

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 22-23, 1986
Washington Hilton Hotel
Washington, DC

WEDNESDAY, January 22, 1986

12:30p	ORIENTATION SESSION/Lunch AAMC Conference Room
6:30pm	JOINT COTH ADMINISTRATIVE BOARD DINNER For Carolyne K. Davis, PhD, former HCFA Administrator Georgetown Room East/West

THURSDAY, January 23, 1986

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

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 23, 1986
WASHINGTON HILTON HOTEL
Edison Room
8:00am-12:00noon

- I. CALL TO ORDER
- II. CONSIDERATION OF MINUTES
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October 28, 1985 Page 14
- III. MEMBERSHIP
- St. Vincent Health Center Page 21
Erie, Pennsylvania
- UCLA Neuropsychiatric Hospital Page 25
Los Angeles, California
- IV. NOMINATING COMMITTEE REPORT Mr. King
- V. SPRING MEETING PLANNING COMMITTEE REPORT Mr. Gambuti
- VI. REPORT OF THE STEERING COMMITTEE ON THE EXECUTIVE COUNCIL
EVALUATION OF MEDICAL INFORMATION SCIENCE Agenda - Page 24
IN MEDICAL EDUCATION
- VII. MALPRACTICE INSURANCE LEGISLATION EXECUTIVE COUNCIL
Agenda - Page 81
- VIII. LCME INVOLVEMENT IN THE ACCREDITATION OF EXECUTIVE COUNCIL
FOREIGN MEDICAL SCHOOLS Agenda - Page 87
- IX. AD HOC COMMITTEE ON GRADUATE MEDICAL EXECUTIVE COUNCIL
AGENDA Agenda - Page 120
- X. COORDINATED MEDICAL STUDENT LOAN PROGRAM EXECUTIVE COUNCIL
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- XIV. ADJOURNMENT

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 12, 1985

PRESENT

Sheldon King, Chairman
C. Thomas Smith, Chairman-Elect
Haynes Rice, Immediate Past Chairman
Robert J. Baker
Jeptha W. Dalston, PhD
Gordon M. Derzon
Gary Gambuti
Glenn R. Mitchell
James J. Mongan, MD
Eric B. Munson
David A. Reed
Thomas J. Stranova
Deal Brooks, AHA Representative

ABSENT

J. Robert Buchanan, MD
Spencer Foreman, MD

GUESTS

Kimberly Dunn, OSR Representative, University TX
Richard Janeway, MD
Kirk Murphy, OSR Representative, Hahnemann

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Paul R. Elliott, PhD
Thomas J. Kennedy, Jr., MD
Richard M. Knapp, PhD
Karen L. Pfordresher
Nancy E. Seline
Kathleen Turner

COTH ADMINISTRATIVE BOARD
Meeting Minutes
September 12, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 8:15am in the Cabinet Room of the Shoreham Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the June 20, 1985 COTH Administrative Board Meeting.

Prior to moving to the agenda, Mr. King welcomed two members of the OSR Administrative Board who would be joining the meeting, and asked that they introduce themselves. He reminded the Board that Mr. Gambuti will chair the committee to plan next year's COTH Spring Meeting in Philadelphia. Other members of the committee are: Chuck Buck, Hospital of the University of Pennsylvania; Jim DeNiro, Veterans Administration Medical Center (Palo Alto); Bob Johnson, District of Columbia General Hospital; Gerry Mungerson, Illinois Masonic Medical Center; and Ed Schwartz, University of Minnesota Hospitals and Clinics. The Committee is to have its first meeting on October 1 to begin its work.

The Chairman reported that there had been established an AAMC Committee on Faculty Practice Plans. That Committee had its first meeting on September 11. The Committee is chaired by Dr. Ed Stemmler, Dean at the University of Pennsylvania. COTH representatives to the Committee are Robert Heyssel, MD, The Johns Hopkins Hospital; John Ives, Shands Hospital; and Raymond Schultze, MD, UCLA Medical Center. A committee also has been established to study the MCAT. Andrew Wallace, CEO at Duke University Hospital, is the COTH representative.

The House Budget Committee is reviewing the Medicare Prospective Payment System. Charles Buck, CEO at the Hospital of the University of Pennsylvania, will be appearing on behalf of COTH/AAMC before that Committee on October 7. Mr. King reminded the Board that Congressman Gray from Philadelphia chairs the House Budget Committee. He also indicated that Dr. Foreman presented a keynote luncheon address to a crowd of over 300 people at the AAMC National Invitational Conference on Clinical Education of Medical Students. Mr. Rice, who was present at that conference, reported that Dr. Foreman carried the COTH flag with brilliance.

Mr. King then reported on an activity in which he was engaged entitled, "Counsel 2000" sponsored by the American Podiatric Association. He reported that there are six schools of podiatry that are graduating approximately 600 students per year, and that those students have a less than 3.0 grade point average. There are only 400 residency positions available and he reported that it would be expected that many more residencies would be requested. He also indicated that there was little in the way of standards for residencies and they varied in the

length of training period. Finally he indicated that the whole question of the scope of service activity of podiatrists was in a state of flux with a fair amount of variation by state concerning the definition of the foot and the various procedures that were permitted to be performed by podiatrists.

As a last matter, Mr. King reminded each of the Board members that there would be a Board meeting on the morning of Monday, October 28, during the AAMC Annual Meeting, and urged that those who had not yet registered for the meeting do so.

At this point Mr. King called on Dr. Knapp for any additional matters he might have to report to the Board. Dr. Knapp indicated that he had called the chief executive officer of Rochester Methodist Hospital in Rochester, MN, and that Mr. Winholtz indicated no displeasure on any policy or other matters related to the hospital's membership in the Council of Teaching Hospitals, but indicated that since most of the policy and other such matters at the Mayo Clinic with regard to education and other service matters were decided by the executives at the Mayo Clinic, the hospital had decided to save the dues which would be spent on the Council of Teaching Hospitals. Dr. Knapp also reported that as requested by the Board, he had asked for a copy of the AHA Survey of Board Chairmen and CEO's on their views concerning relationships with respective associations. The results of that survey were not yet available, and there was some question as to how useful the survey results would be. He then indicated that in discussions with Mr. Smith and Mr. King, it was agreed that discussion of the role of the Council of Teaching Hospitals as well as the AAMC and new directions that should be charted, should come to a close. The staff believes they have appropriate direction based on recommendations of the Board, and that until such time as a leadership change takes place at the AAMC, there would be no need to discuss the matter further. He did indicate the following activities were taking place. The staff is writing for journals that are outside the general readership that teaching hospital directors might read on a regular basis. An article on financing graduate medical education will appear shortly in a journal entitled, Physician Practice Management; a manuscript has been submitted to Business and Health; and a manuscript is under development to appear in a Florida medical journal. In addition, Dr. Knapp indicated that the staff was doing its best to improve and strengthen relationships with staff members of American Healthcare Systems and the Consortium of Jewish Hospitals. Similar efforts are underway with the University Hospital Consortium and Voluntary Hospitals of America.

The AAMC is planning four regional seminars entitled, "Academic Medical Centers and the Challenges Posed by Alternative Delivery Systems." Individuals important to policy making concerning hospital and medical practice matters will be invited to these seminars. The staff is also developing a survey to identify work that is under way within the teaching hospital community to identify problem "DRG's." If sufficient results are identified, a conference on this subject may be held in the late spring or summer of 1986.

Finally, the item on the Board agenda devoted to "Medicare Outpatient Surgery Savings, Access, and Quality Act" points to a direction of establishing a competitive price for free standing facilities and services with which teaching hospitals are going to have to compete. The staff is working on activities the

AAMC could undertake to assist major teaching hospitals in a uniform pricing system.

III. MEMBERSHIP

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

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

NAVAL HOSPITAL, Bethesda, Maryland for full membership.

IV. THE INDEPENDENT STUDENT ISSUE

Paul Elliott, PhD, Director, AAMC Division of Student Programs, joined the Board to describe the controversy surrounding the issue of when a student should be declared independent for the purpose of student financial assistance under Title IV. The AAMC has been working with a coalition of other educational associations under the leadership of the American Council on Education (ACE) to develop a consensus position on the upcoming reauthorization of the Higher Education Act. In all but one instance, the positions taken by the ACE coalition are consistent with positions taken previously by the AAMC. The one instance is the definition of what constitutes an independent student. The question is when a student is independent of his or her parents for determination of need under the Federal Student Loan and Work Study Programs. The coalition has proposed automatic emancipation for all graduate and professional students. This would mean medical students would not be required to provide information on parental resources in order to be eligible for the Guaranteed Student Loan or National Direct Student Loan programs. In the past, the AAMC has stressed that students and their families bear primary responsibility for financing medical education. This past spring, the AAMC's Group on Student Affairs Committee on Student Financial Assistance had a thorough discussion of the issue and unanimously voted against the ACE's proposed stance. Dr. Elliott noted that the ACE's proposal was not consistent with the AAMC's policy that Federal aid to medical students should create and maintain access to the profession for all qualified students. He said that the public was already beginning to question the need for Federal financial aid for students destined to enter a highly remunerative profession. Allowing students of affluent parents to gain access to scarce Federal funds is likely to increase public skepticism. Dr. Elliott asked that the Board support the staff recommendation that the AAMC oppose the ACE consortium position on independent student status.

ACTION: It was moved, seconded, and carried to approve the staff recommendation to oppose the ACE's proposed expansion of the definition of independent student.

V. HEALTH PLANNING

Dr. Bentley reviewed the discussion of health planning, and the recommendation that was voted upon at the June COTH Administrative Board meeting. He stated that the issue had been placed on the agenda once again for two reasons: (1) the Council of Deans' request for further background information, and (2) the need to verify the phrasing of the recommendation made at the June Board meeting. The June recommendation reads as follows:

- o That the Association support state-wide CON review of construction projects which result in new bed capacity or construction projects or new facilities which replace existing beds;
- o That the Association oppose CON review of major medical equipment or new institutional health services that do not result in increased capacity.

Clarification was requested concerning the CON review for renovations (i.e., whether the Board intended that a dollar threshold or some criteria for review be added to the language). Mr. Gambuti stated that in the June discussion, he had alluded to a dollar amount of \$5 million before renovations would be reviewed. Mr. Reed suggested that some dollar figure should be included, perhaps based on a percentage of a hospital's total physical plant. Mr. Smith suggested that the recommendation should refer to "new" rather than "increased" bed capacity, and that criteria defining "expanded bed capacity" as some percentage increase would be more workable than an open-ended requirement. He questioned whether an absolute dollar figure wouldn't be too rigid and suggested the use of some proportional increase in an institution's annual budget as the trigger for CON review. Mr. Munson stated such a concept might discriminate against the smaller, rural hospital. Discussion followed with further consideration of whether specific thresholds might force inequity into the review process. Mr. King stated that the emphasis should be on review of increased bed capacity whether it be new construction or renovations irrespective of the cost. Mr. Mitchell pointed out that it may be best to be silent on the requirement for review of renovations because in that case the institution places itself at risk and is perforce affected by the marketplace and considerations of competition.

The Administrative Board voted unanimously to revise its recommendation as follows:

- o That the Association support state-wide CON review of construction projects which result in increased bed capacity;
- o That the Association oppose CON review of major medical equipment or new institutional health services.

ACTION: It was moved, seconded, and carried to recommend that the Executive Council adopt the revised position on health planning recommended September 12, 1985 by the COTH Administrative Board.

VI. COMMENTARY ON GPEP REPORT

Dr. August Swanson, Director, AAMC Department of Academic Affairs, presented the Executive Council's revised commentary on the GPEP Report. Mr. King questioned conclusion #5 which appears to avoid dealing with the promotion problems of those faculty who do not produce scholarly papers. Dr. Swanson referred to a later entry in the document which does emphasize the need for a high degree of recognition and reward for effective teaching. Mr. Rice noted that the report neglected to allow credit to be given for service and administrative functions in the teaching hospital...activities that are necessary and deserving of attention and reward. Dr. Dalston, although agreeing in principle, stated that the academic system does not readily accommodate such activities which are divergent from the recognized aspirations of the academic environment. Kim Dunn, a representative from the Organization of Student Representatives, argued that medical schools were established to be service institutions and therefore service activities in the teaching hospitals should be recognized and rewarded, as they provide a needed balance to the emphasis on scholarly pursuits. Dr. Dalston stated universities historically do not give equal weight to service activities. Mr. King agreed that recognition of service is lacking in the university environment, and since medical schools must provide community and patient care services, there is an inherent problem with this issue. Dr. Swanson stated that this commentary is to address the GPEP Report itself and not that Report's omissions. The Board agreed to bring these unresolved concerns before the Executive Council for a broader-based discussion.

VII. RESEARCH FACILITIES CONSTRUCTION LEGISLATION

Dr. Thomas Kennedy, Jr., Director, AAMC Department of Planning and Policy Development, presented the research facilities construction legislative proposal to the Board. Dr. Kennedy requested general advice and guidance on behalf of the AAMC, as it negotiates within the program area of research facilities construction. This issue has become particularly relevant to the academic medical community in light of the deterioration of institutional research infrastructure.

The bill under discussion would set aside 10% of the budget of six major Federal research funding agencies - NSF, DOD, HSS, DOE, USDA, and NASA - for university-based research and development devoted to laboratory construction and renovation projects. Dr. Kennedy stated that the AAMC on the whole would prefer a traditional construction program, with funding as part of an NIH authorization appropriated by committees.

In support of the set-aside concept, Mr. Rice pointed out the current imbalance in the allocation of NIH research dollars, with 20% of the nation's medical schools receiving 80% of such funding. Dr. Dalston emphasized the amount of research taking place in the teaching hospital, to which Dr. Knapp suggested that language could be added to include such hospitals under this bill. Mr. Smith questioned whether the Federal government's response to this bill would be to clarify that payment for research-related renovation and construction was historically covered by overhead payments awarded as part of the institution's awarded grants. He also wondered if the bill would be considered a "budget

neutral" proposal with funding for the set-aside coming from the total NIH grant funds. Dr. Kennedy said no one is arguing at this time that overhead payments were to cover these costs, but agreed that "budget neutrality" is a legitimate concern.

Mr. Baker agreed that the AAMC should work to define the institutions to be included in the bill, and especially questioned whether investor-owned institutions would be eligible for these funds. Dr. Kennedy believed all eligible projects would be reviewed. Mr. Rice reiterated that it is important for the AAMC to support activities that are equitable, and not support a continuation of the old style of funding for a few, large institutions at the expense of the smaller institution.

ACTION: It was moved, seconded, and carried by a six vote endorsement that the AAMC support H.R.2823 as modified by the staff recommendations on page 62 of the September Executive Council agenda book, with three Administrative Board members opposing and two members abstaining.

VIII. REPORT OF THE COMMITTEE FOR THE GOVERNANCE AND MANAGEMENT OF INSTITUTIONAL ANIMAL RESOURCES

Dr. John Sherman, AAMC Vice President, described the recommendations of the Committee for the Governance and Management of Institutional Animal Resources as guidelines for improving procedures for the use of animals in research. The guidelines intend to ensure institutional priority for efforts to maintain high standards for the humane care of research animals. He stated that such guidelines are useful because they illustrate both institutional sensitivity to this highly publicized issue, and responsible and accountable use of public funds. Dr. Sherman informed the Board of several text changes that would amend the document to include teaching hospitals by adding the words "and hospitals" on page 73 and changing "university" to "institutions" throughout the document.

Mr. Smith expressed concern with the language on page 74 that states that a high ranking official responsible for the animal resources program should report "directly to the chief executive officer" as possibly interfering with an institution's prerogative to determine organizational responsibilities.

ACTION: It was moved, seconded, and carried to endorse this document pending discussion with the Executive Council on whether or not it would be appropriate to dictate internal institutional organization by including specific reporting requirements in such a document.

IX. TRANSITION TO GRADUATE MEDICAL EDUCATION: ISSUES AND SUGGESTIONS

In order to generate a thoughtful discussion of the problems with selection into residency training programs, Arnold Brown, MD, Chairman of the Council of Deans, requested that the AAMC staff, officers of the Group of Medical Education and the Group on Student Affairs officers develop an agenda item to be discussed at the September Administrative Board meeting. The problems include early match and

early commitment of medical students to particular residency slots, increasing competition among medical students for particular residency slots, and disruption of the normal medical education process by students taking certain electives in their upper class years in order to obtain access to a residency position they believe to be desirable. The agenda item contained numerous suggestions to improve the transition to graduate medical education, but the list is not exhaustive. Dr. Elliott commented that perhaps the most useful thing to come of the exercise of preparing the agenda item was to realize that there were really three separate sets of issues: (1) the selection process, (2) the clinical curriculum, and (3) the counseling process. Among the many recommendations included in the agenda item, Dr. Elliott suggested that four were very straightforward and achievable. They were:

- o Tighten up the third and fourth year elective restrictions that already exist in each of the medical schools;
- o Hold to the October 1 date for the deans submitting a letter of recommendation;
- o Develop a single application process for the residency training positions, similar to that which was developed by the AAMC for medical schools, which would give a structural basis for a single organization to gain control of the process;
- o Create handbooks for each specialty training program.

Dr. Elliott suggested that some action was necessary by the AAMC because the voluntary effort to control early admissions to residency training programs was not working, and students were getting panicky about getting into a program as quickly as possible.

The Board discussed this item, expressing some concern about the recommendation that the hospital directors should assume authority over the admissions to the residency training programs, but it did acknowledge that the institution should have a role in determining what students are admitted to its programs.

Dr. Elliott did not request a specific action from the Board other than expression of their general concerns.

X. MEDICARE OUTPATIENT SURGERY SAVINGS, ACCESS, AND QUALITY ACT

Dr. Knapp began the discussion with a brief description of the bill introduced by Senator David Durenberger (R-MN), which proposes establishing a single rate for the Medicare payment for ambulatory surgical service regardless of whether that service is provided in a hospital outpatient department or in a free-standing ambulatory surgical center. Dr. Knapp briefly described a conversation he had had with the chief executive officer of Manhattan Eye and Ear Hospital, in which the chief executive had alerted Dr. Knapp to the concerns of the eye and ear hospitals. Subsequently, the AAMC sent out a memo to its member institutions asking their reaction to this bill. In addition, Dr. Knapp had discussed this legislation with several congressional staff members. He asked the Board for its

reaction to the bill as currently written. Dr. Knapp did note that in his meetings with congressional staff, there seemed to be a general acceptance of the proposal that the residency training costs allocated to the outpatient services should be passed through just as they are on the inpatient side.

Dr. Cooper noted that the support services offered by hospitals were in excess of those offered by free-standing ambulatory surgery centers, and therefore the hospitals should be able to command a higher price for the surgeries they do. Mr. Smith passed out copies of his letter to Senator Durenberger (included in these minutes as Appendix A). The Senator has made specific reference to charges and costs at Yale-New Haven Hospital in proposing his bill, and Mr. Smith's letter was designed to refute the allegations that Yale-New Haven had extraordinarily high charges. Mr. Smith did concur with Dr. Cooper that there were costs to the backup services that are provided by hospitals. He suggested altering the bill to set fixed payment rates for hospital-based ambulatory surgery based on hospital-specific reasonable costs, but limited to no more than the amount paid for the same procedure on an inpatient basis. Mr. Baker commented that the hospital-specific cost based rates would be essentially cost-based payments, which might be a difficult concept to sell in the current political environment. He suggested an alternative of creating an average hospital rate for similarly situated hospitals. There was some concern expressed among Board members that because appropriate data were lacking, there would be an inability to identify problems that would be caused by such a reimbursement proposal.

After further discussion there was consensus that the AAMC should support the following policies:

- o For all procedures, payment for surgery performed in a hospital outpatient department should not exceed payment for a comparable inpatient DRG;
- o Where the coefficient of variation in current payments for a surgical procedure to hospitals is less than half the average price paid, the price paid for the service should be limited to the average payment to hospitals in the region for similar outpatients;
- o Where the coefficient of variation in current payments for a surgical procedure to hospitals is greater than half the average price paid to hospitals, it is not reasonable to assume patients are sufficiently similar to set limits using an average regional price; and
- o In all cases where a price limit or fixed price payment is established for outpatient services, teaching hospitals should be allowed to claim direct medical education costs on a passthrough basis separate from the fixed price or limit.

A copy of the letter sent to Senate Finance Committee Chairman Packwood is included in these minutes as Appendix B.

XI. ADJOURNMENT

There being no further business, Mr. King adjourned the meeting at 12:00noon.

Yale New Haven Hospital

20 York Street, New Haven, CT 06504

September 10, 1985

The Honorable David Durenberger
U.S. Senator for Minnesota
United States Senate Office
Washington, D.C. 20510

Dear Senator Durenberger:

I am writing in response to your proposed legislation, S.1489, "Medicare Outpatient Surgery Savings, Access, and Quality Act of 1985", and your comments included as part of the Congressional Record of July 24, 1985. While I share the philosophical intent of the legislation to establish a fixed rate reimbursement system for outpatient surgery, I take strong exception to your remarks about the cost of Hospital-based ambulatory surgery and particularly your erroneous statement of cataract surgery charges by Yale-New Haven Hospital.

In the Congressional Record you cited beneficiary co-payments in excess of \$900 based on charges of \$4500 by Yale-New Haven Hospital. This overall charge figure is far in excess of the actual \$1602 average Yale-New Haven charge for this outpatient procedure. Moreover, your statement is particularly misleading since Medicare reimburses reasonable costs rather than charges for the hospital component of outpatient surgery which is exclusive of professional fees.

The actual reimbursement from the Medicare Part B Trust Fund to Yale-New Haven Hospital for outpatient cataract surgery is less than the corresponding inpatient reimbursement rate for the Hospital. Based on the data submitted to the Department of Health and Human Services on Yale-New Haven Hospital's Medicare Cost Filing for 1984, the computed reimbursement to Yale-New Haven Hospital for Ambulatory Cataract Surgery is as follows:

ACILITY SERVICE	AVERAGE HOSPITAL CHARGE	COST TO CHARGE RATIO 1984 FILING	REASON- ABLE COST	REASONABLE COST-REIMBURSE. BY MEDICARE (80%)	BENEFICIARY CO-PAY (20% CHARGE)	ACTUAL MEDICAR REIMBURSE. FROM PART B TRUST FUND
Hospital	\$ 272	42.582%	\$ 116	\$ 93	\$ 54	(Difference of reasonable cost less beneficiary co-payment)
Anesthesia						
Ambulatory	531	73.535%	390	312	106	
O.R. Fee						
Diagnoses	552	76.912%	425	340	110	
Eye Pathol.	113	71.767%	81	65	23	
Medications	110	52.610%	58	46	22	
In. Med/Surg	24	76.912%	18	14	5	
TOTAL:	<u>\$1602</u>		<u>\$1088</u>	<u>\$870</u>	<u>\$320</u>	<u>\$768</u>

As you can see, the Hospital recovers only the "reasonable" cost of the procedure through Medicare payment of \$768 plus the beneficiary co-payment of \$320, for a total of \$1088. The \$768 Medicare payment represents the facility fee component paid to Yale-New Haven specifically addressed in the Congressional Record and is considerably less than \$4500.

When this facility fee for outpatient cataract surgery is compared to the Yale-New Haven Hospital inpatient reimbursement level (excluding indirect medical education) your hypothesis that hospital outpatient rates exceed inpatient rates is proven to be incorrect for Yale-New Haven Hospital. Our current inpatient DRG reimbursement rate is:

DRG 39 - Lens Implantation	
DRG 39 Weight	.4958
Hospital Reimbursement	<u>\$1939.15</u> (maximum allowable)
Assume 80% Part B Payment	<u>\$1551</u>

There are other elements of the legislation on which I would like to comment. The overall purpose of the proposed legislation is to establish a reimbursement system for Ambulatory Surgery based on a fixed fee "...regardless of setting". Such a reimbursement system would probably cause the erosion of Hospital Ambulatory Surgery programs due to the inability to recover reasonable costs, and at the same time, encourage the rapid proliferation of freestanding surgical centers. The impact of this proliferation on the frequency of unnecessary surgical procedures must be considered.

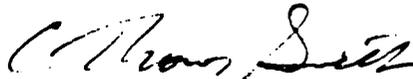
It is clear that costs in a complex full service hospital with all of the sophisticated equipment, service, technology and emergency capabilities operated twenty-four hours per day, seven days per week are higher than a freestanding operation without the same level of sophistication, emergency capability or unlimited hours of operation. Although freestanding surgical centers have demonstrated an ability to successfully perform outpatient surgery for routine cases, they are not prepared, to the same extent as an acute hospital, to manage emergencies that may arise during an ambulatory surgical case. If an emergent situation should arise during a procedure, immediate response and full service are necessary, and hospital-based ambulatory surgery provides a full range of emergency and back-up support. Staff are fully experienced in the management of life threatening situations. To reimburse these substantially different facilities at the same rate regardless of total costs, would be inequitable and illogical. In addition, it is very important to note that the very technological advancements in surgical technique that have created the opportunity for freestanding outpatient surgical centers were developed in and by hospitals. Financial support for the continued advancement of technology as an appropriate hospital-based expense must remain available so as to encourage further cost effective innovations in surgical practice.

In summary, I would encourage your consideration of the following sections as amendments to the original bill.

- o Establish fixed reimbursement rates for hospital-based Ambulatory Surgery based on hospital specific reasonable costs.
- o Limit Hospital-based Ambulatory Surgery reimbursement to a rate not to exceed inpatient DRG rates.
- o Maintain a separate fixed rate reimbursement schedule for freestanding outpatient surgery and update the freestanding Ambulatory Surgery prospective rate at least annually.

I would be more than happy to meet with you in your Washington office to further review the implications of the proposed legislation.

Sincerely,



C. Thomas Smith
President



association of american medical colleges

September 16, 1985

The Honorable Bob Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Chairman Packwood:

In the past few weeks, the price Medicare pays for ambulatory surgery in hospital outpatient departments has received considerable attention. The Association of American Medical Colleges, whose 375 non-Federal major teaching hospitals are major providers of outpatient services, has reviewed this issue carefully and found the most widely discussed proposals:

- o are based on incomplete and inaccurate data;
- o have compared only a very few procedures, primarily cataract surgery; and
- o have compared outpatient departments costs including related laboratory, radiology and prosthetic devices with free-standing surgery center prices excluding laboratory, radiology, and prosthetic devices.

In this situation, the AAMC does not believe it is appropriate or reasonable to use a single payment rate for both hospital outpatient departments and free-standing surgical centers. The Association believes Congress must act with prudence and caution to ensure that beneficiary access to care is protected while better data is collected and analyzed to make future payment decisions. Therefore, the AAMC strongly recommends that any legislation to modify payment rates for ambulatory surgery in hospital outpatient departments incorporate the following principles:

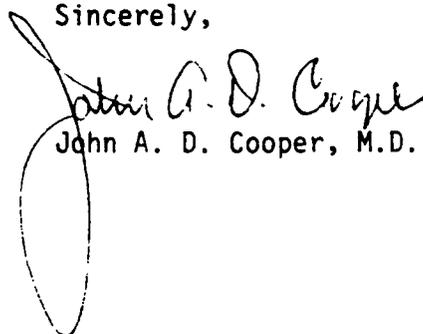
- o for all procedures, payment for surgery performed in a hospital outpatient department should not exceed payment for a comparable inpatient DRG;
- o where the coefficient of variation in current payments for a surgical procedure to hospitals is less than half the average price paid, the price paid for the service should be limited to the average payment to hospitals in the region for similar outpatients;
- o where the coefficient of variation in current payments for a surgical procedure to hospitals is greater than half the average price paid to hospitals, it is not reasonable to assume patients are sufficiently similar to set limits using an average regional price; and

The Honorable Bob Packwood
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September 16, 1985

- o in all cases where a price limit or fixed price payment is established for outpatient services, teaching hospitals should be allowed to claim direct medical education costs on a passthrough basis separate from the fixed price or limit.

The AAMC believes legislation reflecting these principles will balance Congressional interest in improving hospital efficiency with the obligation to protect beneficiary access to services required.

Sincerely,



John A. D. Cooper, M.D.

cc: Members, Committee on Finance

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
October 28, 1985

PRESENT

Sheldon King, Chairman
C. Thomas Smith, Chairman-Elect
Haynes Rice, Immediate Past Chairman
Robert J. Baker
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
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Richard M. Knapp, PhD
Karen L. Pfordresher
Nancy E. Seline
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
Meeting Minutes
October 28, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 7:00am in the Dupont Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the September 12, 1985 COTH Administrative Board Meeting.

III. NOMINATING COMMITTEE REPORT

Mr. Rice reviewed the traditional composition of the COTH Nominating Committee which is comprised of the Immediate Past Chairman as Committee Chairman, the current Chairman, and a member-at-large. The current committee consists of Mr. Rice as Committee Chairman, Mr. King, and Mr. Frank as the member-at-large. He noted that the position of Chairman and Immediate Past Chairman would automatically be filled by C. Thomas Smith and Sheldon King; Spencer Foreman, MD had been nominated as Chairman-Elect. He then gave the Committee's nominations for the three three-year terms on the COTH Administrative Board: Larry Mathis, The Methodist Hospital, Houston; Chuck O'Brien, Georgetown University Hospital, Washington, DC; and Raymond G. Schultze, MD, UCLA Hospital and Clinics, Los Angeles. Additionally, he noted that Barbara Small of the Veterans Administration, San Diego, had been nominated for a single year term on the Administrative Board to fill the remainder of Tom Stranova's term. Mr. Stranova is leaving the VA to become Dean for Administration at Tufts University School of Medicine, Boston. John Ives had been nominated for a one year term as Secretary to fill the remaining term vacated by Dr. Foreman. Mr. Rice presented the remainder of the slate consisting of the 21 three year term and the three one year term nominations to the AAMC Assembly. The complete Nominating Committee Report is included in these minutes as Appendix A.

IV. CURRENT ISSUES FACING THE AAMC

Dr. Knapp indicated there were two issues which raised particular concerns during the weeks immediately preceding the Administrative Board meeting. One was the AAMC's position on financing graduate medical education, and the other was a split between the university and hospital interests on tax-exempt bond legislation. Dr. Knapp asked the Board to consider the tax-exempt bond issue first and asked Ms. Seline to describe the nature of the issue and how the AAMC became the focal point of the disagreement between the hospitals and the universities.

Tax-Exempt Bonds

Ms. Seline reminded the Board of the proposed legislation to limit access to tax-exempt bond financing. The House Ways and Means Committee was working on a draft bill that would limit the total amount of tax-exempt financing that could be issued in any year to \$150 per capita and included under that limit bonds for housing projects, port and airport facilities, hospitals, universities, and small

issue development bonds. Once the Ways and Means Committee's draft proposal became public, the organizations representing the facilities whose access to tax-exempt bonds would be limited by the proposal began to try to extricate their facilities from the cap.

Previously, when limits had been suggested for universities and hospitals, organizations representing both groups had worked together successfully. As an organization with interests in both university and hospital access to capital, the AAMC has cooperated with the efforts of both communities. When the coalitions representing both interests attempted to find members of the Ways and Means Committee who were willing to offer an amendment to exclude all 501(c)(3) organizations from the cap, they met a very significant resistance. The hospitals were criticized chiefly for using tax-exempt bonds to finance the construction or acquisition of doctors' office buildings, parking lots, and other facilities that appeared to be akin to real estate ventures rather than the delivery of health care to the hospitals' patients. The universities were criticized for the large arbitrage earnings they were able to gain. The hospital groups, led by the American Hospital Association, believed their only chance to remove hospitals from the cap for the construction of facilities for the hospital and its patients was to develop an amendment that would preclude the use of the tax-exempt bonds for those purposes Congress found objectionable. The hospital group began work on such language and the AAMC elected to continue to work with that group to ensure that the unique functions of teaching hospitals (e.g., teaching and research) were included in the list of acceptable functions.

In the meantime, the university representatives believed that political support could be found to eliminate all 501(c)(3) organizations from the cap without concessions being made by either the hospitals or the universities. The hospital groups took their proposed language to Representatives Gradison and Matsui. When the university groups learned of the hospitals' proposal, they were upset because it appeared as if their strategy was being undermined. Furthermore, one of the universities' lobbyists misunderstood the hospitals' proposal and initiated a rumor that if the proposal were adopted, the only way the universities could access tax-exempt bonds would be through the hospitals. In fact, the hospitals' proposal did not address university access to bonds because Congressmen Gradison and Matsui had stated they preferred to deal with the hospitals on hospital issues and the universities on university issues.

The AAMC received a telephone call from one of the university organization's representatives who asked whether the AAMC had supported the hospital group's amendment, and when she was informed that we had been supportive of that effort, accused the AAMC of thwarting the universities' interests in favor of those of the hospital. She called several university presidents and other university representatives, some of whom called their medical school dean, teaching hospital director(s), or the AAMC directly to complain.

Mr. King described a meeting of university presidents he had attended just a few days prior to the Board meeting in which he believed several presidents demonstrated they were unfamiliar with the issues of importance to major medical centers. Mr. King suggested better communication was in order. Dr. Buchanan, who had attended the same meeting, concurred with Mr. King's assessment of the problem.

Dr. Buchanan suggested the issue is bigger than this disagreement over tax-exempt bond legislation. He suggested that as the medical center evolves toward a more for-profit-like entity, the university presidents will have difficulty

reconciling the medical centers' behavior with that of the arts and science faculties. He suggested that the AAMC should take the initiative to begin to create an atmosphere in which university presidents could be enlightened to the issues of importance to medical centers. It was suggested that the Association of Academic Health Centers might be useful in helping to create this atmosphere.

Medicare Financing of Graduate Medical Education

Dr. Buchanan outlined the work of the AAMC Committee on Financing Graduate Medical Education, a committee which he chairs. He described the difficulties the Committee has been having in reaching a consensus. He viewed the early part of the Committee's work as a consensus-building effort. A "Statement of Issues" paper was developed and sent to all constituents and the subject was discussed at the 1985 Spring Meetings of all three AAMC Councils. The attempt to achieve broad-based consensus and fully engage all parties in the debate was not a schedule that coincided with legislative efforts to move ahead. The proposals sponsored by Senators Dole, Durenberger, and Bentsen appeared in the Congressional Record on May 16, and the AAMC staff was told by the Senate Finance Committee staff that a hearing would be held on June 3 and the testimony was due on May 29. The Dole, Durenberger, Bentsen bill would support residency training through first board certification or five years, whichever was less. Knowing the proposal would generate controversy, each member of the Committee was called, and while not everyone was able to be reached, there was a general consensus that the approach should be supported. The Executive Committee discussed this issue and was made aware of the Committee's recommendation, in addition to the fact that the Association of Academic Health Centers would be supporting this position as well as the Commonwealth Foundation Academic Health Center Task Force. There was clear acknowledgement of the implications of limiting the period of reimbursement for some medicine, pediatric, surgical, and other subspecialties. There was also an awareness that there would not be uniform support in the medical education community with any departure from the status quo.

Dr. Buchanan reported that over the summer months, significant concern and objection were raised by various members of the internal medicine subspecialty community as well as the American College of Physicians and the Association of Professors of Medicine. Significant pressure has been placed upon the AAMC Committee on Financing Graduate Medical Education and the Association in general to revise its policy as reflected in the testimony delivered on June 3.

While no action was required, the Chairman felt that it was important for all Board members to be aware of the growing controversy around the AAMC position on this issue.

V. ADJOURNMENT

There being no further business, Mr. King adjourned the meeting at 9:00am.

COTH NOMINATING COMMITTEE REPORT

HAYNES RICE, CHAIRMAN

OCTOBER 28, 1985

BY TRADITION, THE COTH NOMINATING COMMITTEE IS COMPOSED OF THE IMMEDIATE PAST CHAIRMAN, THE CURRENT COTH CHAIRMAN, AND ONE MEMBER AT-LARGE. THUS YOUR CURRENT COMMITTEE INCLUDES MYSELF AS CHAIRMAN, SHELDON KING AND BOB FRANK OF BARNES HOSPITAL IN ST. LOUIS AS THE MEMBER-AT LARGE.

I HAVE SEVERAL NOMINATIONS, AND I WILL PRESENT THE ENTIRE SLATE AND LET THE CHAIRMAN TAKE IT FROM THERE.

IN ACCORDANCE WITH AAMC BYLAWS, COTH IS ENTITLED TO 63 REPRESENTATIVES TO THE AAMC ASSEMBLY. THIS YEAR WE HAVE 21 THREE-YEAR TERMS AVAILABLE, AND THREE SINGLE-YEAR TERMS TO REPLACE INDIVIDUALS WHO HAVE LEFT COTH MEMBER INSTITUTION POSITIONS.

NOMINATIONS FOR A ONE-YEAR TERM TO THE AAMC ASSEMBLY, EXPIRING 1986

ERIC MUNSON	NORTH CAROLINA MEMORIAL HOSPITAL CHAPEL HILL, NC
WILLIAM NEWELL, JR.	UNIVERSITY HOSPITAL STONY BROOK, NY
CHARLES U'BRIEN, JR.	GEORGETOWN UNIVERSITY HOSPITAL WASHINGTON, DC

THE FOLLOWING 21 INDIVIDUALS ARE NOMINATED FOR THREE-YEAR TERMS TO THE AAMC ASSEMBLY, EXPIRING 1988

J. SCOTT ABERCROMBIE, JR., MD	UNIVERSITY HOSPITAL BOSTON, MA
JOHN ASHLEY, MD	UNIVERSITY OF VIRGINIA HOSPITALS CHARLOTTESVILLE, VA

JOHN BIHLDORFF

JOHN DEMPSEY HOSPITAL/U CT HEALTH
CENTER, FARMINGTON, CT

CALVIN BLAND

ST. CHRISTOPHER'S HOSPITAL FOR
CHILDREN, PHILADELPHIA, PA

JOHN BUCKLEY, JR.

ST. JOSEPH HOSPITAL, PHOENIX, AZ

JUDGE CALTON

METHODIST HOSPITAL OF MEMPHIS
MEMPHIS, IN

JAMES DOOLEY

VETERANS ADMINISTRATION MEDICAL CENTER
NEW YORK, NY

PAUL GRINER, MD

STRONG MEMORIAL HOSPITAL
ROCHESTER, NY

JOHN IVES

SHANDS HOSPITAL, GAINESVILLE, FL

KEVIN HALPEN

COOPER HOSPITAL/UNIVERSITY MEDICAL
CENTER, CAMDEN, NJ

TERRENCE JOHNSON

VETERANS ADMINISTRATION MEDICAL CENTER
INDIANAPOLIS, IN

STUART KLEIT, MD

INDIANA UNIVERSITY HOSPITALS
INDIANAPOLIS, IN

A. L. LEBLANC, MD

UNIVERSITY OF TEXAS MEDICAL BRANCH
GALVESTON, TX

GARY MECKLENBERG

NORTHWESTERN MEMORIAL HOSPITAL
CHICAGO, IL

JAMES MONGAN, MD

TRUMAN MEDICAL CENTER
KANSAS CITY, MO

THOMAS MULLON

VETERANS ADMINISTRATION MEDICAL CENTER
MINNEAPOLIS, MN

DOUGLAS PETERS

HENRY FORD HOSPITAL
DETROIT, MI

HOWARD PETERSON

PENNSYLVANIA STATE UNIVERSITY
HOSPITAL, THE MILTON S. HERSHEY
MEDICAL CENTER, HERSHEY, PA

MARY PICCIONE

DOWNSTATE MEDICAL CENTER
BROOKLYN, NY

BARBARA SMALL

VETERANS ADMINISTRATION MEDICAL CENTER
SAN DIEGO, CA

MICHAEL STRINGER

UNIVERSITY HOSPITAL
SAN DIEGO, CA

WE HAVE NOMINATIONS FOR TWO SINGLE-YEAR TERMS TO FILL OUT ADMINISTRATIVE BOARD POSITIONS AND 3 NOMINATIONS FOR THREE-YEAR TERMS ON THE COTH BOARD, EXPIRING 1988

FOR A SINGLE YEAR TERM AS SECRETARY

JOHN E. IVES

SHANDS HOSPITAL
GAINESVILLE, FL

FOR A SINGLE YEAR TERM ON THE ADMINISTRATIVE BOARD

TO REPLACE TOM STRANOVA WHO HAS RESIGNED FROM THE COTH ADMINISTRATIVE BOARD AS HE WILL BE LEAVING THE VETERANS ADMINISTRATION

BARBARA A. SMALL

VETERANS ADMINISTRATION MEDICAL
CENTER, SAN DIEGO, CA

FOR 3 THREE-YEAR TERMS ON THE ADMINISTRATIVE BOARD

LARRY L. MATHIS

THE METHODIST HOSPITAL
HOUSTON, TX

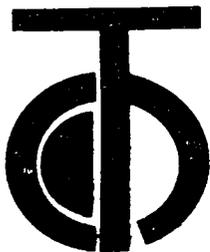
CHARLES M. O'BRIEN, JR.

GEORGETOWN UNIVERSITY HOSPITAL
WASHINGTON, DC

RAYMOND G. SCHULTZE, MD

UCLA HOSPITAL AND CLINICS
LOS ANGELES, CA

IN ADDITION TO THESE NOMINATIONS, WE HAVE THE IMMEDIATE PAST CHAIRMAN WHICH IS AUTOMATIC, SHELDON KING. FOR CHAIRMAN, TOM SMITH, PRESIDENT, YALE-NEW HAVEN HOSPITAL, CT; AND FOR COTH CHAIRMAN-ELECT, THE NOMINATING COMMITTEE RECOMMENDS DR. SPENCER FOREMAN, PRESIDENT, SINAI HOSPITAL OF BALTIMORE.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Saint Vincent Health Center
Hospital Address: (Street) 232 West 25th Street
(City) Erie (State) PA (Zip) 16544
(Area Code)/Telephone Number: (814) 452-5120
Name of Hospital's Chief Executive Officer: Sister Margaret Ann Hardner
Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>572</u>	Admissions:	<u>22,416</u>
Average Daily Census:	<u>407</u>	Visits: Emergency Room:	<u>42,185</u>
Total Live Births:	<u>1,871</u>	Visits: Outpatient or Clinic:	<u>14,779</u>

B. Financial Data

Total Operating Expenses: \$ 72,354,419

Total Payroll Expenses: \$ 49,763,191

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 620,563

Supervising Faculty: \$ 503,721

C. Staffing Data

Number of Personnel: Full-Time: 1705
Part-Time: 558

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 307

With Medical School Faculty Appointments: 15

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

NONE _____

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	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Graduate Medical Education

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

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	18	18	1	1977
Psychiatry	_____	_____	_____	_____
Other:				
Colon & Rectal	2	_____	2	1973
Urology	3	1	2	1947
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As 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.

²As 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: Hahnemann Medical School

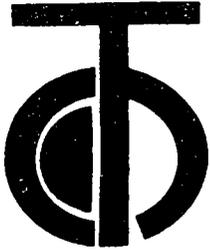
Dean of Affiliated Medical School: Joseph R. DiPalma, M.D.
Associate Dean of Affiliation
Hahnemann University, School of Medicine
Philadelphia, PA 19102-1191

Information Submitted by: (Name) Albert L. Lamp, M.D.

(Title) Director of Medical Affairs

Signature of Hospital's Chief Executive Officer:

Margaret Ann Hardner (Date) 10/25/85
Sister Margaret Ann Hardner, President



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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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: UCLA Neuropsychiatric Hospital
Hospital Address: (Street) 760 Westwood Plaza
(City) Los Angeles (State) California (Zip) 90024
(Area Code)/Telephone Number: (213) 825-0011
Name of Hospital's Chief Executive Officer: Don A. Rockwell, M.D.
Title of Hospital's Chief Executive Officer: Director, UCLA Neuropsychiatric Hospital

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>209</u>	Admissions:	<u>1,820</u>
Average Daily Census:	<u>112</u>	Visits: Emergency Room:	<u>-</u>
Total Live Births:	<u>-</u>	Visits: Outpatient or Clinic:	<u>59,800</u>

B. Financial Data

Total Operating Expenses: \$ 27,032,150

Total Payroll Expenses: \$ 17,761,470

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 781,470
 Supervising Faculty: \$ 237,430

C. Staffing Data

Number of Personnel: Full-Time: 573 Full-Time Equivalent
 Part-Time: -

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 65
 With Medical School Faculty Appointments: 460

Clinical Services with Full-Time Salaried Chiefs of Service (list services):
 Mental Retardation
 and Child Psychiatry Neurology _____

Adult Psychiatry _____

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

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	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	<u>1</u>	<u>160</u>	<u>Required</u>
Psychiatry Other: <u>Electives</u>	<u>23</u>	<u>71</u>	<u>Elective</u>
Neurology	<u>1</u>	<u>160</u>	<u>Required</u>
Neurology Elective	<u>7</u>	<u>18</u>	<u>Elective</u>

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> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	_____	_____	_____	_____
Psychiatry	36	36	-	1960
Other:	_____	_____	_____	_____
Child Psychiatry	16	14	2	1960
Neurology	15	15	0	1957
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As 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.

²As 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: UCLA School of Medicine

Dean of Affiliated Medical School: Sherman M. Mellinkoff, M.D.

Information Submitted by: (Name) John W. Puryear

(Title) Administrator

Signature of Hospital's Chief Executive Officer:

John W. Puryear

(Date) 9/9/85



OFFICE OF THE DEAN
UCLA SCHOOL OF MEDICINE
CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

August 26, 1985

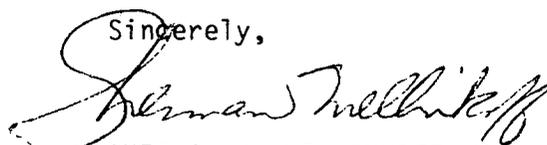
Richard M. Knapp, Ph.D., Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Knapp:

It is my pleasure to provide this letter in support of the UCLA Neuro-psychiatric Hospital's application to become a member of the Council of Teaching Hospitals. The NPH is a separately licensed hospital, serving as the primary neurologic and psychiatric teaching hospital for the UCLA School of Medicine. The hospital is physically contiguous with the UCLA Medical Center. The details of its patient services have been provided by Dr. Rockwell and his staff. Its educational mission is fully integrated with the UCLA School of Medicine. The hospital is the service home for both the Department of Neurology and the Department of Psychiatry and Biobehavioral Sciences. Both departments provide undergraduate, graduate, and postgraduate education under the aegis of the UCLA School of Medicine. Both elective and required clerkships take place at NPH and both departments have large residency programs, as well as fellowships in a variety of areas. There can be no question as to the major role the hospital plays in our educational programs.

The hospital is now administratively separate from UCLA Medical Center and, I believe, quite appropriately wishes to be separately represented in the Council of Teaching Hospitals. They have my full support in this application. Please do not hesitate to contact me if further documentation is necessary.

Sincerely,



SHERMAN M. MELLINKOFF, M.D.

SMM/ar

cc: Charles E. Young, Chancellor
William Schaefer, Executive Vice Chancellor
Raymond G. Schultze, M.D.

AAMC STAFF ACTIVITIES

For the past two years, the COTH Administrative Board has explored the implications of the growing number of hospital organizations (e.g., networks, consortia, alliances such as VHA, AHS, UHC, and CJH) on COTH and the AAMC. For the most part, the discussion has focused on exploring the role and function of COTH/AAMC with regard to matters of education, information and data collection, research, service and advocacy as these new organizations initiate activities in these areas.

As these organizations have begun to mature they are beginning to develop and market various types of insurance products. An example would be the VHA/Aetna preferred provider product. These health delivery and insurance products are designed as "patient acquisition strategies" to provide market share advantages to their sponsors. This type of service activity is quite different from group purchasing, insurance pools, and other activities which lead to economic advantage, but don't directly deal with specific competition for patients.

The appropriate role of AAMC staff members when asked to participate in the development of insurance products has not been addressed. One of the new organizations has welcomed AAMC staff input into its deliberations. Specifically, Jim Bentley has been asked to participate as a member of the National Health Care and Insurance Delivery Council of the University Hospital Consortium. This could benefit the AAMC by helping staff stay up-to-date on key issues of member concern and by assisting a significant group of COTH members. At the same time, staff involvement in the deliberations of one organization as it engages in strategic planning to develop its insurance products could be viewed as inappropriate by COTH members in other alliances. Because the appropriate role for AAMC staff in these situations is unclear, the Administrative Board is asked to discuss appropriate staff involvement in other hospital organizations with reference specifically to competitive delivery issues.



5215 North O'Connor Road
Williams Square, 12th Floor
Irving, TX 75039

P.O. Box 160909
Irving, TX 75016

(214) 830-0000

Voluntary Hospitals of America, Inc.®

December 13, 1985

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

Dear Dick:

I thought it would be well to communicate with you on some recent events of Voluntary Hospitals of America.

I have previously visited with you and your administrative board relative to our public policy efforts. I have indicated to you, and your board, that our effort did not include "lobbying." We did not enter the public policy arena with that in mind for the reasons that I have previously stated to you. However, during this past summer we had a series of three regional board meetings at which this was discussed. It became evident that our Board felt that there would be issues arising, on which, we should take and advocacy position. I have recently learned that what I consider to be a minor change in emphasis has been interpreted as a major change in emphasis. Consequently, I feel obligated to advise you of this occurrence. At this time we have some notion of the issues that might arise and, I can assure you, that they are few and numbered. I can also assure you that we would expect, for the most part, that this effort would be supportive of yours. I want to also assure you that if the contrary should occur that there will be ample opportunity for conversation and advance of any positions, statements or actions.

I am communicating with you, in this way, because I do not want you to feel that I, in anyway, deceived you or was less than forthcoming.

Whatever changes occurred in our situation is not a product of deception but perhaps of illusion. In any event I value our relationship, I anticipate that it will be principally supportive and I would appreciate the opportunity to converse with you further about it.

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Richard Knapp, Ph.D.
Page 2
December 13, 1985

I intend to be spending more time in Washington, in the future, than I have and I would like to look forward to an opportunity for Dave Winston and I to visit with you again.

If this is agreeable, please let me know and we will work on a time to get together.

With kind regards,



Don L. Arnwine
Chairman

DLA:gp

cc: Dave Winston

CORPORATE COMMENTS ON TEACHING HOSPITAL USE

In November 1985, Stuart Kleit, MD, who at the time was director of hospitals at Indiana University Medical Center, sent Dr. Knapp a document entitled, Informed Choices, the Quaker Oats Company's health care guide for its employees. On November 21, the letter which follows was sent to Bill Goldbeck at the Washington Business Group on Health. On December 3, a COTH General Membership memorandum was sent out enclosing a copy of Informed Choices. The segment of the guide which is most provocative reads as follows.

Eventually you will be able to compare the cost of having an appendectomy at Hospital A vs. Hospital B as better data becomes available. Until then, here are a few tips:

- o Ask hospitals to estimate the cost of care for your specific condition;
- o Ask whether they have a high or low proportion of Medicare or Medicaid patients. If it's high (25% or above) you will pay considerably more to make up for what the government doesn't pay;
- o Ask their last year's occupancy rate. If it's less than 85% (100% means all beds are full all the time), they have to charge higher prices to pay for the fixed overhead;
- o If it's a teaching hospital, you can count on its prices being two or three times as high as a non-teaching hospital. Teaching hospitals are not necessary for routine care or surgery.

The memorandum generated nine letters from COTH constituents; they appear on the following pages.

Conversations with Gaylen Young, Director, Office of Health Coalitions and Private Sector Initiatives, American Hospital Association, have indicated that Quaker Oats has revised its Informed Choices publication. The section cited above has been deleted, and actual prices for specific hospitals have been added. Gaylen is sending a variety of corporate health guides for review.

On page 48 a series of recommendations are listed from a recently published book entitled, Improving Health-Care Management in the Workplace. They are worth reading.



association of american medical colleges

November 21, 1985

Willis B. Goldbeck
President
Washington Business Group
on Health
229½ Pennsylvania Avenue, SE
Washington, DC 20003

Dear Bill:

Enclosed is a copy of a Quaker Oats Corporation manual entitled, "A Health Care Consumer's Guide." I call your attention to the three items I have bracketed on page ten.

I don't believe the first one is accurate. Twenty five percent is too low a threshold. I'd be surprised if the average suburban community hospital doesn't have between 30-40 percent Medicare admissions. In addition, I don't believe the principle implied in the policy position is socially responsible.

With regard to the second item, I think 85 percent is an unreasonable occupancy to expect. In this regard, I think at this point you'll find teaching hospitals have among the highest occupancy rates in most communities. Which leads me to my third point.

I don't believe it can be substantiated that teaching hospital prices are two to three times as high as those in a non-teaching hospital. Furthermore, while teaching hospitals may not be necessary for routine care or surgery, it is clearly necessary that medical students, residents, and nursing and allied health students learn in an environment which includes routine care and surgery.

More to the point, I do not find this last point to exhibit any understanding or support for the unique and important contributions of teaching hospitals. I hope you call me so we can discuss this important matter.

Sincerely,

Richard M. Knapp, PhD
Director
Department of Teaching Hospitals

RMK/mhw
Enclosure

PENNSYLVANIA HOSPITAL

The Nation's First Hospital · Founded 1751

DEPARTMENT FOR SICK AND INJURED
EIGHTH AND SPRUCE STREETS
PHILADELPHIA, PENNSYLVANIA 19107
TELEPHONE (215) 829/3312

December 10, 1985

Richard M. Knapp, PH.D.
Director
Department of Teaching Hospitals
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dick:

The December 3, 1985 COTH General Membership Memorandum No. 85-86 with the subject "Corporate Comments on Teaching Hospital Use" has been read. You indicated comments were welcomed.

It is true that the Quaker Oats observations are provocative, but they also may be true in some instances. I don't think a direct challenge would be productive--unless your constituency requires that you produce a response to support their ego.

It would seem to me that most employees would recognize that their employer also has a cost related vested interest when advising about the consumption of health services and would keep this in mind when they study any advice from their employer. In many instances the health provider may well have creditability standing that is at least equal or perhaps even better than an employer's creditability. When the consumer is convinced that he or she has a health problem they will seek a quality solution for the problem. They will want value, not necessarily the lowest price. This is especially true when they are financing their care from a plan that is paid for by their employer.

Because of this it seems to me that a reply from AAMC should not be automatic. We may not like the Quaker Oats approach but I am not sure it is too far off the mark. If the booklet does help the purchasers understand how they can be more informed consumers this is good. I think most will finally decide to purchase health services on the basis of value, not totally on the basis of price.

Sincerely,

H. Robert Cathcart
President

HRC/eak





The University of Texas Medical Branch at Galveston
Office of the Vice President for Hospital Affairs

• Suite J12 • John Sealy Hospital (South Addition) • Galveston, Texas • 77550 • (409) 761-1191

December 10, 1985

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

Dear Dr. Knapp:

Thank you for the copy of "Informed Choices." I agree that the "tips" are a problem and at least in our area, tip #4 is inaccurate and tips #2 and #3 are misleading because of the funding mechanisms for teaching hospitals in our area. If you have not already done so I assume COTH has a right to ask to see the data which support these "tips."

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Alvin L. LeBlanc".

Alvin L. LeBlanc, M.D.
Vice President for Hospital Affairs

ek



The Johns Hopkins Hospital

Robert M. Heyssel, M.D.
President

December 10, 1985

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
AAMC
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dick:

Thanks for sending me the Quaker Oats Company's health care guide. Actually, it was passed out at the small COTH meeting, and my comment at the time was, "we ought to run ads claiming that Quaker Oats is non-nutritious and harmful to your health." Coming from the nation's academic medical centers, that probably would carry some weight. We could both be mad and get even with them! In all seriousness, I am going to send this to our Trustees.

Really, the more appalling of the two statements on page 9 and 10 and the most socially irresponsible is the statement on Medicare and Medicaid patients. Another way of putting that is, "you do not want to be in a hospital that has a lot of poor people or old folk."

Now for a suggestion. I really think that the COTH ought to seriously consider a national ad campaign, develop a logo, etc. We are getting whipped in the marketplace, and the marketplace requires informing people. I would imagine some significant proportion, perhaps even a majority, of academic medical centers are advertising in one way or another at this point. It probably would be more acceptable to advertise today than it might have been two or three years ago. Ads in national media under the sponsorship of COTH could be one part. The other might be preparing materials which could then be used by the centers with flavors, regionally or locally, and made available to COTH member institutions. Anyway, I really think it is worth thinking about, and I hope you all will consider discussing it.

Best wishes.

Sincerely,

Robert M. Heyssel, M.D.

381-4172

419-381-3411

1000 Arlington Avenue
 Mailing Address: C.S. 10008
 Toledo, Ohio 43699



December 12, 1985

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

Dear Dick:

Thank you for sending out the document, Informed Choices. I hope I responded appropriately and I will let you know if we received any other types of consumer guides. I think it is important that medical schools put out their own "propaganda" to justify in lay terms the importance of teaching hospitals and the fact that we are not that expensive when you compare us with similar patient populations. This is something that the Council of Teaching Hospitals or the University Hospital Consortium should take on as a project, and we would certainly support that.

Take care and happy holidays. See you at our next meeting.

Sincerely,

David J. Kolasky
 Executive Director

DJK:bd

Enclosure

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419-381-4172

419-381-3411

3000 Arlington Avenue
Mailing Address: C.S. 10008
Toledo, Ohio 43699



December 16, 1985

Mr. Robert C. Penzkover
Director
Employee Benefits
The Quaker Oats Company
Merchandise Mart Plaza
Chicago, Illinois 60654

Dear Mr. Penzkover:

I just received the copy of your fine publication, Informed Choices, and must applaud The Quaker Oats Company for educating its employees about health care. I was particularly interested in your chapter entitled "Choosing a Hospital." I realize that in a short document it is difficult to include all the nuances subtleties of health care but I feel it is important to point out several items to you that are of some concern to me.

With regard to the issue of "quantity", indeed there is probably a direct correlation between number of procedures done and success rates. However, one needs to look at the number of cases done by each physician as opposed to the number done by a hospital. For example, in your illustration of open heart surgeries, I would rather have a physician who did 200 cases than 200 physicians who did one case each. In either case, the hospital has done 200 but I would suspect the outcomes would be a bit different. So, it is not only the number of cases done by the hospital but also by the physician. In regard to "quality", you need to look at the type of patient that chooses a specific hospital. Studies have shown that medical school hospitals care for sicker patients than the "average" community hospital. As such, one might expect a higher disability and death rate at an academic center. Therefore, when looking at quality, one must look at the type of patient and the severity of illness of the patient and the diagnosis of the patient.

You then raise the issue of "cost of care" and I would simply say that occupancy rate is only one predeterminate of cost. In today's world with HMOs and PPOs, hospitals are discounting their prices and occupancy and cost may not be 100 percent directly correlated. Larger hospitals, too, have a larger base for which to spread fixed overhead and may have some advantage over smaller hospitals when distributing that overhead.

The last issue I would like to raise is that of "cost at teaching hospitals." Indeed, cost at teaching hospitals can be much higher than nonteaching hospitals. This inherent in the educational system and there is indeed a cost of education associated with patient care. There are some studies which compare teaching and nonteaching hospitals by DRG and, when this is done, the price differentials are not very great. In fact, in some cases the medical school hospital experiences less expensive care than a community hospital. Once again, in comparing teaching and nonteaching hospitals one must take into account the DRG and the severity of illness of each patient. The other factor when

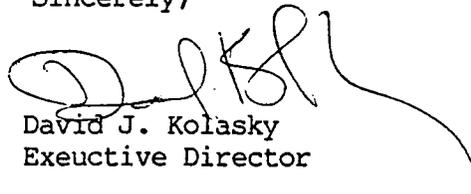
bert C. Penzkover
ie Quaker Oats Company
:ember 16, 1985
ge 2

onsidering teaching hospitals with nonteaching hospitals, is the fact that teaching
ospitals tend to have a higher charity load, and this cost is passed on to consumers of
alth care. Until the government decides to make this a societal problem, someone must
y for the free care.

ice again, I applaud your efforts at putting together this valuable document. Admitting
bias as the executive director of a medical school hospital, I would caution you when
mparing teaching and nonteaching hospitals. For this country's medical care system to
ow, to change and to bring about new and improved methodologies in the treatment of
seases, we need to support medical school hospitals.

ank you very much. Should there be any questions, please feel free to call me.

Sincerely,



David J. Kolasky
Exeuctive Director

K:bd

: Richard Knapp - AAMC
Richard D. Ruppert, M.D.

Gennaro J. Vasile, Ph.D.
President and Chief Executive Officer

December 13, 1985

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

Dear Dick:

I am in receipt of your communication of December 3, 1985, regarding "Corporate Comments on Teaching Hospital Use." As you are well aware, this is a very complex subject requiring much more indepth treatment than I will be able to offer in this letter. However, I did want to get off a few quick thoughts.

My first theme relates to the need at national, state and local levels of penetrating "business coalitions." My experience with these groups suggests they have genuine concerns about their health care costs, but generally act with less than a full understanding of the health care delivery system in their community, state, and nation. This is exacerbated by zealous personnel-types and planning agency staff, with a little better understanding, but not much more, who are trying to make inroads with the representation on various business coalitions. I think there's a real need to penetrate the forms of these business coalitions to increase understanding and present our side of the story. It's clear that the kind of pressure created by documents like "Informed Choices" is going to increase. We cannot afford to be passive with respect to the corporations involved. I believe the business coalition approach at nation, state and local levels is worth thinking about.

Another avenue are the local Chamber of Commerce organizations. Some of these organizations have formed business coalitions for health, while others have been less formal and created health subcommittees. In any case, at the local level, and perhaps even at the state level, these are forms that teaching hospitals can use to begin to get their case on the table. We are a member of our local Chamber and are beginning to pursue a definitive communication strategy. At the local level, CEOs participate in Chamber activities, while personal officers and HSA planning staff are usually excluded. Our intent is to activate the Health Committee of the Chamber and work to increase the understanding of the CEOs and General Managers of companies based on our community and region.

33-57 Harrison Street • Johnson City • New York • 13790
607-770-614C

Richard M. Knapp, Ph.D.

- 2 -

December 13, 1985

Finally, and perhaps most importantly, in my view, teaching hospitals have to develop a definitive pricing strategy. A local non-teaching community hospital has come out aggressively advertising that they are the low cost provider in our community. After beating our brows about being helpless to deal with such advertising, we have come up with a pricing strategy that will allow us to be selectively competitive on the basis of price for high visibility services, e.g., Emergency Room, X-Rays, Laboratory, Labor and Delivery charges, etc. As a consequence, we will be able to advertise that we are low priced provider for those services. Such an approach may lead to a "price war," but we have factored that into our strategy. It's a risk we are prepared to take and frankly, I don't think hospitals like ours have much of a choice. We are going to have to get service-specific in our strategies to compensate for the overall differential on cost related to teaching, research, and highly-specialized services. While more localized, this strategy will help convince industry that we are concerned about price and are prepared to take some risks in order to deal with it.

Dick, I've quickly outline some thoughts on the subject you asked us to address. As noted earlier, the subject is complex and if you wish, please feel free to call me if you want to puruse any of my comments further.

Let me also take the opportunity to wish you and yours the very best of the Holiday Season.

Sincerely,



GOV/djg

PROVIDENCE MEDICAL CENTER
4805 NORTHEAST GLISAN STREET
PORTLAND, OREGON 97213-2967
PHONE: (503) 230-1111



December 16, 1985

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

Re: Corporate Comments on Teaching Hospital Use

Dear Doctor Knapp:

I direct an internal medicine residency which is based in a community hospital in Portland, Oregon. Our program is affiliated with but independent from the nearby Oregon Health Sciences University. I am full Professor of Medicine at the University.

As you may know, Portland, Oregon is one of the most competitive medical marketplaces in the United States. I was particularly distressed by the comments in the document, Informed Choices, distributed by the Quaker Oats Company as a health care guide for its employees. I would certainly encourage you rectify the comments in that document by whatever means is possible. In our local, highly-competitive environment, there are already concerns about the "increased cost" of hospitals that employ house officers. Our repeated arguments regarding quality do not seem to engender much support. There are some arguments that might sway the consumer.

1. There is a difference between community teaching hospitals and University teaching hospitals. Teaching programs based in a community hospital of necessity have a very short length of stay. The house officers provide a great deal of service to private physicians and assist in the short length of stay. House officers dictate the history and physical examination, perform many of the procedures, and dictate the discharge summary. House officers on consultative services dictate consultative documents. All of these activities save the private physician a great deal of time, increase the compliance of private physicians with medical staff and hospital rules, and, overall, contribute to the efficiency of the health care delivered. As I am sure you are aware, many facets of this environment are different than those encountered in a University hospital or a Veterans Administration hospital.
2. We hypothesize that the average expense to a patient with a specific medical diagnosis is no greater in a teaching hospital than in a

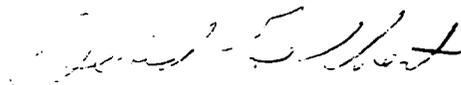
Re: Corporate Comments on Teaching Hospital Use

non-teaching hospital. We feel this hypothesis is justified because of the shortened length of stay for patients cared for by house officers as compared to patients, with the same diagnosis, cared for by private physicians. Even though house officers tend to order more diagnostic tests, their patients stay in the hospital a shorter period of time. The shorter length of stay results from the closer surveillance of the patient's course by house officers. Because house officers are in the hospital some 12-24 hours per day, they are immediately aware of the results of laboratory and x-ray test procedures. This allows the house officers to immediately order whatever is reasonable in the next stage of the patient's evaluation. House officers are easily available to social workers and others important in the discharge planning process.

3. The third facet of the problem does refer to quality of care. Isn't it worth a few extra dollars per day to have a physician available 24 hours per day, 7 days a week for immediate attention of patient problems that vary from falling out of bed to cardiac arrest?

I hope these brief comments are of some assistance to you.

Sincerely yours, ,



David N. Gilbert, M.D.
Director of Medical Education
Providence Medical Center &
Professor of Medicine and
Infectious Diseases
Oregon Health Sciences University

DNG:mc

CREIGHTON UNIVERSITY

Vice President
For Health Sciences

December 16, 1985

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

Dear Dick:

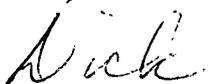
I have read the Quaker Oats comments on teaching hospitals in its advice to employees on choosing a hospital. I doubt that this is likely to have major influence on individuals, though if it were to have and were to become widespread practice it would have major adverse effects. It is an unfortunate symptom of the evolution of health care into a primarily price-competitive market place economy.

I have no marvelous ideas for how to deal with this. I suggest that whenever such a comment comes to light, COTH should write the company and point out the potential harm it is doing to teaching hospitals and the major contribution that teaching hospitals make to our society. There is little or no reason to believe that this will have any effect, but perhaps once in a while it will strike a chord of social responsibility in a corporate executive.

It is likely that we will see much more of this as companies seek to keep their health care costs down and have no concern for our mission. It behooves us to develop other ways to support our academic missions as current means of supporting them are taken away from us. Is there an AAMC or COTH effort to define alternate means of funding the academic costs of teaching hospitals? If not, there ought to be.

If I can help in any way, please let me know.

Sincerely yours,



RICHARD L. O'BRIEN, M.D.
Vice President, Health Sciences
Dean, School of Medicine

RLO/sn

JEWISH HOSPITAL

AT WASHINGTON UNIVERSITY MEDICAL CENTER

December 27, 1985

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

Dear Dick:

This is in response to your membership memorandum #85-6 regarding the Quaker Oats Health Care Guide.

It is an interesting document with some surprising comments from a fairly sophisticated company.

For example, they state "prices rarely depend on quality". I wonder why they would assume that the economic laws that apply to industry don't apply in health care. Do they really put the same value on a physician who graduated at the bottom of his class at Grenada University as the head of the class at Hopkins? According to their conclusion, there is no difference between a Cadillac and a Chevette.

Their conclusion that private payors subsidize Medicare patients might have been true pre the PPS program, but it is the reverse situation for large numbers of hospitals, especially teaching hospitals in today's environment.

They also note that efficiency depends on volume and occupancy, but they want to deny hospitals any volume. It is the same philosophy that pervades our Business Coalition companies in St. Louis who are attracted to Deaconess Hospital because it is the low price leader in the community. They are wildly enthusiastic until they find out that Deaconess is unable to provide tertiary care. I guess you still get what you pay for.

I never did like Quaker Oats in any event.

Best wishes for the new year.

Cordially yours,



David A. Gee
President

DAG:ld

The Jewish Hospital of St. Louis
216 South Kingshighway Boulevard
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(314) 454-7000



St Joseph's Hospital and Medical Center
703 Main Street • Paterson • New Jersey 07503 • (201)977-2250

Continuing Commitment to Care

Office of the Vice President for Medical Affairs

January 3, 1986

Richard M. Knapp, Ph.D.
Director, Dept. of Teaching Hospitals
AAMC
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Knapp:

I have read the Quaker Oats Company's corporate comments on teaching hospitals which you circulated. I think the best way of addressing the last of the four "tips" which are included in the section on "Choosing a Hospital" is for our organization to point out to management of the Quaker Oats Company at the highest levels that the "experienced health care professional" they make reference to in their paragraph "About This Book", a Ms. Lottie A. Kurcz, R.N., is making conclusions and recommendations far beyond her expertise. I think that you can do quite a job on item four.

I don't really think we ought to let them off the hook on items two and three, which are very inexact and misleading.

Should we receive any similar circulations, I will be happy to forward them to you.

Yours very truly,



John A. Paterson, D.D.S.
Vice President for Medical Affairs

JP/ds

IMPROVING HEALTH-CARE MANAGEMENT IN THE WORKPLACE,
Jerome M. Rosow, Robert Zager, Ruth S. Hanft, A Work in America
Policy Study, Pergamon Press, New York

In the fall of 1985 the Work in America Institute published a book entitled Improving Health-Care Management in the Workplace. Following each of nine chapters are a series of recommendations. These twenty-eight recommendations are as follows:

1. Employers and unions should manage health care jointly, wherever feasible. Employees have as strong an interest as their employers in using health-care benefits cost-effectively, and the two parties can gain that end more successfully through joint action than separately. In particular, employee involvement in designing the health-benefit package leads to larger, longer-lasting reductions.
2. Cost sharing, although it has serious side-effects, should be thoroughly explored by the parties as an option which demonstrably lowers costs. Pros and cons should be examined. However, both sides should avoid taking rigid positions on this volatile issue, since it could get in the way of more valuable long-range improvements in the health-care program that require joint action.
3. Employers and unions should ensure that joint actions are supported with appropriate funds, training, and management methods. Investments in joint-action programs produce high returns and have lasting value.
4. Wherever diagnostic, preventive, or treatment services can be provided outside a hospital as safely and effectively as within, and at lower cost, employers and unions should ensure that the health-benefits plan encourages their use by employees, dependents, and retirees. Where such services are not available, employers and unions should stimulate their development.
5. In determining whether a particular out-of-hospital service deserves to be encouraged, employers and unions should take into account such factors as: (1) whether the service unnecessarily increases the total consumption of health care in the community; (2) whether the lower cost of the service has the effect of raising hospital costs in the community; and (3) whether the location of the service causes hardships for the poorest and most seriously ill patients.
6. When employers and unions decide to adopt or increase cost sharing, they should carefully tailor it to encourage cost-effective utilization and to discourage wasteful utilization, but not to cause employees to forgo necessary care. They should also ensure that cost sharing does not place undue burdens on low-wage or catastrophically ill beneficiaries.
7. Employers should involve employees and unions in designing as well as implementing the health-benefits plan. Such participation leads to larger, longer-lasting gains.

8. In order to derive full value from the health plan, employers and unions should:

- select providers on the basis of efficiency, effectiveness, and quality
- pay providers on the basis of prospective rates, negotiated in advance
- reduce the delivery of unnecessary services or services that could be provided more cost-effectively
- monitor and evaluate plan utilization with timely, accurate data
- educate beneficiaries to use the plan cost-effectively

9. When selecting policies and techniques for management of the health plan, employers and unions should:

- state clearly the goals they wish to achieve, the problems they wish to solve, and the financial and political constraints that bind them
- review the tools already at hand within the company and the community
- examine the costs and benefits that others have experienced with policies and techniques of the types under consideration
- determine what kinds of data will be needed and whether they are available

10. Obtaining cost and performance data for use in managing the plan may be difficult and expensive. Before seeking such information, employers and unions should determine that it is truly essential to their purposes. They should use their clout in the following ways:

- change claims forms to provide desired information
- get the carrier or administering insurer to furnish data from other accounts
- get other employers and unions in the area to pool data
- get the state to sponsor a statewide data collection system
- seek advice from firms experienced in collecting and analyzing
- acquire standardized criteria or programs for review

11. Employers and unions should ensure that employees, dependents, and retirees receive information on the kinds of health care available and in a form that will help them become prudent consumers. Such information pertains to:
 - availability of health service in the community (in their own workplace and in other companies in the community)
 - cost (costs of particular services by particular providers; annual costs of care for each employee, for the group for the workplace, for the community)
 - quality (of services delivered by particular physicians, hospitals, and alternative centers in the community)
12. Prevention is potentially one of the most cost-effective approaches to health-care management. Employers should survey their employees, dependents, and retirees, and determine which current and foreseeable health problems are most in need of attention. Based on the outcome of the survey, they should decide whether proven preventive methods of ameliorating these problems are available, and how cost-effective these methods would be in the circumstances of the given organization. To ensure that the work force gives full support to preventive measures, employers should involve employees and their union or unions in designing and carrying out the survey and any programs that flow from it.
13. When a survey discloses that certain preventive measures would be cost-effective, the employer and its union or unions should give top priority to those which have proved most successful in national or local trials, especially if the risk group is of appreciable size -- for example, disease-prevention programs, and programs to screen and apply proven interventions of early stages of disease. Second priority should go to programs in which, if intervention succeeds, health outcomes could be improved and the cost of medical care reduced -- for example smoking cessation, substance moderation, mental health. Third priority should go to programs with sound objectives but still unproven efficacy -- for example, physical fitness, nutrition/obesity control. Low-cost programs which may or may not have an impact on health status or cost of health care but which could improve morale and company esprit should also be considered -- for example, attractive surroundings, health courses of various types, recreational activities, changes in cafeterias.
14. Employers and unions should enter into a preventive program only after developing clearly stated objectives, cost-benefit estimates, and plans for concurrent evaluation.
15. Employers and unions should ensure that preventive programs are reinforced by appropriate corporate practices, for example, smoke-free areas, mandatory use of seat belts in company cars, more nutritious cafeteria menus, reimbursement for prescribed mental-health services. They should also ensure that individual employees' health risks and problems will be kept in confidence.

16. Employers and unions should encourage employees, dependents, and retirees to join HMOs that meet acceptable standards of cost, quality of care, fiscal soundness, and hospital utilization. It is now established that HMOs can furnish health care comparable to that provided by fee-for-service physicians, and at lower cost.
17. After evaluating an HMO and determining that it meets the standards, employers and unions should encourage enrollment by:
 - removing financial and organizational disincentives, if any
 - offering employees positive incentives to join
 - informing employees about available choices among plans
 - allowing the HMO to make sales presentations at the workplace
18. If existing HMOs in the area do not meet the standards, employers and unions should assist those that can be brought up to standard by reasonable means.
19. In areas where no HMOs exist, employers and unions should help to create them. They can do so by providing:
 - managerial and marketing expertise
 - grants for feasibility and marketing studies
 - start-up loans
 - help in organizing consortia with other employers and unions
 - recruiting key leadership for incipient HMOs
20. Employers and unions intent on improving health-care management should develop a strategic framework to coordinate their action programs. A corporate strategy makes it possible to avoid omissions and overlapping and ensures that the various programs tend in the same direction.
21. A corporate health-care strategy should include the following elements:
 - A review of the organization's experience in health care, forecast of its present tendencies, and selection of targets for improvement
 - A survey of the organization's current data sources and an estimate of those it will need
 - Practical goals for improvement
 - Assessment and redesign of the organization's health benefits
 - A plan for managing health benefits more effectively
 - For each aspect of the strategy, an assignment of responsibilities and an allocation of staff and financial and data resources
 - Active, visible support from top management

22. Employers and unions should apply their clout at community level to reduce hospital capacity to the optimum, since the existence of excess capacity counteracts all efforts to lower the cost of hospitalization. The optimum, at present, is the capacity that would be required if prepaid group HMO hospitalization rates were the norm for the community.
23. Employers and unions, in collaboration with other civic leaders and interested parties, should ensure that hospital-capacity reduction proceeds in accordance with an openly-arrived-at, community-wide, hospital-specific plan. If such a plan does not exist, employers and unions should work with local hospital-systems agencies to ensure that one is developed and carried out.
24. Employers and unions should ensure that the community plan provides for the needs of the indigent and the underserved. Hospitals that serve these sectors of the community tend to be the weakest financially, but their closure may cause widespread distress and a political furor that undermines further efforts to reduce capacity.
25. Employers and unions should ensure that the community plan provides for hospital employees to receive suitable advance notice of closures and organized assistance in obtaining new jobs. Nonmanagement employees of hospitals suffer the most in a closure, although they are the least to blame. They have the smallest resources to fall back on and the greatest difficulty in finding replacement jobs.
26. Employers and unions, working through coalitions and coalitions and local health-planning agencies, should press for an area plan that establishes where high-cost technological services are to be sited and should also make a compact to abide by the plan. The plan should be designed to meet that area's needs efficiently, taking due account of accessibility, quality, and cost.
27. Employers and unions should ensure that managers, employees, dependents, and retirees are fully informed about the area plan.
28. Employers and unions should ensure that their health-benefits plans operate in the following ways:
 - High-cost technological services are reimbursed only if they are performed at facilities designated by the area plan. If there is no area plan, facilities should be designed on the basis of criteria of quality and volume
 - The charges allowed for high-cost technological services are reviewed annually to keep them in line with (a) the normal decline of actual costs, and (b) the greater skill of physicians who perform the services and their increased number.
 - Payment is denied for any technology not approved for Medicare coverage.