A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING
BREAKFAST

October 29, 1984
Conrad Hilton Hotel
Room #412
Chicago, Illinois
7:00-9:00am

I.	CALL TO ORDER	
II.	CONSIDERATION OF MINUTES September 13, 1984	Page 1
III.	THE COMMON FUND	Page 14
IV.	NOMINATING COMMITTEE REPORT	Mr. Frederick
V.	JOINT COMMISSION ON ACCREDITATION OF HOSPITALS	Page 54
VI.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 13, 1984

PRESENT

Haynes Rice, Chairman
Sheldon S. King, Chairman-Elect
Earl J. Frederick, Immediate Past Chairman
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
William B. Kerr
Eric B. Munson
David A. Reed
C. Thomas Smith
Thomas J. Stranova
William T. Robinson, AHA Representative

ABSENT

Glenn R. Mitchell

GUESTS

Robert M. Heyssel, MD
Richard Janeway, MD

STAFF

David S. Baime
James D. Bentley, PhD
John A. D. Cooper, MD
Richard M. Knapp, PhD
Thomas J. Kennedy, Jr., MD
Len T. Koch
Karen L. Pfordresher
Nancy E. Seline
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
Meeting Minutes
September 13, 1984

I. CALL TO ORDER

Mr. Rice called the meeting to order at 9:00am in the Jackson Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the June 28, 1984 COTH Administrative Board meeting.

III. PAYING CAPITAL COSTS IN COTH HOSPITALS

Dr. Bentley opened discussion of capital payment under the Medicare program by reviewing the five areas of consensus reached by the ad hoc committee chaired by Mr. Frank, and recalling that the Board had considered several transition period options at its June meeting. Because the deans and faculty were less comfortable with this issue in June than the COTH Board, staff was requested to redraft the agenda paper to include numerical examples for the most discussed options. The revised paper was included in the agenda. Dr. Bentley reviewed the examples individually. In the discussion period, Mr. Smith suggested that the recommended action be modified to state that the percentage add-on should be at a level consistent with Medicare's present percentage for capital expenditures. This was agreeable to all. Dr. Dalston suggested that the recommended principles failed to address the particular capital needs of the research-intensive hospitals but acknowledged that historical data did not demonstrate above average capital costs for this group. Dr. Foreman questioned whether an example with a $30 million project was adequate to describe the implications of the policy options for COTH members. In response, Dr. Bentley noted the project was equal to 85% of the hospital's annual expense budget.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board adopt as Association policy on paying capital costs under Medicare the five areas of consensus recommended by the Ad Hoc Committee and the transition period option which allows a hospital its choice of (1) cost reimbursement for depreciation and interest or (2) a prospective percentage add-on that is no less than Medicare's current percentage for capital expenditures.

IV. MODIFYING THE MEDICARE PAYMENT SYSTEM

Dr. Bentley introduced this topic by recalling that the Board's January meeting was cancelled because of snow. To prepare for Congressional interest in the prospective payment system, Drs. Knapp and Bentley contacted each Board member and discussed the AHA's proposal for a "blended" rate. All Board members favored supporting the AHA's proposal; however, the action remained an informal one. The present agenda item was developed in order to have a formal decision on the AHA's proposal. Dr. Bentley then reviewed the AHA's proposal and concluded that it appeared to be in the best interest of COTH members.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board endorse the DRG specific price blending proposal of the American Hospital Association and that the AAMC work with the AHA to incorporate this feature into the Medicare prospective payment system.

. . . . .

At this point the Chairman indicated that he had a number of announcements to make. He indicated that there is a heavy testimony schedule ahead over the next two weeks. He will be making a presentation on "uncompensated care" that afternoon before the National Council on Health Planning and Development. He reminded Board members that the Council is chaired by Yoshi Honkawa of Cedars-Sinai Medical Center in Los Angeles. On Thursday, September 20, Mort Rapoport, MD, President, University of Maryland Hospital, will appear before the Special Committee on Health Care Cost Containment of the National Conference of State Legislators. He will discuss the issues of financing graduate medical education, uncompensated care, diagnostic case mix, regional and standby services, and the provision of an environment for clinical research and technology development.

On Friday, September 21, Tom Smith, President, Yale-New Haven Hospital, will present testimony to the Health Subcommittee of the Senate Finance Committee on financing graduate medical education. (This testimony was postponed and rescheduled for October 1.) On Friday, September 28, Dr. Heyssel will present testimony to the Health Subcommittee of the Senate Finance Committee on the subject of "uncompensated care."

The Chairman then recalled that at the June COTH Administrative Board meeting, a motion was passed requesting that the AAMC review the possibility of joining with the Association of Academic Health Centers in their study of the pro's and con's of university ownership of teaching hospitals. He reported that had been accomplished and a joint grant proposal has been submitted to a foundation with excellent funding prospects.

The Chairman then asked Mr. Frederick to report on the COTH Nominating Committee interaction with the AHA Nominating Committee. Mr. Frederick reported that on June 30 he and Dr. Knapp had made an appearance before the AHA Nominating Committee and had submitted three names to the Committee for consideration as AHA Board members. He indicated that he had heard from Mr. Robinson who staffs that committee in early August with the news that he himself had been nominated to serve on the American Hospital Association Board. He indicated that while he found the situation to be somewhat awkward, he was honored with the opportunity and after due consideration agreed to accept the nomination to the Board.

The Chairman next asked Mr. Kerr to report on the AHA Metropolitan Hospital Section. Mr. Kerr indicated that the Section had discussed fully the AHA capital proposal and wished to make it clear that the capital "add on" for Medicare purposes would be added to the "full base." He also reported that the American Hospital Association had exhibited a strong level of interest and commitment to the issue of uncompensated care, and efforts were being made to come up with practical proposals that might have some possibility of showing some progress on the issue.

Finally, he reported that on the Sunday of the week of the AAMC Annual Meeting, the Section would be holding a one day meeting entitled, "Survival Strategies for Metropolitan Hospitals in a Changing Environment." He urged COTH Administrative Board members to attend.

The Chairman then called on Dr. Dalston to report on the teaching hospital committee of the Association of Academic Health Centers. Dr. Dalston indicated that the reponses to the survey on priority areas of interest were coming in and would be shared with the Board as soon as they were available. He indicated that a discussion had been held concerning the joint study on the university ownership of teaching hospitals. The next meeting of the committee will be held shortly after the AAHC meeting in Key West next month.

At this point the Chairman distributed a letter that Dr. Cooper had written to Mr. Gilbertson concerning the criteria for selection of a new president of the American Hospital Association and the needs and prospects for the health industry in the near future. A copy of the letter is included as Appendix A to these minutes. The Chairman indicated that he felt that relationships with the American Hospital Association, while always good, had been substantially strengthened over the past year. He felt that a letter would be in order expressing those thoughts and thanking Alex McMahon for being so responsive.

The Chairman next called on Dr. Knapp to make some announcements. He covered the following matters:

- On July 5, 1984 all members of the COTH Administrative Board received a carbon copy of a letter to Mr. Frederick from L. Donald Slaughter, MD. A copy of that letter is included as Appendix B to these minutes. Dr. Knapp indicated that the AAMC Office of the President is aware of this letter and it has been reviewed by AAMC Counsel.

- The Board was reminded that Professor Judy R. Lave, PhD, of the University of Pittsburgh is under contract to the AAMC to produce a paper entitled, "The Medicare Adjustment for the Indirect Costs of Graduate Medical Education: Historical Development and Current Status." A final draft of the paper has been submitted to the Department of Teaching Hospitals staff for review and comment. It is expected that the paper will be available shortly after the AAMC Annual Meeting.

- The leadership group from hospitals with burn centers has awarded a contract to ICF, Inc. to develop a national coalition of burn center hospitals. Mr. Joseph Rees, a government relations/ public affairs consultant with The Keefe Company, is working with ICF to do the organizational development work while ICF will do most of the substantive technical reimbursement and analytical work. A copy of the proposal was distributed to Board members for review.

- It was noted that Mr. Rice will be appearing before the National Council on Health Planning and Development to present testimony entitled, "Uncompensated Care and the Teaching Hospitals." A copy of the testimony was distributed to the Board for review.

- A large three-ring bound notebook entitled, "Peer Review Organization Objectives: A Synopsis" had been made available by the Health Care

Financing Administration (HCFA) which included a compilation of summaries of objectives negotiated and included in the contracts for each PRO area for the first 31 contracts that had been signed. The only contracts that had been signed which were in areas in which COTH Board members were located were in the states of Missouri and North Carolina. Copies of those two contracts were distributed for Board members to review. A variety of concerns were expressed by individual Board members concerning the extent to which the objectives set forth in the contracts were realistic. It was stated that in many cases these contracts had been negotiated by the leadership of a state medical society. In some cases the objectives may have been overstated in order to obtain the contract from a competing organization. Dr. Knapp explained that there had been a variety of pressures placed upon individuals and organizations in the negotiating situation and Dr. Carolyne Davis in a recent meeting had indicated that she would be willing to review once again the contract objectives six months subsequent to their signature. Whether or not this program will be operated as an educational venture with a spirit of cooperation or whether or not it will be a regulatory oriented program remains to be seen and undoubtedly will vary from state to state. All members were urged to become actively involved in the PRO negotiation and operation within their respective states.

- Dr. Knapp indicated that the Survey of Universityy Owned Teaching was proceeding slowly and would become available in late 1984. He also indicated that the results of the Survey to Determine the Implications of the Medicare Prospective Payment System were also not being returned as rapidly as had been hoped. A report will be prepared for the Board. However, the staff is not completely convinced that the results are such that one would have confidence to release them to the general membership and the public broadly.

V. LETTER FROM AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. Rice at this point in the meeting distributed a letter from David M. Brown, MD, Dean Designate at the University of Minnesota. A copy of this letter is included in these minutes as Appendix C. The letter concerns the position of the American Physical Therapy Association that the degree to be awarded to students who enroll in entry level education for the physical therapist after December 31, 1990, and satisfactorily complete all requirements, shall be the first professional degree in physical therapy and shall be a graduate or post baccalaureate degree. Dr. Brown urged that the AAMC take a strong position to oppose this move. Mr. Rice asked the Board members whether or not they felt COTH/AAMC should become involved in this issue. Following general discussion, it was agreed that this was an issue that should be taken up through proper channels at the American Hospital Association. If support were needed from the AAMC it was recommended that such support should be forthcoming for the position taken by the American Hospital Association.

VI. PROCESS FOR SELECTION OF NEW AAMC PRESIDENT

At this point in the meeting, the COTH Administrative Board was joined by Dr. Heyssel and Dr. Janeway, AAMC Chairman and Chairman-Elect respectively. Dr. Heyssel introduced Dr. Janeway and indicated that they had agreed that the

selection process should be initiated during Dr. Janeway's term of office, and that Dr. Janeway would therefore appoint a search committee. Dr. Janeway outlined his initial thoughts on the subject and asked the COTH Board members for their advice and consultation. The following observations and suggestions were made:

- It was recommended that a search firm be employed to work with the search committee. It was felt that the search committee would not likely be organized to provide the backup support for its activities and that it would be unwise and awkward to charge any current AAMC staff member with this responsibility. The search firm should be one that has excellent connections to the worlds of foundations, governments, business and industry, hospitals as well as scientists and academic posts. It was recommended that the committee be appointed with all deliberate speed. Already a variety of undercurrents are developing and the appointment of a committee with a specific charge would serve to provide some direction to this activity.

- It was recommended that qualifications and criteria be set forth early in the search process. Several Board members believed this to be extremely important so that substantive debate over qualifications becomes the issue rather than personal dynamics. There are also several qualification matters that need to be determined early (e.g., whether or not the individual is a physician and the extent to which a science background is important). It was recommended that the short and long range expectations be set forth in the charge so that the question of whether a person with a short time left in his/her career would be appropriate or whether a younger person would be a better selection.

- It was recommended that the objectives of the Association be re-assessed and included in the charge to the Committee. Relationships with other organizations and expectations for the future of the AAMC are matters that ought to be assessed in the context of selecting a new chief executive.

- It was recommended that close attention be given to process. All members of the AAMC should believe they have had an opportunity to have their views recognized. In addition, it was felt that the search committee should consult widely with other hospital and medical organizations to determine their expectations and views of the future.

VII. HEALTH CARE IN THE 1990'S: TRENDS AND STRATEGIES

The report entitled, "Health Care in the 1990's: Trends and Strategies," sponsored by the American College of Hospital Administrators and completed in conjunction with Arthur Andersen & Co. was briefly reviewed. Dr. Knapp reported that Dr. Cooper had served as a respondent to the Delphi questionnaire and did have the opportunity to review the initial questionnaire. Some Board members expressed concern about how some of the questions were asked. For example, concerning whether research and education costs should continue to be financed out of the patient care dollar, it was believed that the two issues should have been separated rather than combined since they are substantially different. Others believe that the questions were worded in such a way as to force an answer in a way which did not really reflect one's views on the subject. There was also some

question as to whether or not in some cases the document sounded like an advocate document rather than a descriptive one. Notwithstanding these concerns, there was general agreement that it was helpful to have a good summary view of the environment in which individual institutions must operate and that the survey was a useful way of doing so.

VIII. JCAH REPORT ON ACADEMIC HEALTH CENTER HOSPITALS

A JCAH internal memorandum from Dr. Roberts to the Accreditation Committee concerning academic health center hospitals was discussed as it appeared in the agenda book. The following points were made in the discussion.

- The tone of the report seems to imply a negative view of external evaluation. However, it was suggested that these institutions, and departments and divisions within them, subject themselves to many evaluation processes. The negative view is specific to the JCAH. It is suggested in the report that because of the high caliber of the practitioners in academic centers and the "fishbowl" nature of the scrutiny placed on these practitioners, competence is constantly under review. Thus, there is a feeling on the part of the JCAH that the view in the academic community is that the JCAH requirement of formalized systems to assess compentence, and specifically the privileged delineation process, is duplicative and unnecessary. It was the consensus on the part of the Board that this did not reflect their view.

- Also expressed in the document is a JCAH view that it is is probably more helpful to tap into the teaching and research processes to judge their effectiveness in monitoring and improving the quality of care rather than requiring a parallel system of quality assurance. This also was not a view that was shared by the Board.

- There was also a discussion of the difference between qualified versus competent, process versus outcome, and the quality of the surveyors as a generalized problem.

In summary the Board felt that there was a stereotyped approach perceived to be the view of the academic community with regard to quality assurance on the part of the JCAH with which the COTH Administrative Board did not agree. It was requested that this report be placed on the agenda once again for review either at the October 29 Administrative Board breakfast or the January 1985 Administrative Board meeting.

IX. MATCHING MEDICAL STUDENTS FOR ADVANCE RESIDENCY POSITIONS

The AAMC recently examined the selection process for specialty residency positions that commence at least one year after graduation (PGY-2). The Council of Academic Societies presented a proposal that all internships (PGY-1) and residency (PGY-2 and beyond) positions be offered only through the National Residency Matching Program (NRMP), rather than the current practice of individual specialties conducting independent matching activities. The proposal also stated that medical schools should not release summary reports of student achievement until October 1 of the senior year.

ACTION: It was moved, seconded, and carried to endorse the resolution as presented. However, it was suggested that the October 1 date for letters of achievement be separated from the NRMP issue so that the matters can be debated separately.

X. REPORT OF THE PROJECT PANEL ON THE GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN

The General Professional Education (GPEP) Report entitled "Physicians for the Twenty-First Century" was distributed to the Board for their review and action. Note was made that the Council of Deans wished to revise the recommendation that appeared in the Agenda for Executive Council Meeting.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board support the Council of Deans' revised recommendation which reads as follows:

> The AAMC is indebted to this distinguished panel of educators for its search examination of the challenges facing those preparing physicians for the 21st century. The examination itself has stimulated parallel and collaborative inquiries at both medical schools and undergraduate colleges. This three-year effort has set in motion a process of self-renewal that will be given additional impetus by the publication of the Panel's Report.
>
> It is an extraordinarily useful agendaof issues and the AAMC therefore commends it to its members and to all of those engaged in the enhancement of education for medicine.
>
> We are very hopeful that the report will stimulate a high level of attention and personal commitment by the faculties of member medical schools. In its continuing efforts to assist its member schools in improving the quality of physician education, the AAMC will create a formal mechanism to review the report and to advise on its use in the development of policies and the design of Association programs.

XI. LOW LEVEL RADIOACTIVE WASTE DISPOSAL

Dr. Kennedy and staff reported that the deadline allowing states to deny access for disposal of low level radioactive waste is January 1, 1986. Currently there are only 3 states with approved sites, although the law encourages multi-state compact arrangements. These compacts must be approved by the legislature of each member state. After January 1, compacts can, by law, exclude non-compact states from using their disposal sites.

Suggested AAMC activities to encourge compact formation included: alerting membership to encourage local inititatives, lobby the governors' offices to encourage action, working with the AHA in forwarding this issue to a broader constituency.

Dr. Kennedy also reported on the status of the student loan consolidation for medical school graduates. The Senate will soon consider S. 2491, a bill to reauthorize and revise the expiring consolidation program. The major difference

between House and Senate bills is whether or not the criteria of "need" should be applied to eligibility for consolidation of loans. S. 2491 is consistent with AAMC policy that subsidy be based on documented need.

ACTION: It was moved, seconded, and unamimously approved that the AAMC should suport the position incorporated in S. 2491, using a "needs analysis" for loan consolidation eligibility.

A report on the definition of classified information in Department of Defense regulations and the Department of Commerce's Export Administration Act was briefly presented by Dr. Kennedy for the information of the Board. Focusing on chemistry innovations, the Act could threaten academic freedom. University presidents are currently addressing the issue of possible restrictions of the flow of scientific information that this may present.

XII. MEMBERSHIP APPLICATIONS

Following discussion and appropriate consideration, the following action was taken:

ACTION: It was moved, seconded, and carried to approve:

(1) VETERANS ADMINISTRATION MEDICAL CENTER, Mountain Home, Tennessee for full membership;

(2) BAYFRONT MEDICAL CENTER, St. Petersburg, Florida for corresponding membership.

Dr. Knapp reported that subsequent to the September 13 Action approving Women's Hospital in Las Vegas, Nevada for corresponding membership, it was learned that this hospital is a for-profit institution. This Action is in direct violation of the current AAMC bylaws and Dr. Knapp indicated that he was sending the chief executive of that institution a letter of apology for the failure to more accurately discern the situation, but that current AAMC policy does not permit the participation of investor-owned hospitals in the affairs of the Council of Teaching Hospitals. A copy of that letter is included in these minutes as Appendix D.

XIII. ADJOURNMENT

With no new business, the meeting was adjourned at 12:30pm.

association of american medical colleges

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

(202) 828-0460

September 11, 1984

E. E. Gilbertson
Chairman, Criteria Committee
c/o Michael Guerin
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. Gilbertson:

The purpose of this letter is to respond to your request for a summary of my thoughts on both the future of the health care industry and, in particular, the leadership qualities that will be needed by the next AHA president. I wish to call attention to the enclosed document entitled, "New Challenges for the Council of Teaching Hospitals." The significant major trends facing teaching hospitals and the significant needs of teaching hospitals are set forth. In addition, the advocacy, economic, information, education, and research roles we see on behalf of our teaching hospital constituents are outlined in the report.

There is one matter reviewed in the document to which I believe special attention should be given. On page nine, a list of new hospital organizations competing for national attention is provided. In addition to these hospital organizations, a myriad of physician and other provider organizations are increasing their staff time and attention to issues of concern to the American Hospital Association. The president of the American Hospital Association must have the interest and ability to work with a broad group of private sector organizations, many of which are interested in the same issues. This particular need for an individual who can provide effective linkages to lead to broad consensus is very likely to be increasingly difficult in the competitive environment of the future.

I would hope the individual chosen to succeed Alex McMahon would be sensitive to the following major issues:

- The current competitive environment may very easily result in reducing access to hospital and medical services for those who are unable to pay. Leadership on this issue is vital to the future of our medical care system;
- Basic and clinical research must be supported. Research in the medical sciences has made significant advances in the past two decades, and we must maintain our leadership position in the world;
- A high quality environment for undergraduate and graduate medical education must be maintained;

- There is a need to understand the interdependent nature of education, clinical research, and the complex services provided in the medical center environment. These institutions must not be viewed as islands apart from the medical care system but rather as the backbone of the medical system;

- Constant attention must be paid to the relationship between physicians and hospitals as well as other provider organizations. A constructive relationship is vital to providing quality medical services in the future.

Some of my observations are generic, and I know pertain to all segments of the hospital constituency. Others are particularly directed at teaching hospitals. I hope you will consider each of these points as you move ahead in your deliberations. I would be happy to discuss these matters with you if you should so wish.

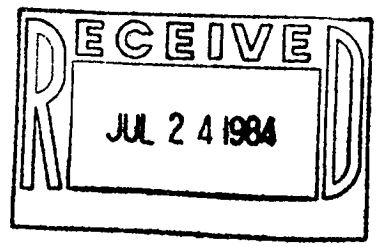
Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Enclosure

L. DONALD SLAUGHTER, M.D.
Behavioral Toxicology
Internal Medicine
3724 Kimberly Way
Carmichael, California 95608
(916) 486-1825



July 5, 1984

Earl J. Frederick, President
Council of Teaching Hospital Officers, 1982-83
Children's Memorial Hospital
2300 Children's Plaza
Chicago, Illinois 60614

Dear Mr. Frederick:

I am enclosing a copy of a letter to medical school members of the AAMC concerning proposed federal legislation to expand centralized authority over physicians along with a copy of "Anatomy of a Modern Inquisition" to indicate some of the hazards of combining psychiatric propaganda and psychiatric political terrorist tactics with the interstate doctors' credentialling process and network. I believe that it must be especially important to you and your hospital since on the last page of the documentation I have included, there is a copy of a letter addressed to the director of medical education at the Children's Memorial Hospital which is dated August 31, 1976 from Emergency Medical Systems, Inc. of San Francisco and a Dr. Ronald I. Jacoby, M.D.; which was in the Interstate Doctors' Credentialling process and from a member of the interstate doctors' credentialling chain inquiring about me.

Could you explain to me what this Dr. Ronald Jacoby was doing writing to your hospital (Childrens' Memorial Hospital) in Chicago Illinois? How did Dr. Visotsky answer that inquiry? Why did he answer that inquiry six months later? Was I ever affiliated in any way with Childrens' Memorial Hospital? I do know that this same Dr. Ronald Jacoby caused me to lose several non-medical as well as several medical positions with all the economic and other losses and damages associated.

Do you understand or see any danger in a "health care program violation information system" by federal legislation and by further centralization of power in a computer system in Washington, D.C. from which to "sanction physicians nationally"?

Sincerely,

L. Donald Slaughter, M.D.

cc: Mr. Haynes Rice
Mitchell T. Rabkin, M.D.
James W. Bartlett, M.D.
Jeptha W. Dalston, Ph.D.
Spencer Foreman, M.D.
Irvin Goldberg
Sheldon S. King
Glenn R. Mitchell
David A. Reed
John V. Sheeban
C. Thomas Smith
Robert E. Frank
William T. Robinson
Council of Academic Societies

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Laboratory Medicine and Pathology
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Box 198 Mayo Memorial Building
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Minneapolis, Minnesota 55455
(612) 373-8623

August 28, 1984

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

Dear John:

The American Physical Therapy Association (APTA) has mandated that as of January 1, 1985, "all accredited baccalaureate degree and postbaccalaureate certificate educational programs for the physical therapist include with their completed self-study a copy of their plan for transition to the first professional degree in physical therapy at the graduate or postbaccalaureate degree level". This is consonate with ATPA's position that, "The degree to be awarded to students who enroll in entry-level education for the physical therapist after December 31, 1990, and satisfactorily complete all requirements shall be the first professional degree in physical therapy and shall be a graduate or postbaccalaureate degree".

I am concerned that the justification for this unilateral action is adequate to warrant this conclusion and that the costs for the education programs are prohibitive.

I urge that the AAMC take a strong position to oppose this move. The timing is particularly crucial since the 1985 date of declaration locks in the decision making process.

Has the Executive Council taken any action on this matter?

Thank you for your attention to this.

Sincerely,

David M. Brown, M.D.
Professor and Dean Designate

DMB:cj

association of american medical colleges

September 24, 1984

Ms. Willa J. Stone
Administrator
Women's Hospital
2025 East Sahara Avenue
Las Vegas, Nevada 89116

Dear Ms. Stone:

On July 11, 1984 I notified you that the COTH Administrative Board and AAMC Executive Council had endorsed Women's Hospital's application for corresponding membership in the Council of Teaching Hospitals (Attachment A). The final step in COTH membership is approval for membership by the AAMC Assembly at its Annual Meeting. Recently, I have learned that Women's Hospital is a for-profit corporation. As stated in the membership application materials sent to you and on the face of the application completed by Women's Hospital (Attachment B), COTH is limited to 501(c)(3) and publicly (i.e., governmentally) owned hospitals. As a for-profit hospital, Women's Hospital is not eligible for membership in COTH, and the application will not be presented to the AAMC Assembly.

I apologize for any misunderstanding this matter may have caused. Because no dues invoice was mailed, no dues have been paid and, thus, there is no need for a refund.

The issue of investor owned hospital participation in the Council of Teaching Hospitals was discussed and debated at the COTH Spring Meeting last May, and will be discussed once again at the institutional membership meeting in Chicago. I've enclosed a copy of the spring meeting program and the Chicago agenda for your review. This issue has also been raised in the attached publication, "New Challenges ..." on page 9.

If there are ways in which we can be helpful to you, I hope you will call upon us. However, I do request that Women's Hospital not identify itself as a member of either the Association of American Medical Colleges or its Council of Teaching hospitals.

Thank you.

Sincerely,

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

RMK/mrl
Attachments

cc: Robert M. Daugherty, Jr., M.D., Ph.D.
Dean, University of Nevada
School of Medicine

THE HOSPITAL FUND

A small group of teaching hospital chief executives stimulated and provided with staff support by the leadership of the Department of Epidemiology and Public Health at Yale University have been working to establish a short-term cash management fund. The fund is to be modeled on The Common Fund, a very successful fund exclusively for colleges, universities, and independent schools. This program is described beginning on page 15.

The development of the Hospital Fund is at the stage where it needs approval from the Office of the Comptroller of the Currency. In the draft letter to the Deputy Comptroller, set forth on page 22, the applicants propose to state, "The concept of The Hospital Fund, Inc. was first proposed some months ago by representatives of the Department of Epidemiology and Public Health of Yale University in coordination with the leadership of the Council of Teaching Hospitals."

The staff recommends the COTH Administrative Board take formal action approving this statement.

October , 1984

Mr. Dean Miller
Deputy Comptroller for Trusts
Office of the Comptroller
of the Currency
419 L'Enfant Plaza East, S.W.
Washington, D.C. 20219

Dear Mr. Miller:

The Philadelphia National Bank (the "Bank") hereby applies for the written approval of the Comptroller of the Currency under Section 9.18(c)(5) of the Comptroller's Regulations for the establishment and maintenance by the Bank of a common trust fund (the "Common Trust Fund") for certain nonprofit hospitals and hospital associations. The Common Trust Fund is proposed to be established in conjunction with the recent organization of The Hospital Fund, Inc., a new Connecticut nonprofit membership corporation whose members will consist of hospitals and other health care institutions which are exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, and hospital associations which are tax-exempt under Section 501(c)(6) of the Code.

The concept of The Hospital Fund, Inc. was first proposed some months ago by representatives of the Department of Epidemology and Public Health of Yale University in coordination with the leadership of the Council of Teaching Hospitals. It came about partly in response to the perceived need for nonprofit hospitals to begin employing more innovative techniques in the management of their finances, as one element of an overall effort to stem the alarming escalation of health care costs in the nation. The results of the preliminary investigations made by members of this Department suggested that an important area in which nonprofit hospitals have generally lagged behind the large proprietary health care organizations has been the efficiency with which they have invested their endowment and other funds.

As a result of these investigations, a group of concerned leaders of the medical-academic community concluded that the investment funds of nonprofit hospitals, unlike those of the large proprietary institutions, are generally invested inefficiently on an individual basis. Based upon these findings

the group has organized a new nonprofit steering organization, The Hospital Fund, Inc., to explore and develop opportunities for its member nonprofit hospitals to improve the returns on their investment portfolios through the use of more effective investment techniques.

The Hospital Fund, Inc. proposes to address the goal of improved efficiency in the investment of the funds of its member nonprofit institutions by entrusting them to a large regional bank with demonstrated trust capability, one which could give these hospitals access they would not otherwise have to a specialized wholesale money-market management tailored to their needs. The Hospital Fund, Inc. approached The Philadelphia National Bank because of its experience of ten years with a comparable fund organized for the collective investment of assets of nonprofit educational institutions.

The Bank has agreed to undertake the investment of the short-term assets of these nonprofit hospitals in its Trust Department. To maximize the prospects for favorable investment returns, the Bank proposes to develop a special trust investment program responsive to the requirements of these hospitals. For added efficiencies, the Bank proposes to invest the funds of the individual member hospitals primarily through a common trust fund of the Bank. In view of the unique nature of the proposal, the Bank has determined to form a new common trust fund exclusively for this program.

For its part, The Hospital Fund, Inc. would serve as an intermediary or liaison with the participating nonprofit hospitals, to represent them in their relationship with the Bank and to advise the Bank concerning their special requirements. Each participating hospital or hospital association would be required to be a member of the corporation and would be charged a modest fee in amount sufficient to defray the corporation's administrative expenses. The corporation would remain nonprofit.

Enclosed are three copies of the proposed "Plan of the Common Trust Fund for Hospitals", designed to create the Common Trust Fund in which the designated assets of the Bank's client nonprofit hospitals would normally be invested. The method of operation of the proposed Common Trust Fund is described generally in the enclosed Plan. It may be noted that the common fund will be accessible only to members of The Hospital Fund, Inc. which have established bona fide trust relationships with

the Bank. As indicated in the Plan, the Common Trust Fund will at all times be invested in assets of high quality and liquidity, such as U.S. government and federal agency securities and prime money-market instruments. Contributions and withdrawals would be permitted daily on the basis of current fair market values calculated daily.

Although the Bank has prepared a prototype form of trust agreement which it would be prepared to enter into with a member nonprofit hospital or hospital association to establish the initial trust relationship with the client institution, the Bank would not insist upon rigid adherence to this or any other standardized form for creating the trust relationship. What would be important for the program is that the client hospital or hospital association be a nonprofit health care institution or association tax-exempt under Section 501(c)(3) or 501(c)(6) of the Internal Revenue Code of 1954, as amended.

The Bank and The Hospital Fund, Inc. anticipate that collective investment of these funds through a common trust fund will be the most efficient way of implementing the program. Accordingly, it is expected that each participating institution will authorize the Bank to invest its funds in this fashion. However, the underlying relationship between the Bank and the client institution will be a traditional trust relationship, and this will require that the decision to invest the funds collectively will not necessarily be automatic. Consequently, when the Bank's fiduciary duties to its client so indicate, the Bank will not hesitate to withdraw the funds from collective investment. We enclose for your information a draft of a form of prototype trust agreement that the member hospitals could use to create the initial trust relationship with the Bank.

One further comment of a general nature. The program described above will not be available, much less promoted, to the general public. Rather, access to it will be strictly limited to nonprofit tax-exempt hospitals and hospital associations which become members of The Hospital Fund, Inc. The program will not be advertised or otherwise promoted by the Bank.

You will note that the Plan conforms in substantially all respects with the requirements of subsection (b) of Section 9.18 of the Comptroller's Regulations applicable to common trust funds generally. Because the fund and its operation will vary in minor respects from the requirements of subsection (b) of Section

9.18, approval is requested to operate the fund under subsection (c)(5) of Section 9.18, which permits funds received or held by a national bank as fiduciary to be invested collectively, to the extent not prohibited by local law, in such other manner as is approved in writing by the Comptroller. We are advised by counsel that the organization and operation of the Common Trust Fund will not be prohibited by Pennsylvania law.

Under Section 9.18(b)(9)(i) of the Comptroller's Regulations, no funds may be invested in a participation in a collective investment fund if as a result of such investment the participant would have an interest aggregating in excess of ten percent of the then market value of the fund. In view of the nature of the investments authorized for the proposed fund and the type of institutions involved, it would be unnecessarily confining to require that the limit of ten percent always be observed. At the outset of a new collective trust fund such as this one, the amounts of short-term funds available to the various participating trusts often vary widely, so much so that it would seem undesirable to limit any one participation to ten percent.

As the membership of The Hospital Fund, Inc. and familiarity with the program both grow in the initial years, it may be expected that the ten percent ceiling will become a norm to be observed in practice most of the time. However, the readily marketable nature of the assets of the fund, which would include highly liquid government securities and similar investments, should afford substantial protection against the potential effects of large and unexpected withdrawals. Moreover, the Plan would specifically authorize the Bank to limit withdrawals in exceptional circumstances when the best interests of the participants require. Thus, we believe that under the circumstances the Comptroller could approve the Plan under subsection (c)(5) of Section 9.18, despite the absence of the customary 10% ceiling, without doing violence to the policies underlying Section 9.18 generally.

Section 9.18(b)(12) of the Comptroller's Regulations requires that a national bank administering a collective investment fund have the exclusive management of the fund, and this requirement would be observed in all fundamental respects in the fund in question. The Bank will exercise exclusive management of the fund. In the management of the portfolio of the Common Trust Fund the Bank would be assisted by its

investment advisory affiliate, Fischer, Francis, Trees & Watts, Inc. ("FFTW"). FFTW is an experienced and well regarded professional money manager with a national reputation for excellence in short-term fixed-income investments, the type of assets in which the Fund would be primarily invested.

FFTW's role would be closely confined by guidelines established and reviewed from time to time by the Bank in consultation with The Hospital Fund, Inc. Furthermore, such individual portfolio transactions as are agreed to by the Bank to be negotiated by FFTW would be subject to constant supervision by responsible Bank trust officers through electronic links between the Bank and FFTW.

In view of the experience gained in the past decade of a working relationship between the Bank and FFTW, and taking into account the Bank's ability to monitor transactions in a timely fashion and direct correcting trades immediately if required, we believe it may fairly be said that the proposed Common Trust Fund will at all times remain under the Bank's exclusive control for Regulation 9 purposes.

If the Comptroller approves the proposed Common Trust Fund, the Plan will be submitted to the Bank's Board of Directors for its approval. Following such approval and formal execution of the Plan, an executed copy of the Plan will be filed with the Comptroller.

Please do not hesitate to call me if you should require further explanation of the proposal before you review the enclosed papers or if otherwise you need any additional information concerning it. If you anticipate that the Comptroller will have difficulty in concurring with the conclusions expressed above, we would appreciate an opportunity to discuss them with you in person at your early convenience. We thank you for your consideration of this matter.

Very truly yours,

PLAN OF THE
COMMON TRUST FUND FOR HOSPITALS

ARTICLE I

Purpose of Fund, Status of Bank and Definitions

§1.1. Purpose. This Fund is hereby established and shall be maintained exclusively for the collective investment and reinvestment of monies contributed thereto by The Philadelphia National Bank as trustee of the Participating Trusts.

§1.2. Bank as Trustee of Fund. In its administration of the Fund, the Bank shall act as trustee thereof for the benefit of the Participating Trusts, with all the powers, duties, rights and immunities by law applicable to trustees generally, and shall have legal title to the assets of the Fund, and exclusive management thereof.

§1.3. Bank to be Governed by Applicable Law. In its administration of the Fund, the Bank shall also be governed by and conform to the applicable laws of the United States and the Commonwealth of Pennsylvania, and all applicable rules and regulations from time to time promulgated thereunder, with respect to the administration of collective investment funds, and Bank shall have all the powers and duties thereby provided.

§1.4. Definitions. Unless the context otherwise requires, the following definitions shall apply:

(a) "Account" shall have the meaning assigned to such term in Section 4.1 hereof.

(b) "Bank" shall mean The Philadelphia National Bank, a national banking association.

(c) "Business Day" shall mean a day other than a Saturday, Sunday or legal holiday for banking institutions in either New York City or Philadelphia.

(d) "Fund" shall mean The Common Trust Fund for Hospitals.

(e) "Hospital" shall mean either (i) an organization described in and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, which is organized and operated exclusively for non-profit health care purposes or (ii) a hospital

association described in and exempt from taxation under Section 501(c)(6) of such Code.

(f) "Net Asset Value of the Fund" shall mean the total assets of the Fund less the total liabilities of the Fund, valued in both cases by the Trustee by reference to current market prices. In determining the Net Asset Value of the Fund, the Trustee shall be guided by principles designed to achieve equity among the Participating Trusts.

(g) "Net Asset Value per Unit of the Fund" shall mean, as of any date, the Net Asset Value of the Fund as of such date divided by the number of Units of the Fund outstanding as of such date. Any fractions involved in the computation of the Net Asset Value per Unit of the Fund shall be adjusted to the nearer cent unless the Bank shall determine to adjust such fractions to a fraction of a cent.

(h) "Participating Trust" shall mean any trust participating in the Fund.

(i) "Unit" shall mean each of the units of undivided ownership into which the beneficial interest in the Fund shall be divided pursuant to Section 3.1 hereof.

ARTICLE II

Concerning Participating Trusts and the Nature of their Ownership in the Fund

§2.1. Who May Participate. Participations in the Fund shall be limited to trusts established by Hospitals which trusts are authorized by their terms or otherwise by law to be invested collectively in a common trust fund. Such Participating Trusts shall be the sole contributors to and participants in the Fund.

§2.2. Nature of Ownership of Participating Trusts. The Participating Trusts shall be deemed to have an undivided interest in the net assets of the Fund and not to have any individual ownership in any particular asset of the Fund.

ARTICLE III

Units of Beneficial Interest in the Fund

§3.1. Creation and Allocation of Units. The beneficial interest in the Fund shall be divided into Units. Each Unit shall represent an equal proportionate interest in the Fund. All Units shall be the same, and no Unit shall have any preference or priority over any other Unit. Upon the initial contribution of cash to the Fund, the Bank shall select the number of Units into which the beneficial interest in the amount contributed will be divided. The Bank shall then allocate such Units to the Account of the Participating Trust making such contribution and credit such Account accordingly. If more than one Participating Trust makes the initial contribution, such Units shall be apportioned among their Accounts ratably. In all future contributions to the Fund the Bank shall create and allocate to the contributing Participating Trust additional Units on the basis of the Net Asset Value per Unit of the Fund immediately before the contribution, all as more fully provided in Sections 4.1 and 4.2 hereof. The Bank shall record on its books maintained pursuant to Section 4.3 hereof the number of Units allocated to each Account, and no certificate or other document evidencing any direct or indirect interest in the Fund shall be issued in any form. There shall be no limit on the number of Units which may be outstanding at any time. The number of Units outstanding at any time may be represented in part by fractional Units, rounded to the nearer fourth decimal place. The Bank may at any time and from time to time, upon notice to each Participating Trust, subdivide or combine the Units outstanding into a greater or lesser number of Units without thereby changing the proportionate beneficial interests in the Fund.

ARTICLE IV

Accounts, Contributions and Withdrawals, and Periodic Statements

§4.1. Accounts. The Bank shall establish and maintain on its books an account for each Participating Trust (herein called such Participating Trust's "Account") to which the Bank shall credit or debit Units under the following circumstances. On the occasion of each contribution to or withdrawal from the Fund by a Participating Trust (after the initial contribution to the Fund referred to in Section 3.1 hereof), the Bank shall credit or debit to the Account of the Participating Trust making the contribution or withdrawal, as the case may be, that number

of Units equal to the quotient (rounded to the nearer fourth decimal place) derived by dividing the amount being contributed or withdrawn, as the case may be, by the Net Asset Value per Unit of the Fund as of the date of and immediately before giving effect to the contribution or withdrawal. Any Units debited from an Account on the occasion of any such withdrawal shall be promptly cancelled, and such cancellation shall be recorded by the Bank on its books maintained pursuant to Section 4.3 hereof.

§4.2. Contributions and Withdrawals. Contributions to and withdrawals from the Fund shall be made only in cash and in collected funds and only on the basis of the Net Asset Value of the Fund as of the date of contribution or withdrawal. A Participating Trust may make a contribution to or withdrawal from the Fund on any Business Day, provided that no such withdrawal shall exceed an amount equal to the product of the number of Units held in the Account of such Participating Trust on the date of withdrawal times the Net Asset Value per Unit of the Fund on the same date. The Bank in its discretion may, but shall not be obligated to, limit the amount which may be withdrawn from or credited to the Fund at any time when it deems it necessary to do so in the best interests of the Fund and the Participating Trusts.

§4.3. Records. The Bank shall maintain such books and records regarding the amounts and dates of contributions to and withdrawals from the Fund, all credits and debits made to the Account of each Participating Trust, the Net Asset Value per Unit of the Fund and the number of Units allocated to each such Account as may be required in order that the Bank as trustee of such Participating Trust may prepare such reports and statements concerning the participation of such Participating Trust in the Fund as it may be required to furnish to the Hospital which established such Participating Trust.

ARTICLE V

Investment and Administrative Powers of the Bank as Trustee of the Fund

§5.1. Banking Services. In discharging its responsibility for the proper exercise of its powers with respect to the management of the Fund, the Bank may:

(a) Deposit monies of the Fund in, and establish overdraft privileges with, one or more private, state or national banks within or without the Commonwealth of Pennsylvania or the United States of America (other than the Bank); and

(b) Deposit monies of the Fund representing funds awaiting investment or distribution in, and establish temporary net cash overdraft privileges with, the Bank.

§5.2. Return Volatility. The Fund shall be invested in such a manner as to cause, as nearly as may be practicable, the anticipated volatility of the return of the Fund to be generally comparable to those of portfolios which have a weighted-average maturity of between one day and one year and are invested in accordance with the investment powers and limitations set forth in Section 5.3.

§5.3. Investment Powers and Limitations. All monies contributed to the Fund by any Participating Trust and all other receipts of the Fund, whether by way of dividends, interest or otherwise, shall be commingled and invested collectively. All assets of the Fund shall be invested and reinvested, directly or indirectly, in the following, without legal or statutory restrictions:

(a) Obligations of, or fully guaranteed as to both principal and interest by, the United States of America;

(b) Obligations, other than obligations described in clause (a), of national and international government sponsored agencies, including without limitation federally sponsored agencies having outstanding obligations eligible to be underwritten to a limited or unlimited extent by national banks under paragraph "Seventh" of Section 5136 of the Revised Statutes (12 U.S.C. §24, "Seventh");

(c) Rated Qualified Obligations (hereinafter defined) of commercial banks (other than the Bank, except as otherwise expressly permitted hereby) or bank holding companies organized under the laws of the United States of America or any State thereof. Included are certificates of deposit, bankers acceptances, finance bills, commercial paper, notes and debentures.

(d) Rated Qualified Obligations of corporations organized under the laws of the United States of America or any State thereof. Included are commercial paper, notes and debentures.

(e) Rated Qualified Obligations of foreign governments and foreign commercial banks or other foreign corporations. Included are government securities, commercial paper, bank deposits and bankers acceptances.

(f) Repurchase agreements with respect to investments referred to in clauses (a) through (e) above, inclusive.

(g) Futures contracts for the purchase or sale for future delivery of obligations referred to in clauses (a) through (f) above, inclusive.

(h) Options for the purchase or sale of investments referred to in clauses (a) through (g) above, inclusive.

Without limiting the generality of the foregoing, the Bank may lend securities held in the Fund upon such terms as it may deem appropriate, provided that the obligations of the borrowers shall be fully secured by cash or obligations referred to in clauses (a) through (f) above, inclusive. No funds shall be invested in bonds, commercial paper or other obligations of any one person, firm or corporation if as a result of such investment the total amount invested in bonds or other obligations issued or guaranteed by such person, firm or corporation would aggregate in excess of ten percent of the Net Asset Value of the Fund as most recently determined, provided, that this limitation shall not apply to investments in obligations referred to in clause (a) above. As used in this Plan, the term "Rated Qualified Obligations" shall mean obligations which are rated, or which are issued by issuers that are rated, or which are issued by issuers that then have outstanding other obligations which are rated, as being of high grade investment quality by one or more major rating agencies of recognized standing in the investment community. In exercising its discretion with respect to the acquisition, retention or disposition of any investment, the Bank shall act in good faith and shall be governed by the rule of prudence applicable to trustees in general. All investments of the Fund shall either be denominated in United States dollars or be fully hedged (as nearly as may be practicable under the circumstances) against currency risk while held.

§5.4. Power to Administer Assets. The Bank shall have the sole right at all times to sell, convert, exchange, transfer, acquire, manage, change and dispose of the assets comprising the Fund and shall have and may exercise any and all rights and privileges in respect of all securities therein as though the absolute owner thereof.

§5.5. Registration of Securities. The Bank shall have the right to cause any securities held in the Fund to be registered, and to carry any such securities or other assets, in the name of a nominee or nominees.

§5.6. **Third Persons Not Obliged to See to Application of Payments.** No person dealing with the Bank shall be under any obligation to make any inquiry concerning the authority of the Bank hereunder or to see to the proper application of any payments made to the Bank.

ARTICLE VI

Audits, Reports and Accounts

§6.1. **Annual Audit.** The Bank shall at least once during each period of 12 months cause an adequate audit to be made of the Fund by auditors responsible only to the Bank's Board of Directors. In the event that such audit is performed by independent public accountants, the reasonable expenses of such audit may be charged to the Fund.

§6.2. **Court Accountings.** At any time when in the exercise of its discretion the Bank shall deem it advisable, the Bank may file an account of its administration of the Fund in a court of competent jurisdiction, and all costs of such accounting required or allowed by such court shall be payable out of the Fund.

§6.3. **Financial Reports.** The Bank shall at least once during each period of 12 months prepare a financial report of the Fund, and such report or reports shall be prepared, filed, published and made available to interested parties in accordance with applicable laws and regulations. The Bank shall be relieved from all liability as to transactions shown in such financial report except those with respect to which an interested party shall, within 60 days after the filing of such report, file with the Bank a written statement claiming willful misconduct or lack of good faith on the part of the Bank.

ARTICLE VII

Taxes

§7.1. **Taxes Paid by Bank.** The Bank shall make and file such informational and other tax returns as may be required of it with respect to the Fund. The Bank shall be entitled to be reimbursed out of the Fund for any and all taxes or assessments paid by it with respect to the Fund or any asset or the income thereof, pursuant to any statute or regulation requiring such payment.

§7.2. Inconsistencies with Laws or Regulations.

(a) If any of the provisions of this Plan are in any way contrary to or inconsistent with any law of the United States, or any rule or regulation of the United States Treasury Department or Internal Revenue Service prevailing from time to time, with respect to the computation or payment of Federal income taxes, the keeping of the accounts of the Bank or the computation of such taxes, or the distribution among the Participating Trusts of any income or deductions, or profits or losses of the Fund, in connection with such taxes, the Bank shall incur no liability for following any such law, rule or regulation.

(b) If any of the provisions of this Plan are in any way contrary to or inconsistent with any law of the Commonwealth of Pennsylvania, or any rule or regulation of the Pennsylvania Department of Revenue or the taxing authorities of any political subdivision of said Commonwealth prevailing from time to time, with respect to the computation or payment of any tax due the Commonwealth of Pennsylvania or any political subdivision thereof, the keeping of the accounts of the Bank or the computation of such taxes, or the charging of the same against the assets of the Fund, the Bank shall incur no liability for following any such law, rule or regulation.

§7.3. Information Required to be Supplied by the Bank. The Bank shall provide each Participating Trust such information as may be necessary concerning the Fund and the Account of such Participating Trust to enable such Participating Trust to make and file such informational and other tax returns as may be required of it.

ARTICLE VIII

Compensation and Expenses of the Bank

§8.1. Compensation. The Bank may charge to the Fund a fee for the management and administration of the Fund; provided, however, that the fractional part of such fee proportionate to the interest of each Participating Trust shall not, when added to any other fees, commissions or compensation charged by the Bank to such Participating Trust, exceed the total amount of such fees, commissions or compensation which would have been charged to such Participating Trust if no assets thereof had been invested in the Fund.

§8.2. Expenses. Except as expressly provided to the contrary by applicable laws and regulations, the Bank may charge to the Fund all reasonable expenses incurred by it in the administration of the Fund, exclusive of fees, commissions or other compensation provided for above in Section 8.1 hereof but including expenses incurred under Sections 6.1, 6.2 and 10.2 hereof, to the same extent as similar expenses would be chargeable to Participating Trusts if incurred in the administration thereof.

ARTICLE IX

Amendments, Termination and Replacement of the Bank

§9.1. Amendments. This Plan may be amended from time to time by the Bank in the manner and upon the conditions hereinafter stated:

(a) This Plan having been approved by the board of directors of the Bank, any amendment thereof must also be approved by said board or an executive committee thereof. Any such amendment must also be approved as to form by legal counsel.

(b) Any such amendment shall be filed with the original Plan, together with a certified copy of the resolution of the board of directors of the Bank approving such amendment and the written approval of legal counsel. Any amendment to this Plan which is made to conform its provisions to any amendment of any applicable laws of the United States or the Commonwealth of Pennsylvania, or any rules or regulations promulgated pursuant to any of them, shall take effect as of the effective date of the amendment to such laws, rules or regulations. No other amendment shall take effect until the end of a calendar month designated by the Bank, notice of which together with a copy of the proposed amendment shall be mailed by the Bank to each Participating Trust at least 30 days prior to such effective date. The Participating Trust to whom such notice is mailed shall be deemed to have approved and consented to any amendment of this Agreement if it shall not have filed with the Bank, on or before five days prior to the date specified in such notice for the taking effect of such amendment, its objection to such amendment. Any such objection shall be deemed to constitute a direction by the Participating Trust to withdraw from the Fund, at the end of the calendar month

as of which such amendment is to take effect, the full amount represented by the Units held in its account.

§9.2. **Termination.** The board of directors of the Bank, or an executive committee thereof, may in its discretion by resolution direct the termination and liquidation of the Fund; provided, however, that the Bank shall send not less than 60 days' prior written notice of its intention to direct the termination and liquidation of the Fund to each Participating Trust (which notice shall specify the effective date of termination established by such board). In the event that the Participating Trusts (or any other persons or entities they may have authorized to act for them) shall, prior to the expiration of such notice period, act to remove the Bank (or accept its resignation) as trustee of the Participating Trusts and to designate another bank as successor trustee as provided in Section 9.3 hereof, the Fund shall not terminate and the Bank shall transfer all assets of the Fund to such other bank as trustee under the collective investment plan adopted by such other bank in the manner provided in Section 9.3 hereof. In the event that no successor trustee is so designated as provided in Section 9.3 hereof prior to the expiration of such notice period, the Bank shall send not less than 30 days' prior written notice of the adoption of such resolution terminating the Fund to each Participating Trust, and after the date of such notice no further contributions to or withdrawals from the Fund shall be made, and all of the assets then held therein shall be liquidated and the proceeds of such liquidation together with any uninvested cash balances of the Fund shall be distributed to the Participating Trusts ratably in accordance with the Accounts of the Participating Trusts on the date of liquidation.

§9.3. **Replacement of the Bank.** The Bank shall continue to act as the trustee of the Fund so long as it acts as Trustee of the Participating Trusts in accordance with the instruments pursuant to which the Participating Trusts are established. In the event that the Bank shall resign or be removed as such trustee of the Participating Trusts in accordance with the provisions of such instruments and another bank shall have been designated as successor trustee of the Participating Trusts and shall have adopted as its own plan a plan for the collective investment of the assets of the Participating Trusts which is substantially identical to this Plan of the Common Trust Fund for Hospitals, the Bank shall transfer all assets of the Fund to such other bank and render a full account to such other bank in its capacity as trustee of the trust maintained under such plan. The Bank shall transfer assets and render its account in such a way as to minimize the loss of earnings of the Fund.

ARTICLE X

Miscellaneous

§10.1. Discretion of the Bank to be Absolute; How Exercised. Whenever in this Plan it is provided that any power may be exercised by the Bank or any act or thing may be done by the Bank, involving the exercise of discretion, the discretion of Bank, when exercised in good faith and with reasonable care, shall be absolute and uncontrolled, and its determination, when so made, to act or refrain from acting, or to exercise such power or refrain from so doing, and as to the time or times and the manner in which action is to be taken or such power exercised, shall be binding upon each Participating Trust and each person, firm or corporation having or claiming any interest therein.

§10.2. Advice and Services. The Bank may consult with legal counsel, selected with due care, with respect to the meaning and construction of this Plan or any provision hereof, or concerning its powers or obligations hereunder, and shall be protected for any action taken or omitted by it in good faith pursuant to the opinion of such counsel. The Bank may retain one or more affiliated or unaffiliated persons, firms or corporations within or without the Commonwealth to provide investment and investment advisory, trading, accounting, bookkeeping, record keeping, banking, custodial or safekeeping services (and authorize any such persons, firms and corporations providing custodial or safekeeping services to redeposit securities and other assets held by them in custody with other custodians and to register and carry any such securities in the name of a nominee or nominees) and, subject to the Bank's duty to exercise general supervision over the conduct of such persons, firms or corporations, shall be entitled to rely upon the advice and services furnished.

§10.3. Representation by the Bank in Judicial Proceedings. In any judicial proceeding affecting any property or security constituting all or a part of the Fund, each Participating Trust and each Hospital having or claiming to have any interest in any Participating Trust and in the Fund shall be deemed to be fully represented by the Bank for all purposes if the Bank shall be a party to such proceeding, and shall be deemed through such representation to be duly before the tribunal in which such proceeding shall be pending.

§10.4. Effect of Mistakes. No mistake made in good faith and in the exercise of due care in connection with the administration of Fund shall be deemed to be a violation of the Bank's duties if promptly after the discovery of the mistake the

Bank takes whatever action may be practicable in the circumstances to remedy the mistake.

§10.5. **Pennsylvania Law to Control.** The terms, provisions and effect of this Plan shall be construed and enforced in accordance with the laws of the Commonwealth of Pennsylvania.

§10.6. **Notices.** Whenever any notice is or may be required to be given by the Bank to any person, such notice shall be given by service thereof upon such person in hand, either within or without the Commonwealth of Pennsylvania, or by mailing the same to such person at the last address of such person appearing upon the general address files kept by the Bank.

§10.7. **Words of Number.** Unless the context otherwise requires, words denoting the singular number may, and where necessary shall, be construed as denoting the plural number and words of the plural number may, and where necessary shall, be construed as denoting the singular number.

§10.8. **Effect of Plan.** All Participating Trusts and any persons beneficially interested therein or having any claim with respect thereto, shall be bound by the provisions of this Plan as the same may be amended from time to time.

§10.9. **Successors and Assigns.** This Plan and all the provisions thereof shall be binding upon and inure to the benefit of the Bank and its successors, and each Hospital and its successors and assigns having or claiming to have any interest in any Participating Trust or the Fund.

§10.10. **Execution In Counterparts.** This Plan may be executed in any number of counterparts, each of which shall be and shall be taken to be an original and all collectively but one instrument.

IN WITNESS WHEREOF, THE PHILADELPHIA NATIONAL BANK has caused this Plan of The Common Trust Fund for Hospitals to be signed and its seal to be hereunto affixed and duly attested, by its authorized officers, this ____ day of _____, 1984.

THE PHILADELPHIA NATIONAL BANK

By:_____
Title:

Attest:_____

TRUST AGREEMENT

ARTICLE I

Purpose of Trust and Definitions

§1.1. Execution. This Trust Agreement is executed, as of the date set forth above the signatures of the parties hereto, by the Hospital identified as such on the signature page hereof, as settlor, and The Philadelphia National Bank, as Trustee, to provide for the establishment of a trust, upon the terms and conditions hereinafter set forth, to enable the settlor to invest more efficiently its funds to meet current needs in assets of the kind authorized hereunder.

§1.2. Definitions. Unless the context otherwise requires, the following definitions shall apply:

(a) "Agreement" shall mean this Trust Agreement, as amended from time to time.

(b) "Bank" shall mean The Philadelphia National Bank, a national banking association.

(c) "Business Day" shall mean a day other than a Saturday, Sunday or legal holiday for banking institutions in either New York City or Philadelphia.

(d) "Hospital" shall mean the settlor of the trust referred to in Section 1.1 hereof, which settlor is either (i) an organization described in Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, and which is organized and operated exclusively for non-profit health care purposes or (ii) a Hospital association described in and exempt from taxation under Section 501(c)(6) of such Code.

(e) "Trustee" shall mean the Bank in its capacity as trustee of the trust created hereby.

(f) "Trust Fund" shall mean the assets held by the Trustee subject to the trust created hereby.

ARTICLE II

Representations and Establishment

§2.1. Representations. The Hospital represents that it has full power and authority to establish a trust in accordance with the provisions of this Agreement and to make contributions thereto; that the establishment of the trust created hereby does not, and such contributions will not, contravene any law or regulation applicable to the investment of the funds contributed or the provision of any agreement or other instrument binding upon the Hospital; that the execution and delivery of this Agreement, the establishment of such trust and all contributions to be made to such trust have been and will be duly authorized by all required action of the Hospital's governing board of authority; and that the Hospital is either (i) a non-profit health care facility exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, or by reason of its being an agency or instrumentality of a state, territory or possession of the United States or a political subdivision thereof or (ii) a hospital association described in and exempt from taxation under Section 501(c)(6) of such Code.

§2.2. Establishment. In consideration of the premises and the mutual covenants herein contained, the Bank and the Hospital do hereby constitute, create and establish a trust consisting of all amounts contributed by the Hospital to the Trustee hereunder from time to time. The Trustee shall receive all contributions paid to it hereunder and shall hold, manage and administer the same, together with the income therefrom and any other increments thereon, in trust, in accordance with the provisions of this Agreement. It shall be a condition to the Trustee's acceptance of any contribution to it hereunder that the Hospital shall not contribute to the Trust Fund any funds attributable to any retirement plan that provides for employee contributions or variable benefits nor any funds as to which the Hospital does not have the immediate, sole and exclusive use, benefit and enjoyment.

ARTICLE III

Investment and Administration

§3.1. Banking Services. In discharging its responsibility for the proper exercise of its powers with respect to the management of the Trust Fund, the Trustee may deposit monies of the Trust Fund in, and establish overdraft privileges

with, one or more private, state or national banks within or without the Commonwealth of Pennsylvania or the United States of America (including the Bank).

§3.2. Return Volatility. The Trust Fund shall be invested in such a manner as to cause, as nearly as may be practicable, the anticipated volatility of the return of the Trust Fund to be generally comparable to those of portfolios which have a weighted average maturity of between one day and one year and are invested in accordance with the investment powers and limitations set forth in Section 3.3.

§3.3. Investment Powers and Limitations. All monies contributed to the Trust Fund by the Hospital and all other receipts of the Trust Fund, whether by way of dividends, interest or otherwise, shall be invested and reinvested, directly or indirectly, in the following, without legal or statutory restrictions:

(a) Obligations of, or fully guaranteed as to both principal and interest by, the United States of America;

(b) Obligations, other than obligations described in clause (a), of national and international government sponsored agencies, including without limitation federally sponsored agencies having outstanding obligations eligible to be underwritten to a limited or unlimited extent by national banks under paragraph "Seventh" of Section 5136 of the Revised Statutes (12 U.S.C. §24, "Seventh");

(c) Rated Qualified Obligations (hereinafter defined) of commercial banks or bank holding companies organized under the laws of the United States of America or any State thereof. Included are certificates of deposit, bankers acceptances, finance bills, commercial paper, notes and debentures.

(d) Rated Qualified Obligations of corporations organized under the laws of the United States of America or any State thereof. Included are commercial paper, notes and debentures.

(e) Rated Qualified Obligations of foreign governments and foreign commercial banks or other foreign corporations. Included are government securities, commercial paper, bank deposits and bankers acceptances.

(f) Repurchase agreements with respect to investments referred to in clauses (a) through (e) above, inclusive.

(g) Future contracts for the purchase or sale for future delivery of obligations referred to in clauses (a) through (f) above, inclusive.

(h) Options for the purchase or sale of investments referred to in clauses (a) through (g) above, inclusive.

Without limiting the generality of the foregoing, the Trustee may lend securities held in the Trust Fund upon such terms as it may deem appropriate, provided that the obligations of the borrowers shall be fully secured by cash or obligations referred to in clauses (a) through (f) above, inclusive. No funds shall be invested in bonds, commercial paper or other obligations of any one person, firm or corporation if as a result of such investment the total amount invested in bonds or other obligations issued or guaranteed by such person, firm or corporation would aggregate in excess of ten percent of the market value of the Trust Fund as last determined, provided, that this limitation shall not apply to investments in obligations referred to in clause (a) above. As used in this Trust Agreement, the term "Rated Qualified Obligations" shall mean obligations which are rated, or which are issued by issuers that are rated, or which are issued by issuers that then have outstanding other obligations which are rated, as being of high grade investment quality by one or more rating agencies of recognized standing in the investment community. In exercising its discretion with respect to the acquisition, retention or disposition of any investment, the Trustee shall act in good faith and shall be governed by the rule of prudence applicable to trustees in general. All investments of the Trust Fund shall either be denominated in United States dollars or be fully hedged (as nearly as may be practicable under the circumstances) against currency risk while held.

§3.4. Collective Investment of Trust Fund. Notwithstanding the provisions of Section 3.3 hereof, the Trustee may at any time and from time to time transfer such part or all of the Trust Fund as it shall deem advisable to the Bank as Trustee of The Common Trust Fund for Hospitals established pursuant to the Bank's Plan of The Common Trust Fund for Hospitals dated _____, 1984, as amended from time to time, for the purpose of collective investment under such Plan with the assets of other participating trusts, so long as such common trust fund is invested in a manner consistent with Section 3.3 hereof, and the Trustee may withdraw the same from investment

under such Plan at any time. The provisions of such Plan shall constitute a part of this Agreement, and the investment and administration of all assets constituting a part of the Trust Fund which are so transferred by the Trustee to the Bank as trustee of such common trust fund shall be governed by the provisions of the Plan. Anything herein to the contrary notwithstanding, the value of any portion of the Trust Fund constituting a beneficial interest in such common trust fund shall be determined when and in the manner provided under such Plan.

§3.5. Power to Administer Assets. The Trustee shall have the sole right at all times to sell, convert, exchange, transfer, acquire, manage, change and dispose of the assets comprising the Trust Fund and shall have and may exercise any and all rights and privileges in respect of all securities therein as though the absolute owner thereof.

§3.6. Registration of Securities. The Trustee shall have the right to cause any securities held in the Trust Fund to be registered, and to carry any such securities or other assets, in the name of a nominee or nominees.

§3.7. Authorization to Request Recommendations from Representative. The Trustee is hereby authorized, on a periodic basis, to review with The Hospital Fund, Inc., a Connecticut not-for-profit corporation which the Hospital represents it has appointed as its representative in connection with this trust relationship (herein called the "Representative"), the investment results of the common trust fund referred to in Section 3.4 and to request the recommendations of the Representative regarding general investment policy guidelines with respect to the investment of the assets of this trust in such common trust fund (including recommendations as to the cash requirements of the respective trusts participating therein) and the operating methods of such common trust fund.

ARTICLE IV

Contributions and Withdrawals and Statements

§4.1. Contributions and Withdrawals. Contributions to and withdrawals from the Trust Fund shall be made only in cash and in immediately available funds. Except as herein otherwise expressly provided, the Hospital may make contributions to and withdrawals from the Trust Fund on any Business Day, provided that the right to withdraw any part of the Trust Fund invested in any common trust fund of the Bank shall be subject to the

limitations on the times and amounts of withdrawals contained in the plan of such fund or imposed by the Bank as trustee thereof pursuant to authorization contained in such plan.

§4.2. Statements. The Trustee shall prepare and send to the Hospital the following periodic statements, each in a format mutually satisfactory to the Trustee and the Representative:

(A) On or before the third Business Day following the date of each contribution to or withdrawal from the Trust Fund, a statement showing the amount and date of such contribution or withdrawal and the amount and date of each other contribution to or withdrawal from the Trust Fund theretofore made during the same calendar month.

(B) On or before the tenth Business Day following the end of each calendar month, a statement showing:

(i) The aggregate market value of the investments in the Trust Fund as of the beginning of such month;

(ii) The date and amount of each credit or debit made to the Trust Fund during such month (including credits and debits made in respect of contributions and withdrawals); and

(iii) The aggregate market value of the investments in the Trust Fund as of the end of such month.

§4.3. Annual Financial Report. In the event that any part of the Trust Fund shall be transferred by the Trustee to the Bank as trustee of a common trust fund, the Bank as such trustee shall furnish to the Hospital upon request a copy of the annual financial report of such common trust fund covering the period of such transfer.

§4.4. Discharge with Respect to Statements and Annual Financial Reports. In the absence of the filing by the Hospital in writing with the Trustee and the Representative within 60 days of exceptions or objections to any statement or annual financial report given or rendered pursuant to this Article IV claiming gross negligence, willful misconduct or lack of good faith on the part of the Trustee or the Representative, or both, the Trustee and the Representative shall be released, relieved and discharged with respect to all matters and things set forth therein as though such account had been settled by a court of competent

jurisdiction. In the event of the filing of exceptions or objections in the foregoing manner with respect to one (but not both) of the Trustee and the Representative, the other shall nonetheless be released, relieved and discharged in the manner described in the preceding sentence. No person other than the Hospital or the Representative may require an accounting or bring any action against the Trustee with respect to the trust created hereunder or the Trustee's acts or omissions as Trustee, and no person other than the Hospital or the Trustee may bring any action against the Representative with respect to the trust created hereunder or the Representative's acts or omissions as Representative.

ARTICLE V

Court Accounting

§5.1. Trustee Discretion. At any time when in the exercise of its discretion the Trustee shall deem it advisable, the Trustee may file an account of its administration of the trust hereunder in a court of competent jurisdiction, and all costs of such accounting required or allowed by such court shall be payable out of the Trust Fund. The only necessary party to any such action or proceeding shall be the Hospital, although the Trustee may, if it so elects, bring in as parties any other person or persons.

ARTICLE VI

Taxes

§6.1. Taxes Paid by the Trustee. The Trustee shall make and file such informational and other tax returns as may be required of it with respect to the Trust Fund. The Trustee shall be entitled to be reimbursed out of the Trust Fund for any and all taxes or assessments paid by it with respect to the Trust Fund or any asset or the income thereof, pursuant to any statute or regulation requiring such payment.

§6.2. Inconsistencies with Laws or Regulations.

(a) If any of the provisions of this Agreement are in any way contrary to or inconsistent with any law of the United States, or any rule or regulation of the United States Treasury Department or the Internal Revenue Service prevailing from time to time, with respect to the computation or payment of Federal

income taxes, the keeping of the accounts of the Trustee or the computation of such taxes, or the distribution to the Hospital of any income or deductions, or profits or losses, in connection with such taxes, the Trustee shall incur no liability for following any such law, rule or regulation.

(b) If any of the provisions of this Agreement are in any way contrary to or inconsistent with any law of the Commonwealth of Pennsylvania, or any rule or regulation of the Pennsylvania Department of Revenue or the taxing authorities of any political subdivision of said Commonwealth prevailing from time to time, with respect to the computation or payment of any tax due the Commonwealth of Pennsylvania or any political subdivision thereof, the keeping of the accounts of the Trustee or the computation of such taxes, or the charging of the same against the assets of the Trust Fund, the Trustee shall incur no liability for following any such law, rule or regulation.

§6.3. Information Required to be Supplied by the Trustee. The Trustee shall provide the Hospital with such information as may be necessary concerning the Trust Fund to enable the Hospital to make and file such informational and other tax returns as may be required of it.

ARTICLE VII

Compensation and Expenses of the Trustee

§7.1. Compensation. Subject to the provisions of Section 7.3 hereof, the Trustee may charge to the Trust Fund a fee for the management and administration of the Trust Fund in such amount as may be agreed upon by the Trustee and the Representative from time to time.

§7.2. Expenses. Subject to the provisions of Section 7.3 hereof and except as expressly provided to the contrary by applicable laws and regulations, the Trustee shall charge to the Trust Fund all reasonable expenses incurred by it in the administration of the Trust Fund, exclusive of the fees provided for above in Section 7.1 hereof but including expenses incurred under Sections 5.1 and 9.5 hereof.

§7.3. Payment of Compensation and Expenses and Limitations Thereon. Whenever the Trust Fund or any portion thereof is invested in the common trust fund referred to in Section 3.4 hereof, the fees and expenses of the Trustee provided for in this Article VII may be charged against and paid from such common trust fund and apportioned among the trusts participating

in such common trust fund (including the trust created hereunder) to the extent their respective assets have been invested in such common trust fund in accordance with the provisions of the plan of such common trust fund; provided, however, that the total amount of the fees and expenses so apportioned to the Trust Fund shall not, when added to any other fees (or other commissions or compensation) or expenses charged directly to the Trust Fund, exceed the total amount of such fees (or other commissions or compensation) or expenses which would have been charged to the Trust Fund if no assets thereof had been invested in such common trust fund.

ARTICLE VIII

Amendments and Termination

§8.1. Amendments. This Agreement may be amended by the Trustee and the Hospital at any time and from time to time by an instrument in writing executed by each of the Trustee and Hospital. Such instrument may be signed in the name and on behalf of the Hospital by the Representative if provision therefor has been made. In all events, a counterpart of each such amendment shall be furnished promptly to the Representative. Any such amendment which is made to conform the provisions hereof to any amendment of applicable laws of the United States or the Commonwealth of Pennsylvania, or any rules or regulations promulgated pursuant thereto, shall take effect as of the effective date of the amendment to such laws, rules or regulations. No other amendment shall take effect until the end of a calendar month designated by the Trustee, notice of which shall be mailed by the Trustee at least 30 days prior thereto with a copy of the proposed amendment to the Hospital and the Representative. The Hospital shall be deemed to have approved and consented to any amendment of this Agreement executed on its behalf by the Representative as hereinabove provided if notice of such amendment is received by the Hospital in accordance with the provisions of the preceding sentence and the Hospital shall not have filed its objection to such amendment within ten Business Days following the date of the mailing of the notice thereof. Any such objection shall be deemed to constitute a direction by the Hospital to terminate and liquidate the trust created hereunder in accordance with Section 8.3 hereof at the end of the calendar month during which such direction is given.

§8.2. **Termination by Representative or Trustee.** Either the Representative by resolution of its board of directors, or the Trustee by action of one of its duly authorized officers, may direct the termination and liquidation of the trust created hereunder. The Representative or the Trustee so acting shall send to the other and to the Hospital not less than 60 days' prior written notice of such direction. After the date of such notice no further contributions to or withdrawals from the Trust Fund shall be made by the Hospital. Subject to the limitations on the times and amounts of withdrawals contained in the plan of any common trust fund of the Bank with respect to any part of the Trust Fund invested in such common trust fund or imposed by the Bank as trustee of such common trust fund pursuant to authorization contained in such plan, and subject to the provisions of such plan relating to liquidation, all of the assets then held in the Trust Fund shall be liquidated and the proceeds of such liquidation, together with any uninvested cash balances constituting part of the Trust Fund, shall be distributed to the Hospital. Upon such distribution the trust created hereunder shall terminate.

§8.3. **Termination by Hospital.** Notwithstanding the provisions of Section 8.2, the Hospital may direct the termination and liquidation of the trust created hereunder by an instrument in writing filed with the Trustee (which shall be accompanied by a certified resolution of the Hospital's governing board or authority authorizing such termination and liquidation). The Hospital shall promptly furnish the Representative with a copy of any such instrument. In the event of such direction, subject to the limitations on the times and amounts of withdrawals contained in the Plan of any common trust fund of the Bank with respect to any part of the Trust Fund invested in such common trust fund or imposed by the Bank as trustee of such common trust fund pursuant to authorization contained in such plan, and subject to the provisions of such plan relating to liquidation, the assets then held in the Trust Fund shall be liquidated and the proceeds of such liquidation, together with any uninvested cash balances constituting part of the Trust Fund, shall be distributed to the Hospital. Upon such distribution the trust created hereunder shall terminate.

ARTICLE IX

Trustee and Miscellaneous

§9.1. Resignation and Replacement. The Trustee may resign at any time by mailing written notice of such resignation to the Hospital and the Representative, such notice to take effect not less than 30 days after the mailing of such notice. The Representative may, by resolution of its board of directors, remove the Trustee at any time by mailing written notice of such removal to the Trustee and the Hospital, such notice to take effect not less than 30 days after the mailing of such notice. In the case of the resignation or removal of the Trustee, the Representative may, by resolution of its board of directors, appoint a successor trustee. Any successor trustee shall have the same powers and duties as those conferred upon the Trustee named in this Agreement. In the event that a successor trustee shall establish a collective investment fund under a plan which is substantially the same as the Plan referred to in Section 3.4 hereof, the provisions of this Agreement applicable to the investment of all or any part of the Trust Fund in the Common Trust Fund referred to in such Section shall be applicable to the collective investment fund established under such similar plan and the definition of "Bank" shall be deemed appropriately amended to refer to such successor plan and trustee. Nothing herein shall be deemed to prohibit the transfer of assets of any common trust fund directly by the Bank, acting as the trustee thereof, to any successor trustee appointed as provided in this Section 9.1.

§9.2. Settlement of Accounts. In the event that the Bank ceases to act as Trustee because of resignation, replacement or other cause, it shall, subject to the last sentence of Section 9.1 hereof, transfer all assets of the Trust Fund to the Hospital and render a full accounting to the Hospital or any successor trustee; provided, that the Bank shall transfer assets and render an accounting in such a way as to minimize loss of earnings of the Trust Fund. In the absence of the filing in writing with the Trustee by the Hospital or such successor trustee of exceptions or objections to such account claiming gross negligence, willful misconduct or lack of good faith on the part of the Trustee, within 60 days of the sending of such accounting to the Hospital, the Trustee shall be discharged in the manner provided under Section 4.4 hereof with respect to its statements.

§9.3. Liability of Trustee. The Trustee shall not be liable for making any payment under the trust hereunder except to the extent that there are adequate assets in the Trust Fund for the making of such payment. The Trustee shall be indemnified out

of the assets of the Trust Fund for any expenses and damages it may incur by reason of any action taken or omitted to be taken in good faith with respect to the Trust Fund, including defense expenses reasonably incurred.

§9.4. **Discretion of the Trustee to be Absolute; How Exercised.** Whenever in this Agreement it is provided that any power may be exercised by the Trustee or any act or thing may be done by the Trustee, involving the exercise of discretion, the discretion of the Trustee, when exercised in good faith and with reasonable care, shall be absolute and uncontrolled, and its determination, when so made, to act or refrain from acting, or to exercise such power or refrain from so doing, and as to the time or times and the manner in which such power is to be exercised or such action is to be taken, shall be binding upon the Hospital.

§9.5. **Advice and Services.** The Trustee may consult with legal counsel, selected with due care, with respect to the meaning and construction of this Agreement or any provision hereof, or concerning its powers or obligations hereunder, and shall be protected for any action taken or omitted by it in good faith, pursuant to the opinion of such counsel. The Trustee may retain one or more affiliated or unaffiliated persons, firms or corporations within or without the Commonwealth of Pennsylvania to provide investment and investment advisory, trading, accounting, bookkeeping, record keeping, banking, custodial or safekeeping services (and authorize any such persons, firms and corporations providing custodial or safekeeping services to redeposit securities and other assets held by them in custody with other custodians and to register and carry any such securities in the name of a nominee or nominees) and, subject to the Trustee's duty to exercise general supervision over the conduct of such persons, firms or corporations, shall be entitled to rely upon the advice and services furnished.

§9.6. **Effect of Mistakes.** No mistakes made in good faith and in the exercise of due care in connection with the administration of the Trust Fund shall be deemed to be a violation of the Trustee's duties if promptly after the discovery of the mistake the Trustee takes whatever action may be practicable in the circumstances to remedy the mistake.

§9.7. **Reimbursement of Representative.** The Hospital hereby authorizes and directs the Trustee to charge to the Trust Fund, not later than the date ten Business Days following the end of each calendar month, and pay to the Representative, as reimbursement for expenses incurred by it in performing its services hereunder, such amount as may be agreed to by the Hospital and the Representative from time to time. The Trustee may rely conclusively on written advice from the Representative as to the amount of any such agreed reimbursement.

§9.8. **Pennsylvania Law to Control.** The terms, provisions and effect of this Agreement shall be construed and enforced in accordance with the laws of the Commonwealth of Pennsylvania.

§9.9. **Notices.** Whenever notice is or may be required to be given by the Trustee to any person, such notice shall be given by service thereof upon such person in hand, either within or without the Commonwealth of Pennsylvania, or by mailing the same to such person at the last address of such person appearing upon the general address files kept by the Trustee.

§9.10. **Third Person Not Obligated to See to Application of Payments.** No person, firm or corporation dealing with the Trustee shall be under any obligation to make any inquiry concerning the authority of the Trustee hereunder or to see to the proper application of any payments to the Trustee.

§9.11. **Currency.** All contributions, withdrawals and other transactions with respect to the Trust Fund shall be made and recorded in coin or currency which, at the time thereof, is legal tender for the payment of public and private debts in the United States of America.

§9.12. **Words of Number.** Unless the context otherwise requires, words denoting the singular number may, and where necessary shall, be construed as denoting the plural number and words of the plural number may, and where necessary shall, be construed as denoting the singular number.

§9.13. **Effect of Trust Agreement.** The Hospital and any person, firm or corporation beneficially interested in the Trust Fund, or having any claim with respect thereto, shall be bound by the provisions of this Agreement as the same may be amended from time to time.

§9.14. **References to Board of Directors.** References in this Agreement to the board of directors of either party shall be deemed to include a reference to any executive committee of such board of directors incumbent and acting at the time.

§9.15. **Successors and Assigns.** This Agreement and all the provisions thereof shall be binding upon and inure to the benefit of the Trustee and its successors, and the Hospital and its successors and assigns having or claiming to have any interest in the Trust Fund.

§9.16. Execution in Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be and shall be taken to be an original and all collectively but one instrument.

IN WITNESS WHEREOF, this Trust Agreement has been duly executed by the Hospital and the Bank this _____ day of _____, 19__.

_____,
as Hospital

By_____

Title_____

Employer Identification No._____

THE PHILADELPHIA NATIONAL BANK, as Trustee

By_____

Title_____

Joint Commission on Accreditation of Hospitals

At its last meeting, the Board reviewed a JCAH study of hospital accreditation in academic medical centers. Attachment A, a draft letter to Dr. James Roberts of the JCAH conveying the Board's observations, is presented for your comments.

Attachment B is a copy of the original JCAH memorandum and report. Dr. Roberts will be joining the Board at 8:00 a.m. on October 29 to discuss the report and announce the Commission's plan to study whether an academic health center's involvement in research and teaching represents an effective mechanism for systematic quality assurance.

aamc association of american medical colleges

D R A F T 10/19/84

October 19, 1984

James S. Roberts, M.D.
Vice President for Accreditation
Joint Commission on Accreditation
of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Jim:

At its September 28, meeting, the Administrative Board of the Council of Teaching Hospitals reviewed your June 7 memorandum on accreditation in academic health centers. In its discussion, the Board made three observations:

- The COTH Administrative Board does not share the apparent perceptions of some in academic medicine that the JCAH duplicates other accreditation organizations and is unnecessary because of the internal evaluation activities of the center.

- The COTH Administrative Board does not believe that the hospital's internal process for education and research presently provide an adequate substitute for JCAH quality care standards.

- The COTH Administrative Board does believe that continued efforts need to be made to improve the quality of JCAH surveyors and to have the surveyors emphasize the outcome of a process rather than the process itself.

While the Board will continue to review and study your memorandum to become more fully aware of your findings, both the Board and staff welcome your interest in our members and are pleased that you are proceeding with a committee to explore the role educational/research process could play in JCAH accreditation.

Sincerely,

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

RMK/mrl

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

JCAH

Attachment B

June 7, 1984

M E M O R A N D U M

To: Accreditation Committee

From: James S. Roberts, M.D. JSR

Subject: Academic Health Center Hospitals
Accreditation Committee Meeting, June 15, 1984
Agenda Item II-E

Background

Academic health center hospitals are a relatively small (approximately 3%) but important group of the hospitals surveyed by the JCAH. Periodically the Commission receives complaints from such institutions relative to its standards, surveyors and survey processes. Additionally, members of the Accreditation Committee have often raised concerns about the survey processes and findings from surveys of such institutions.

To better understand and define these issues, JCAH staff undertook a study, reviewing accreditation data and interviewing key administrative, medical, nursing and quality assurance personnel at five of these institutions. This paper outlines the nature of the study, its findings and recommendations.

Definitional Issues

There are approximately 1549 hospitals with residency programs and there is great variation within this group as to the degree to which teaching is a predominent mission. Because virtually all of the concern being voiced about the JCAH has come from those teaching hospitals which are components of academic health centers, it is this group which we chose to study. These institutions have a high proportion of geographically full-time faculty, residency programs which cover most physician specialities, and often have programs for teaching medical, nursing and other health care students. They are committed to research and have close, if not controlling ties with medical schools.

While probably not totally inclusive we identified a universe of 157 hospitals associated with such centers and thus eligible for this study. They were selected from the membership of the Association of Academic Health Centers with the addition of several other institutions known by staff to be academic health center hospitals but not appearing in the membership of the Association. Of this 157, 34 hospitals were surveyed in 1982 constituting a 22% sample of the total universe. It is this group of 34 hospitals which is included in the data presented below.

Accreditation Data

Using data from the Aggregate Survey Data file for 1982 a review was conducted of the accreditation decisions and survey findings in these 34 academic health center hospitals.

In all cases the hospitals were accredited. Table I indicates that 15 out of 34 or 44% of these hospitals received three year accreditation without contingencies. As indicated in the table this compares favorably with the total universe of hospitals. However, the difference is not statistically significant.

Table I

		Accreditation Decision		
	#	% Acc. Without Cont.	% Acc. with Cont.	%NA
Academic Health Center Hospitals	34	44	56	0
All Hospitals	1361	40	58	2

To explore the survey findings in more detail, analyses were made of the most frequent contingencies (Appendix I), most frequent recommendations (Appendix II) and the reasons for contingencies in academic health center hospitals as compared to all hospitals (Appendix III). Finally, Appendix IV compares the reasons for contingencies in academic health center hospitals when the building problems often found in such institutions are removed from the analysis.

The analysis by contingencies in Appendix I indicates that the major areas of compliance difficulty for academic health center hospitals are in Medical Records, Building and Grounds and Quality Assurance. Delinquent medical records was the problem causing the highest percentage of contingencies (23.5%). Of note is the fact that 18 of the 37 listed problems related to building and grounds standards--reflecting the tendency of university hospitals to be housed in older facilities.

When the SRF items are analyzed by the total number of recommendations (Appendix II), there are changes in the ranking of items seen in Appendix I, plus the addition of new items. The regular review and evaluation of the quality of care in special care units, a quality assurance item, has the highest percentage of total recommendations (51%). The medical records item ranked first by contingencies is now ranked second, but additional medical record items become more prominent. In addition, new items from

Central Services, Pharmaceutical Services and Medical Staff appear in the rank order indicating three more areas in which a substantial number of recommendations are received, even though none of them contributed to any contingencies. Building and Grounds items are less prominent.

It is also of interest to compare academic health center hospitals with all hospitals (Appendix III). The top 20 items with the highest percentage of contingencies for all hospitals were all Quality Assurance items. However, for the academic health center hospitals only half (10/20) of the top twenty items were Quality Assurance items. The remainder consisted of one Medical Records item, ranked first, and nine Building and Grounds items.

The problem areas of quality assurance that were common to both groups of hospitals (6/20) involved the review of antibiotic usage, special care units and anesthesia services; documentation in meeting minutes of the recommendations and actions resulting from review of patient care; documentation in medical staff executive committee meeting minutes that recommendations from all medical staff groups are received and acted upon; and surgical case review when no specimen was removed.

The remaining quality assurance item (4/20) particular to academic health center hospitals consisted of hospital-sponsored ambulatory care concerns; documentation that the review of the quality of hospital-sponsored ambulatory care is performed at least twice annually, involves the use of medical records and pre-established criteria, and includes action taken on the findings of review and evaluation; and documentation of review of surgical patients who require hospitalization following ambulatory surgery. These items were not in the top twenty items with contingencies for all hospitals. The higher percentage of contingencies in the area of ambulatory care may be explained if academic health center hospitals more often have organized ambulatory care units. Exploration of this possibility was beyond the scope of this study.

If the Building and Grounds items are removed from the rank ordering of academic health center hospital contingency items (Appendix IV), the top twenty would then consist of 19 Quality Assurance items in addition to the delinquent medical records item. With this ranking, the academic health center hospitals and all hospitals have eleven top contingency items in common. In addition to the six items discussed previously, both hospital groups have compliance difficulty with:

1. Documentation of review of appropriateness of ER patient care
2. Documentation of action and follow-up on surgical case review findings
3. Documentation of review of the quality of radiologic services
4. Medical staff review of blood transfusions
5. Drug utilization review

Areas in which all hospitals exhibit compliance difficulty which are not shared by academic health center hospitals (9/20) include: the delineation of clinical privileges; review of respiratory and nuclear medicine services; actions taken on the findings of antibiotic usage review of ER care using medical records and pre-established criteria on a monthly basis; and three items evaluating the rehabilitation services.

These analyses indicate that, with the exception of more difficulties with their buildings, academic health center hospitals have problems generally similar to those in all other hospitals in that they cluster in the quality assurance area.

Interview Results

As noted earlier, JCAH staff visited several large academic teaching institutions to conduct informal discussions concerning JCAH standards, survey processes and surveyors. The institutions visited were:

-Thomas Jefferson Medical Center; Philadephia, Pennsylvania

-Massachusetts General Hospital; Boston, Massachusetts

-Rush-Presbyterian St. Luke's Medical Center, Chicago, Illinois

-University of Indiana Medical Center; Indianapolis, Indiana

-Duke University Medical Center; Durham, North Carolina

These institutions were chosen because they had recently been surveyed, they are major teaching centers and, in most cases, JCAH staff had easy access to one of the leaders and could thus be assured of open discussions.

The visits to these five centers were exceedingly valuable. In all cases we met with the key leaders of the institution and had frank, to-the-point discussions. There was support for a serious review of JCAH's interactions with academic teaching hospitals and gratitude for the opportunity to directly express opinions and make suggestions.

For the most part, there was consensus that it was very important to have an effective voluntary, private-sector, professionally sponsored hospital accreditation program. Some participants seemed to believe that the primary value of the JCAH was to serve as an alternative to government regulation. Others felt that external, private-sector assessment had its own intrinsic value and thus favored making the JCAH as effective and influential as possible. All expressed the view that the JCAH could do much better in its dealings with academic health center hospitals. Outlined below are the specific areas suggested for change as well as a discussion of an important philosophical issue which surfaced during the visits.

Areas of Suggested Change

1. JCAH should review its standards to eliminate those which prompt unnecessary paperwork. Stated differently, JCAH should be concerned only with items that have important effects on quality.

2. Standards should focus more on patient outcomes and less on structure and procedures.

3. Surveyors are a key to success. They must gain a better understanding of the structures and functions of academic health center hospitals. Using surveyors having past or, if possible, current experience in such settings would be exceedingly helpful.

4. More attention needs to be given to the central role played by Department Chairmen in academic teaching centers.

5. The governing bodies of such hospitals are often distant organizationally, functionally and sometimes geographically from the hospital. JCAH needs to accommodate to this reality.

6. Because of the high caliber of the practitioners in such institutions and the "fish bowl" nature of the scrutiny placed on everyone's practice, competence is constantly under review. Thus formalized systems to assess competence, as sought by JCAH in its privilege delineation processes, are duplicative and unnecessary.

7. There is a need to reflect the fact that care in such centers is provided in the context of intensive dedication to teaching and research. Because this devotion to teaching and research represents a commitment to patient care quality, the JCAH should tap into these processes to judge their effectiveness in monitoring and improving the quality of care rather than require a parallel system of quality assurance.

For the most part these issues have been raised by others--they are concerns which are not completely unique to teaching hospitals. With the exception of the last issue, these concerns are being addressed implicitly in the revisions of the AMH, the series of changes being explored in the 1984 series of modified surveys, and in work on improving standards and survey processes for privilege delineation.

Item 7 however, is unique and represents, in the view of staff, a problem JCAH should specifically address. As stated by those interviewed, the problem is that teaching and research responsibilities are conducted in ways which involve ongoing assessment of individual and aggregate performance concerning quality of care. Mechanisms cited include morning residents

rounds, attending rounds, morbidity and mortality conferences, CPCs, etc. It is argued that together these processes represent an effective monitoring of the quality of care and that a parallel system of formalized quality assurance is unnecessary. Countering this argument is the question of whether these endeavors are so focused upon teaching that they concentrate on the unusual and illustrative case rather than the full spectrum of care provided. That is, do they truly constitute systematic quality assurance? The scope of this study did not allow conclusions to be drawn except to say this is a key issue for further work.

Philosophical Issue

Major U.S. academic health center hospitals are generally considered to provide the best health care available in the world. Their staffs consist of individuals highly knowledgeable and skilled in their fields and surrounded by the latest in technologically-advanced equipment and the most skilled support personnel. These institutions pride themselves on the quality of their work and enjoy the well-deserved respect of the general public.

Given this, several of those interviewed questioned whether any external organization could effectively evaluate their institutions. While many stated that the criticisms of voluntary hospital accreditation would be eliminated if the above noted actions were taken, JCAH staff was left with the nagging concern that many others held the belief that academic health center hospitals would never be significantly aided by external assessment related to quality of care. This was best stated by one participant who said that voluntary accreditation was a useful way to keep government out of hospitals but was not helpful in improving care in his hospital. He felt that the internal, formal and informal mechanisms noted above, and not compliance with external standards, would improve care. While not conveyed by all institutions or by all those interviewed, such a philosophy was often evident in the discussion and, we believe, would have been more prominent if we had discussed these issues with the next lower level of leadership and the practitioners in these institutions.

While some might consider such opinions as academic arrogance, staff does not take this view. Rather, we believe that these statements represent the honest beliefs of individuals clearly committed to quality patient care. In considering them, one is hard pressed to deny that our major academic health center hospitals represent the cutting edge in medical knowledge. They are the final point of referral for difficult patient problems and thus are acknowledged by the public and health care practitioners as being the best. Yet there are examples of teaching institutions which have had significant problems with quality of care and JCAH accreditation. It is also important to observe that, while the mix varies, virtually all teaching institutions care for patients whose problems range from the mundane to the most complex. As noted above, one

wonders if the commitment to teaching and research at times focuses attention on the unusual and complex at the expense of the routine.

It has not been possible in this study to sort out fact from impressions on this important issue. Staff believes, however, that this basic questioning of the value of external assessment of quality in academic health center hospitals should not be ignored. Rather, in conjunction with leaders of these institutions, JCAH should study this problem with the specific objective of finding reasonable methods to strengthen the impact of JCAH on the quality of care.

Conclusions

For some time there has been discontent with JCAH among academic teaching center hospitals and questioning by some Commisssioners of the validity and usefulness of present JCAH standards and surveys related to such institutions. The study outlined above represents a first attempt to address this important problem.

Its results, though not conclusive in all aspects, do provide additional impetus to the current effort to revise the AMH. Additionally, the series of pilot tests undertaken in 1983 and continuing this year are designed to modify the survey process in a way which addressess several of the problems identified by this study.

However, as noted above, there are two critical findings which are not currently being addressed by the Commission. They relate to the basic question of the value of external assessment related to quality care and to whether the teaching and research processes represent adequate compliance with JCAH's requirements for hospital-wide, systematic quality assurance. Pursuit of these questions is important, but should only be undertaken if there is firm commitment by JCAH and the leaders of this field to the value of well designed external review and programs of systematic quality assurance in such institutions. That is, JCAH would need to reconfirm the importance of having such mechanisms to all hospitals, and the leaders of the academic health center hospital field would need to support this concept. Without such support, it would be wasteful of limited resources to devote the considerable time necessary to find mechanisms to improve the value and relevance of our work to such hospitals.

Thus, staff concludes the following:

1. It is important and useful for all types of health care organizations to conduct systematic quality assurance and undergo periodic external assessment.

2. JCAH must devote specific attention to the "areas of suggested changes" noted earlier in this report. Of particular importance is the need to find mechanisms to tap into teaching and research processes to judge the effectiveness of these activities in monitoring and improving the quality of care.

3. It would be appropriate to review the results of this study with leaders of the Council of Teaching Hospitals and the Association of Academic Health Centers. Such a review should include consideration of how best to pursue necessary changes.

*** Recommendation

Staff recommends Accreditation Committee approval of this study's findings and conclusions and the Committee's endorsement of same to the Board of Commissioners.

SURVEY REPORT FORM ITEMS WITH THE GREATEST PERCENTAGE OF CONTINGENCIES - 1982

Rank Order Of Contingencies	Questions	% With Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations? (n=34)	23.5
2.0	For all buildings designed in or before 1973 and for buildings designed after 1973 that are less than 2 stories in height, are chutes or other vertical openings protected with partitions having at least 1-hour resistive rating? (n=23)	21.7
4.0	*Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit? (n-31)	19.0
4.0	Do service doors in laundry chutes have at least a Class B fire-resistive rating? (n=21)	19.0
4.0	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery? (n=21)	19.0
6.0	Are all doors in required 2-hour rated fire separations provided with positive latching? (n=22)	18.2

* SRF items that are also in the top twenty items with contingencies in the National Survey, 1982.

Rank Order Of Contingencies	Questions	% with Contingencies
7.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers? (n=29)	17.2
7.5	Are the dampers in duct penetrations of smokestop partitions closed upon activation of a smoke detector within the duct system? (n=29)	17.2
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually? (n=31)	16.1
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation? (n=31)	16.1
11.0	If corridor doors contain louvers or transoms, are they closed and made smoke tight by permanent noncombustible construction? (n=26)	15.4

Rank Order Of Contingencies	Questions	% With Contingencies
12.5	When corridor enclosures involve the use of vision panels, are the panels set in approved steel frames? (n=33)	15.2
12.5	* When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed? (n=33)	15.2
15.5	On each floor, do smokestop partitions limit the maximum area of each smoke compartment to no more than 22,500 square feet of which the upper limit of either length or width is 150 feet? (n=34)	14.7
15.5	* Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups? (n=34)	14.7
15.5	* Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and action instituted, resulting from the review of the care and treatment of patients served by the hospital? (n=34)	14.7
15.5	* Is an ongoing review of antibiotic use documented? (n=34)	14.7

Rank Order Of Contingencies	Questions	% With Contingencies
18.5	Are all corridors separated from institutional sleeping and treatment rooms and other use areas by partitions that are constructed to resist the passage of smoke? (n=31)	12.9
18.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical record and pre-established criteria? (n=31)	12.9
20.0	* Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented? (n=32)	12.5
23.5	When corridor enclosures involve the use of vision panels, are the panels of fixed wired glass? (n=33)	12.1
23.5	When corridor enclosures involve the use of vision panels, are the panels not in excess of 1296 square inches? (n=33)	12.1
23.5	Are doors in smokestop partitions fitted adequately to prevent the spread of smoke? (n=33)	12.1
23.5	* Does the medical staff review blood transfusions for proper utilization (eg., use of whole versus component blood)? (n=33)	12.1

Rank Order Of Contingencies	Questions	% With Contingencies
23.5	Is surgical case review (tissue committee function) performed on a monthly basis? (n=33)	12.1
23.5	* When surgical case review (tissue committee function) is performed, is there written evidence of any required action and follow-up on the findings? (n=33)	12.1
32.0	Are corridor doors fitted with latching that ensures maintenance of a tight closure? (n=34)	11.8
32.0	Are corridor doors at least 1 3/4 inch solid bonded wood core or equivalent? (n=34)	11.8
32.0	Are doors in partitions separating hazardous areas kept closed? (n=34)	11.8
32.0	Are smokestop partitions continuous from outside wall to outside wall? (n=34)	11.8

Rank Order Of Contingencies	Questions	% With Contingencies
32.0	* Is there evidence that drug utilization and effectiveness in the hospital is reviewed? (n=34)	11.8
32.0	Does the director of the pharmaceutical service participate in those aspects of the hospital's quality assurance program that relate to drug utilization and effectiveness? (n=34)	11.8

LA/edc

Appendix II

SURVEY REPORT FORM ITEMS WITH THE GREATEST PERCENTAGE OF TOTAL RECOMMENDATIONS - 1982

ık Order Total commendations	Questions	% With Recommendations
1.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit? (n=31)	51.3
2.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations? (n=34)	44.1
3.0	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed? (n=33)	42.4
4.0	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and action instituted, resulting from the review of the care and treatment of patients served by the hospital? (n=34)	41.2
5.0	Does the clinical resume contain pertinent instructions for further care (such as physical activity limitations, medications, diet)? (n=34)	41.2
6.0	Is the unit dose drug distribution system in use throughout the hospital? (n=34)	35.2

nk Order Total commendations	Questions	% With Recommendations
7.0	Does the emergency medical record include condition of patient on release? (n=31)	32.2
8.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers? (n=29)	31.0
8.5	Are the dampers in duct penetrations of smoke-stop partitions closed upon activation of a smoke detector within the duct system? (n=29)	31.0
11.0	Are laboratories protected by at least 1-hour fire-resistive construction and an approved automatic fire extinguishing system or at least 2-hour fire resistive construction? (n=33)	30.3
11.0	Does the design and work flow pattern provide for separation of soiled or contaminated supplies from those which are clean and sterile? (n=33)	30.3
11.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel? (n=33)	30.3

ank Order of Total commendations	Questions	% With Recommendations
17.5	Are all toilet and bathing areas used by patients equipped with an emergency call system? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their qualifications? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their status? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their clinical duties? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their responsibilities? (n=34)	29.4
17.5	Do the medical staff bylaws require revision in some areas? (n=34)	29.4

Rank Order Of Total Recommendations	Questions	% With Recommendations
17.5	Is the pharmacy and the therapeutics function of the medical staff being performed? (n=34)	29.4
17.5	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups? (n=34)	29.4
17.5	Is an ongoing review of antibiotic use documented? (n=34)	29.4
17.5	Have criteria been established for an ongoing review of antibiotic use? (n=34)	29.4

A/edc

University Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations?	23.5
2.0	For all buildings designed in or before 1973 and for buildings designed after 1973 that are less than 2 stories in height, are chutes or other vertical openings protected with partitions having at least 1-hour resistive rating?	21.7
4.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	19.0
4.0	Do service doors in laundry chutes have at least a Class B fire-resistive rating?	19.0
4.0	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery?	19.0
6.0	Are all doors in required 2-hour rated fire separations provided with positive latching?	18.2
7.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers?	17.2
7.5	Are the dampers in duct penetrations of smokestop partitions closed upon activation of a smoke detector within the duct system?	17.2
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually?	16.1
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation?	16.1
11.0	If corridor doors contain louvers or transoms, are they closed and made smoke tight by permanent noncombustible construction?	15.4
		15.1

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
1.0	Is there an ongoing review of antibiotic usage documented?	24.9
2.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions, and actions instituted resulting from the review of the care of patients served by the hospital?	24.8
2.5	Have there been actions (antibiotic) taken on the findings of the reviews made?	24.8
4.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	22.4
5.0	Is the quarterly review and evaluation of the quality or appropriateness of anesthesia care documented?	18.7
6.0	When surgical case review is performed, does it include all cases in which no specimen was removed?	18.2
7.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel?	17.8
8.0	Is there documentation of the timely review and evaluation of the appropriateness of emergency patient care?	17.2
9.0	Is the quality and appropriateness of respiratory care services evaluated regularly (quarterly)?	16.4
10.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed at least quarterly?	15.9
11.5	Is there a reasonably comprehensive delineation of clinical privileges for each member of the medical staff?	15.7
11.5	Is there written evidence of any required action (surgical case) and follow-up on the findings?	15.7
13.5	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic	.1

University Hospitals			All Hospitals		
Rank Order Of Contingencies	Questions	% Contingencies	Rank Order Of Contingencies	Questions	% Contingencies
12.5	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed?	15.1	13.5	Does the review and evaluation (of ER medical records) involve the use of the medical record and pre-established criteria?	15.1
15.5	On each floor, do smokestop partitions limit the maximum area of each smoke compartment to no more than 22,500 square feet of which the upper limit of either length or width is 150 feet?	14.7	15.0	Is a review and evaluation of emergency care performed at least monthly?	14.7
			16.0	Does the medical staff review blood transfusions for proper utilization?	14.4
15.5	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	14.7	17.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts on the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	13.9
15.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and actions instituted, resulting from the review of the care and treatment of patients served by the hospital?	14.7	18.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed using predetermined criteria?	12.8
15.5	Is an ongoing review of antibiotic use documented?	12.9	19.0	Is the review and evaluation of the quality, safety and appropriateness of the nuclear medicine service documented?	12.7
18.5	Are all corridors separated from institutional sleeping and treatment rooms and other use areas by partitions that are constructed to resist the passage of smoke?	12.9	20.0	Is there evidence that drug utilization in the hospital is reviewed?	10.9
18.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical record and pre-established criteria?	12.5			
20.0	Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented?				

University Hospitals Without Building and Grounds SRF Items

Rank Order Of Contingencies	Questions	% Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations?	24
2.5	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	19
2.5	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery?	19
4.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually?	16
4.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation?	16
6.0	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed?	15
8.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	15
8.0	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and actions instituted, resulting from the review of the care and treatment of patients served by the hospital?	15
8.0	Is an ongoing review of antibiotic use documented?	15
10.0	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical	13

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
1.0	Is there an ongoing review of antibiotic usage documented?	25
2.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions, and actions instituted resulting from the review of the care of patients served by the hospital?	25
2.5	Have there been actions (antibiotic) taken on the findings of the reviews made?	25
4.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	22
5.0	Is the quarterly review and evaluation of the quality or appropriateness of anesthesia care documented?	19
6.0	When surgical case review is performed, does it include all cases in which no specimen was removed?	18
7.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel?	18
8.0	Is there documentation of the timely review and evaluation of the appropriateness of emergency patient care?	17
9.0	Is the quality and appropriateness of respiratory care services evaluated regularly (quarterly)?	16
10.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed at least quarterly?	16
11.5	Is there a reasonably comprehensive delineation of clinical privileges for each member of the medical staff?	16
11.5	Is there written evidence of any required action (surgical case) and follow-up on the findings?	16
13.5	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic	15

University Hospitals Without Building and Grounds SRF Items

Rank Order Of Contingencies	Questions	% Contingencies
11.0	Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented?	13
13.0	Does the medical staff review blood transfusions for proper utilization?	12
13.0	Is surgical case review (tissue committee function) performed on a monthly basis?	12
13.0	When surgical case review (tissue committee function) is performed, is there written evidence of any required action and follow-up on the findings?	12
17.0	Fo. the purpose of reviewing and evaluating the care and treatment of patients served by the hospital, is there a monthly meeting of the medical staff in the nondepartmentalized hospital, or the departmental or major clinical service staffs in a departmentalized hospital?	12
17.0	Have criteria been established for an ongoing review of antibiotic use?	12
17.0	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic services provided is performed?	12
17.0	Is there evidence that drug utilization and effectiveness in the hospital is reviewed?	12
17.0	Does the director of the pharmaceutical service participate in those aspects of the hospital's quality assurance program that relate to drug utilization and effectiveness?	12
20.0	Is there documentation of the timely review and evaluation of the quality and appropriateness of emergency patient care?	10

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
13.5	Does the review and evaluation (of ER medical records) involve the use of the medical record and pre-established criteria?	15
15.0	Is a review and evaluation of emergency care performed at least monthly?	15
16.0	Does the medical staff review blood transfusions for proper utilization?	14
17.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts on the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	14
18.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed using predetermined criteria?	13
19.0	Is the review and evaluation of the quality, safety and appropriateness of the nuclear medicine service documented?	13
20.0	Is there evidence that drug utilization in the hospital is reviewed?	11