primarily on the fact that National Jewish Hospital and Research Center, has been an important affiliate of the University of Colorado School of Medicine for many years. The staff at National Jewish have full-time appointments at the School of Medicine and in fact have their tenured guaranteed by the National Jewish Hospital.

Among the roles that the Hospital plays in the School of Medicine programs are the following.

1. Teaching: Not only undergraduate medical student but also graduate students in the various basic sciences, spend a portion of their training in the National Jewish Hospital. In addition, residents and many disciplines rotate through hospitals and an integrated residency, one partner of which is National Jewish Hospital. Finally, the various CME programs are presented at National Jewish Hospital by their faculty along with their colleagues from the University of Colorado, School of Medicine.

2. Faculty at the National Jewish Hospital, teach at all levels of the medical education continum as well as in graduate education courses in the Medical School. This teaching is primarily focused in the discipline for the faculty members have their affiliations and they represent an enormous resource for the School.

3. In terms of research, many joint projects are currently underway between faculty members from the University of Colorado, School of Medicine and the National Jewish Hospital Medical Center. Some of these involve training while others involve straight laboratory investigation.

4. In the area of patient care, National Jewish has been a major adjunct to the University of Colorado. In fact there are numerous examples of cooperation in the care of patients, especially in those challenging cases which require an unusual degree of expertise to manage effectively.

For these reasons, I would recommend without reservation that National Jewish Hospital and Medical Center be granted membership in the Council fo Teaching Hospitals.

Thanking you in advance, I remain,

Sincerely,

M. Roy Schwarz, M.D
Dean

MRS/le

LONG ISLAND JEWISH—HILLSIDE MEDICAL CENTER • NEW HYDE PARK, NEW YORK 11042 (212) 470-2111

JAMES E. MULVIHILL, D.M.D.
Vice President for Education and Research

A Clinical Campus of The Health Sciences Center,
The State University of New York at Stony Brook

July 16, 1980

Dr. Richard M. Knapp
Director
Department of Teaching Hospitals
Association of American Medical
Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dick:

Bob Match has noted this year's format of the National Resident Matching Program's Institution Agreement (enclosed).

He has asked what are the actual or potential implications to teaching hospitals of the Dean's signatory statement (see page 4), and whether or not this is an item that should be discussed at the next meeting of the COTH Administrative Board.

Perhaps you could give me or Bob a call on this at your convenience? Thank you.

Very best regards.

Sincerely,

James E. Mulvihill, D.M.D.

cc: Dr. R. Match

enc.

bc

# NATIONAL RESIDENT MATCHING PROGRAM

1603 Orrington Avenue, Evanston, Illinois 60201

The National Resident Matching Program is sponsored by the American Hospital Association, the American Protestant Hospital Association, the Association of American Medical Colleges, the Catholic Health Association, the American Medical Association, the American Medical Student Association, the American Board of Medical Specialties, and the Council of Medical Specialty Societies. The Program is also endorsed by the Association for Hospital Medical Education, and the medical services of the federal agencies offering training programs.

# INSTITUTION AGREEMENT

For First-Year Appointments in Graduate Medical Education 1981-82

(Starting April 1 through December 31)

1. Name of individual for NRMP correspondence

2. Institution name: LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER

3. Address

4. Address

5. City: NEW HYDE PARK — State: NY — Zip Code: 11042

This is an Agreement between the institution named above (the "Institution") and the National Resident Matching Program, an Illinois not for profit corporation (the "NRMP"). The Institution is an organization offering positions to students entering their first-year of graduate medical education. NRMP conducts a national program which matches such students with such positions (the "Matching Program").

In consideration of its acceptance in the Matching Program, the Institution agrees to:

1. Abide by the NRMP official schedule, including accepting applications from participants in the Matching Program up to December 19, 1980, rating applicants and returning rating forms by January 14, 1981, not releasing results of the match and not seeking to fill any unmatched positions until 12:00 Noon EST on March 18, 1981, and offering formal appointments promptly to individuals matched with the Institution, and in any case not later than April 10, 1981;
2. Abide by the Policies of the NRMP, a copy of which has been received by the Institution;
3. Send to the NRMP a list of all programs and positions which the Institution will make available to medical students, and to notify, through the Institution's authorized representative, the NRMP before September 12, 1980 of any changes in the Institution's listing of programs and positions;
4. Offer appointment to such programs and positions to all applicants matched with the Institution by the Matching Program;
5. Make or require no commitments or contracts with students prior to the notification of the selections made through the Matching Program;
6. Refrain from accepting an applicant who was matched with another Institution or program and not subsequently released to take a position at the Institution;
7. Pay the following fees to NRMP:

| | | | |
|---|---|---|---|
| Institutional Registration Charge | $20.00 | Matched Applicants | $10.00 each |
| Program Registration Charge | $10.00 each | Late Quota or Program Changes (after Nov. 14, 1980) | $40.00* |
| | | *For a block of changes made at one time | |

8. Provide all the information requested in the Exhibits of this Agreement;
9. Submit to NRMP confidential applicant rank order lists which, when confirmed by the Institution, shall be the sole determinants of the order of preference among its applicants; and
10. Return this agreement to NRMP by July 31, 1980.

The Institution, by its authorized official, hereby certifies that the information it has provided in this Agreement (including Exhibits) is true and correct to the best of its knowledge.

For the Institution:

Signature _____ Title _____ Date _____

For the NRMP: _____

Office Use Only

C ____ Hospital Code

Name _____

Location ____ Order ____

EXHIBIT A. INFORMATION FOR THE OFFICIAL NRMP DIRECTORY

Please indicate below** the programs and number of positions to be offered through the NRMP to applicants seeking first-year appointments in graduate medical education. *NRMP code numbers will be assigned in the official NRMP directory being prepared for applicant use to only those programs that you request on this form ** in the column "Number of Positions Offered in NRMP."*

| Specialty Field in which first-year appointments are being offered for academic year 1981-82 | Last 2 digits for matching first-year of graduate medical education | *Number of positions offered in NRMP* | Last 2 digits for matching first-year of graduate medical education | *Number of positions offered in NRMP* |
|---|---|---|---|---|
| Anesthesiology | Categorical – 65 | | Categorical* – 77 | |
| Dermatology | Categorical – 66 | | Categorical* – 90 | |
| Family Practice | Categorical – 18 | | | |
| Internal Medicine | Categorical – 68 | 30 | Categorical* – 32 | |
| Neurological Surgery | Categorical – 69 | | Categorical* – 92 | |
| Neurology | Categorical – 70 | | Categorical* – 93 | |
| Obstetrics – Gynecology | Categorical – 71 | 4 | Categorical* – 35 | |
| Ophthalmology | Categorical – 72 | | Categorical* – 94 | |
| Orthopedic Surgery | Categorical – 73 | | Categorical* – 95 | |
| Otolaryngology | Categorical – 74 | | Categorical* – 96 | |
| Pathology | Categorical – 75 | | Categorical* – 36 | |
| Pediatrics | Categorical – 80 | 10 | | |
| Physical Med. & Rehabilitation | Categorical – 81 | | Categorical* – 97 | |
| Psychiatry | Categorical – 82 | | Categorical* – 76 | 8 |
| Radiology – Diagnostic | Categorical – 87 | | Categorical* – 98 | |
| Radiology – Therapeutic | Categorical – 88 | | Categorical* – 99 | |
| Surgery | Categorical – 84 | 13 | Categorical* – 33 | |
| Urology | Categorical – 85 | | Categorical* – 89 | |
| Other _____ | Categorical – | | Categorical* – | |

** And on supplemental list ☐ (check if used)

| Flexible Programs | Last 2 Digits of NRMP Code | *Number of Positions in NRMP* | *List* Specialties which are sponsors of the flexible program(s) |
|---|---|---|---|
| | 20 | | |
| | 11 | | |

Final date for revising numbers of positions appearing in Directory is September 12, 1980

Please *print* the name of the director (first, initial, last) *of each program offered in the NRMP* in the appropriate bo
Please have the Program Director *sign* to indicate acceptance of the terms of the Institution Agreement and that the program offered will have LCGME accreditation for the academic year beginning July 1, 1981.

| | Name | Signature |
|---|---|---|
| 65/77 | | |
| 66/90 | | |
| 18 | | |
| 68/32 | EDWARD MEILMAN MD | |
| 69/92 | | |
| 70/93 | | |
| 71/35 | JOSEPH J. ROVINSKY MD | |
| 72/94 | | |
| 73/95 | | |
| 74/96 | | |
| 75/36 | | |
| 80 | PHILIP LANZKOWSKY MD | |
| 81/97 | | |
| 82/76 | ROBERT M. CHALFIN MD | |
| 87/98 | | |
| 88/99 | | |
| 84/33 | LESLIE WISE MD | |
| 85/89 | | |
| | | |

If an NRMP program uses several hospitals for regular rotations of at least three months duration please indicate the program(s) and name(s) of the other hospitals used below:

| Specialty Program Type | | Hospital(s) Participating | Office Use Only |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(Use additional pages if necessary)

Office Use

1. Hospital is associated with _____ ☐☐☐
Medical School

Type of association ☐☐ (Use letter and number code from lists below)
Letter Number

Office Use

2. Hospital is associated with _____ ☐☐☐
Medical School

Type of association ☐☐ (Use letter and number code from lists below)
Letter Number

| Hospital (Letter): | Hospital has (Number): |
|---|---|
| X Owned/operated by University/ Medical School | 1. Required ( ± elective) clerkships |
| Y Associated with a Medical School under written agreements for undergraduate and/or graduate medical education | 2. Only elective clerkships |
| Z Some departments associated with Medical School under written agreements but no institutional agreement | 3. No required or elective clerkships |
| O No agreements of association with Medical School | |

Dean

Exhibits A, B and C have been reviewed for information by the Dean or Deans of the Medical School(s) with which this Institution has an association for graduate and/or undergraduate medical education.

1. _____ _____
Dean Medical School

2. _____ _____
Dean Medical School

DRAFT DOCUMENT

AAMC AD HOC COMMITTEE ON COMPETITION

## OVERVIEW

Fundamental changes in the way health insurance and services are selected and purchased are increasingly being advocated by many health economists, business groups, and legislators as a means to stimulate cost consciousness among providers (hospitals and physicians) and consumers (individuals enrolling in health plans and patients seeking care). These proposals, which have been commonly referred to as the "competitive" approach to cost containment, often call for changes in tax laws and requirements for employers to offer multiple health plan choices to their employees. Some proposals would begin to abolish reimbursement, utilization, and planning regulations presently imposed by the federal government.

The expected result of legislation encouraging competition is that individuals and health insurance plans on behalf of their beneficiaries will look much more carefully at hospital costs and physicians fees when purchasing or contracting for health care services. In turn, those providing the services -- hospitals, HMOs, physicians -- will compete to provide their services at the lowest possible cost. Although quality of care, access, and other factors would influence consumer choice, it is presumed that price would be the primary consideration and that cost-savings would be the primary benefit.

The most obvious concern for teaching hospitals is that their costs are generally higher than those of non-teaching hospitals. Many of the high costs of teaching hospitals may be explained by such factors as the presence of educational programs, technology development and testing, patient case mix, and charity care. Presently, these activities are funded by patient care revenues, either directly or through cross subsidization. Under competitive pricing, individual consumers and third parties, HMOs, and IPAs negotiating on their

behalf may be unwilling to pay the cost of programs which may not be of any immediate, personal benefit. If this situation occurred, the teaching hospitals may be placed at a distinct disadvantage. Some of the services they now perform and products they produce may be jeopardized. On the other hand, depending on how a free market system is structured, the teaching hospital may be very competitive in some areas. In fact, if given a choice between competition and regulation, many teaching hospitals may argue on the side of competition.

The role of the AAMC Ad Hoc Committee on Competition is to assess the potential impact of competition on teaching hositals, to develop recommended AAMC policy on competition, and to identify alternative initiatives institutions might undertake in a price competitive market. This document is intended to begin to meet these objectives by:

- describing how policy makers and opinion leaders view teaching hospitals under price competition;
- describing price competition within the context of other environmental and health policy changes emerging in the eighties;
- identifying the critical issues for teaching hospitals under price competition;
- identifying the range of initiatives teaching hospitals might undertake to succeed and maintain high performance standards in a price competitive market.

## HOW THE POLICY MAKERS AND OPINION LEADERS VIEW TEACHING HOSPITALS UNDER COMPETITION

"I can't believe that economics will doom the greatest medical education system in the world. Price, after all, is not always the controlling factor. Hospitals also survive on their reputations, the quality of their medical staff, and their relationships with other institutions."(1)

--J. Alexander McMahon
President
American Hospital Association

Those associated with teaching hospitals as well as the public might find the above remarks reassuring, and the comments may very well be accurate. However, the implications of price competition for teaching hospitals may be uneven and difficult to predict. Until recently, little has been stated publicly and published about the implications of competition for teaching hospitals. The situation is changing. The academicians who have been primarily responsible for the conceptual development of the legislative proposals which encourage competition have begun to speculate on the potential impact on teaching hospitals.

Paul Ellwood, President, Interstudy, made some of the following remarks at the 1980 COTH Spring Meeting (2):

> "Perhaps the most important and lengthy change required by competitive pressures will be to revamp the entire system of paying for medical education. For every teaching hospital, whether the teaching mission is cut back or expanded, intensified competition for patient care dollars will be played under a changed and reasonably well-defined set of rules for health delivery, and an evolving and less clearly defined method for funding graduate medical education."
>
> "Most teaching hospitals are located in communities with very high rates of hospital utilization, and are therefore, 'easy marks' for organizations that can provide high quality care with even moderate reductions in hospital use."
>
> "I suspect that despite their technological supremacy, most teaching hospitals operate under inhibitions that will prevent them from starting the first plan in town -- inhibitions such as a superstar head of medicine who insists on autonomy, aggravating town/gown disputes; reluctance of the faculty to deliver primary care; and perhaps an unvoiced fear that users of your hospital may pay a high price for its leadership in research and education."
>
> "The lead time required to prepare academic institutions to be competitive may be from two to five years, and those entering the competitive market late must pay a high price to get back patients who have left them for the earlier competitors."

These rather ominous remarks were followed by the following suggestions:

- Teaching hospitals should take the following three steps to prepare for a competitive market.

  1) Have a greater commitment to personal service, including more emphasis on primary care and establishment of long-term, personal relationships between consumers and members of the medical staff.

  2) Establish genuine multispecialty group practice with the teaching staff.

  3) Adopt some form of prepayment.

- With respect to medical education, Ellwood advocates the establishment of a National Commission on the Financing of Medical Education which might take on the following responsibilities.

  1) The educational integrity and well-being of the institutions that take part in producing health workers.

  2) The difficult question of how to allocate costs to education, research, and patient care.

  3) The legitimate concerns of communities and purchasers of medical care in the numbers and distribution of physicians trained.

  4) Finally, and most important, if the money for medical education doesn't come from patient revenues, who will pay for it?

Clark Havighurst of Duke University, in a memo titled "Competition in Health Services -- An Equal Number of Questions and Answers," made the following comments about education, research, and charity care (3):

> "To a significant though unknown degree university and some other medical centers are dependent on earning monoply profits to finance educational and research endeavors. In a competitive world, these resources would undoubtedly be jeopardized. It should be no argument against competition, however, that it deprives the industry of discretionary funds with which it does things it regards as desirable. Nevertheless, new subsidies must be found to replace at least some of those that may be eliminated by competition. Resort to other sources of funding will bring subsidies into the open and will require new social judgements about the appropriateness of each. Society may be unwilling to continue subsidies at the rate they have been involuntarily provided in the past, and some worthy activities may in fact go unfunded."
>
> "Cross-subsidies within hospitals are currently financing a great deal of indigent care, and competition surely threatens the continuation of these subsidies. In the short run, decisions on certification of need can legitimately protect internal subsidies, but one has to hope that,

in the long run, hidden financing will become unacceptable and will be replaced by new public subsidies."

Alain Enthoven of Stanford University briefly referred to treatment of teaching hospitals under competition in the Shattuck Lecture by stating (4):

"For them to be able to compete, the teaching and research costs of university medical centers would need to be separately identified and subsidized on their own merit."

While several Congressmen who support competition have indicated in hearings that special grants would be provided to teaching hospitals to help support the costs of education, only one bill -- the Gephardt/Stockman bill -- has explicitly stated how educational costs would be financed. Section 301 includes the following language (5):

a) The Secretary shall make grants to, or enter into contracts with, entities (other than educational institutions) to compensate them for not more than 70 percent of the direct cost of providing gradute medical education and training for nurses and other health care professionals through accredited educational programs, to the extent the Secretary finds such compensation is necessary to provide training for needed health care professionals. Such grants and contracts shall be made only with entities which are public or private, nonprofit, charitable organizations.

b) Budget Act Limitation -- The authority of the Secretary to enter into contracts under this Section shall be limited in any fiscal year to such extent or in such amounts as may be provided in advance in appropriation acts.

A summary of the views of those who have been instrumental in developing mechanisms to instill market forces in health care suggests that:

- Because of their participation in education, research, tertiary care, and charity care, teaching hospitals do not fit neatly into competitive models. Nevertheless, some believe that a competitive system can be devised that will treat teaching hospitals equitably.

- Most agree that special funding will be required to help pay for some of the costs associated with these activities. As currently being discussed, the funding would most likely focus on the direct costs of medical education with a small chance for funding of indirect educational and research-related costs.

- No one is very clear about how the administrative details of a separate fund might actually work.

## COMPETITION WITHIN THE CONTEXT OF OTHER TRENDS IN HEALTH CARE

Some have argued that price competition can revolutionize the way health care is organized and provided, restructure a perverse set of financial incentives, and lower costs while retaining or even improving quality and access to care. These claims are overly optimistic and probably misleading. Moreover, many of the purported impacts of a price competitive health care market are likely to emerge with or without intensification of price competition. The American Hospital Association's Environmental Assessment of the Hospital Industry for the next three to five years makes the following statements (6):

- The growth of multi-institution arrangements will enhance the coordination of services and the linkage of service systems. Increased interest in HMO development by hospitals and IPAs will focus on what is the role of the existing providers in the development of HMOs, rather than whether a HMO is appropriate.

- The HMO model will be adopted or modified by some hospitals choosing to move away from the exclusive provision of traditional inpatient care and as hospitals explore new sources of revenue and utilization in conjunction with inpatient services. In some instances, this may involve new dimensions in the relationship between hospitals and other sponsors of participants in HMO activity, notably physicians and third party payers.

- Employers will attempt to reduce their outlays for health insurance by proposing modifications in third-party payment systems by offering cost-sharing insurance programs, health incentives, and health education programs to employees, and by participating in and sponsoring HMOs and other alternative delivery mechanisms.

- Physicians will increasingly work in multi-physician teams in treating patients. These teams may develop from group practices created by physicians themselves or from new staff organization methods in hospitals that increase the number of full-time employed physicians.

- The cost of research and teaching conducted at teaching hospitals will increasingly be recognized as a distinct element of the costs incurred by these hospitals. Alternative payment mechanisms will be

explored to cover these costs, thus making the cost of patient care at teaching hospitals more readily comparable to costs at non-teaching hospitals.

This prognosis for the eighties seems reasonable, and price competition may encourage some of these changes. On the other hand, regulation could, perhaps, bring about the same results. Price competition could intensify comparison of hospital costs and utilization of inpatient services, experimentation with alternative delivery systems, examination of educational costs, more prudent purchasing of health insurance plans by employers, and regionalization of health services. The regulatory agenda might do the same -- through mandatory cost containment, PSROs, planning legislation, technology guidelines, and incentives for HMOs.

In theory, regulation and price competition represent two very different approaches, but they are not as clearly separable as often portrayed and the potential of either to mold the future of the industry may be overstated. Many of the changes described by AHA's environmental assessment are already occurring -- in areas where there is absence of price competition or heavy regulation. Many changes most likely will not be a result of a change in philosophy about financing and regulating health care. They will be a response to economic realities. Thus, the potential benefits ascribed to these two approaches by their advocates will be muted by the country's general economic, political, and social environment with which the health industry cannot disassociate itself.

An evaluation of price competition, which this paper attempts to do, must include but go beyond a discussion of the events that are likely to occur regardless of the financing and regulatory structure. The emphasis should be on the degree to which competition facilitates or impedes those changes and the

identification of any events that will be uniquely attributable to price competition.

For teaching hospitals, the main question may be how to organize for the expected changes. Teaching hospital relationships with community hositals, nursing homes, ambulatory care sites, HMOs, attending physicians, medical school faculty, physician assistants, nurse practitioners, the community, and patients will have to be re-examined. How does the teaching hospital want to position itself in an increasingly entrepreneurial industry where the number and complexity of inter-institutional arrangements are rapidly growing? It is within this broad context that the specific implications of competition for teaching hospitals should be addressed.

## ISSUES FOR TEACHING HOSPITALS

Underlying the competitive models being proposed is the assumption that hospitals provide a relatively standardized product which is identifiable in terms of costs and quality. This assumption raises several issues for teaching hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities result in higher average costs, presently financed through patient care revenues, competitive pricing resulting from proposed legislation raises questions about the future ability of teaching hosptials to meet these multiple responsibilities.

There are seven specific areas which may be impacted by a move towards price competition:

- Undergraduate Medical Education,
- Graduate Medical Education,

- Research and Technology development,
- Tertiary Care and Case Mix,
- Charity Care,
- Ambulatory Care, and
- Quality of Care.



Undergraduate Medical Education

Total enrollment in U.S. medical schools, which has more than doubled since 1963, now exceeds 62,000 (7). Since the late sixties, medical school curriculum has placed greater emphasis on primary care training. These two developments have created a dramatic increase in the need for additional and varied types of clinical clerkships. As a result, the university-owned hospitals and hospitals that are primary affiliates of medical schools are still the settings for most clerkships training, but numerous other community hospitals and ambulatory care settings are now participants in undergraduate medical education.

The direct costs of providing clinical clerkships may not be large, but the indirect costs are substantial. The productivity loss associated with teaching medical students, particularly in the outpatient areas, have been documented in the literature (8,9,10). The supervisory costs and opportunity costs for those teaching the students can be large. Although differences of opinion about the magnitude of the costs of clinical clerkships may exist, there is no doubt that the presence of medical students adds to the overall operating costs of the hospital.

Presently, the direct and indirect costs of education are funded primarily through patient care dollars. Under price competition, the possibility exists that community hospitals and ambulatory care sites that have helped accommodate

the increased need for clerkships will discontinue their affiliations with medical schools so that their prices will remain competitive with other area hospitals. This could lead to increased educational loads for major teaching hospitals which may not have enough patients to meet any added educational responsibilities. For those who do continue to provide clerkships, additional pressures may be created to expect students to provide more direct services at the expense of education.

## Graduate Medical Education

There are approximately 64,000 residents presently in training (7). Nationwide, total 1979-80 expenditures for house staff stipends and benefits were about $1.2 billion (11). About 80 percent of all residents are in COTH member hospitals which spent, on average, $2.4 million per hospital on house staff stipends and benefits in 1979-80 (see Tables 9-10). There are other direct costs of graduate medical education including physician supervision, meals, and educational space and equipment, as well as indirect costs and productivity problems associated with residency training.

Because the costs of graduate medical education are greater and easier to quantify than those for undergraduate clinical training, they will be more subject to careful scrutiny under price competition. Third parties, HMOs, and others contracting with hospitals for their services may be sensitive to these costs and reluctant to permit subscribers to use teaching hospitals for anything but complex, referral care. Hospitals may also have second thoughts about the number and types of programs they sponsor. Certain programs, which may train residents in underserved specialties or geographic areas, but add significantly to operating costs, may be phased out. Based on past evidence, it is also likely

that the developing HMOs and alternative delivery systems will be reluctant to participate in graduate medical education. These developments could raise uncertainty about which hospitals will continue their commitment to education and whether the size and types of programs will be consistent with the nation's health manpower needs.

Research and Technology Development

As biomedical research discovers new techniques, teaching hospitals have been the settings where this research is translated into medical practice and disseminated to physicians and other health care institutions. On June 13, 1980, the Washington Post reported that the Health Care Financing Administration has decided to reverse, at least temporarily, their decision of last September to pay the cost of heart transplants for Medicare patients at the University of Arizona and Stanford. Heart transplants, which the article reported are performed at a rate of 50 per year in the country, might jump to 2,000 a year at a total cost of $200 million if they were fully covered by Medicare.

The point of this example is not to raise the issue of whether Medicare dollars should pay for heart transplants but is to cite one case where a large third party decided to draw the line on expenditures for expensive technology, even though it could lead eventually to other, cheaper and more effective forms of treatment. Under competition, competing health plans will undoubtedly be reluctant to fund unproven, high cost technology, even though the new procedure, given time, might be widely and effectively used at reasonable cost. In the past, teaching hospitals have been committed to the exploration of new technology and treatment patterns. This activity may have to be curtailed in a competitive environment.

Tertiary Care and Case Mix

Related to the commitment to research and technology is the provision of regional, tertiary care services to seriously ill patients. Historically, these services have been provided by teaching hospitals. Some would argue that regionalization of hospital care is inevitable and that complex, tertiary care will be centralized in a smaller number of major medical centers.

The provision of tertiary care is unquestionably expensive. Present pricing and cost allocation policies in teaching hospitals often result in a cross-subsidization from primary and secondary care to tertiary services. In addition, the educational costs associated with tertiary care services are high, and an increasing number of community hospitals are providing these services without providing education. Thus, the high costs of tertiary care and current pricing policies raise questions about whether HMOs and other third parties will be willing to contract with teaching hospitals on behalf of their subscribers for tertiary care at the true cost of providing these services.

The provision of complex procedures and services themselves adds to the costs of teaching hospitals. However, the complexity of the patient diagnostic case mix in many teaching hospitals also adds directly to the costs of routine care, such as nursing and dietary services. As a consequence, the prices of teaching hospitals for routine care may reflect a higher average cost per patient than those prevailing in community hospitals which treat a less intensely ill patient population. Thus, even if educational, research, and the other unique non-patient costs of teaching hospitals could be separately identified, the unbundled, pure patient costs might still be higher than those in non-teaching hospitals. And even if the tertiary care services were accurately costed out,

the routine portion of pure patient costs might be higher because of the level of staffing and services required to treat a more intensely ill patient population.

## Charity Care

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near-poor of their communities. This care includes not only inpatient services, but ambulatory care on a large scale. Economically disadvantaged patients often pay no charge or a charge that is below cost. Hospitals remain financially viable by pricing services to full-paying patients at levels sufficient to subsidize the charity care. For hospitals to be price competitive, this cross subsidization would be difficult to maintain. Hospitals may be reluctant to continue any extensive commitment to treating patients who are unable to pay. Furthermore, a curtailment in charity care could also shrink the patient population available for teaching, thus jeopardizing educational programs.

## Ambulatory Care

Per visit costs of hospital-based ambulatory care and other ambulatory care settings participating in medical education are often significantly higher than the costs of office visits of community physicians. Many reasons for the differences are typically cited. In the case of ambulatory care facilities separate from hospitals, productivity losses due to the presence of physicians in training are cited as a reason. Many states and the Federal government have helped to offset these costs by providing grants for primary care training. Hospital-based ambulatory care also has the productivity problem resulting from

education. However, in this setting, there are additional cost differences explainable by the cost allocation guidelines which burden outpatient departments with overhead costs not present in freestanding clinics.

Most of the literature suggests that the presence of education in ambulatory or outpatient departments makes it very difficult for them to be self-supporting (8,9,10,15). Rarely are fees or costs competitive with fees for office-based visits. Some will argue, however, that free-standing ambulatory care centers with educational programs can be productive, and in cases where the center is a source of inpatient business, the satellite is a profitable venture. Thus, the evidence is inconclusive, but it is clear that given current operations, some ambulatory care programs and primary care training sponsored by teaching hospitals and medical schools may suffer with the introduction of market forces.

## Quality of Care

Proponents of the free market in the provision of health care argue that quality of care may be enhanced because it would be a key factor in a consumer's decision about where to obtain care. Some argue that PSROs will finally focus on their original purpose -- to monitor quality. However, it is questionable whether most people will have enough evidence available to make an informed decision about the quality of care. John Colloton, Director of the University of Iowa Hospitals and Clinics, made the following statement: "Quality differences are difficult to communicate to the average consumer, causing disproportionate consideration to be given to the cost of services. This facilitates the development of plans which are competitively priced but do not assure access to tertiary-level care" (14). Robert Heyssel, Executive Vice President and Director of Johns Hopkins Hospital, has expressed similar words of caution: "We tend to

forget that if the fee-for-service system supposedly makes money by doing too much, it is also true that an HMO can make money by doing too little," (15).

None of the competition bills address quality; all place an emphasis on price, an explicit criteria that everyone can measure and understand. It is conceivable that a number of health plans may develop that are competitively priced, but that these plans may not make provisions for access to patient care of a minimally acceptable level of quality.

## Financial Implications for Teaching Hospitals

Two generalizations may be drawn from the discussion of the above seven issues. First, teaching hospitals have a wide variety of products, many of which involve more than the delivery of inpatient hospital care. Second, a consequence of these multiple responsibilities is that teaching hospitals generally have higher average costs than non-teaching hospitals.

Increasingly regulators and legislators are asking for data documenting the unique responsibilities of teaching hospitals. Regulation calling for increased competition will produce a greater demand for this data if the Federal government decides that separate funding for clinical education and/or other activities is desirable to create a fair competitive environment for teaching hospitals.

Documenting the higher costs of teaching hospitals using crude measures such as per admission or per diem costs is not difficult. American Hospital Association data suggests that primary affiliates of medical schools have adjusted per admission costs that are more than twice as high as those in non-teaching hospitals (see Tables 1-2). It is also reasonable to assume that most of these differences can be explained by the characteristics outlined above.

However, assigning a meaningful dollar value to each of the characteristics is an extremely troublesome task. For example, while nationwide expenditures on the direct costs of resident stipends and benefits are relatively easy to estimate, very little is known about the costs of supervisory, teaching physicians, and still even less is known about the indirect costs of education. Although many studies have attempted to quantify separately the costs associated with patient case mix, tertiary care services, nursing intensity and other attributes of teaching hospitals, there is no consensus about the magnitude of these costs. Further study should not be discouraged, but one must recognize that it will be impossible to develop a precise, statistical measure that can explain the incremental costs associated with closely related and overlapping activities such as education, research, and tertiary care. The fact is that there are enough estimates available to support any case one wants to make. The level of the dollar differences between teaching and non-teaching hospitals should not be the major emphasis of debate. Instead, the focus must be on describing the unique contributions of teaching hospitals and on emphasizing that there are very real and sizeable costs associated with these contributions which should not be overlooked in the haste to squeeze the alleged fat out of the health care industry. These contributions cannot be provided if no one is willing to pay for them.

## STRATEGIES FOR TEACHING HOSPITALS

The extent to which price competition will be imposed formally on the health care industry is unkown, but some forms of competition appear inevitable. Assuming price competition will be the scenario for the future, what are the

options for teaching hospitals? How should they respond? The following suggests five approaches teaching hospitals might adopt under price competition.

- Separate Funding of Unique Costs
- Become Part of Multi-Hospital System
- Establish Your Own HMO or "Alternative Delivery System"
- Contract with HMOs/Alternative Delivery Systems
- Do Not Participate in Alternative Delivery Systems

The list is not exhaustive, nor are the options mutually exclusive or necessarily competing. What is successful in one setting may not be appropriate in another, and as a result, a national prescription for teaching hospitals is probably not helpful.

## Separate Funding of Unique Costs

Academicians, legislators, and third parties may be willing to accept that under price competition, a portion of the costs of teaching hospitals which is associated with teaching and research should be separately funded. Some would argue that stable, separate funding would ensure ongoing commitment to these socially desirable activities and would not give non-teaching hospitals an unfair competitive advantage.

If teaching hospitals were to take this approach, they would be asked to document, better than has been done previously, costs uniquely associated with their teaching functions. Any legislation including a special fund or grants may not provide separate financing for activities for which there are not firm cost estimates. For example, the Stockman/Gephardt bill would authorize grants equaling 70 percent of the direct cost of graduate medical education, a figure which can be measured, but is probably an unacceptably low estimate of what teaching hospitals believe is the marginal cost of their teaching-related responsibilities.

In evaluating this approach several of the potential negative impacts should be considered:

- Separate funding of graduate medical education may limit medical schools and teaching hospitals' ability to make local decisions about their residency programs. As Paul Ellwood has stated, "It's clear that whoever bears the cost of medical education will increasingly want to specify the numbers, types, and geographic distribution of those whose education is being subsidized." (2)
- Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending. The level

of funding would have to be renegotiated annually before a changing cast of decision-makers who would have varying perspectives and knowledge about GME financing.

- The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be? Even if total funding is adequate, wouldn't individual hospitals be vulnerable to significant yearly fluctuations?

Become Part of Multi-Hospital System

At least one-fourth of all hospitals and one-third of all hospital beds are now a part of a multi-hospital system (17). While a number of major teaching hospitals have not participated in multi-hospital arrangements, many have been leaders in the multi-hospital movement. The advantage of developing a multi-hospital system would be to capture a regional population with the teaching hospital serving as the referral center surrounded by community hospitals as well as nursing homes, ambulatory satellites and other health care facilities. James Campbell, President of Rush-Presbyterian-St. Luke's Medical Center, is an advocate of this approach and has attempted to implement his ideas at Rush. Nationwide, he envisions the development of between 120 and 150 university-based, vertical systems which would "link tertiary hospitals, academic centers, nursing homes, mental health facilities, home care and primary care clinics, including HMOs and fee-for-service medical clinics."(18) He says that "in short, each system would have two basic components. The academic component would produce medical and administrative talent for the systems, and the other component would provide effective, efficient patient care." Under such a system, price competititon may not be a strong factor because all of the competition would, in effect, be under the same umbrella organization.

There are many who would argue that multi-hospital systems are not feasible for large teaching hospitals, primarily because of the incompatibility of teaching hospital objectives with non-teaching hospital objectives. Mark Levitan, Executive Director of the Hospital of the University of Pennsylvania, is apprehensive about the ability of university-owned hospitals to be active in this area: "The faculty that is the core of the medical staff of the teaching hospital is not driven by a motivation to provide service, but rather by a motivation to provide education and research."(18) In fact, some would still argue that the core mission of some teaching hospitals is education, not patient care. If this is the case, conflicts may arise in a system where all of the hospitals with the exception of the central, teaching facility, have objectives strictly limited to quality, patient care.

Establish Your Own HMO or "Alternative Delivery System"

An HMO or "alternative delivery system" (ADS) could easily be part of a full-blown, vertical, multi-hospital system as described above. However, a teaching hospital does not need to be tied to a series of community hospitals and health facilities to initiate a prepaid health plan that would be based on teaching hospital based clinics and/or community based clinics for ambulatory care and the teaching hospital for inpatient care. This approach advocates that teaching hospitals establish their own health plans to compete against the other plans that presumably would arise under price competition. Rigorous marketing campaigns might be undertaken that would stress the quality and scope of services available as well as the credentials of the medical staff. Even if these plans were slightly more expensive than those that relied on community hospitals, potential subscribers may select the plan because of the perceived superiority of

the care available. Robert Heyssel argues that: "As for competition with an HMO, it is my opinion that if we (teaching hospitals) can't beat them, we should own them. What you own cannot take its business someplace else. An institutionally-owned HMO will incur higher hospitalization costs, but we are in a position to make a pitch for quality that will appeal to some people."(15) Reflecting on the experience of the Columbia Medical Plan, which is loosely affiliated with Johns Hopkins Hospital, Heyssel notes that "while the plan is a success in numerous respects, the aims in regard to teaching and training have fallen by the wayside and will likely stay there indefinitely. The reason? Simply, the economics of prepaid ambulatory group practice. There is not money to defray the real cost of teaching."(15)

There is evidence that some teaching hospitals have succeeded at establishing viable hospital-sponsored HMOs. There are approximately 30 medical schools participating in a prepaid group health plan (see Table 5). Five of these are sponsored by the medical school or a university-owned hospital.

Several of the positive experiences are worth noting. A prepaid group practice of the Long-Island Jewish Hillside Medical Center was extremely successful in constraining hospital utilization. Budgeted at 25 percent below the Blue Cross community experience, the plan actually achieved rates per 1,000 enrollees that were 50 percent below the average, even with an adversely selected population (19).

A second plan at George Washington University, which utilizes a university-owned hospital for hospitalization of its subscribers, has been able to offer the lowest family coverage premium compared to several other sizeable HMOs in the District of Columbia. Controlling hospital utilization rather than per diem costs has been an important reason for the modest premiums, but the plan

has had other reasons for success. For example, the contributions of senior house staff to patient care has enabled the HMO to operate with fewer full-time primary care physicians and other health professionals. Similar to Heyssel, Ron Kaufman, Vice President for Medical Affairs and Executive Dean at George Washington University School of Medicine, believes the success of George Washington could not have happened in the presence of extensive educational activities. He warns that, "Involvement in medical education, especially at the undergraduate level, should be extremely limited and is cost ineffective."(13)

The Medical Care Group of Washington University, a prepaid group practice in St. Louis, found that the presence of residents reduced the productivity of faculty physicians, but the productivity of the similar residents more than compensated for that loss.(8)

Thus, there are examples of medical schools and teaching hospitals which have established successful HMOs. It is fair to add, however, that HMOs housed in the medical school environment have had their share of problems. Many, such as the Georgetown plan or the Hopkins-Columbia plan began as medical school/teaching hospital ventures which evolved into essentially free-standing plans, operating outside of the school's policies and control, often utilizing community hospitals rather than teaching hospitals as the primary source of hospital care for their enrollees. The evidence is not yet sufficient to determine if HMOs sponsored by teaching hospitals can be successful on a wide-scale basis.

Contract with HMOs/Alternative Delivery Systems

Instead of sponsoring an alternative delivery system health plan, teaching hospitals may choose to participate in one or more plans, primarily in the form of contracts with these plans to provide hospital care for a negotiated price. Presumably, an HMO would want to contract with teaching hospitals for tertiary care services and with community hospitals for secondary care. Many HMOs, including some of the large Kaiser plans are already sending their subscribers to teaching hospitals for certain types of surgical and medical treatment. In areas where there may be several health plans, but only one major tertiary care hospital, that hospital may be able to negotiate an attractive price for providing such care. Price may not be the only basis for negotiations. A teaching hospital may agree to provide tertiary care services only if the health plan agrees to use the hospital for some other types of more routine care. A teaching hospital may also contract to receive payment from the health plan on something other than a capitation basis so that it is not at risk should certain patients require lengthy hospitalization.

One must also consider the potential drawbacks. The primary physician of the patient is employed or associated with the health plan. This physician or at least the plan will be financially at risk when referring patients for tertiary care services. As a result, the health plan may insist in its relationship with the teaching hospital that many of the procedures done by the teaching hospital, particularly if they are high cost, must be cleared in advance with the primary physician and the health plan. Such requirements could compromise the automony and judgment of the teaching hospital physician and may not be in the patient's best interest as well.

## Do Not Participate in Alternative Delivery Systems

A fifth option for teaching hospitals under price competition is not participate in alternative delivery systems. Some may argue that the currently discussed tax law changes and other mechanisms to stimulate competition are shortsighted gimmicks that cannot begin to reshape health care financing and reform the organization of patient services. It might also be argued that the presently structured health care system is operating effectively, highly regarded by most consumers, and worth the investment of dollars it now receives. For these reasons, the teaching hospitals may contend that it is in their best interests to permit others to experiment with alternative systems but remain on the sidelines themselves with the belief that competition will be a concept of the past in the near future. This is not to say teaching hospitals could not become more competitive under this approach by marketing their services, improving efficiency, and providing superior quality care. It suggests that they would simply not take an active part in establishing or participating in alternative delivery systems. Instead they would favor traditional reimbursement arrangements.

## CONCLUSION

Five strategies for teaching hospitals to survive under competition have been suggested -- one primarily political approach (negotiate for separate funding) and four institution specific responses. The institutional responses fall on a wide spectrum. At one end of the spectrum is the teaching hospital which is the center of a regional multi-hospital system that includes a range of health care facilities and its own prepaid health plan. The next two options would not include participation in a multi-hospital system, but would advocate

sponsorship of a prepaid health plan or contracts with those sponsoring such plans. At the other end of the spectrum, a teaching hospital could choose to maximize its competitive position by improving on what it has done best in the past, believing that consumers and third parties will continue to be willing to finance their services regardless of the presence of alternative delivery systems.

It is inappropriate to suggest any one of the five approaches or combination of approaches is best for all teaching hospitals. The local situation varies dramatically. It might be useful, however, for teaching hospitals individually to explore these and other options available. Even if legislation encouraging competition were passed next year, major reform of the health care industry would be a long-term proposition. However, the trend toward competitive solutions is underway, and it is not too soon to examine the implications for teaching hospitals and the patients they serve.

## Table 1

Total Hospital Expenditures
United States 1978
All Hospitals

Adjusted Per Diem & Adjusted Per Admission Cost Comparisons
by Teaching Status and Bed Size

| Hospital Group | Number of Hospitals | Average Total Expenditures Adjusted Per Diem | Average Total Expenditures Adjusted Per Admission |
|---|---|---|---|
| 1. Primary Affiliates | | | |
| 500 + | 58 | $ 292 | $ 2,768 |
| 250 - 499 | 27 | 290 | 2,604 |
| 100 - 249 | 8 | 310 | 2,510 |
| 0 - 99 | 1 | 213 | 1,852 |
| Total | 94 | $ 292 | $ 2,689 |
| 2. Hospitals Affiliated with Medical Schools | | | |
| 500 + | 226 | $ 221 | $ 2,038 |
| 250 - 499 | 292 | 220 | 1,805 |
| 100 - 249 | 148 | 217 | 1,646 |
| 0 - 99 | 2 | 231 | 1,030 |
| Total | 668 | $ 220 | $ 1,846 |
| 3. Non-Affiliated Hospitals with Residencies | | | |
| 500 + | 19 | $ 187 | $ 1,697 |
| 250 - 499 | 68 | 185 | 1,577 |
| 100 - 249 | 80 | 195 | 1,546 |
| 0 - 99 | 3 | 159 | 909 |
| Total | 170 | $ 189 | $ 1,564 |
| 4. Non-Teaching Hospitals | | | |
| 500 + | 33 | $ 177 | $ 1,529 |
| 250 - 499 | 252 | 179 | 1,383 |
| 100 - 249 | 1,815 | 171 | 1,256 |
| 0 - 99 | 2,688 | 151 | 951 |
| Total | 4,788 | $ 160 | $ 1,093 |

Source: AHA 1979 Annual Survey

## Table 2

Total Hospital Expenditures
United States 1978
All Hospitals

Adjusted Per Diem & Adjusted Per Admission Cost Relationships by Teaching Status

| | Average Total Expenditures | | | |
|---|---|---|---|---|
| | Adjusted Per Diem | | Adjusted Per Admission | |
| | Cost | % Increase | Cost | % Increase |
| 1. Primary Affiliates | $ 292 | | $2,689 | |
| | | 32.7% | | 45.7% |
| 2. Hospitals Affiliated with Medical Schools | 220 | | 1,846 | |
| | | 16.4 | | 18.0 |
| 3. Non-Affiliated Hospitals with Residencies | 189 | | 1,564 | |
| | | 18.1 | | 43.1 |
| 4. Non-Teaching Hospitals | 160 | | 1,093 | |

Source: AHA 1979 Annual Survey

Table 3

DRAFT

Average Hospital Expenditures for Residents' Stipends and Fringe Benefits
1978-79

| Hospital Category | Number of Hospitals | Expenditures for Residents' Stipends and Fringe Benefits | |
|---|---|---|---|
| | | Mean | Median |
| All Responding Hospitals | 338 | $2,431,725 | $1,672,829 |
| by Geographic Region | | | |
| Northeastern | 141 | 2,301,194 | 1,691,225 |
| Southern | 63 | 2,372,245 | 1,642,331 |
| Midwestern | 89 | 2,407,509 | 1,599,961 |
| Western | 45 | 2,971,886 | 1,786,835 |
| by Affiliation Relationship | | | |
| University-Owned | 54 | 4,071,034 | 4,008,355 |
| Major Affiliate | 239 | 2,249,545 | 1,562,224 |
| Limited Affiliate | 37 | 1,312,891 | 1,151,796 |
| by Hospital Ownership | | | |
| State-Owned | 34 | 3,833,032 | 3,646,090 |
| Municipally-Owned | 32 | 4,305,317 | 3,023,000 |
| Church-Owned | 33 | 1,897,880 | 1,495,596 |
| Other, Nonprofit | 171 | 2,245,360 | 1,555,362 |
| Veterans Administration | 68 | 1,577,105 | 1,287,658 |
| by Bed Size | | | |
| Less than 385 Beds | 84 | 1,598,636 | 1,112,097 |
| 385-512 Beds | 80 | 1,858,636 | 1,235,231 |
| 513-695 Beds | 89 | 2,323,931 | 1,880,367 |
| Greater than 695 Beds | 85 | 3,907,256 | 3,154,137 |

Total National Expenditures on House Staff Stipends and Benefits for 1979-80 were approximately $1.2 billion.

Source: 1979 COTH Survey of House Staff Stipends, Benefits, and Funding

Table 4

Residents' Stipends and Benefits as a Percentage of Hospital's Total Operating Budget, 1978-1979

| | Number of Hospitals | Percentage of Hospital Budget | | | |
|---|---|---|---|---|---|
| | | 25th Percentile | Median | Mean | 75th Percentile |
| All Responding Hospitals | 316 | 2.7% | 3.8% | 4.2% | 5.3% |
| Geographic Region | | | | | |
| Northeastern | 133 | 2.9 | 3.9 | 4.4 | 5.3 |
| Southern | 58 | 2.7 | 4.0 | 4.5 | 6.3 |
| Midwestern | 81 | 2.4 | 3.2 | 3.6 | 4.2 |
| Western | 44 | 2.8 | 4.4 | 4.7 | 5.7 |
| Affiliation Relationship | | | | | |
| University-Owned | 50 | 4.6 | 6.0 | 6.6 | 8.7 |
| Major Affiliate | 224 | 2.6 | 3.5 | 3.9 | 4.9 |
| Limited Affiliate | 36 | 2.0 | 2.8 | 3.4 | 4.0 |
| Hospital Ownership | | | | | |
| State-Owned | 32 | 4.7 | 6.8 | 7.4 | 9.0 |
| Municipally-Owned | 29 | 4.4 | 5.6 | 5.8 | 6.4 |
| Church-Owned | 31 | 2.0 | 2.7 | 3.5 | 4.4 |
| Other, Nonprofit | 159 | 2.5 | 3.3 | 3.6 | 4.5 |
| Veterans Administration | 65 | 2.8 | 3.5 | 3.9 | 4.7 |
| Hospital Bed Size | | | | | |
| 385 or fewer | 76 | 2.9 | 3.7 | 4.5 | 5.3 |
| 386 - 512 | 76 | 2.6 | 3.6 | 4.0 | 5.0 |
| 513 - 685 | 85 | 2.5 | 3.9 | 4.0 | 5.0 |
| 686 or more | 79 | 2.7 | 3.8 | 4.5 | 6.0 |

Table 5

U.S. MEDICAL SCHOOLS AND RELATIONSHIPS WITH HMOs, SPRING 1980

Legend

Considering = currently debating the possibility of ownership or affiliation with an HMO
Sponsorship = either sponsors or has otherwise developed its own HMO
Affiliation = affiliated with an existing local HMO for teaching purposes

| | | |
|---|---|---|
| University of Alabama | Considering | |
| University of South Alabama | Considering | |
| University of Arizona | Affiliation | Arizona Health Plan<br>Group Health of Arizona |
| University of Arkansas | Considering | |
| University of California, Davis | Considering | |
| University of California, Irvine | | |
| University of California, Los Angeles | | |
| University of California, San Diego | Considering | |
| University of California, San Fran | | |
| Loma Linda University | | |
| University of Southern California | | |
| Stanford | Affiliation | Pennisula Health Service |
| University of Colorado | | |
| University of Connecticut | Considering | |
| Yale University | Sponsorship | Yale Health Plan |
| | Affiliation | Community Health Care Center Pla |
| Georgetown University | Affiliation | Kaiser/Georgetown University Community Health Plan |
| George Washington University | Sponsorship | George Washington University Health Plan |
| | Affiliation | Group Health Association |
| Howard University | Considering | |
| University of Florida | Considering | |
| University of Miami | Considering | |
| University of South Florida | Affiliation | Prepaid Health Care, Inc. |
| Emory University | | |
| Medical College of Georgia | Considering | |
| University of Hawaii | Affiliation | Kaiser Permanente Health Group |
| University of Chicago | Affiliation | Michael Reese Health Plan |
| The Chicago Medical School | | |
| University of Illinois | Considering | |
| Loyola University | Considering | |
| Northwestern University | Considering | |
| Rush Medical College | Affiliation | Anchor Organization for Health Maintenance |
| Southern Illinois | Considering | |
| Indiana University | | |
| University of Iowa | | |
| University of Kansas | Developing a sponsored program | |
| University of Kentucky | Considering | |
| University of Louisville | | |

| | | |
|---|---|---|
| Louisiana State, New Orleans | | |
| Louisiana State, Shreveport | | |
| Tulane University | | |
| Johns Hopkins University | Affiliation | Columbia Health Plan<br>East Baltimore Health Plan<br>Chesapeake Health Plan |
| University of Maryland | Considering | |
| Boston University | Affiliation | Independent Practice Association |
| Harvard Medical School | Sponsorship | Harvard Community Health Plan |
| University of Massachusetts | Considering | |
| Tufts University | Affiliation | Independent Practice Association |
| Michigan State University | | |
| University of Michigan | Considering sponsorship of plan | |
| Wayne State University | Affiliation | Health Alliance Plan<br>Comprehensive Health Services of Detroit, Inc. |
| Mayo Medical School | | |
| University of Minnesota, Duluth | Considering | |
| University of Minnesota, Minneapolis | Considering | |
| University of Mississippi | | |
| University of Missouri, Columbia | | |
| University of Missouri, Kansas City | Developing sponsored program | |
| St. Louis University | Considering | |
| Washington University | Sponsorship/ Affiliation | Medical Group of St. Louis |
| Creighton University | | |
| University of Nebraska | | |
| University of Nevada | | |
| Dartmouth | Considering | |
| New Jersey College of Medicine, Newark | | |
| New Jersey College of Medicine, Rutgers | Sponsorship | Rutgers Health Plan |
| University of New Mexico | | |
| Albany Medical College | | |
| Albert Einstein | | |
| Columbia University | Considering | |
| Cornell University | Considering | |
| Mount Sinai | Affiliation | Health Insurance Plan of New Yor |
| New York Medical College | | |
| New York University | | |
| University of Rochester | Affiliation | Genessee Valley Group Health Association |
| State University of New York at Buffalo | | |
| State University of New York, Downstate | Considering | |
| State University of New York at Stony Brook | | |
| State University of New York, Upstate, Syracuse | Considering | |
| Bowman Gray | Considering | |
| Duke University | Considering | |
| University of North Carolina, Chapel Hill | Affiliation | Statewide HMO |
| University of North Dakota | | |

Table 5 (cont.)



| | | |
|---|---|---|
| Case Western Reserve | Considering | |
| University of Cincinnati | Considering | |
| Medical College of Ohio, Toledo | Considering | |
| Ohio State | Affiliation | United Health Plan |
| University of Oklahoma | | |
| University of Oregon | Affiliation | Kaiser Permanente Health Plan |
| Hahnemann Medical College | Affiliation | Philadelphia Health Plan |
| Jefferson Medical College | Affiliation | Health Service Plan of Pennsylvania |
| Medical College of Pennsylvania | Affiliation | Health Maintenance Organization of Pennsylvania |
| Pennsylvania State | | |
| University of Pennsylvania | Affiliation | Penn Urban Health Maintenance Organization |
| University of Pittsburgh | Affiliation | Penn Group Health Plan |
| Temple University | Considering | |
| Brown University | Affiliation | Rhode Island Group Health Association |
| University of South Carolina | | |
| University of South Dakota | | |
| Meharry | Considering | |
| University of Tennessee | Considering | |
| Vanderbilt University | | |
| Baylor | Considering | |
| Texas Tech | | |
| University of Texas Southwestern | | |
| University of Texas at Galveston | | |
| University of Texas, Houston | Considering | |
| University of Texas, San Antonio | Considering | |
| University of Utah | | |
| University of Vermont | Developing sponsored program, Vermont Health Pla | |
| Eastern Virginia | | |
| Virginia Commonwealth | Considering | |
| University of Virginia | Considering | |
| University of Washington | Affiliation | Puget Sound Group Health Cooperative |
| West Virginia | | |
| Medical College of Wisconsin | Considering | |
| University of Wisconsin | Considering | |
| University of Puerto Rico | | |
| Drew Postgraduate School | | |
| Morehouse | | |
| Uniformed Services University | | |
| East Carolina | | |
| Northeastern Ohio | | |
| Wright State University | Considering | |
| Oral Roberts University | | |
| University of South Carolina, Columbia | | |
| East Tennessee | | |
| Texas A&M | Affiliation | Centroplex Health Plan, Inc. |
| Marshall | Considering | |
| Catholic University of Puerto Rico | | |

## REFERENCES


1. Friedman, Emily, "Competition and the Changing Face of Health Care," Hospitals, July 16, 1980, pp. 64-67.

2. Ellwood, Paul, "Can Teaching Hospitals Survive in a Price Competitive Medical Care World?", Presentation at the COTH Spring Meeting, May, 1980.

3. Havighurst, Clark C., "Competition in Health Services -- An Equal Number of Questions and Answers," Presentation at Project Hope Institute for Health Policy Studies Seminar, Competition and Regulation of Health Services -- Are They Compatible?, May, 1980.

4. Enthoven, Alain C., "Shattuck Lecture - Cutting Cost Without Cutting the Quality of Care," New England Journal of Medicine, June, 1978, pp. 1229-1238.

5. "National Health Care Reform Act of 1980," H.R. 7527, June 19, 1980, 96th Congress, Second Session.

6. Environmental Assessment of the Hospital Industry, Update, March, 1980, Division of Corporate Planning, American Hospital Association, 1980.

7. Journal of the American Medical Association, March 7, 1980, p. 868.

8. Kahn, Lawrence, et al., "The Cost of a Primary Care Teaching Program in a Prepaid Group Practice," Medical Care, January, 1978, pp. 61-71.

9. Pawlson, L. Gregory, et al., "Medical Student Instructional Costs in a Primary Care Clerkship," Journal of Medical Education, July, 1979, pp. 551-555.

10. Stern, Robert S., "Graduate Education in Primary Care: An Economic Analysis," New England Journal of Medicine, September 22, 1977, pp. 638-643.

11. Knapp, Richard and Butler, Peter, "Financing Graduate Medical Education," New England Journal of Medicine, October 4, 1979.

12. Butler, Peter, COTH Survey of House Staff Stipends, Benefits, and Funding, 1979, Association of American Medical Colleges, Washington, D.C., 1980.

References (cont.)

13. Kaufman, Ronald P., "Calling the Role for the HMO: At George Washington, Teaching is Present and Accountable," Harvard Medical Alumni Bulletin, June, 1980, pp. 8-13.

14. Colloton, John W., National Health Insurance and Its Implications for Academic Health Centers, Presentation to the Association of American University Presidents, Washington, D.C., April 21, 1980.

15. Heyssel, Robert M., "Calling the Role for the HMO: But in Baltimore, Despite the Best Laid Educational Schemes, School's Out," Harvard Medical Alumni Bulletin, June, 1980, pp. 9-13.

16. American Hospital Association Annual Survey, 1979.

17. Vraciu, Robert and Zuckerman, Howard, "Legal and Financial Constraints in the Development and Growth of Multiple Hospital Arrangments," Health Care Management Review, Winter, 1979, pp. 39-47.

18. Johnson, Donald, "University Hospitals will Anchor Vertical Systems," Modern Healthcare, December, 1979, pp. 50-54.

19. Light, Harold and Match, Robert, "The Potential of the Teaching Hospital for the Development of Prepaid Group Practices," Medical Care, August, 1976, pp. 643-653.

aamc association of american medical colleges

July 23, 1980

Marc Roberts, PhD
School of Public Health
Harvard University
677 Huntington
Boston, Massachusetts 02115

Dear Doctor Roberts:

We are delighted that you have agreed to speak at the Council of Teaching Hospital's General Session at the AAMC Annual Meeting this fall in Washington, DC. The session will be held on October 27 at the Washington Hilton Hotel from approximately 2:00-4:00pm. Last year about 300 people attended and I expect that this year's program will attract about the same number. Most will be chief executives from major teaching hospitals.

The general session follows lunch at noon and a short business session. We would be pleased if you could join us for lunch at the head table.

On the printed program, the title of your presentation will be, "The High Cost Patient: Implications for Public Policy and Teaching Hospitals". We hope that you will talk for 30-45 minutes and cover some of the following matters:

- What are the facts about high cost patients? What does research reported in the literature say about who the high cost patients are? (eg, the papers by Zook and Moore, and Schroeder, Showstack and Roberts which appeared in the New England Journal of Medicine.)
- How do the high cost patients in teaching hospitals compare to those in non-teaching hospitals?
- What are the implications for the above findings for government health policy? -- catastrophic national health insurance, Medicare reimbursement policies, health planning, and legislation which encourages competition, among others you may wish to identify.
- What are the implications of this evidence and policy discussion for hospital chief executives? What are the issues for them and possible actions that can be taken?

Your presentation will be followed by two reactors which have not yet been selected. If you have suggestions of individuals who might well serve this role, please give me a call (202/828-0490). In addition, it would be helpful if you could provide me with at least a draft copy of your remarks two weeks ahead of time so that the reactors might have an opportunity to review the general theme of your remarks, and prepare their reactions. If you do not prepare a written text, an outline would still be useful. Following your presentation and the two responses, there will be a period for questions from the audience.

We will pre-register you for the entire AAMC meeting and send you a preliminary copy of the meeting schedule when it is available. We will cover all of the expenses you incur in connection with attendance at the meeting. If you need a hotel room, please let me know so that we can make a reservation. As the time of the meeting draws nearer, I will be in touch with you about further details. Please send me your curriculum vitae, and a picture if you have one available. If you wish to discuss any of these matters, please give me a call.

Sincerely,

Dick Knapp

Richard M. Knapp, PhD
Director
Department of Teaching Hospitals

RMK/mhw
cc: Stuart Marylander
Mitchell Rabkin, MD

Dr. Roberts

I really appreciate your interest in speaking and look forward to meeting and hearing you.

Dick Knapp

## COTH MEMBERSHIP TERMINATION AS OF JANUARY 1, 1980

1/ Rancho Los Amigos Hospital
7601 East Imperial Highway
Downey, California 90242
CEO: E. J. Foley, Administrator

2/ McLean Hospital
115 Mill Street
Belmont, Massachusetts 02178
CEO: F. de Marneffe, MD

3/ Health Sciences Center Hospital
602 Indiana Avenue
Lubbock, Texas 79417
CEO: C.O. Trimble, Jr, Assoc Executive Director

4/ Gorgas Army Hospital
Department of the Army
Headquarters, USAMD
Activity Panama
APO Miami 34004
CEO: J. R. Salcedo, MD, Chief Professional Services

THE UNIVERSITY OF CONNECTICUT
HEALTH CENTER

August 21, 1980

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

Dear John:

The nature and outcome of our recent certificate of need (C.O.N.) application for a body computed tomography scanner at the UCHC may have some interest for other academic medical centers. In the process of that application's review and eventual approval (with conditions), issues were raised and precedents set which may be of interest to the AAMC as examples of the changing regulatory environment in which academic health centers must function. Some of those issues flow from our history and our state's regulatory commission and may represent a "special case"; others have broader ramifications and concern matters which are being debated nationally.

In order to set the scene for this drama, a detailed "case study" is attached describing the history and process (Exhibit 2). I will attempt here only to present and discuss the outcomes and their significance.

PROBLEM

In 1978, the Department of HEW developed as part of its responsibility under P.L. 93-641 a set of "National Guidelines for Health Planning" to guide federal and state planning and regulatory agencies in reviewing and deciding upon the appropriate distribution of certain medical services. One of those guidelines was for CT scanners, proposing a minimum volume level of 2500 scans/year as the level of volume to justify the placement of such machines. In addition, P.L. 93-641 allowed regional HSA's to adjust volume standards upward or downward, and our local HSA in its recent review of the National Guidelines voted to increase the minimum required volume to 3000 or more scans/year.

SCHOOL OF MEDICINE
FARMINGTON, CONNECTICUT 06032

The UCHC decided, in mid-1978, that a CT scanner would be required on site to meet the educational, research, and tertiary service responsibilities of the School of Medicine and University Hospital. The size, age, and stage of development of the University Hospital, however, made the prospect of meeting the federal and local standards quite unlikely. That fact did not diminish the need for the scanner, but it did effect our approach.

PROCESS

The decision was made, after an abortive attempt to meet the standards, to put forth an application based primarily on the educational and research reponsibilites of the School of Medicine and Health Center. In addition to being the only approach we could take with integrity, it turned out to be strategically correct. We were, after a year of reviews and endless argument, approved for the scanner, but with conditions.

The only other example we know of in which an academic health center has been able to get approval for a C.O.N. on the basis of education and research is that of the Medical College of Ohio, in 1978. This, then, could be an "exception" of some importance to the country's medical schools and university hospital unless there are many instances of which we are not aware.

OUTCOMES

The process of review and approval by the state's C.O.N. agency also included another issue with which the AAMC has been concerned in the past--the imposition of otherwise unrelated conditions to a C.O.N. decision by the state agency. This tactic is increasingly being used by our Commission on Hospitals and Health Care, as applications are held "hostage" to other concessions.

In our case the conditions of approval were two:

1. Costing and funding of the scanner

2. The development of an institutional long-range plan

Those two issues and their ramifications are discussed in some detail below (the text of the "agreements" is attached to this letter as Exhibit 1).

I. COSTING/FUNDING

Recognizing that the volume guideline for CT scanning is an attempt to assure a reasonable cost/scan, and that the application's basis was the UCHC's education and research responsibilites, the UCHC proposed that the scanner's funding be split between the University Hospital and the School of Medicine.

A "community average" charge was decided upon for each scan, with total patient revenues calculated as this "community average" charge times the number of scans. That precedent has, I believe been used before in setting charges for services at many university hospitals. The shortfall between the total operating cost of the scanner and the patient revenues was proposed as the Medical School's contribution to the operation, and represented the cost we were willing to pay for education and research. Although the principle here has already been established, it becomes more painfully evident in a low-volume service. It has greater implications for small university hospitals but certainly affects the larger institutions as well. Who, indeed, pays for medical education?

Another issue related to funding was the attempt by the state C.O.N. agency to mandate which funds the School of Medicine could use to pay for the Education and Research subsidy. This issue is complicated by the fact that the CHHC, by vague mandate and even vaguer "clarification" by the state's attorney general, may indeed have some legal authority over Medical School revenues derived from professional fees. (see Attachment 4 to case study). That concerns us greatly, and may be a point worth following up.

Here the argument takes on ethical overtones: the review panel was concerned that the School not pay for the shortfall using clinically-generated income since "the patients would be paying twice".

Obviously, the distinction between the clinical and other revenues becomes blurred within the Medical School, with the faculty practice plan income supplying one-third of the School's total funding, which is then used together with state general fund support and various other funds.

We fought their demand for a while, countering principle with principle, but in the end (having recognized the essential arbitrariness of the demand but their strong symbolic and political attachment to it) agreed to draw the Medical School's portion from "non-patient revenues". The fact that clinical income obviously would be used to "back-fill" the holes thus created was not raised by the review panel, and we opted to let that particular sleeping dog lie.

There seems to be a possible precedent here as well. It may be only our problem due to Connecticut's legal and political vagaries; I wonder if others have faced it.

## II. LONG-RANGE PLAN

The panel's other concern, to avoid setting a precedent by the CT scanner's approval, and to control future requests, was at the root of the second "agreement" (see Exhibit 1).

Historically, the "role of the Health Center" has been one of the most studied and most argued issues in the last decade and one of the most worrisome to planning and regulatory agencies. It was in an attempt to deal with that issue and the issues of "what's coming, does it need to be at the Health Center or could it be elsewhere, and what criteria should we use to evaluate its need at the Health Center", that the panel proposed the "study"

(actually, a long-range plan for capital projects).

The "study", as proposed, has the following elements:

a. Development by UCHC of proposed future capital needs (equipment, construction, new programs)

b. Evaluation of those needs as to whether they must be met at the Health Center or could be provided elsewhere.

c. Presentation of the outcomes of the above process to a three member panel made up of the chairs of the Commission on Hospitals and Health Care (the state C.O.N. agency), the University Board, and the Board of the region's HSA.

d. Evaluation by that group of the plan "completeness" (i.e. whether it has appropriately addressed the issues of regionalization vs. the needs of a university health center)

e. A moratorium on clinically-related capital projects or C.O.N.'s for the duration of the "study" (i.e. until the panel agrees it is "complete") or until 12/31/81, whichever comes first.

The areas of this effort in which you may be interested and where I may be calling on some staff people at AAMC include:

a. The definition of the educational, research and patient care mission of an academic health center and its special needs;

b. The development of a strategy by which such needs may be made clear to those whose chief concerns are cost containment and pleasing political masters.

The attachment of conditions, such as our "long-range plan", seems to be the wave of the future both locally and nationally. Our case might offer an important precedent for the future of academic health centers by answering in some detail the question "What is a University Teaching Hospital?" Depending on how it is developed and conducted, it could go a long way toward the development of a more concrete policy statements regarding the role and functions of the medical school and university hospital in a regulated health care system.

SUMMARY

We may represent an opportunity for a case study of the academic medical center vs. the federal, state, and local regulatory agencies over issues of role,

scope, responsibilities, and finance. If you feel this would be worth discussing in more detail as a matter of interest to the AAMC, we would be willing to meet with you or your staff to discuss it further.

Sincerely yours,

Robert U. Massey, M.D.
Dean

John M. Glasgow, Ph.D.
Acting Vice President for
Health Affairs

James Malloy
Hospital Director

/lam
cc: Richard M. Knapp, Ph.D.
Director, Dept. of Teaching Hospitals

James I. Hudson, M.D.
Director, Dept. of Health Services

P.S. As this case also has ramifications which could be of interest to the Association of Academic Health Centers, a similar letter has been sent to John R. Hogness, M.D., President of the AAHC.

# STATE OF CONNECTICUT

*COMMISSION ON HOSPITALS AND HEALTH CARE*

July 31, 1980

In the Matter of an Application
Pursuant to Sec. 19-73k l&m, G.S. by

University of Connecticut Health
Center

Notice of Final Decision
Commission on Hospitals and Health Care
Docket Number 80-522-S

TO: John M. Glasgow, Ph.D
Acting Vice President for
Health Affairs/Executive Director
University of Connecticut Health Center
Farmington, Connecticut 06032

Dear Dr. Glasgow:

This will serve as notice of the final decision of the Commission on Hospitals and Health Care in the above matter, as provided by Sec. 19-73k l&m G.S. At its meeting on July 29, 1980, the Commission adopted the proposed settlement in lieu of the finding and order of the hearing panel as the order of the Commission on Hospitals and Health Care. A copy of the settlement as adopted by the CHHC in lieu of the panel's proposed finding and order is attached hereto for your information.

cc: Bureau
HSA IV
Theodore M. Space, Hartford
Hospital

By order of the
Commission on Hospitals and Health Care

E. Cortright Phillips a.s.

E. Cortright Phillips, as
Chairman

*Phone:*
340 Capitol Ave. — Hartford, Connecticut 06115

*An Equal Opportunity Employer*

State of Connecticut

Commission on Hospitals and Health Care

Docket Number 80-522-S University of Connecticut Health Center

## Agreed Settlement

WHEREAS, the University of Connecticut Health Center is required pursuant to Section 19-73 m, Connecticut General Statutes, to submit applications for certain capital expenditures to the Commission on Hospitals and Health Care; and

WHEREAS, the University of Connecticut Health Center has submitted an application to expend $1,476,135 to acquire a computerized tomography scanner system; and

WHEREAS, the Commission deems it acceptable, in accordance with regulations of the Commission in Sections 19-73 k, 19-73 m, Connecticut General Statutes, that the hospital make such expenditure in accordance with the terms set forth herein;

NOW THEREFORE, the University of Connecticut Health Center and the Commission on Hospitals and Health Care hereby stipulate and agree pursuant to Section 19-73 m Connecticut General Statutes that:

(1) The University of Connecticut Health Center shall expend an amount not to exceed $1,476,135 to obtain a computerized tomography scanner system to be installed at John Dempsey Hospital.

2) The operating cost of the scanners which are set forth in Attachment #1, shall be funded by a combination of patient revenue and revenue derived from non-patient sources. Non-patient sources shall include but not be limited to such sources as the Health Center's general fund account, the School of Medicine's capitation account, and the School of Medicine's research account.

6) This agreed settlement is an order of the Commission with all the rights and obligations attended thereto, and the Commission may enforce the agreed settlement pursuant to provisions to 19-73 q Connecticut General Statutes if the University of Connecticut Health Center fails to comply with these terms.

July 29 1980
Date

Frederick Carnovale M.D. Chairman Bd. Trustees
Duly Authorized Agent of University of Connecticut Health Center

The aboved agreed settlement having been presented to the Commission at its meeting on July 29, 1980 is accepted and so ordered by the Commission.

E. Cortright Phillips
Chairperson

ATTACHMENT #1

| EXPENDITURES: | | | | | |
|---|---|---|---|---|---|
| Personnel | $ 29,500 | $ 31,710 | $ 34,090 | $ 36,650 | $ 43,395 |
| Fringe Benefits | 7,375 | 7,930 | 8,525 | 9,160 | 10,850 |
| Supplies | 25,650 | 27,790 | 29,925 | 32,060 | 38,200 |
| Maintenance | - | 35,000 | 35,000 | 35,000 | 40,000 |
| Telephone | 2,000 | 2,000 | 2,000 | 2,000 | 2,576 |
| Interest | 93,545 | 74,836 | 56,127 | 37,418 | 21,709 |
| Depreciation | 144,700 | 144,700 | 144,700 | 144,700 | 144,700 |
| Indirect Costs | 136,010 | 139,214 | 137,238 | 130,032 | 140,000 |
| TOTAL EXPENDITURES | $ 438,780 | $ 436,180 | $ 447,605 | $ 427,020 | $ 441,430 |

*FROM OTHER UNIVERSITY HEALTH CENTER FUNDS

Attachment #2

It is agreed that a five-year, long-range plan projecting the Health Center's future certifica of need requests (i.e., major capital equipment, new program, and construction) will be developed by the University of Connecticut Health Center and submitted to the Commission on Hospitals and Health Care according to the following mechanism:

1. That long-range plan will be developed by the UCHC before 12/31/81.

2. In the course of that plan's development, UCHC staff will confer on a regular basis with a three member "advisory group" and with Commission and HSA staff in order to assure that concerns which should be addressed in such a plan are considered and are appropriately addressed. The design and development of the plan will be approved by the advisory group, taking into account the issues identified in the proposed "minimum requirements" Att. 2(a).

3. The "advisory group" will have the following composition:

    a. Chair of Commission on Hospitals and Health Care
    b. President of the Board of the Health Systems Agency of North Central Connecticut
    c. Chair of University of Connecticut Board of Trustees

4. That advisory group will have the authority to rule whether the plan as submitted is "complete" or "incomplete";

    a. If it is ruled "complete", it will be submitted to the University of Connecticut Board for its approval, to the Board of Higher Education and then the Commission Hospitals and Health Care for a period of review not to exceed 60 days.

    b. If it is ruled "incomplete", the areas of deficiency will be noted, and it will be returned to the University of Connecticut Health Center for further consideration, revision, and resubmission to the advisory group.

## Scope of the Plan

### I. Purpose of the Plan:

The purpose of the plan is two-fold:

a. The plan will identify and prioritize those needs of the University of Connecticut which require that specific expenditures be undertaken at facilities subject to CHHC jurisdication over the next five years.

b. The plan will identify methods by which educational and research needs of the University of Connecticut can be met through utilization of existing clinical facilities other than John Dempsey Hospital. In addition, the study will identify those specific educational needs which cannot be met through joint undertakings with other area clinical facilities.

It is recognized by the parties that the study will be conducted in accordance with the following principles:

a. It is recognized by all the parties that the University of Connecticut Medical School should continue to develop as a program of the highest possible quality.

b. In seeking to meet its clinically related needs, the University of Connecticut should, to the maximum feasible extent, utilize clinical resources existing within the region and avoid the duplication of clinical resources for largely teaching purposes.

c. In seeking to meet its clinically related needs, the University of Connecticut should, in all possible cases, adopt the least costly option which feasibly meets the educational and/or research need involved.

d. In performing the study, the University of Connecticut should conduct ongoing discussions directly with other area hospitals (prior to the choice of any particular alternative) to determine which teaching needs might be met at such facilities.

## II. Scope of the Plan:

The plan will encompass the years 1981-1986 and will identify all needs of the University of Connecticut which will require that specific expenditures be undertaken at facilities subject to CHHC jurisdiction during the period in question. Moreover, the study will examine the educational policies or requirements which affect decisions regarding the development of clinical resources as well as the policies which affect the relationship between the University of Connecticut and the existing clinical facilities other than the John Dempsey Hospital.

The plan will contain (but not be limited to) the following elements:

A. Background:

1) The plan will identify the relationship of the University of Connecticut to area clinical facilities other then John Dempsey Hospital. In doing so, the study will identify any teaching programs currently undertaken jointly with other area hospitals, shared facilities or resources, currently shared faculty or other relationships which might bear upon the future development of clinical resources.

2) The plan will describe the existing role of the UConn Health Center in meeting existing and future clinical and educational needs of the University of Connecticut Medical School.

3) The plan will outline those conditions or criteria which must generally be met by teaching/clinical sites to adequately serve the need of the University.

E. Alternatives Considered:

The plan will list each of the alternatives considered by the University of Connecticut for meeting each of the needs described under C above. Each alternative will be described in terms of the benefits, drawbacks, associated capital and operating costs and method by which such costs would be financed. The preferred alternative will be designated and a rationale presented to why the preferred alternative was chosen.

F. Specific Issues to be Addressed:

The scope of the plan will include, but not be limited to, an examination of the following issues identified by the University in its long range plan and FY '82 capital budget submission to CHHC:

- -Cardiac Catheterization Laboratory
- -Neonatal program expansion
- -Expansion of clinic area
- -Renovation of laboratory building
- -Expansion of dental clinic
- -Expansion of emergency room
- -Allied Health building
- -Geriatric long-term care facility