

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

April 3-4, 1985  
Washington Hilton Hotel

WEDNESDAY, April 3, 1985

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Independence Room (Discussion with Don Arnwine)
7:30pm	COTH ADMINISTRATIVE BOARD RECEPTION Jackson Room
8:00pm	COTH ADMINISTRATIVE BOARD DINNER Independence Room

THURSDAY, April 4, 1985

8:00am	COTH ADMINISTRATIVE BOARD MEETING Hamilton Room
Noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Hemisphere Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD MEETING

April 4, 1985  
Washington Hilton Hotel  
Hamilton Room  
8:00am-Noon

- I. CALL TO ORDER
- II. CONSIDERATION OF MINUTES  
January 24, 1985 Page 1
- III. MEMBERSHIP
- A. New Members Page 25
1. City of Faith Hospital, Tulsa, OK Page 26
2. St. Elizabeth Hospital Medical Center, Youngstown, OH Page 31
3. St. Mary's Hospital, Waterbury, CT Page 36
- B. Participation of Investor-Owned Hospitals Page 41
- IV. UPDATE ON CONSORTIUM ACTIVITIES
- A. University Hospital Consortium Mr. Baker
- B. Associated Health Care Systems Mr. Reed
- C. Consortium of Jewish Hospitals Dr. Foreman
- V. LCME FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL Executive Council  
Agenda - Page 16
- VI. ADDITION TO THE GENERAL REQUIREMENTS FOR GME Executive Council  
Agenda - Page 63
- VII. CERTIFICATION AND GME Executive Council  
Agenda - Page 89
- VIII. COTH GENERAL SESSION AT THE AAMC ANNUAL MEETING Page 47
- IX. FINANCING GRADUATE MEDICAL EDUCATION Executive Council  
Agenda - Page 72
- X. FOLLOW-UP ON MEDICARE POLICY DECISIONS Dr. Bentley

XI. INFORMATION ITEMS

- A. Survey of Teaching Hospital Data Systems
- B. Clinical Research and Prospective Payments

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XII. OTHER BUSINESS

XIII. ADJOURNMENT

COTH ADMINISTRATIVE BOARD  
Meeting Minutes  
January 24, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 8:00am 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 October 29, 1984 COTH Administrative Board Meeting.

Before moving directly to the agenda, the Chairman indicated he had a number of items to share with the Board. He first introduced and welcomed Jim Mongan, MD, Executive Director of the Truman Medical Center in Kansas City, Missouri; and Gary Gambuti, President, St. Luke's-Roosevelt Hospital Center in New York City. He indicated that Bob Baker, Director, University of Nebraska Hospital, was unable to attend the meeting due to a prior a commitment. Mr. King indicated that he hoped the new members would feel comfortable to join in the conversation and discussion very quickly.

The Nominating Committee by tradition has been chaired by the Immediate Past Chairman of COTH and consists additionally of the current Chairman and an individual appointed by the current Chairman. Thus, Mr. King indicated that the Committee this year will be chaired by Haynes Rice and include himself in addition to Bob Frank, President, Barnes Hospital in St. Louis, Missouri. He also reported that at his suggestion Dr. Mitchell Rabkin, President, Beth Israel Hospital in Boston, had been appointed to serve on the AAMC Flexner Award Committee. Finally, he asked Board members to recall the group had an extensive discussion concerning the JCAH with its staff at the October Board meeting in Chicago. The Committee that has been identified in the minutes is being brought together and Jim Bentley is a member of that Committee and will attend its first meeting on January 30.

The Chairman then made some observations on his views concerning the Board agendas and how he hoped they would be followed as he pursued his style as Chairman. He indicated that it had always been clear that there are some issues that all members regard as having primary importance to teaching hospital executives, some in which there is marginal interest, and some in which there is very little interest. In the past this has been expressed informally in terms of Board behavior towards these issues as they were discussed. He indicated that since there is a full agenda in the meeting today, he would like to make this policy a little more explicit. In reviewing the Executive Council agenda under Action Items, there is a consent agenda. For the most part this is housekeeping. He indicated that he would assume that the consent agenda would be approved as a single action unless a request is heard to the contrary from a particular Board member. In the future he asked that as Board members review the agenda, if there are items on the Executive Council agenda that are not on the COTH agenda, he'd like to hear about it beforehand so that a change can be made if a given Board member had requested it. Because of the extensive discussion today he indicated that he did not think it was necessary to discuss the GPEP follow-up activities

on page 42 of the Executive Council agenda book. Additionally, since there was extensive discussion concerning financing graduate medical education the previous evening, he indicated that item should be omitted from the agenda for the morning. Finally, concerning radioactive waste, he didn't feel this matter needed discussion but chose to call it to the attention of Board members because it is important. He hoped each Board member would urge their respective state hospital associations to get involved and work with deans or individuals in their respective institutions who are responsible for this issue. Finally, he reported that at Haynes Rice's suggestion, the AAMC has been working with the AHA on this issue as well.

### III. MEMBERSHIP

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

- ACTION: It was moved, seconded and carried to approve:
- (1) ST. PETER'S MEDICAL CENTER, New Brunswick, New Jersey for full membership;
  - (2) SHADYSIDE HOSPITAL, Pittsburgh, Pennsylvania for full membership.

Dr. Knapp called attention to the correspondence between John Gaffney, Executive Director of St. Joseph Hospital, and himself concerning the status of St. Joseph Hospital as a COTH member. That correspondence indicates that until such time as a firm policy decision is reached with regard to participation of investor-owned hospitals in the Council of Teaching Hospitals, St. Joseph will continue to be included as a member of COTH.

Attention was then called to the report on COTH member institutions which have dropped membership in the Council since 1980. The 31 hospitals that have terminated membership in the Council of Teaching Hospitals between the years 1980-84 were reviewed. Attention was called by various members to the following institutions:

- o The Queen's Medical Center, Honolulu, HI
- o Greater SE Community Hospital, Washington, DC
- o The Jewish Hospital and Medical Center of Brooklyn, Brooklyn, NY
- o LDS Hospital, Salt Lake City, UT
- o Veterans Administration Medical Center, Kansas City, MO
- o Veterans Administration Medical Center, Salt Lake City, UT

Mr. King, Mr. Rice, Mr. Gambuti, Dr. Knapp and Mr. Stranova indicated that they would be in touch with the above institutions respectively.

### IV. NOMINATING COMMITTEE REPORT

Mr. Rice indicated that a number of events had occurred which had caused Chairman Sheldon King to ask the Nominating Committee to take action and make some recommendations. Essentially there were three matters before the group:

- o For personal reasons Bill Kerr, Director, Hospitals and Clinics at the University of California, San Francisco, submitted his resignation from a three-year term on the AAMC Executive Council;
- o Secondly, there are four AAMC Assembly members who are no longer chief executives of COTH member institutions and they need to be replaced;
- o Thirdly, the American Hospital Association Nominating Committee will hold a hearing on February 4 to hear recommendations for positions on the AHA Board of Trustees.

Mr. Rice indicated that he would present these matters in the above order and ask for a motion to accept all recommendations as a group.

Since Bill Kerr was a member of the Executive Council, it is that body that needs to take action on his replacement. The Nominating Committee recommended that Dr. Buchanan occupy this position for a three-year term. That matter does not require COTH Board approval; it is on the Executive Council agenda for action. When Dr. Buchanan occupies this position on the AAMC Executive Council, an individual needs to be elected to replace Dr. Buchanan in the remaining two years of his term on the COTH Administrative Board. The Nominating Committee recommended that Gordon Derzon, Superintendent, University of Wisconsin Hospital and Clinics, be elected to serve the remaining two years of Dr. Buchanan's term.

To replace the four individuals who are members of the AAMC Assembly but no longer serve as chief executive officers of COTH member institutions, the following recommendations were made:

- o Barry Spero, President, Mt. Sinai Hospital Medical Center, Cleveland, should replace Bill Corley whose term expires in 1986, and who left Akron General Medical Center for Community Hospital of Indianapolis which is not a full COTH member;
- o The other three Assembly members were Veterans Administration medical center chief executives and it is recommended that the following individuals replace those three who are no longer serving as VA chief executives in COTH member institutions:
  - Al Gavazzi, Medical Center Director, VA Medical Center, Washington, DC;
  - Ronald Nelson, Medical Center Director, VA Medical Center, Sepulveda, CA;
  - James Stephens, Medical Center Director, VA Medical Center, Allen Park, MI.

The third matter concerns an action which was taken at the Administrative Board meeting on November 7, 1983 and reads as follows:

The COTH Administrative Board requests the COTH Nominating Committee recommend the names of three individuals to be approved by the Board in January 1984 who would be recommended to the AHA Nominating Committee as candidates for the AHA Board of Trustees. Further, the Chairman of the COTH Administrative Board or the COTH Nominating Committee should appear and

present these three names to the AHA Nominating Committee at its hearing on the subject on January 30, 1984 and each year thereafter.

There was also agreement that, in the absence of time, the Nominating Committee should have the authority to move ahead in the absence of approval of the recommendations of the COTH Administrative Board. Mr. Rice indicated that he is scheduled to appear before the AHA Nominating Committee on February 4, 1985 and on behalf of the COTH Nominating Committee requested approval to place the following three names before the AHA committee:

- o Robert M. Heyssel, MD, The Johns Hopkins Hospital
- o Stuart J. Marylander, Cedars-Sinai Medical Center
- o Mitchell T. Rabkin, MD, Beth Israel Hospital

ACTION: It was moved, seconded, and carried to approve the COTH Nominating Committee report as presented by Mr. Rice.

The Chairman requested that a letter be sent to Mr. Kerr indicating the Board's best wishes and expressing the fact that his participation and contributions will be sorely missed. A copy of the letter written on behalf of the Board is included in these minutes as Appendix A.

#### V. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS SEARCH COMMITTEE

Dr. Knapp called attention to the letter from Dr. Lewis, Chairman of the JCAH Search Committee requesting assistance in identifying potential candidates for the position of President of the Joint Commission on Accreditation of Hospitals. Dr. Knapp indicated that the names of Joseph Gonella, MD, Dean at Jefferson Medical College; and Jim Block, President, Rochester Area Hospitals Corporation, might be names the Board could consider. There was agreement that these were names that Dr. Cooper should submit if they indicated an interest in the position. Subsequent discussions with these individuals as well as a number of others resulted in the letter included in these minutes as Appendix B written to Search Committee Chairman, Dr. Lewis. It should be noted that Dr. Gonella declined to be nominated as a candidate for the position.

#### VI. INVESTOR-OWNED TEACHING HOSPITAL MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS

This issue was debated at the COTH Spring Meeting in May of 1984 as well as the COTH Business Meeting in November 1984. The points made in these as well as other discussions were outlined on the Board agenda. The following questions were posed for discussion:

1. Is it appropriate for COTH/AAMC to represent broadly the community of medical education and yet exclude some organizations participating in medical education because of their ownership status?
2. Are there other positive or negative points that need to be raised in the debate which have not been already mentioned?
3. What is the process the Board would recommend to address and reach a conclusion on this issue?

The following points were made:

- o There is the substantive issue which concerns the question of what is this organization all about and what role does institutional ownership play with regard to the nature of this organization? Separate but related to this question are the politics of the issue in the COTH membership.
- o These matters should be discussed separately. Perhaps there is something to be learned from the individuals who are chief executives of these investor-owned teaching hospitals.
- o There are in the current membership a number of members who use the label teaching hospital for marketing purposes and in many respects behave in a manner consistent with the investor-owned hospital community.
- o Investor-owned companies would not be members; teaching hospitals that are owned by these corporations would be members.
- o There is a serious question as to whether one ought to question the motives of individuals and institutions.
- o If we do not move ahead and invite these organizations to participate, we may appear to be negative, strident, and unwilling to respond to change.
- o Once a positive decision is made, there is no way to reverse it.
- o The values, orientation, and objectives of these institutions are not consistent with those of the vast majority of members currently comprising the Council of Teaching Hospitals.

Following further extensive discussion of these as well as points made in earlier debate, it was suggested that it might be worthwhile to send a survey to the current COTH membership and report on the results of that survey at the COTH Spring Meeting. After brief discussion there was a consensus that such a survey would only highlight the issue in a manner that would not necessarily be conducive to a sound decision. As the discussion moved ahead, it became apparent that a majority of the Board members favored participation of investor-owned hospitals in the Council of Teaching Hospitals.

**ACTION:** It was moved, seconded, and carried by majority to request that the staff draft a recommendation that the AAMC bylaws be changed to allow for full participation in the Council of Teaching Hospitals by investor-owned teaching hospitals. This recommendation would be placed before the COTH membership at its Business Session at the COTH Spring Meeting in San Francisco, May 10. This draft recommendation should be reviewed by the COTH Administrative Board at its meeting on April 4.



## VII. MEMBERSHIP AND SERVICE ISSUES FOR COTH

A number of issues that had been discussed during the development of the paper entitled, "New Challenges..." were reviewed once again. The nature of these issues was as follows.

- o Advocacy activities and efforts. The increasing complexity of the advocacy and representation environment in Washington was discussed. Of specific concern was the extent to which organizations such as the University Hospital Consortium, the Federation of Jewish Hospitals, Associated Health Care Systems, and Voluntary Hospitals of America would develop or have developed advocacy activities on the Washington scene. Don Arnwine, President, VHA, has agreed to join the COTH Administrative Board for a discussion of this issue at the April 3 evening Board session. In addition, Bob Baker, President, University Hospital Consortium, will make a report on that group's activities at the Board meeting on April 4.
- o Economic service activities. On January 20, 1983 the Executive Council reached a decision that it would be unwise for the Association to develop economic service programs unless there is a clearly expressed constituent desire for a service that the Association would be uniquely qualified to provide. There was a consensus that the AAMC should not re-open the question of providing economic services to its members.
- o Information sharing activities. Information sharing through survey efforts and "research reports" is a major function of the COTH/AAMC. The housestaff survey, executive salary survey, and the COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data are examples of information sharing. Medical education costs, resident staffing patterns, case-mix research, and the impact of the Medicare payment system are other examples of information sharing. Since the COTH membership reaches across all of the newly developing and probably competitive organizations, it would appear logical for COTH to continue current surveys and initiate new efforts as the needs arise. Inevitably, some of these organizations will undertake their own efforts in these areas.

It was agreed that every effort ought to be taken to ensure that unnecessary duplication does not occur and that harmonious relationships continue. Bob Baker will be presenting the activities of the university hospital consortium at the April 4 meeting, and Don Arnwine may touch upon this area in his presentation on the evening of April 3. The staff was encouraged to continue all efforts to be informed and to keep others informed of all activities related to the newly developing organizations.

- o Categorization of COTH members. COTH members have been classified on the basis of their relationship with the college of medicine, and this classification has been published in the "New Challenges..." paper. A number of researchers have requested a copy of the categorization to use for research purposes. While it might be difficult for a researcher to accomplish, the variables to reconstruct the list are public data. This being the case there was a consensus that the names of the hospitals in

each category should be shared with researchers and other individuals who wish to use the classification for legitimate purposes.

#### VIII PROPOSAL TO STUDY RESIDENT STAFFING

Representatives of Arthur D. Little, Inc. have met twice with AAMC staff to explore the possibility that the AAMC would be interested in serving as the principal client in a study of residency staffing patterns in COTH hospitals. Dr. Bentley briefly reviewed the history of these discussions and summarized the study plan. Noting that staff had study design questions about the absence of a severity measure, the use of length of stay weights for DRGs, and the presumption of a standard clinical organization across hospitals, Dr. Bentley asked if Board members had additional concerns. Mr. King noted that the length of stay adjustment did not include a regional adjustment and that the treatment of clinical fellows was unclear. Mr. Smith suggested that Dr. Bentley contact Mr. Kues of The Johns Hopkins Hospital who was directing a broader, but less detailed, study. The Board's consensus was that the AAMC should participate in a pilot study with a small number of interested COTH members.

#### IX PROPOSED POLICY ON MEDICARE WAIVERS

In anticipation of possible legislative or regulatory action that would alter a state's ability to receive a waiver from the Medicare Prospective Payment System, the Board considered recommending that the AAMC adopt an official policy on Medicare waivers. This issue was thought to be important because New Jersey had just completed a protracted and complex series of negotiations with the Department of Health and Human Services in order to obtain a renewal of its waiver. The waivers for Maryland and New York will be reconsidered during 1985, and the Massachusetts waiver will be up for renewal in 1986. In addition, other states may be considering applying for a waiver.

It was noted that the waivers are controversial because some opponents of the waivers have asserted that more Medicare money was being spent in the waived states than would otherwise have been spent if the Medicare Prospective Payment system had been in place. In a budget neutral system, if the waived states receive more money, then less is available for all other states. The opinions of COTH members regarding state waivers vary depending largely upon their experience with or expectation of establishing a reasonable state program.

After a brief discussion, there was agreement that the AAMC support the continued opportunity for states to be granted waivers from the Medicare payment system as long as a state does not receive more Medicare money than the amount to which it would otherwise be entitled. This recommended position leaves states the option to adopt their own payment programs, but does not advocate that they do so.

**ACTION:** It was moved, seconded, and carried unanimously that the AAMC should actively support the state waivers from the Medicare payment system to the extent that states do not spend more funds than would be spent had they not received a waiver.

## X, XI MEDICARE PROSPECTIVE PAYMENT SURVEY RESULTS AND POLICY POSITIONS FOR MEDICARE BUDGET PROPOSALS

Dr. Bentley opened the discussion of Medicare payment policies by reviewing seven tables the staff had prepared to show the impact of prospective payment on the membership (see Appendix C to these minutes). Mr. Rice noted that census is declining in many hospitals and Dr. Buchanan reported the increasing patient severity at his hospital. Both trends compound the adverse impacts of the payment trends. The Board then reviewed the agenda item recommending seven policy positions for the AAMC to take in light of anticipated budget recommendations from the Reagan administration. In discussion, Mr. Mitchell suggested the VHA/Bain data might help identify the source of regional differences in hospital costs. Dr. Mongan expressed concern about the implied priority of the seven recommendations and suggested that the first priority be to retain the hospital-specific and 50% regional average prices. Board members agreed with his point and his recommendation. Mr. Gambuti commented on the proposed wage index policy and supported making changes only prospectively. Mr. Reed encouraged staff to review the final document to ensure that the position supporting direct medical education does not imply the AAMC is backing away from its support of the resident-to-bed adjustment. Lastly, Mr. Smith urged the AAMC to work together with other organizations supporting similar policies.

- ACTION:
- It was moved, seconded, and carried to support the following policy positions on Medicare's Prospective Payment System:
- o The Association of American Medical Colleges vigorously opposes any freeze in DRG prices;
  - o The Association of American Medical Colleges strongly recommends that Congress amend the Prospective Payment System so that payments are based on a DRG specific, blended rate of hospital-specific and federal component prices. If Congress is unwilling to enact DRG specific price blending, then the Association of American Medical Colleges recommends that the Congress amend the DRG price formula so that it is based on a blend of 50% hospital-specific costs and 50% regional average costs;
  - o The Association of American Medical Colleges supports recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and a regression equation which incorporates only variables used in determining hospital DRG payments;
  - o The Association of American Medical Colleges opposes strongly any change or reduction in the passthrough for direct medical education costs until a comprehensive assessment of financing graduate medical education is completed and fully considered;

- o The Association of American Medical Colleges supports correcting the wage index numbers used in prospective payments but recommends amending the law to eliminate the current requirement that the new index numbers be applied retroactively to October 1, 1983;
- o The Association of American Medical Colleges recommends that Congress require HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment.

## XII AAMC SURVEY ON FACULTY PRACTICE PLANS

An AAMC Survey on Faculty Practice Plans, proposed by the Division of Institutional Studies for distribution to members of the COD, CAS and COTH, was reviewed by the Board. The questionnaire will be adapted for each Council, with the COTH target population being those 116 hospitals with a close relationship with the medical school as evidenced by the fact that the majority of hospital chiefs of service are department chairmen in the medical school.

Several Board members suggested alterations or additions for consideration. Dr. Buchanan stated a question distinguishing whether the plan is housed in the medical school or the hospital would be germane to interpretation of subsequent responses. It was also suggested that it would be important to know whether the plan operated within the framework of the medical school, the university, a separate foundation, or a for-profit corporation. Further comments reiterated the hope that the scope of the survey to COTH participants be expanded. Mr. Munson suggested asking whether practice plans had entered into any joint venture arrangements with hospitals. He also proposed a question concerning the role of the hospital chief executive officer in the governance and management of the plan. It was noted that it may be important to know the definition of full-time faculty, the extent to which full-time faculty must participate in the plan, and the extent to which part-time or voluntary faculty participate.

## XIII AUPHA PROPOSED INITIATIVE

Dr. Knapp called attention to a letter from Gary Filerman, PhD, and attached letters from Mohan Garg and Barbara Barzansky which appear as Appendix D to these minutes. Particular attention was called to the top of page three of the letter stating, "We now believe that the focus of the project should be on the role of the hospital administrator in bringing about needed changes in the teaching hospital."

Following brief discussion, there was consensus that Dr. Knapp should work out a "reasonable relationship" with AUPHA, and the Center for Educational Development at the University of Illinois for COTH/AAMC involvement in this project.

## XIV ADJOURNMENT

There being no new business, the meeting was adjourned at noon.



# association of american medical colleges

January 29, 1985

William B. Kerr  
Director of Hospitals  
and Clinics  
University of California, SF  
505 Parnassus Avenue  
San Francisco, California 94143

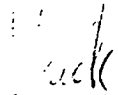
Dear Bill:

At the Board meeting on January 24, the COTH Administrative Board members noted with regret your resignation from the AAMC Executive Council. Each member expressed best wishes to you personally, and wanted to be sure you know you'll be missed.

Robert Buchanan, MD was elected to serve your term on the Executive Council, and Gordon Derzon was elected to fill the remaining two years of Dr. Buchanan's term on the COTH Administrative Board.

Agendas will continue to be sent to you to keep you posted on our activities. Stay in touch, and I look forward to seeing you soon. My best to Janice.

Sincerely,

  
Richard M. Knapp, PhD  
Director  
Department of Teaching Hospitals

RMK/mhw



# association of american medical colleges

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

February 25, 1985

(202) 828-0460

C. S. Lewis, Jr., M.D.  
Chairman  
Search Committee  
JCAH  
P.O. Box 148069  
Chicago, Illinois 60614

Dear Dr. Lewis:

As promised in my letter of January 3, I would like to recommend that the Search Committee consider the following individual for the position of president of the JCAH:

James A. Block, M.D.  
President  
Rochester Area Hospitals' Corporation  
220 Alexander Street, S. 702  
Rochester, New York 14607

I have discussed this matter with Dr. Block and he is willing and interested in being a candidate for the position. I recommend him highly.

Two other individuals who should be considered are:

Edward A. Wolfson, M.D.  
Dean for Clinical Campus (Binghamton)  
State University of New York  
Upstate Medical Center at Syracuse  
Binghamton, New York 13901

Dennis S. O'Leary, M.D.  
Dean for Clinical Affairs  
The George Washington University  
School of Medicine  
2300 Eye Street, N.W.  
Washington, D.C. 20037

I wish you well as you move ahead with the search.

Sincerely,

John A. D. Cooper, M.D.

Table 1

Comparison of Medicare Revenue with Single and Double  
Resident-to-Bed Adjustment, First PPS Year

<u>Medicare Inpatient Revenue</u>	<u>Number of Hospitals</u>	
	<u>Single Adjustment</u>	<u>Double Adjustment</u>
Less Than Allowable Cost	63	40
Greater Than Allowable Cost	81	106
Greatest Gain	\$8,743,273	\$10,589,858
Greatest Loss	-7,270,500	-5,399,000

Table 2

Resident-to-Bed Adjustment as Percentage of  
Total Inpatient Medicare Revenue,  
First PPS Year

<u>Percentage</u>	<u>Number of Hospitals</u>
Less than 4%	57
4 - 7.99%	75
8 - 11.99%	19
12 - 15.99%	2
16% or more	2
Not ascertained	28
Total	183



Table 3

Comparison of Hospital-Specific and Regional Rates,  
First PPS Year, COTH Responses

<u>Region</u>	<u>Hospital Specific Greater</u>	<u>Regional Price Greater</u>	<u>Not Ascertained</u>
New England (CT, ME, MA, NH, RI, VT)	21	2	0
Middle Atlantic (PA, NJ, NY)	20	3	13
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	16	4	2
East North Central (IL, IN, MI, OH, WI)	39	6	0
East South Central (AL, KY, MS, TN)	6	1	0
West North Central (IA, KS, MN, MO, NB, ND, SD)	16	1	0
West South Central (AR, LA, OK, TX)	7	1	0
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	6	0	1
Pacific (AK, CA, HI OR, WA)	<u>16</u>	<u>2</u>	<u>0</u>
Total	147	20	16

Table 4

Range in Regional Price as a Percentage of Hospital-Specific Price  
First PPS Year, COTH Responses

<u>Region</u>	<u>Regional Price</u> <u>Hospital Specific Price</u>	
	<u>Low</u>	<u>High</u>
New England (CT, ME, MA, NH, RI, VT)	59%	119%
Middle Atlantic (PA NJ, NY)	56	110
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	39	216
East North Central (IL, IN, MI, OH, WI)	54	116
East South Central (AL, KY, MS, TN)	56	102
West North Central (IA, KS, MN, MO, NB, ND, SD)	54	208
West South Central (AR, LA, OK, TX)	54	108
Mountain (AZ, CO, ID MT, NV, NM, UT, WY)	56	99
Pacific (AK, CA, HI, OR, WA)	49	220

Table 5

## Regional PPS Prices as a Percentage of National Prices

<u>Region</u>	<u>Urban</u>	<u>Rural</u>
New England (CT, ME, MA, NH, RI, VT)	105%	109%
Middle Atlantic (PA, NJ, NY)	96	109
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	97	97
East North Central (IL, IN, MI, OH, WI)	106	106
East South Central (AL, KY, MS, TN)	88	97
West North Central (IA, KS, MN, MO, NB, ND, SD)	101	97
West South Central (AR, LA, OK, TX)	95	94
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	95	99
Pacific (AK, CA, HI, OR, WA)	103	106

Table 6

PPS Phase-in for July 1 Fiscal Year

	Blend		
	<u>Hospital Specific</u>	<u>Regional</u>	<u>National</u>
7/84 - 9/84	75	25	0
10/84 - 6/85	75	18.75	6.25
7/85 - 9/85	50	37.5	12.5
10/85 - 6/86	50	25.0	25.0
7/86 - 9/86	25	37.5	37.5
10/86 - 6/87	25	0	75
7/87	0	0	100

Table 7

PPS Payments with a Price Freeze and Phase In

	<u>Amount</u>
Hospital Specific	\$6,467
Regional	5,111 (includes resident adjustment)
National	4,821 (includes resident adjustment)

Medicare Payment for Case Weight of 1.00

7/84 - 9/84	\$6,128
10/84 - 6/85	6,110
7/85 - 9/85	5,753
10/85 - 6/86	5,475
7/86 - 9/86	5,341
10/86 - 6/87	5,232
7/87	4,821

## AUPHA

ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION  
1911 NORTH FORT MYER DRIVE, SUITE 503/ARLINGTON, VIRGINIA 22209/(703) 524-5500

GARY L. FILERMAN, Ph.D.  
President

January 3, 1985

Richard Knapp, Ph.D.  
Council on Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle, N.W., Suite 200  
Washington, DC 20036

Dear Dick:

In early June the National Fund for Medical Education and the Kellogg Foundation held a conference in Georgia to assess progress of their projects and impacting medical education to encourage more cost effective physician behavior. I was a presenter at that session and my presentation led to several suggestions for follow up activities designed to stimulate a more effective interface between administration and clinical leadership.

The most promising of those was an initiative from the Center for Educational Development at Illinois. We convened a meeting in Chicago in August which involved leaders of major teaching hospitals, the medical schools and the health administration programs in the city. My intent was to create a consortium of leaders in residency level education and in health administration to identify new patterns of education for both residents in health administration and medicine. That focal point was the result of the conclusion from the Kellogg conference that previous investments in undergraduate medical education did not show much promise.

The enclosed letter presents the follow up to those discussions. It seems to me that we are on to something of significant potential. AUPHA has been the focal point for the health administration side and perhaps at this point it would be constructive to bring in COTH on the medical education side and thus have a pair of consortia at the national and local levels which would use the Chicago metropolitan area as a laboratory. I have long entertained the hope that we could collaborate and this may present that opportunity.

Richard Knapp, Ph.D.  
January 3, 1985  
Page 2

I am optimistic that funding is obtainable and could be so structured as to provide some support for the National Advisory Committee which in my new concept would be a joint AUPHA/COTH endeavor. As you know, our own financial constraints are severe so the project must be approached in a way which assures some return on our investment of energy. That can wait for later consideration but in the meantime I invite your response to me on the substance of the letter and then I will respond to the folks in Illinois. Best wishes for the New Year. I look forward to hearing from you.

Sincerely yours,

  
Gary L. Filerman

/ko't



Center for Educational Development  
808 South Wood Street  
Box 6998, Chicago, Illinois 60680  
(312) 996-3590

December 19, 1984

RECEIVED 12 23 1984

Gary Filerman, Ph.D., President  
Association of University Programs  
in Health Administration  
Suite 503  
1911 Fort Meyer Drive  
Arlington, VA 22209

Dear Gary:

It has been a long time since September 13, 1984, and you may be wondering about the progress of the proposal that we discussed. Since that time, we have been meeting extensively with various relevant individuals. In this brief report, we would like to bring you up to date on the present state of project development and suggest an approach for the future.

As you are well aware, during our dinner meeting we were provided with a proposal on cost-containment education developed by Northwestern University. This proposal has been funded by the Pew Foundation and is now being implemented. The educational interventions included in that grant incorporate, in summary form, most of the educational strategies utilized in past research. As a consequence of this the three of us decided that our efforts should complement, not duplicate, the Northwestern project. We agreed that four or five educational institutions in the Chicago area should serve as our case study sites, that our project should have a strong research base, and the general goal should be to develop innovative ways to bring physician leaders in graduate medical education and hospital administrators together for the purpose of affecting graduate medical education.

Therefore, we began contacting responsible individuals at Rush Medical College (Wayne Lerner), Children's Memorial Hospital (Earl Frederick), Mercy Hospital and Medical Center (Sr. Shiela Lyne), Lutheran General Hospital (Dr. Leighton Smith, head of the department of Family Practice), Wyler Hospital of the University of Chicago (Drs. Ron Anderson and Jay Berkelhamer) and the University of Illinois Hospital (Mr. James Malloy). Dr. Stephen Shortell of Northwestern University expressed interest in the project and agreed to serve as an advisor on the methodology of organizational change.



We have had fruitful discussions with Wayne Lerner and he is quite enthusiastic about participation. He is of the opinion that physicians are not likely to change as a result of the financial threat to teaching hospitals arising from prospective payment. He felt that educational interventions should include a curricular offering on the new market forces that are changing the health care delivery system. According to him, this type of intervention would be acceptable to program directors and residents and be likely to result in a more cost conscious and better prepared physician. Wayne, in conjunction with Dr. Russe (dean of the medical school) has issued a memorandum to all chiefs of service inviting them to consider the attached proposal. As of today, the heads of the departments of family practice and obstetrics-gynecology have expressed interest. We will know the responses of the other services within the next month.

Earl Frederick is in the process of revising the organizational structure of Children's Memorial Hospital to separate the components of education and patient care. This is a built-in intervention that could be used to assess the effects of an administrative level organizational change on graduate medical education. While Mr. Frederick is willing to cooperate, he does not wish to increase the stress that his programs directors are feeling as a result of the hospital reorganization.

Sr. Shiela is interested in the idea of the research proposal and has promised to raise the issue with several programs that might be candidates for participation. Dr. Anderson is anxious to work with us and introduced us to Dr. Berkelhamer, who is director of outpatient pediatrics. The type of intervention that Dr. Berkelhamer is interested in implementing has to do with feedback to residents about their cumulative ordering behavior. This makes it similar to the Northwestern proposal. We are exploring other options with him, but he is busy and has limited time to participate in reserach.

At Lutheran General Hospital and the University of Illinois, the type of interventions that seem acceptable to our faculty contacts have mainly to do with patterns of resident supervision within individual programs. Thus, at many of the institutions where we have been in touch with "interested" faculty it seems as if the changes that they are willing to institute are similar to the educational-level interventions that characterize the Northwestern project.

In considering the above results of our first stage of planning, we would like to suggest the following approach for your consideration. We still strongly support the idea that the project goals should be to:

- (1) develop joint decision-making structures that include physician leaders in graduate medical education and hospital administrators so as to create an environment in which physicians would become cost effective deliverers of health care, and
- (2) identify information that could be added to the curriculum of programs in hospital administration.

We now believe that the focus of the project should be on the role of the hospital administrator in bringing about needed changes in the teaching hospital. In other words, we would not concentrate on changing graduate medical education directly but on the role of the hospital administrator in making the needed changes in graduate medical education. This still requires us to understand the teaching hospital as an organization (in fact the requirement is now stronger), but the analysis focuses on:

- (1) how teaching hospitals are changing or will change based on the new financial environment,
- (2) what skills will teaching hospital administrators need to "keep up" with and rationally direct the changes, and
- (3) how can these skills best be taught/learned.

The results of this project should, therefore, be directly relevant to the 138 existing programs in health administration. This of course includes new ways of structuring graduate medical education and some of the of the other issues that we have been considering. The new focus, however, frees us somewhat from the need to identify interventions to implement in specific graduate medical education programs.

The general approach that we have been discussing thus far can be utilized to good effect in this project. We envision two general groups contributing their specialized skills and expertise. First, a working group consisting of representatives from CED, AUPHA, and perhaps a hospital administrator and physician would be responsible for developing the methodology for the project and doing the actual data collection. An advisory group, consisting of a nationally-known panel of hospital chief executive officers and graduate medical education program directors would review the plans and the data generated by the working group at several day-long meetings per year. A possible design for this project includes a series of data collection and data analysis steps that might be structured as follows:

- (1) select a sample of teaching hospitals and through a questionnaire/interviews with administrators, physicians, other personnel assess the changes (e.g., organizational, administrative, financial) that are occurring,
- (2) do some in depth case studies of organizations where certain types of changes have been attempted to determine the new roles/skills that are required of hospital administrators,
- (3) design ways to include these in the curriculums of health administration programs.

The advisory group would be utilized to both react to the data collected and to assist in the planning of next steps. Since the composition of this advisory group is critical to the success of the project, your input is essential. Some of the participants at the September 13th meeting might serve as a core onto which others could be added.

The products of this research would be as follows:

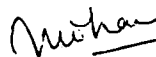
- (1) the possibility of direct curriculum additions/changes in health administration programs to reflect the changing nature of the teaching hospital and role of the hospital administrator,
- (2) continuing education programs for hospital administrators/graduate medical education program directors to inform them about new and innovative ways to manage teaching hospitals , and
- (3) a general addition to the literature about the teaching hospital as a complex organization and way that teaching hospitals are evolving as a result of changed economic conditions.

We will, in this revised project plan, have addressed the original goals of the project but in a different, and hopefully more manageable and relevant way. Direct interventions, if they occur at all, will be confined to the end of the project. Descriptive analysis, with an emphasis on individual, organizational, and environmental level variables, will be the major focus.

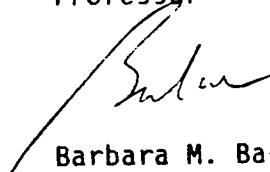
Please let us know your thought on this. We are continuing to stay in touch with all our contacts. This new approach will not negate the work that we have done thus far.

With best wishes for happy holidays.

Sincerely,



Mohan L. Garg, Sc.D.  
Professor



Barbara M. Barzansky, Ph.D.  
Assistant Professor

MLG/BB/amg

## MEMBERSHIP APPLICATIONS

Three hospitals have applied for membership in the Council of Teaching Hospitals. The applicants and the staff recommendations for type of membership are:

### HOSPITAL

### STAFF RECOMMENDATION

City of Faith Medical Center  
Tulsa, Oklahoma

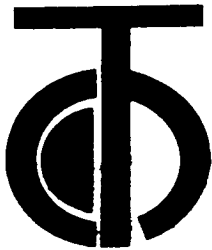
Full Membership

St. Elizabeths Hospital  
Youngstown, Ohio

Full Membership

St. Mary's Hospital  
Waterbury, Connecticut

Full Membership



APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: City of Faith Hospital  
Hospital Address: (Street) 8181 South Lewis  
(City) Tulsa (State) OK (Zip) 74137  
(Area Code)/Telephone Number: ( 918 ) 493-100  
Name of Hospital's Chief Executive Officer: B. Joe Gunn  
Title of Hospital's Chief Executive Officer: Hospital Administrator

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>294</u>	Admissions:	<u>3,678</u>
Average Daily Census:	<u>75*</u>	Visits: Emergency Room:	<u>10,656</u>
Total Live Births:	<u>-0-</u>	Visits: Outpatient or Clinic:	<u>53,970</u>

\* Current average 140 per day

B. Financial Data

Total Operating Expenses: \$ 21,502,715

Total Payroll Expenses: \$ 6,517,255

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 730,000  
 Supervising Faculty: \$ 149,861

C. Staffing Data

Number of Personnel: Full-Time: 329  
 Part-Time: 67

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 76  
 With Medical School Faculty Appointments: 76

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

<u>Internal Medicine</u>	<u>Surgery</u>	<u>Pediatrics</u>	<u>Pathology</u>
<u>Family Medicine</u>	<u>Pediatrics</u>	<u>Radiology</u>	<u>Anesthesiology</u>
<u>Emergency Medicine</u>			

Does the hospital have a full-time salaried Director of Medical Education?: The Dean and Medical Director are the same person, and he is responsible for this.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>4</u>	<u>12/clerkship</u>	<u>Required</u>
Surgery	<u>4</u>	<u>12/clerkship</u>	<u>Required</u>
Ob-Gyn	<u>6</u>	<u>8/clerkship</u>	<u>Required</u>
Pediatrics	<u>6</u>	<u>8/clerkship</u>	<u>Required</u>
Family Practice	<u>5</u>	<u>9-10/clerkship</u>	<u>Required</u>
Psychiatry	<u>6</u>	<u>8/clerkship</u>	<u>Required</u>
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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B. Graduate Medical Education

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

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible				
	12/year			
Medicine	36 total	6	8	Nov. 1980
Surgery				
Ob-Gyn				
	4/year			
Pediatrics	12 total	1	4	Oct. 1982
	8/year			
Family Practice	24 total	18	2	Nov. 1978
Psychiatry				
Other:	3/year			
<u>Anesthesia</u>	9 total	3	5	June 1983
<u>Radiology</u>	5 total	3	2	Nov. 1982

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

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

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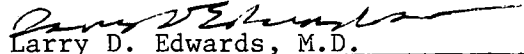
IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

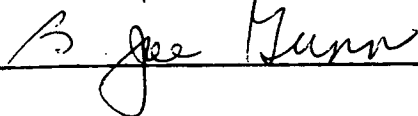
Name of Affiliated Medical School: Oral Roberts University School of Medicine

Dean of Affiliated Medical School:  Larry D. Edwards, M.D.

Information Submitted by: (Name) B. Joe Gunn

(Title) Hospital Administrator

Signature of Hospital's Chief Executive Officer:



(Date) 12-19-84



FEB 11 1985

# Oral Roberts University

8181 South Lewis • Tulsa, Oklahoma 74137

SCHOOL OF MEDICINE  
OFFICE OF THE DEAN

(918) 493-8147

December 13, 1984

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

Dear Sirs:


It is with pleasure that the Oral Roberts University School of Medicine recommends the City of Faith Hospital for teaching hospital membership on the Council of Teaching Hospitals.

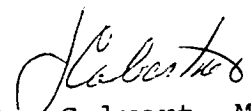
The City of Faith Hospital serves as the primary teaching hospital for the majority of the students' required clinical rotations. In addition, the clinical department chairperson serves as chief of the hospital's corresponding clinical department.

The hospital is new and has a growing patient census. The hospital will be used increasingly as a resource for student and resident training as the patient census increases. As the school's primary teaching hospital, the City of Faith Hospital plays a major and significant role in the medical school's educational programs.

As the primary hospital for this medical school's teaching programs, O.R.U. School of Medicine recommends the City of Faith for membership in C.O.T.H.

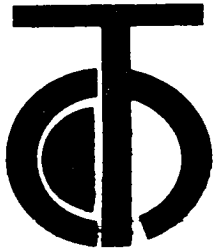
Sincerely,

  
Larry D. Edwards, M.D.  
Dean, School of Medicine

  
Jon Calvert, M.D., Ph.D.  
Associate Dean for  
Clinical Sciences

LDE/JC/kc

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COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Elizabeth Hospital Medical Center

Hospital Address: (Street) 1044 Belmont Avenue

(City) Youngstown (State) Ohio (Zip) 44501

(Area Code)/Telephone Number: (216) 746-7211

Name of Hospital's Chief Executive Officer: Sister Susan Schorsten

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>756</u>	Admissions:	<u>26,785</u>
Average Daily Census:	<u>654</u>	Visits: Emergency Room:	<u>36,572</u>
Total Live Births:	<u>2,635</u>	Visits: Referred & Outpatient Clinic:	<u>156,489</u>

B. Financial Data

Total Operating Expenses: \$ 99,170,000

Total Payroll Expenses: \$ 54,077,937

Hospital Expenses for:

Supervising Faculty: & Fringe Benefits: \$ 11,280,997  
 \$ not available

C. Staffing Data

Number of Personnel: Full-Time: 2391  
 Part-Time: 810

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 232  
 With Medical School Faculty Appointments: 123

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

Laboratory      Internal Medicine      Education  
Ob/gyn Education

Does the hospital have a full-time salaried Director of Medical Education?: YES

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>3</u>	<u>12</u>	<u>Required</u>
Surgery	<u>3</u>	<u>12</u>	
Ob-Gyn	<u>6</u>	<u>24</u>	
Pediatrics	<u>----</u>	<u>----</u>	<u>----</u>
Family Practice	<u>----</u>		<u>----</u>
Psychiatry	<u>6</u>	<u>21</u>	
Other: _____			
_____			
_____			

B. Graduate Medical Education

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

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	<u>5</u>	<u>2</u>	<u>3</u>	<u>1975</u>
Medicine	<u>12</u>	<u>7</u>	<u>5</u>	<u>1947</u>
Surgery	<u>6</u>	<u>3</u>	<u>2</u>	<u>1949</u>
Ob-Gyn	<u>3</u>	<u>3</u>	<u>0</u>	<u>1949</u>
Pediatrics	<u>----</u>	<u>      </u>	<u>      </u>	<u>      </u>
Family Practice	<u>4</u>	<u>1</u>	<u>3</u>	<u>1977</u>
Psychiatry	<u>----</u>	<u>      </u>	<u>      </u>	<u>      </u>
Other:	<u>4</u>	<u>4</u>	<u>0</u>	<u>1974</u>
<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

Name of Affiliated Medical School: Northeastern Ohio Universities College of Medicine

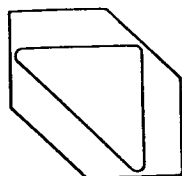
Dean of Affiliated Medical School: Colin Campbell, M.D.

Information Submitted by: (Name) *W. Robert Kennedy*  
 (Title) W. Robert Kennedy, Ph.D.  
DIRECTOR OF MEDICAL EDUCATION

Signature of Hospital's Chief Executive Officer:  
*Sister Susan Schuster, Rm* (Date) *February 20, 1985*

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COLLEGE OF MEDICINE



Rootstown, Ohio 44272 Phone: 216.325.2511

January 30, 1985

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

Dear Sir:

I am pleased to support the application of St. Elizabeth Hospital Medical Center, Youngstown, for membership in the Association of American Medical Colleges, Council of Teaching Hospitals. St. Elizabeth Hospital Medical Center is one of the major teaching hospitals of the Northeastern Ohio Universities College of Medicine.

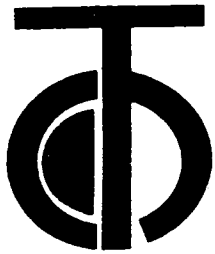
Clinical faculty from St. Elizabeth Hospital Medical Center provide instruction for sophomore students for courses in Principles of Ambulatory Care, Principles of Medicine, Radiology and Organ Systems Pathology. St. Elizabeth Hospital Medical Center is the site for junior year clerkships in Internal Medicine, Surgery, Ob/Gyn, Psychiatry and Pediatrics. Several senior electives are also provided by the hospital's clinical faculty.

St. Elizabeth Hospital Medical Center is dedicated to both undergraduate and graduate education. I am pleased to support their application for membership in the AAMC Council of Teaching Hospitals.

Sincerely,

Colin Campbell, M.D.  
Provost and Dean

CC:cfe



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Mary's Hospital  
Hospital Address: (Street) 56 Franklin Street  
(City) Waterbury (State) Connecticut (Zip) 06702  
(Area Code)/Telephone Number: ( 203 ) 574-6000  
Name of Hospital's Chief Executive Officer: Sister Margaret Rosita  
Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>347</u>	Admissions:	<u>14,378</u>
Average Daily Census:	<u>300</u>	Visits: Emergency Room:	<u>36,288</u>
Total Live Births:	<u>887</u>	Visits: Outpatient or Clinic:	<u>66,192</u>

B. Financial Data

Total Operating Expenses: \$ 55,924,301

Total Payroll Expenses: \$ 29,648,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,390,000  
 Supervising Faculty: \$ 959,462

C. Staffing Data

Number of Personnel: Full-Time: 1111  
 Part-Time: 597

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 257  
 With Medical School Faculty Appointments: 75

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

<u>Medicine</u>	<u>Surgery</u>	<u>Pediatrics</u>	<u>Psychiatry</u>
Cardiology	Pulmonary Dis.	Nephrology	Emergency Medicine
Inflammatory Dis.	Gastroenterology	Hematology	

Does the hospital have a full-time salaried Director of Medical Education?: yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	Medicine 2/6 wks. Cardiology 2/mo	60 18	both both
Surgery	4-6/mo.	60	both
Ob-Gyn	2/mo.	12	both
Pediatrics	6/mo.	51	both
Family Practice			
Psychiatry	2/mo.	16	both
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



B. Graduate Medical Education

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

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	_____	_____	_____	_____
Medicine	29	4	25	1949
Surgery	14	2	12	1949
Ob-Gyn	1/3 mo	1		1979
Pediatrics	15	3	12	1974
Family Practice	_____	_____	_____	_____
Psychiatry	_____	_____	_____	_____
Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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

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IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

Name of Affiliated Medical School: Yale University School of Medicine

Dean of Affiliated Medical School: Leon E. Rosenberg, M.D.

Of the 4 programs with residents, the only unusual features are -

1. one of the medical floors is covered by Yale attendings. We think this a worthwhile learning experience for the house officers as well as a quality assurance mechanism.
2. of the hospitals affiliated with Yale, this is the only one that maintains a surgical research lab at Yale. <sup>the</sup> A lab experience is not viewed as being on the track of an academic career but is considered a conditioning, a disposition of mind, an awareness that is a desirable component in the training program.
3. The Pediatric Program is perhaps more distinctive. It is one shared with the Waterbury Hospital and is the ambulatory setting of the University of Connecticut Primary Care Pediatric Training Program. It is an outstanding program that has been competitively successful in obtaining training funds.

Paul D. Doolan  
Information Submitted by: (Name) Dr. Paul D. Doolan, M.D.

(Title) Director of Clinical Services

Signature of Hospital's Chief Executive Officer:  
Sister Margaret Rosita (Date) 3/4/85

THE UNIVERSITY OF CONNECTICUT  
HEALTH CENTER

OFFICE OF THE DEAN  
SCHOOL OF MEDICINE

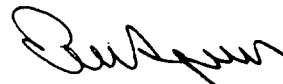
January 30, 1985

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

Dear Sir:

St. Mary's Hospital and the University of Connecticut School of Medicine have a close relationship in the clinical educational arena. It is one of our permanent sites for the third year clerkship in medicine and has been ongoing and successful for several years. St. Mary's also offers to our students electives in the fourth year, which are also frequently utilized and have been educationally very sound. Although we do not have a major affiliation agreement equivalent to that of the Greater Hartford Consortium hospitals, functionally it resembles the same type of relationship. Over the next few months, we are going to be rewriting our affiliation agreement with St. Mary's Hospital, bringing the two institutions closer together.

Sincerely yours,



Eugene M. Sigman, M.D.  
Dean

EMS/led

FOR-PROFIT TEACHING HOSPITAL PARTICIPATION IN  
THE COUNCIL OF TEACHING HOSPITALS

It is recommended that the following statement be placed before the COTH membership at the May 10, 1985 Business Meeting in San Francisco.

Participation of for-profit teaching hospitals was discussed at the COTH Spring Meeting in Baltimore in May 1984, the October 1984 Annual Meeting in Chicago, and a variety of other forums. The Administrative Board of the Council of Teaching Hospitals has reviewed and analyzed all aspects of the debate over this issue. The Board recognizes there are strong personal views on this issue. However, the Administrative Board believes the Council of Teaching Hospitals of the Association of American Medical Colleges is organized to support the patient care, education, and research missions of teaching hospitals, and that the tax status of the hospital should not exclude hospitals sharing common interest in supporting these objectives.

Therefore, the Administrative Board of the Council of Teaching Hospitals recommends:

The AAMC bylaws be amended to permit individual for-profit hospitals to join the Council of Teaching Hospitals provided they meet the membership requirements that apply to all other hospitals.

. . . . .

Attached is material pertinent to the legal questions associated with the above-stated action. The Administrative Board needs to discuss the two points in the body of Joe Keyes' March 12, 1985 memorandum.



# association of american medical colleges

## MEMORANDUM

TO: Richard Knapp, Ph.D., Director, Dept. of Teaching Hospitals  
FROM: Joseph A. Keyes, Jr., Staff Counsel *JAK*  
DATE: March 12, 1985  
SUBJ: Membership in COTH of Investor-Owned Hospitals

The attached correspondence deals with the impact on the Association's status as a tax exempt charity of any Bylaw change which would permit investor-owned institutions (who are otherwise eligible) to remain or become members of the Council of Teaching Hospitals.

In short, we have been advised by our tax counsel that the AAMC should not amend its Bylaws until it has received a ruling from the Internal Revenue Service that such an action would not result in the loss of the status as a tax exempt charity under Section 501(c)(3) of the Internal Revenue Code of 1954. We then asked Mr. Myers to set out the questions we would be required to answer in order to permit him to draft a ruling request on our behalf. Appropriate background material was provided as an enclosure to my letter of February 26, 1985. By letter of March 3, 1985, Mr. Myers reports that he now has sufficient information to begin the preparation of a ruling request. He requires two additional pieces of information from us: 1) the number of such hospitals likely to apply for membership as compared to the total membership of the COTH; and, 2) any support or justification we could offer that would enable him to say that, "any private benefit which may accrue to the few proprietary members is incidental in improving the quality of education at those teaching hospitals." It would seem that this matter is an appropriate focus for the next COTH Administrative Board discussion of this topic.

Attachments



**association of american  
medical colleges**

February 12, 1985

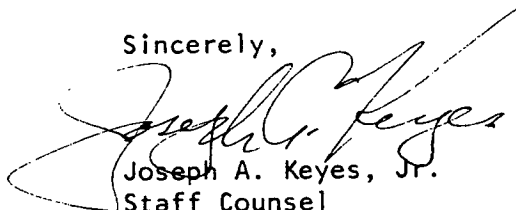
John Holt Meyers, Esq.  
Williams, Meyers & Quiggle  
Suite 900, Brawner Building  
888 Seventeenth Street, NW  
Washington, DC 20006

Dear Jack:

The Council of Teaching Hospitals (COTH) Administrative Board plans to offer a resolution at the COTH Spring Meeting in early May urging that the AAMC amend its bylaws to permit investor owned hospitals, which otherwise qualify to remain or become members of the COTH. As you know, such an amendment requires action by the Assembly on recommendation of the Executive Council. The Executive Council is cognizant of your advice that such an action not be taken without the prior review and acquiescence of the Internal Revenue Service so as to assure that the AAMC status as a 501(c)(3) charity will not be jeopardized. I believe it highly unlikely that this advice would be disregarded. It seems appropriate, therefore, that we now give consideration to the identification of the essential elements of an appropriate submission to the IRS.

It is my assumption that we will be required to demonstrate that we will continue to be "organized and operated exclusively for charitable purposes" and that the restructured organization will not result in "private inurement." Since we have, in the past, relied on the ownership or tax status of our members to demonstrate these characteristics, it would appear that a new showing will be required. It would be quite helpful if you would lay out for us the questions we need to address to assist in the preparation of the submission to the Internal Revenue Service.

Sincerely,



Joseph A. Keyes, Jr.  
Staff Counsel



# association of american medical colleges

February 26, 1985

John Holt Myers, Esquire  
Williams, Myers and Quiggle  
Attorneys and Counselors at Law  
Suite 900, Brawner Building  
888 Seventeenth Street, NW  
Washington, DC 20006

Dear Jack:

In response to your request for a specification of the conditions which the AAMC would impose upon investor-owned hospitals which otherwise qualify to remain or become members of the COTH, I am enclosing the packet of materials we currently provide to prospective applicants for membership. Most importantly, it includes a description of COTH Organization and Membership -- specifying membership criteria, and an Application for Membership. Note that the latter requires, in addition to detailed information descriptive of the hospital's involvement in undergraduate and graduate medical education, the submission of a copy of the hospital's medical school affiliation agreement and a letter of recommendation from the dean.

At the present time, it is my understanding that there is no change in the membership requirement contemplated other than the modification of the current ownership limitation.

For clarity sake, I should specify that the matter under discussion is "teaching hospital membership," not "corresponding membership."

Please call if this requires further elaboration.

Warm regards.

Very truly yours,

Joseph A. Keyes, Jr.  
Staff Counsel

Enclosures

WILLIAMS, MYERS AND QUIGGLE  
ATTORNEYS AND COUNSELORS AT LAW  
SUITE 900 BRAWNER BUILDING  
888 SEVENTEENTH STREET, N.W.  
WASHINGTON, D. C. 20006

AREA CODE 202-333-5900

WILLIAM M. WILLIAMS  
(1921-1932)  
EDMUND B. QUIGGLE  
(1921-1935)  
PAUL FORREST MYERS  
(1921-1965)

ROBERT HOLT MYERS  
JOHN HOLT MYERS  
JAMES W. QUIGGLE  
JOE L. OPPENHEIMER  
ROBERT O. TYLER  
THOMAS ARDEN ROHA  
MARC E. ALBERT  
  
SUSAN L. FLAHERTY  
JOHN J. RALSTON  
DAVID A. HEBNER

March 5, 1985

Joseph A. Keyes, Jr., Esquire  
Staff Counsel  
Association of American Medical Colleges  
One Dupont Circle, N. W.  
Washington, D. C. 20036

Dear Joe:

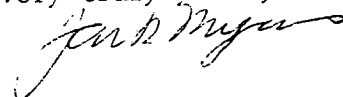
Thank you for the information included in your letter of February 26 and the accompanying documents. I believe that this will provide us with most of the necessary facts to complete a request for ruling by the Internal Revenue Service that for-profit teaching hospitals should be eligible for membership in the Council of Teaching Hospitals. For your information, I am enclosing a copy of Revenue Ruling 74-146. This holds that a nonprofit organization of accredited educational institutions will not lose its IRC Section 501(c)(3) status because the membership includes a small number of proprietary schools. This is the basic ruling on which we would rely. There are at least one or two private letter rulings to the same effect.

I believe that the Internal Revenue Service should reach the same conclusion with respect to the membership of for-profit teaching hospitals. In this connection, it would be helpful to have some idea of how many such hospitals are likely to apply for membership as compared to total membership of the organization. I would hope that we would be able to say that any private benefit which may accrue to the few proprietary members is incidental to improving the quality of education at those teaching hospitals.

If you want us to go ahead and draft a ruling request, please let me know.

With best regards,

Very truly yours,



JHM/jp  
Enclosure



Federal income tax under section 501(c)(3) of the Code.

*26 CFR 1.501(c)(3)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.*

**Educational institution accreditation organization.** A nonprofit organization of accredited educational institutions, whose membership includes a small number of proprietary schools, and whose activities include the preparation of accreditation standards, identification of schools and colleges meeting these standards, and the dissemination of accredited institution lists qualifies as an exempt organization under section 501(c)(3) of the Code.

#### Rev. Rul. 74-146

Advice has been requested whether an organization with the activities described below is advancing education for purposes of exemption from Federal income tax under section 501(c)(3) of the Internal Revenue Code of 1954 where the organization otherwise qualifies for such exemption.

The organization's principal activity is to identify those schools and colleges located in a specific geographic region of the United States as being of sufficient acceptable quality to be designated as accredited institutions. Its activities are controlled by institutional members. Only institutions which are accredited may be admitted as institutional members. The actual accrediting activity is carried on by committees which are drawn from the members of the organization and which are designated as a Commission on Higher Education and a Commission on Secondary Schools. Each committee is invested with the power to set standards and to enforce compliance with such standards for the accreditation of educational facilities coming under its specific jurisdiction. Neither its charter nor its bylaws

prohibit the accreditation and membership of proprietary schools (educational facilities operated for profit). However, there are a very few proprietary schools in the region and these have been, on application, accredited and approved for membership in the organization. Such schools represent a small minority of the members of the organization.

Specific standards and requirements for accreditation of schools and colleges are prepared and published by the organization. A list of the names of accredited institutions is prepared and disseminated regularly. The accreditation by the organization is recognized on a local, regional, national and international basis. The accreditation program is designed to foster excellence in education, and develop criteria and guidelines for assessing educational effectiveness. It encourages institutional improvement of educational endeavors through continuous self-study and evaluation. It assures the educational community, the general public, and other agencies or organizations that an accredited educational institution has clearly defined and appropriate educational objectives, has established conditions under which their achievement can reasonably be expected, appears in fact to be accomplishing them substantially, and is so organized, staffed, and supported that it can be expected to continue to do so. The organization also provides counsel and assistance to establish and develop new institutions. Accreditation is retained by member institutions through a process of evaluation and periodic review by the applicable committees of the organization.

The organization's income is obtained primarily from membership dues.

Section 501(c)(3) of the Code provides for the exemption from Federal income tax of organizations organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" includes the advancement of education.

The development and publication of standards for accreditation of schools and colleges, along with their regular inspection and evaluation, and the development of recommendations for improvement of such institutions are all activities which support and advance education by providing significant incentive for maintaining a high quality educational program. Any private benefit that may accrue to the few proprietary members because of accreditation is incidental to the purpose of improving the quality of education.

Accordingly, the organization qualifies for exemption from Federal income tax under section 501(c)(3) of the Code.

Even though an organization considers itself within the scope of this Revenue Ruling, it must file an application on Form 1023, Application for Recognition of Exemption, in order to be recognized by the Service as exempt under section 501(c)(3) of the Code. The application should be filed with the District Director of Internal Revenue for the district in which is located the principal place of business or principal office of the organization. See section 1.501(a)-1 of the regulations.

*26 CFR 1.501(c)(3)-1: Organizations organized and operated for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.*

**Prevention of cruelty to animals; birth control.** A nonprofit organization formed to prevent the overbreeding of cats and dogs by providing funds to pet owners who wish to have their pets spayed or neutered but cannot afford the cost of such operations qualifies for exemption under section 501(c)(3) of the Code.

# association of american medical colleges

## AAMC ANNUAL MEETING CO TH GENERAL SESSION THEMES

- 1972 EXTERNAL FISCAL CONTROLS ON THE TEACHING HOSPITAL
- 1973 THE ECONOMIC STABILIZATION PROGRAM AND OTHER HEALTH  
INDUSTRY CONTROLS
- 1974 NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR  
TEACHING HOSPITALS
- 1975 RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM:  
IMPLICATIONS FOR THE TEACHING HOSPITAL
- 1976 CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS
- 1977 PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR  
CONTROLLING THE DEMAND FOR HOSPITAL SERVICES
- 1978 MULTIPLE HOSPITAL SYSTEMS AND THE TEACHING HOSPITAL
- 1979 CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL  
TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT
- 1980 THE HIGH COST PATIENT: IMPLICATIONS FOR PUBLIC  
POLICY AND THE TEACHING HOSPITAL
- 1981 IMPLEMENTING COMPETITION IN A REGULATED HEALTH  
CARE SYSTEM
- 1982 HEALTH CARE COALITIONS: TRUSTEES IN A NEW ROLE  
OR BUSINESS AS USUAL
- 1983 ETHICAL DILEMMAS AND ECONOMIC REALITIES
- 1984 STRATEGIC PLANNING AND THE TEACHING HOSPITAL:  
LESSONS FROM OTHER INDUSTRIES
- SEVERITY MEASURES: THE TEACHING HOSPITAL DIFFERENCE

The staff would appreciate some discussion and guidance in selecting a topic and speaker(s) for the CO TH portion of the October 1985 AAMC Annual Meeting.

March 12, 1985

Mr. Mark Levitan  
President  
Albert Einstein Healthcare Foundation  
York and Tabor Roads  
Philadelphia, PA 19141

Dear Mark:

Shared Data Research (SDR), an independent research firm, specializing in health industry information system trends, has been asked to conduct a national survey of computer usage by member hospitals of the Council of Teaching Hospitals (COTH). The survey will compare each hospital's information system price, performance, level of end-user satisfaction, budget, staffing, technology and current and planned system capability to that of other teaching hospitals.

The purpose of this letter is to ask your hospital to sponsor this national survey. The sponsorship of yours and fourteen other prestigious COTH hospitals is being sought to encourage broad survey participation. Your hospital's sponsorship of this survey will be indicated by signing a letter of support. This letter will then be sent to the Chief Information Officer and Chief Executive Officer of the 376 COTH member hospitals (excluding Veterans Administration hospitals). The letter will be circulated for signature during the week of March 25, 1985. A copy of the letter that you will be asked to sign is enclosed for your review and consideration.

SDR is well qualified to conduct the survey. The firm began collecting data through on-site, direct mail and telephone survey methods in 1981. During this three year period, a data base has been created containing information describing the products and services of over 300 vendors, audits of over 2,200 hospital information systems and, product evaluations by more than 20,000 end-users. The data base is kept current through quarterly update.

The process for publishing the data books will include the collection of data by Arthur Young and Company, on-site, at each participating hospital. The data collection process will take less than 4 hours of your staff's time. The completed surveys will then be sent to SDR for compilation of 80 statistical comparisons for each hospital. Each of the 80 statistics will be presented in graphic format. The set of hospital statistics will then be analyzed by a university professor who will, where appropriate, provide description and analysis of unique circumstances. An Executive Summary will be provided. SDR will then bind the data book and forward it to Arthur Young and Company for formal presentation at the hospital.

For your information we have enclosed with this letter: a copy of the letter, that you will be asked to sign the week of March 25, 1985; sample graphs from the proposed data book and a titles listing; and, reprints of selected articles written by SDR for Hospitals magazine.

*Dick - This letter was sent to the persons whose names are highlighted on the attached. The pricing structure shown for all COTH hospitals is also enclosed and highlighted.*

*Many Thank*

*P.S. Sorry about the blip in the structure and process (Wade letter)*

*AS*



SHARED DATA RESEARCH the information source

1000 ...

Mr. Mark Levitan  
March 12, 1985  
Page 2

The hospitals that are being asked to sponsor the project are: Beth Israel Hospital, Boston; Northwestern Memorial Hospital, Chicago; University of Alabama Hospital, Birmingham; University of Iowa Hospital and Clinics, Iowa City; University of Chicago Hospitals and Clinics, Chicago; Cedars-Sinai Medical Center, Los Angeles; Presbyterian Hospital in the City of New York, New York; University Hospitals, Cleveland; The Johns Hopkins Hospital, Baltimore; Massachusetts General Hospital, Boston; Albert Einstein Medical Center, Philadelphia; Hospital of the University of Pennsylvania, Philadelphia; Duke University Hospital, Durham; The Oregon Health Sciences University, Portland; and Parkland Memorial Hospital, Dallas.

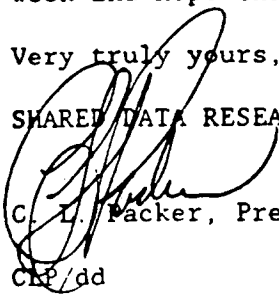
The price to your hospital for the data book is \$4,900. This price includes the on-site collection of data by Arthur Young and Company, evaluation by the professors, the compilation and publication of the data book and, the final presentation by Arthur Young and Company. All travel and out-of-pocket expenses are included in the price. The Chief Information Officer of each sponsoring hospital will be invited to participate in the identification of twenty special statistics to be included in the final data book.

Timing of the project is described in the following. During the week of March 25, 1985, an original of the attached letter will be circulated for signature by your Chief Information Officer. Therefore, your verbal agreement to sponsor the survey is needed by March 22, 1985. The general mailing of the sponsors' letter, containing all sponsors' signatures, will be sent to all 376 COTH teaching hospitals during the week of April 8, 1985. If you have any questions please feel free to call: Mr. John Wade, Director of Information Systems, Northwestern Memorial Hospital, 312-649-2000; Richard Knapp Ph.D., Director, Council of Teaching Hospitals, 202-828-0490; Mr. Edward J. Zak, Partner, Arthur Young and Co., 303-297-9500; or, Mr. Clinton Packer, President, SDR, 216-656-2524.

We think you will agree that the need for this survey is well founded; that the process is simple, efficient and does not require much time; and that the price is reasonable. We believe that your sponsorship will encourage other hospitals to join us in this national effort. We have estimated that we need eighty participants to have a good base for study. I will call you late next week and hope that you will agree to be a sponsoring hospital.

Very truly yours,

SHARED DATA RESEARCH

  
C. L. Packer, President

CLP/dd

Enclosures

## SPECIAL SUPPLEMENT

### CLINICAL RESEARCH AND PROSPECTIVE PAYMENT

by Karen Pfordresher  
Staff Associate

The Medicare Prospective Payment System was initiated as part of the Social Security Amendments of 1983. This new reimbursement system rewards cost effective behavior by using pre-determined, per-case payments to hospitals for inpatient services. This system will not be fully implemented until 1986, thus allowing the Health Care Financing Administration (HCFA) to conduct studies of alternative methods of support for certain existing, essential costs of medical care. These studies will include reviews of how Medicare pays for capital costs, possible prospective payments for currently exempt specialty hospitals, an assessment of the feasibility of DRG-type (diagnosis-related group) payments for physician inpatient services, and the analysis of many other issues that together form the intricate framework of the current national medical care system.

Therefore, the many historical relationships fundamental to this framework are now under scrutiny and may be vulnerable to cost cutting measures. An issue which has not yet received the attention it deserves concerns the impact of the new payment incentives on clinical research. Reinforcing the belief that clinical research may be vulnerable to federal cost cutting is the debated assumption that patient participation in research is more costly than the standard care that the patient would have received. Upon initial consideration, this may appear to be a relatively straightforward issue. However, a more thoughtful review suggests analysis of the issue is fraught with difficulties.

#### Analysis Complexities

An analysis of the costs of clinical research should include a determination of the extent of its independence from and integration with the provision of routine care. No systematic body of knowledge has shown that services provided according to a research protocol cost more than care for the same diagnosis in the absence of a research protocol. Many elements confound the ability to conduct an acceptable study.

- Primarily, the issue's complexity relates to the difficulty of isolating procedures and therapies ordered and performed under research protocols from those that could occur under a routine or standard regimen, and identifying their specific costs. Also, standard treatment regimens vary from physician to physician and institution to institution. Since the standard regimen acts as the independent variable, care must be taken to be sure comparability is established.
- Identifying clinical trial patients and a matched control group for comparative purposes presents other dilemmas. In many diseases for which research is conducted there exists no generally accepted treatment. For some

problems, no recognized therapy has been found to be generally acceptable, nor has any procedure been found to be effective. Thus, a variety of palliative treatments which vary widely in terms of cost may be the alternative to the research protocol.

- Clinical trials vary in complexity, from testing the dosage and administration of drugs to the use of new technologies, therapies or invasive procedures.
- Involvement in clinical trials may be related to consideration of the complexity or stage of illness. In other words, research participation may be focused on the sicker patients. This would establish a further degree of difficulty in isolating research-related costs, due to the lack of agreement as to how severity measures can be imposed as evaluative criteria.
- There exists the question of how practice pattern variation may affect the cost of patient care. Individual physician reaction to patient pain, proclivity to either surgical or medical intervention, and other variables make it difficult to compare patients involved in research to those excluded. Once again, there exists no standard regimen of care. The treatment decision is often based on individual physician behavior, local protocol, and the availability of clinical research services. Therefore, any acceptable study must include participation from more than a few hospitals and physicians in different parts of the country.
- Care must be given as well to agreement on the time frame acceptable for comparison of research and non-research related costs of care. Clinical trial participation may be of short duration, extend over several years, require inpatient or outpatient follow-up, or extended or shortened nursing time due to drug administration.
- Finally, the outcome of the treatment provided should be included in the analysis. While treatment under the standard regimen may have been less costly, it also may have been less effective. Although admittedly difficult to measure, the quality of the outcome must be assessed as well.

Any analysis of the question, "Does it cost more to provide medical care under a research protocol?" must be multi-dimensional. With adequate separation of the attributes of accepted, routine regimens of care versus research protocol management, it may be possible to analyze the real cost of participation in clinical research, and determine whether or not it is indeed more expensive. However, much work remains to be done.

#### Current Medicare Policy

Prior to prospective payment, the *Medicare Provider Reimbursement Manual* stated in its introduction that "the basic rule applicable to a provider's research costs is such that expenditures, over and above those related to usual patient care, are excluded from allowable costs." Part I of the manual continues the definition of research versus routine, covered costs as follows:

"Research in the context of this principle means a sys-

tematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing, and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or preserving health." (Section 502.1)

"Where research is conducted in conjunction with or as a part of the care of patients, the costs of the usual patient care are reimbursable to providers to the extent that such costs are not met by research funds.

Usual patient care costs incurred in conjunction with the research must be specifically identified in those situations where a portion of the research funds is applicable to usual patient care costs. In these instances, providers must maintain statistics on research patients for each research project to identify the patients and the patient days and ancillary charges applicable to the usual patient care furnished by providers." (Section 504.2)

"In the context of this principle, extraordinary patient care is the care rendered [t]o research patients which is not medically reasonable, necessary, or ordinarily furnished to patients by providers. Such care is represented by additional patient care days and additional ancillary charges identified as non-Medicare in the patient care cost centers." (Section 502.3)

"Usual patient care is the care which is medically reasonable, necessary, and ordinarily furnished (absent any research programs) in the treatment of patients by providers under the supervision of physicians as indicated by the medical condition of the patients. Also, this definition intends that the appropriate level of care criteria must be met for the costs of this care to be reimbursable. Such care is represented by items and services (routine and ancillary) which may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing, and other related professional health services." (Section 502.2)

"Costs of research are not reimbursable to providers. Where, however, research is conducted in conjunction with or as part of the care of patients, the costs of usual patient care are reimbursable to the extent such costs are not met by research funds. The costs of extraordinary patient care based on research objectives are not reimbursable." (Section 504.2)

The implementation of prospective payments in 1984 dramatically altered Medicare's point of view regarding research-related, inpatient care. Under prospective payment, a hospital's production costs are irrelevant to the Medicare per-case reimbursement—an amount pre-determined, except for circumstances for which "outlier" payments apply. This payment system functionally addresses itself to the validity of the admission, rather than to justification of extraordinary care. In the January 3 final regulation, HCFA stated that:

"Specifically, Medicare's objective is to see whether, in cases where clearly noncovered services have been furnished to a beneficiary, there are nevertheless sufficient

covered services remaining so that payment of the DRG is appropriate."

Therefore, for hospitals to receive prospective payments for their patients involved in research protocols, they must show on their medical records, abstract, and Medicare bill that the patient would normally have been admitted for diagnosis or treatment even if the research protocol was not being used.

#### **Interest Shown in the Possible Impact of the Prospective Payment System on Clinical Research**

Many individuals have questioned the impact of prospective payments on research. Their questions and the different analyses currently underway are briefly described below. It is vitally important that any such analysis be done carefully and in a controlled, specific manner. Incorrect, invalid information will only further cloud a very important issue.

- Senator Robert Dole (R-KS), then Senate Finance Committee chairman, raised the question of whether HCFA had "deliberately ignored" the intent of Congress to allow wider extension of exceptions for community cancer centers than appears in the promulgated regulations (published September 1, 1983) implementing the prospective payment system. This issue was raised in a March 9, 1984 letter to the Department of Health and Human Services' Secretary Heckler from Senator Dole.
- The Association of Community Cancer Centers (ACCC) has initiated a campaign for the acceptance of DRG 471, currently not in the payment scheme, to cover research costs. To support this request, John Yarboro, chief of Hematology-Oncology at the University of Missouri Medical School and the new ACCC president, announced the initiation of a study to highlight the "difference in cost between those patients on clinical trials and those being managed conventionally." Although their methodology was called into question by the National Cancer Institute, the ACCC reported to the National Cancer Advisory Board Subcommittee on September 23, that preliminary data from four hospitals showed that costs per admission for research protocol patients exceeded those for non-protocol patients.
- The House of Representatives' Committee on Appropriations, during deliberation of the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, expressed concern regarding reports that "the new prospective payment system mandated by the Social Security Amendments may have an unintended and harmful effect on clinical trials." The Committee report states that "hospitals may now be unwilling to participate in clinical trials because of the extra expenses for patient care which are mandated by a research protocol."
- In response to this concern, the National Center for

Health Services Research (NCHSR) is now working with the National Cancer Institute to determine whether care rendered to patients involved in clinical trials is "more, less, or equally as expensive as nonclinical trial care." This study, coordinated by Dr. John Marshall, director of NCHSR, will measure hospital cost differences for patients participating and not participating in clinical research, controlled statistically and matched for patient diagnosis, stage of cancer, and age. Variables to be held constant include hospital teaching status, bed size, location, and other comparative factors. Cost data will be compared to the calculated prospective 1986 DRG payment (when the payment system is fully implemented) and therefore results of this study are not expected for two years.

- The National Institute of Mental Health (NIMH) is addressing the problem of establishing an adequate patient classification system for mental disorders, and is attempting to develop an alternative to DRGs, "based on such variables as age, marital status, and type of treatment as well as on diagnosis." Papers and studies on this and other issues relating to prospective payments for mental health services have been authored by Carl Taube, Ph.D., deputy director of the Division of Biometry and Epidemiology at NIMH, Paul Widem, A.C.S.W., assistant chief, mental health economics research branch of that division, and How-

ard H. Goldman, M.D., Ph.D., assistant director for Mental Health Financing at NIMH.

- The NCI Eastern Cooperative Oncology Group is conducting a pilot study to analyze the relative cost differences for comparable patients participating and not participating in clinical trials, and to determine relative cost differences within DRGs. Paul Carbone, M.D., chairman of the Eastern Cooperative Oncology Group stated that preliminary results show only 20 percent of the patients on study are over sixty-five, whereas the distribution was expected to be closer to 50 percent. In addition, when disaggregated to include only inpatient treatments, where DRG payments would apply, the possible impact of prospective payments would effect only three percent of the patients on study. Further analysis is being done to determine if a particular disease-specific subset of patients is more likely to be effected by the new payment system.

#### Too Soon for Conclusions

Until data from valid studies can be reviewed and interpreted, the question of whether or not the prospective payment system influences or adversely effects participation in clinical research remains unanswered. The AAMC would like to know more about this important issue; if you have concerns, suggestions, or data that would encourage a more thorough understanding, please call Karen Pfordresher of the Department of Teaching Hospitals at (202) 828-0496.