



**association of american
medical colleges**

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

June 18, 1987

9:30am

Washington Hilton Hotel

Caucus Room

one dupont circle, n.w./washington, d.c. 20036

COTH ADMINISTRATIVE BOARD

Chairman: Spencer Foreman, MD
Montefiore Medical Center

Chairman-Elect: J. Robert Buchanan, MD
Massachusetts General Hospital

Immediate Past Chairman: C. Thomas Smith
Yale-New Haven Hospital

Secretary: John E. Ives
Shands Hospital

Gordon M. Derzon
University of Wisconsin Hospital
and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Jerome H. Grossman, MD
New England Medical Center, Inc.

William H. Johnson, Jr.
University of New Mexico
Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

Charles M. O'Brien, Jr.
Georgetown University Hospital

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

C. Edward Schwartz
Hospital of the University
of Pennsylvania

Barbara A. Small
Veterans Administration
Medical Center

Alexander H. Williams
AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

June 17-18, 1987

The Washington Hilton Hotel
Washington, DC

September 9-10, 1987

Same

COTH SPRING MEETINGS

May 11-13, 1988

The New York Hilton Hotel
New York, NY

May 10-12, 1989

The Hotel del Coronado
San Diego, CA

AAMC ANNUAL MEETINGS

November 7-12, 1987

The Washington Hilton Hotel
Washington, DC

November 12-17, 1988

The Marriott Hotel
Chicago, IL

October 28-November 2, 1989

The Washington Hilton Hotel
Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 17-18, 1987
Washington Hilton Hotel
Washington, DC

WEDNESDAY, June 17, 1987

- 6:00p JOINT ADMINISTRATIVE BOARDS SESSION.
 Guest Speaker: James Wyngaarden, MD
 Director, National Institutes of Health
 Jefferson West Room
- 7:00p JOINT BOARDS RECEPTION AND DINNER
 Jefferson East Room

THURSDAY, June 18, 1987

- 7:30a JOINT BOARDS BREAKFAST
 Guest Speaker: Honorable Willis Gradison, Jr. (R-OH)
 Map Room
- 9:30a COTH ADMINISTRATIVE BOARD MEETING
 Caucus Room
- 12:30p JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON
 Military Room
- 1:30p AAMC EXECUTIVE COUNCIL BUSINESS MEETING
 Cabinet Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 18, 1987
WASHINGTON HILTON HOTEL
Caucus Room
9:30am-12:30pm

- I. CALL TO ORDER
- II. CHAIRMAN'S REPORT Dr. Foreman
- III. CONSIDERATION OF MINUTES, April 16, 1987 Page 1
- IV. COTH AGENDA ITEMS
- A. DISCUSSION: Regulation of Housestaff Hours Page 10
- B. DISCUSSION: Medicare Payments for Capital Page 20
- C. ACTION: Defining a COTH Member Page 35
- D. ACTION: Membership Applications
- Georgia Baptist Medical Center Page 39
Atlanta, Georgia
RECOMMENDATION: Full Membership
- The Staten Island Hospital Page 46
Staten Island, New York
RECOMMENDATION: Full Membership
- V. EXECUTIVE COUNCIL AGENDA
- A. ACTION: Change in AAMC Statement on Medical Education of Minority Group Students Executive Council Agenda - Page 18
- B. ACTION: Organizing Group on Faculty Practice Executive Council Agenda - Page 21
- C. ACTION: ACGME Policy Matter Executive Council Agenda - Page 25
- D. ACTION: New Schedule for Executive Council Meetings Executive Council Agenda - Page 27
- E. ACTION: Mandatory Health Benefits Executive Council Agenda - Page 28

F. ACTION: Possible AAMC Activities Related
to AIDS

Handout

G. DISCUSSION: AAMC Activity on AIDS
Legislation

Executive Council
Agenda - Page 31

VI. OLD BUSINESS

VII. NEW BUSINESS

VIII. ADJOURN

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
April 16, 1987

PRESENT

Spencer Foreman, MD, Chairman
J. Robert Buchanan, MD, Chairman-Elect
C. Thomas Smith, Immediate Past Chairman
Gary Gambuti
Jerome H. Grossman, MD
William H. Johnson, Jr.
Larry L. Mathis
Charles M. O'Brien, Jr.
Raymond G. Schultze, MD
C. Edward Schwartz
Barbara A. Small
Alexander H. Williams, AHA Representative

ABSENT

Gordon M. Derzon
John E. Ives
James J. Mongan, MD

GUESTS

D. Kay Clawson, MD
John W. Colloton
Edward J. Stemmler, MD

STAFF

James D. Bentley, PhD
Linda E. Fishman
Richard M. Knapp, PhD
Sonia M. Kohan
David Moore
Robert G. Petersdorf, MD
Nancy E. Seline
John F. Sherman, PhD
August G. Swanson, MD
Judith L. Teich
Kathleen Turner
Melissa H. Wubbald

COTH ADMINISTRATIVE BOARD MEETING
MINUTES
April 16, 1987

I. Call to Order

Dr. Foreman called the meeting to order at 8:00 a.m. in the Independence Room of the Washington Hilton Hotel. He welcomed Alexander Williams of the American Hospital Association, who will be the AHA's representative to the COTH Board. Dr. Foreman introduced David Moore, a staff associate in the AAMC's Office of Government Relations.

II. Chairman's Report

Dr. Foreman reported that Sheldon King, chief executive officer of Stanford University Hospital, has been named to the Prospective Payment Assessment Commission (ProPAC). He will serve a three-year term. John Colloton, director of the University of Iowa Hospitals and Clinics recently finished a four-year ProPAC term.

In the absence of Dr. James Mongan, the Chairman of the COTH Spring Meeting Planning Committee, Dr. Foreman reported on the upcoming Spring Meeting. He encouraged Board members to attend and noted the evening reception with Dr. Petersdorf. Dr. Foreman pointed out that for many COTH members, this will be their first opportunity to meet the AAMC President and asked Board members to help Dr. Petersdorf circulate so that as many attendees as possible could meet him.

Dr. Foreman announced that Dr. Bentley's duties as vice president may require that he address other AAMC Boards. Therefore, the Board will be staffed by Nancy Seline, who has been named Executive Secretary of the Board.

Dr. Foreman called on Mr. Smith to report on his presentation to the AHA Nominating Committee. Mr. Smith stated it is a tradition for the Immediate Past Chairman of the COTH Administrative Board to serve as chairman of the COTH Nominating Committee and to present COTH suggestions to the AHA Nominating Committee. This year, Mr. Smith appeared before the AHA Committee and thanked them for their support in keeping the COTH membership well-represented since there are four members of the COTH on the AHA's Board of Trustees.

III. Minutes of the Board Meetings of September 1986, and January 1987

ACTION: It was moved, seconded, and carried to to approve the minutes of the September 11, 1986 and January 21, 1987 COTH Administrative Board Meetings.

IV. Staff Report from the Vice President for Clinical Services

Dr. Bentley reported on the publication of two surveys. The COTH Survey of Housestaff Stipends, Benefits, and Funding and the COTH Survey of Academic Medical Center Hospitals Financial and Operating Data (TEFRA Year) were recently distributed to member institutions. Dr. Bentley

expressed the staff's intention to publish the next housestaff survey before January 1988.

Dr. Bentley commented about the time consuming and complex nature of the academic medical center survey. The number of hospitals included in the survey increased considerably over previous years. All data inconsistencies had been carefully checked. He noted that with the approval of the Commonwealth Fund, an advisory committee of CEOs, COOs, and CFOs will re-examine this survey.

Dr. Bentley updated the Board on the HRSA funded study of the transition of medical education. He stated that one-half of the site visits have been completed and the project team has received excellent cooperation. The selected institutions have taken very different approaches to education in the new clinical environment. Dr. Bentley also stated that an important by-product of the study is improved relations with the residency review committees.

Ms. Seline noted that interest in the study has been heightened by the nervousness about decreases in the number of students who matched for positions in internal medicine through the NRMP. Dr. Foreman asked Board members to comment on the significance of the decline in students matching into training programs, suggesting that this year may represent an abnormality rather than a trend. Dr. Buchanan thought that the match results might indicate that internists should examine the content of the training program versus students' career goals. Dr. Schultze emphasized the cyclical nature of the match, pointing to the example of the problem in surgery about seven years ago. However, some of the most highly regarded programs had problems in the match this year, while usually just the less desirable programs have problems. Dr. Foreman hypothesized that just as in pediatrics, internal medicine may split into two streams, hospital and office-based.

Dr. Bentley summarized progress on The Commonwealth Fund grant by giving examples of inconsistent data found in the Medicare cost report data file and other data sources. Mr. Mathis expressed his concern about the impact of using incorrect data to determine payment policy. Dr. Foreman recognized that the data may result in information that challenges some of the favorable myths about teaching hospitals.

Dr. Buchanan asked whether further Congressional or regulatory interest had developed in the variation in teaching costs per resident. These differences had been discussed at the previous Board meeting. Dr. Bentley replied that the extent of faculty support and the number of faculty as well as different accounting mechanisms can affect the reported costs, but no convincing reason for the other variation has been found.

Dr. Bentley noted that Rep. Waxman (D-CA) and his staff have identified this variation. He said that according to the COH Survey of Medical Education Costs in 1986, most academic medical centers have cost in the \$40,000-60,000 per resident range. Many institutions, but largely not academic medical centers, had costs per resident in excess of \$120,000. Dr. Foreman cautioned that the data may be unreliable. Nevertheless, Board members expressed concern about vulnerability of the funding for faculty support and residency training costs in light of these differences in reporting.

Dr. Bentley briefly summarized the current methodology used to determine the regression curve of the indirect medical education adjustment, and then described the impact of the changes in the case mix variable on the resident-to-bed ratio. He explained how various changes to the system - the disproportionate share adjustment and the inclusion of New York State data - affect the adjustment. The Congressional Budget Office (CBO) has estimated a regression curve beginning at 6.9% without a disproportionate share adjustment and 4.6% with a disproportionate share adjustment.

Dr. Foreman explained that the issue at hand was whether to continue to support the AAMC policy of an empirically determined adjustment derived from current data and a regression equation which includes only PPS payment variables, or to try to minimize the decrease in the size of the adjustment. Dr. Buchanan cautioned that the AAMC should carefully consider the issue of whether moving away from a data driven adjustment would damage the AAMC's credibility with key Congress members and their staffs. Board members agreed that a formula-driven adjustment is intellectually honest. Dr. Foreman, however, pointed out that a decrease in the adjustment to 4.6% would be perceived by many COTH members as a serious threat to their financial stability. After some discussion, Dr. Knapp stated that the staff could work to minimize the effect of the change in any single year while remaining consistent with current policy. In light of Dr. Knapp's remarks, Board members agreed that the current AAMC policy of supporting an empirically correct adjustment remained an acceptable position.

V. COTH Spring Meeting

To secure a site for the 1990 COTH Spring Meeting, Board members were asked to discuss their preferences regarding meeting location, format, and type of hotel. Members voted to hold the meeting in a city setting rather than at a resort. Board members agreed that since the 1989 meeting would be on the west coast, the 1990 meeting should be on the east coast. In addition, most of the Board indicated the desire to keep a tight business meeting format, but to hold the meeting in a fun city.

Boston and Charleston were nominated as potential sites for the 1990 meeting. Charleston was designated as the first choice.

VI. COTH Directory

Board members were asked to discuss the utility of the current COTH Directory, how it might be improved and how sensitive member institutions might be about publications of any new data items. Board members generally agreed that in its present form, the Directory is not very useful. Suggestions on its improvement ranged from a simple list of members to reporting COTH members and their data in the AAMC Directory. The Board agreed that staff should continue to explore various alternatives for presenting COTH information.

VII. AAMC Annual Meeting

Board members were asked to consider two proposals designed to adapt COTH activities to the new annual meeting format. In order to avoid losing attendees after the early afternoon joint council meeting, the Board decided to request an additional thirty minutes for the COTH luncheon and

business meeting on Monday, November 9 and to avoid a late afternoon general session.

VIII. AAMC/AAHC Forum

Dr. Petersdorf reported on the joint AAMC/AAHC Forum which was held at the conclusion of the AAHC Spring Meeting. He described the meeting as cordial and collegial, stating that the organizations have the same goals. Dr. Hogness chaired the meeting, during which there was a discussion of the study on physician supply, a presentation on the budget, and a discussion of the recent testimony on appropriations for the Veterans Administration recently presented before both the House and the Senate by Drs. Korn and Petersdorf.

Two unresolved issues emerged from the Forum. The first involved a group of government representatives, employed by Vice Presidents or Presidents of the universities affiliated with the AAHC. Concern was expressed that representatives of this group might advocate positions that are contrary to the interests of the academic medical centers. Although no organization appeared to want to take responsibility to be a parent for the group, it was felt that the group should not be left without support. For example, the AAMC's Office of Government Relations should have input into their activities.

The second issue concerned the formulation of an AAMC group on practice plans. Dr. Petersdorf stated that the vice-presidents were uncomfortable about the creation of this group, although there was general agreement that it is important to know what is going on in the world of practice plans. Dr. Bentley will meet with Dino Agro to keep the AAHC abreast of the development of this group.

Another concern raised during the Forum was the American Board of Internal Medicine's (ABIM) one year extension to the requirements for becoming board certified in cardiology. This was a unilateral action but raises concerns about funding and institutional responsibility for training.

Dr. Petersdorf reported on the recent quarterly meeting with the Veterans Administration attended by AAMC Executive Staff members. Dr. David Worthen will be retiring early due to illness. Among the issues discussed at the meeting were the Inspector General's concern about faculty splitting time between the VA and other institutions, the closure of six cardiac surgery units, the AAMC's study of medical education in ambulatory settings, and the forthcoming report of the VA's task force to study its resource allocation methods. In addition, the changes in dates for the resident and fellow match, the VA clarification of appointments of clinical clerks into accredited programs, and the VA's search for good applicants for specialty fellowships in psychiatric research and clinical pharmacology were discussed.

IX. AAMC Task Force/Initiative on Physician Manpower

Dr. Petersdorf reported that the steering committee for the Task Force is almost complete. Public institutions comprise 60% of the schools and are particularly vulnerable to manpower decisions. They have been well-represented on the Task Force. The first meeting of the steering committee is scheduled for May 28.

X. International Medical Scholars Program

Dr. Swanson discussed the proposed international medical scholars program. It would not be established as an independent agency, but would be governed in the same way as ACGME. It was suggested that the agency should not have to go to the parent organizations for each operating detail, but just for basic policy guidelines; he stressed that the organizations should not be "another ECFMG".

ACTION: A motion for AAMC participation in the program was made, seconded and approved.

XI. Faculty Practice Committee

In June 1985, the Executive Council approved the formation of a Committee on Faculty Practice, with the charge to identify the critical issues facing academic medical centers as a result of the changing practice environment. The Committee met first in September 1985, and a second time in October 1986. Dr. Stemmler who chaired the Committee, said the Committee recommended that the Association establish a separate group within the AAMC on faculty practice. The Committee felt it was important for the Association to provide a common source of information and a forum for discussion of each of the component parts of the academic medical center. Dr. Stemmler's Committee also recommended that the AAMC provide conferences and educational programs designed to meet the needs of the leadership in faculty practice plans.

ACTION: A motion was made, seconded, and approved to accept the report of the Faculty Practice Committee.

XII. ACGME Issues

Dr. Swanson initiated a discussion of proposed changes in the General Requirements of the Essentials of Accredited Residencies. One revision would preclude graduates from non-LCME accredited medical schools in the U.S. from entering ACGME accredited residency programs. One such school exists in Puerto Rico. Dr. Foreman objected because the change would permit everyone but students from San Juan Batista Medical School in Puerto Rico to enter ACGME accredited programs. He noted that licensed students from (unaccredited) Caribbean medical schools are not prevented from entering residencies. The San Juan Batista students are U.S. medical school graduates, and, therefore, ineligible for the ECFMG exam.

Dr. Swanson stated that the real problem is that the Commonwealth of Puerto Rico has permitted the development of an unaccredited school. Dr. Grossman wondered if this action or any other might persuade Puerto Rico to require San Juan Batista to become accredited. Dr. Swanson suggested the action would discourage other states from allowing unaccredited medical schools to exist. Mr. Williams pointed out that the action might be viewed as inherently discriminatory and anti-Hispanic.

ACTION: Dr. Buchanan proposed to table the issue at this time but suggested it be reconsidered if the staff can come forward with more compelling suggestions for equitable treatment of the San Juan Batista students in the future. The motion was seconded and approved. Dr. Buchanan added that there is need to look at state licensure requirements to see if this action is necessary. Dr. Foreman suggested consideration

of a change that would allow the San Juan Batista students to take the ECFMG exam.

Another proposed change to the General Requirements of the Essentials of Accredited Residencies was to add a new section on professional liability insurance. This proposed change would suggest that trainees in graduate medical education should have professional liability coverage, including legal defense, against awards for claims filed after the completion of graduate medical education. The coverage is limited to incidents occurring within the scope of the educational program. Mr. Williams stated that the AHA's concern in this matter is that the Essentials not become a "bill of rights" for residents. The AHA believes professional liability coverage is an economic rather than an educational matter and does not belong in this document on residency training. Dr. Clawson replied that the AHA members at the meeting of his ACGME committee accepted this revised, carefully worded version.

Dr. Foreman objected to the portion of the proposed change calling for the disclosure of the amount of professional liability insurance the hospital carries. He viewed this as unnecessary for the residents and potentially dangerous if known or discovered by potential litigants.

ACTION: Dr. Buchanan suggested changing the portion of the proposed revision calling for disclosure of the "full details" of the hospital's liability to "general information"; this was approved, and then the language was moved, seconded and approved.

The third proposed change added a requirement that institutions make special provisions to inform residents of the problems of chemical dependence among medical students, residents, and physicians in practice, and specialized resources for treatment and rehabilitation for chemical dependence accessible to the residents in that institution or program.

It was suggested that among nursing staff, the policy is much stricter. Anyone discovered to have a drug problem is fired. Nursing would see this language as "mollycoddling" the resident. Dr. Foreman noted the change does not preclude the residents also being fired. There was some confusion over whether the term "specialized facilities" referred to a "residents only" treatment facility or to facilities designed to treat drug-related problems. It was clarified that the latter meaning was intended.

ACTION: A motion was made, seconded, and passed to approve the proposed language.

XIII. AAMC's Role in AIDS Problem

In reaction to Dr. Koop's presentation on AIDS the previous evening, Dr. Stemmler asked the Board to consider the Association's role with regard to the AIDS epidemic. Mr. Gambuti pointed out that often the proper course of treatment for these patients is unclear. Dr. Grossman stressed the importance of the development of home care activities so afflicted individuals can have access to appropriate levels of care.

Dr. Buchanan stated that smaller interventions, done earlier and in settings other than hospitals, such as nursing homes, for shorter admissions, may also be appropriate. The major impact on social service workers, and the major contribution that they make to the care of AIDS patients, was also discussed. It was suggested that staff develop this issue for future consideration.

XIV. Use of Animals

Dr. Sherman informed the Board that medical students have been protesting the requirements that they use live animals in the educational process. A number of students, including one in veterinary school, are suing to protest such requirements.

ACTION: Dr. Sherman stated that schools and hospitals need to be alerted to the possibility of this problem and have a formal plan to address these situations. A motion to this effect was made and approved.

Dr. Foreman, however, stated his feelings that this staff recommendation was not as strong as it might have been, and that a specific policy recommendation is required. Dr. Sherman pointed out that the AAMC faces a diversity of attitudes within its membership on this issue. A survey of the use of animals in the educational process in health professions found remarkable diversity between programs. Although many people feel that quality is compromised by the use of fewer animals, the increased cost of laboratory animals has caused many educators to reconsider the efficaciousness of using animals. Dr. Foreman stated that the AAMC needs to develop a credible defense for those institutions that continue to use live animals and pointed out that not all schools agree with the movement toward computerized basic science and simulated patients. There was a general consensus that the courts will stand behind the faculty if there is an accord on the policies for the use of animals at the institution. Dr. Sherman agreed that the courts were reluctant to intrude on the educational process.

XV. Tulane Commendation

Dr. Sherman briefly discussed the proposed commendation for Tulane Medical School, which assumed responsibility for the "Silver Spring Monkeys." Tulane was accused of "neglect" when one of the monkeys died of pneumonia.

ACTION: A motion in favor of approving the commendation was moved, seconded, and approved.

XVI. JCAH Accreditation and the Academic Medical Center

Dr. Bentley summarized the efforts of the JCAH to address the objections of academic medical center hospitals to the recent JCAH reviews. Most of the complaints have been that the JCAH does not make adequate allowances for the teaching and research functions of academic medical centers, including recognition of the teaching function as an alternative in fulfilling quality assurance requirements. As a result, the JCAH conducted a study of the degree to which these activities substitute for quality assessment.

Among its conclusions, the report noted:

- o Academic health center hospitals do have unique characteristics that set them apart from other hospitals, including expertise at subspecialty and supersubspecialty levels of care and the openness of the concurrent review process of patient care as part of the educational function.
- o However, academic medical centers have a low level of compliance with all clinical medical staff standards for quality assurance, particularly the monitoring and evaluation of quality and appropriateness.
- o Academic health centers require a fuller understanding of the risks and benefits of documentation associated with the requirements of the monitoring and evaluation model of quality assurance.
- o New guidelines are needed for judging the adequacy of monitoring and evaluation for tertiary care in the multiple subspecialty units and for clinical research patients.
- o A substantial portion of the academic health center hospitals' patient population presents common problems requiring common forms of diagnosis and treatment. In this patient population, all JCAH standards should be applied, except that all large hospitals should be allowed to use a representative sampling of high volume procedures in lieu of total review.
- o There are no compelling arguments for adopting new JCAH standards specifically for academic health centers.

In light of these conclusions, Dr. Bentley requested the Board's input on the extent to which the AAMC should work with the JCAH to improve comprehension of and compliance with JCAH quality assessment standards in academic medical center hospitals. The Board supported the concept of helping the JCAH in this matter. Mr. Gambuti commented that the issue would not go away and that quality assessment programs were not working as well as the department chairmen thought they were.

The Board recommended that staff seek an invitation from the JCAH to participate in efforts to improve comprehension of and compliance with quality assessment standards.

XVII. International Medical Scholars Program

Dr. Swanson presented the proposal for an international medical scholars program to be sponsored by the AAMC, ABMS, AHA, AMA, CMSS, and the ECFMG. Its purpose would be to provide opportunities for foreign physicians to receive a portion of their training in the United States before returning to their native country to practice. The proposal called for a governing board made up of representatives from the six sponsoring organizations. The program's day-to-day operations would be directed by the ECFMG.

Dr. Buchanan questioned whether the ECFMG would have to seek Board approval on every action. He suggested that the ECFMG be given the

Dr. Buchanan questioned whether the ECFMG would have to seek Board approval on every action. He suggested that the ECFMG be given the authority to make decisions related to operations. Dr. Swanson stated that guidelines would have to be developed on this subject, but that this was the goal.

ACTION: A motion to approve AAMC participation in the program was moved, seconded, and carried.

XVIII. Adjournment

The meeting was adjourned at 12:00n.

REGULATION OF RESIDENT HOURS

As the result of a recent incident at the New York Hospital in which it is alleged that the hours worked by a resident contributed to the death of a patient, the State Health Commissioner has announced regulations limiting the work hours of residents to:

- o no more than 12 consecutive hours assigned to the emergency service and
- o no more than 16 consecutive patient care hours without at least an 8 hour break.

Two New York Times reports of the health commissioners actions are included as attachment 1 and 2. Attachment 3 is the activity analysis of staff hours from the recently completed Arthur Young and Company study. Table 1 in attachment 3 shows the typical hours per week for a responding resident in medical center hospitals, type 4, is 77.7 which includes 20.7 "on-call" hours.

The COTH Administrative Board is asked to review attachments 1 and 2 on developments in New York state and recommend what course of action, if any, the AAMC should take in the matter.

II. ACTIVITY ANALYSIS

Prior Research

The present analysis follows a tradition evolving from early industrial studies. Studies of the graduate medical education process following this tradition begin with those of Payson, et al (1961) and Fisher and Cotsona (1965) who utilized time study to compare expenditure patterns. Schumacher (1968), Gillander and Heiman (1971), Pursell and Rolinson (1972), Hughes, et al (1973), and Crosbie (1977) all studied one or another detail of the teaching and patient care process using the time study approach. Paiva, et al (1975) focused on research activities, while Lindenmuth, et al (1978) related the activities of medical students to the clinical practices of physicians using self-recording logs.

In contrast to the "micro" studies, other research has looked at the larger question of how various labor activities in the hospital might be allocated to the joint outputs, patient care, teaching/learning, and research. A study conducted by Technomics (1975) attempted to apply allocation principles (enunciated earlier in the 1972-3 Institute of Medicine (IOM) study) based on specific task characteristics. Thus, if a house officer with or without teaching responsibility observes a patient care activity, the time expended is judged to be allocable fully to education. The activity analysis of the present study is designed in a manner very similar to the Technomics study, but extends knowledge by combining several factors in an unique manner:

- o a focus on education activities;
- o an ability to disaggregate and link activity variables in unusual detail;
- o differentiation of four major classes of labor;
- o a comparison of teaching and non-teaching hospitals.

Method

The data for this part of the study was based on self-logged diaries submitted by respondents. In each of the 45 study hospitals, a sample from each of four professional categories, physicians, nurses, residents, and "other health professionals", were asked to maintain for ten days a log of daily activities in half-hour increments. The goal of participation was 100 percent of residents in the teaching hospitals, 50 percent of the nurses at all 45 hospitals, 100 percent of other health professionals (physicians assistants, nurse practitioners, nurse anesthetists, etc.), and 100 percent of the attending staff responsible for the majority of admission during the preceding year.

Participants made entries in a passport-sized book that divided each day into half-hour increments. Coded entries provided a means of capturing four items of information on staff activities in half-hour increments:

Activity - distinguished by 20 different types of activity. Major categories were patient care, education, research, administration, and personal;

Role - indicated primarily whether individual was performing activity under supervision, or alone;

Location - where in the hospital the activity was performed;

3

Education weight - numerical value indicating percent of half-hour, if any, spent in resident education.

The combination of the 20 activity codes and 6 role codes (8 for residents) provided 120 possible descriptions of activity in any one half-hour period among each of the four labor classes. The 120 combinations were combined into 6 discrete activity descriptions, using the respondents' estimates of the percent of resident education as the allocation basis for separating joint activities. This was done by calculating an average estimate of percent resident education for each labor class at each hospital and allocating to education a proportionate amount of all joint time for the labor class.

Our approach to the allocation of joint activities was to rely on respondents estimates of the percentage of joint time representing the educational component. The percentage was entered as a separate column on the logging instrument. This approach is, in one sense, an outgrowth of the Technomics concept of "standard task duration". It was not however, our intention to attempt to measure or determine a standard duration for activities. However, our estimate of educational time for a joint activity was determined by requesting respondents to determine their own "competent time" for a particular task, and attributing the additional time required for the joint task as the educational component. These estimates were then compiled as a weighted average "percent resident education" by labor class by hospital type and used as the basis for allocation of joint activities. The level of aggregation of the final data results was necessitated by the response rates encountered for some hospitals in the study.

Response Rates

The response rate in the 45 hospital sample ranged from 23 to 84 percent, depending on labor class. Nonetheless, the activity analysis achieved an unprecedented level of participation by health care professionals in a study of this type and includes responses from a total of 15,435 including 3,300 physicians. The total number of observations (obtained by multiplying the number of respondents in each hospital by 480 discrete half-hour observations and three classifications of personal time) approached 86,000,000 for the 45 hospital sample. The two subclasses of labor with the lowest response rates were attending physicians in Type 2 hospitals and temporary residents with less than 4-8 weeks remaining in their rotation at a given hospital. The response rates were always best for non-physicians. Attending physicians have response rates ranging up to 45 percent in non-teaching hospitals and 37 percent for university teaching hospitals. Resident response rates ranged from 37-78 percent. The larger hospitals tended to have the poorest response rates (under 50 per cent), however, these larger hospitals also had at least 10 respondents per physician category.

Although difficulty with non-response by participants precluded analysis at as disaggregate a level as was originally planned, the sample of participants in each hospital was large enough to minimize, at the hospital level, problems with low response rates in any one hospital or among a single type of hospital.

Findings

Observed distribution of activities, originally classified by both role and percent of education, is summarized by work effort categories in Table 1.

TABLE 1
LABOR HOUR DISTRIBUTION HOURS PER WEEK
(% IN PARENTHESES)

HOSPITAL TYPE	LABOR CLASS	PATIENT CARE	RESIDENT LEARNING	EDUCATION* TEACHING OR LEARNING	RESEARCH	ADMINISTRATION	OTHER**	TOTAL HOURS	RESPONSE RATE
4	Attendings	24.3 (33.7)	22.6 (29.0)	12.7 (17.5)	5.6 (7.8)	8.1 (11.2)	21.5 (29.0)	72.1 (100)	37%
	Residents	29.2 (37.6)		1.4 (1.8)	2.9 (3.8)	0.9 (1.2)	20.7 (26.6)	77.7 (100)	39%
	Nurses	30.1 (78.7)		2.3 (5.9)	0.4 (0.9)	3.4 (9.0)	2.1 (5.5)	38.3 (100)	52%
	OHP	34.2 (66.8)		5.3 (10.5)	2.6 (5.1)	1.4 (2.7)	7.3 (14.4)	50.8 (100)	51%
3	Attendings	28.0 (40.8)	20.5 (27.3)	7.6 (11.0)	1.8 (2.6)	5.8 (8.4)	25.6 (37.2)	68.8 (100)	28%
	Residents	30.3 (40.2)		1.3 (1.7)	0.8 (1.1)	0.8 (1.0)	21.6 (28.7)	75.3 (100)	37%
	Nurses	30.2 (84.9)		1.2 (3.4)	0.1 (0.3)	2.9 (8.1)	1.2 (3.3)	35.6 (100)	56%
	OHP	34.9 (75.9)		3.9 (8.4)	0.5 (1.2)	1.7 (3.6)	5.0 (10.8)	46.0 (100)	67%
2	Attendings	29.5 (49.3)	17.9 (24.7)	4.0 (6.7)	0.5 (0.9)	4.1 (6.8)	21.8 (36.4)	59.9 (100)	23%
	Residents	33.5 (46.3)		2.4 (3.3)	0.1 (0.2)	1.2 (1.7)	17.2 (23.8)	72.4 (100)	50%
	Nurses	28.5 (83.3)		1.3 (3.7)	0.1 (0.3)	3.1 (8.8)	1.4 (3.9)	34.8 (100)	60%
1	Attendings	31.6 (39.7)	29.6 (35.1)	14.1 (17.6)	0.9 (1.1)	3.4 (4.2)	29.9 (37.4)	79.9 (100)	37%
	Residents	30.4 (36.1)		2.3 (2.7)	0.2 (0.2)	0.6 (0.7)	21.2 (25.2)	84.3 (100)	78%
	Nurses	30.8 (87.6)		1.9 (5.4)	0.2 (0.4)	1.3 (3.7)	1.03 (2.9)	35.2 (100)	84%
0	Attendings	38.7 (53.4)		1.7 (2.3)	0.4 (0.6)	2.4 (3.3)	29.3 (40.4)	72.5 (100)	45%
	Nurse	30.6 (82.1)		2.0 (5.5)	-	2.4 (6.5)	2.2 (5.9)	37.2 (100)	70%

* Consists of Continuing Education or Education of Other Health Professionals (Including Medical Students but not Residents)

** Consists of : On-call Time, and for Attendings, Time Spent in Private Office or Hospitals Other than Site Hospital

The percent of resident time spent in learning increased from Type 2 to Type 4. Type 1 does not follow this trend. As a result of the increased resident education in Types 3 and 4, there is a lower percentage of resident time spent in patient care in Types 3 and 4 combined than in 1 and 2 combined.

Physicians also spend less time in patient care in Types 3 and 4 than in 1 and 2. Physicians in major teaching hospitals spend more time in administration, research, and education than in other hospitals. This tends to suggest that there is more substitution in major teaching hospitals among labor classes. The production function results, which further adjust for case mix and severity agree with those obtained here.

The results are similar to results of two prior studies mentioned above, the Technomics and IOM studies.

Distribution of Activities
(Percent of Hours)

<u>Labor Category</u>	<u>Patient Care</u>	<u>Education</u>	<u>Research</u>	<u>Other</u>	<u>Total</u>
IOM House Officer	49	43	4	4	100
Faculty	37	33	20	10	100
Technomics	52				
Arthur Young (Type 4)					
House Officer	51*	42	5	2	100
Attendings	48*	25	11	16	100

*Excludes on-call & in transit

A work effort distribution was also performed by year of residency within each type. A review of the results indicate a decrease in patient care and an increase in resident learning as the residency year increases. A decrease in the amount of

patient care is logical when one looks at the nature of residency programs. Many programs work on the buddy system. A new resident will be teamed with one or more residents with experience. The new resident will perform more patient care allowing the higher level residents more time to learn from their experiences and to teach other residents.

Once one goes beyond year 3 of the residency program the decrease in patient care varies but there is an overall downward trend in patient care. Other activities rather than resident learning account for the change.

MEDICARE PAYMENTS FOR CAPITAL

In 1984, the AAMC Executive Council adopted a statement on "Medicare Payment of Capital Costs," which included six principles to guide staff in legislative and/or regulatory developments. While a complete copy of the statement is included as attachment 1, the principles included in the statement are the following:

1. The AAMC supports replacing institutionally specific, cost based retrospective payments for capital with prospectively specified capital payments.
2. The AAMC supports separating capital costs into two components -- (1) movable equipment and (2) fixed equipment and plant.
3. The AAMC supports incorporating capital payments for movable equipment into prospective payment using a percentage "add-on" to per case payments.
4. The AAMC supports a percentage add-on to per case prices for capital costs of fixed equipment and plant that is no less than Medicare's current percentage of hospital payments for facilities and fixed equipment provided that the add-on is based upon a per case price which appropriately compensates tertiary care/teaching hospitals for their distinctive costs.
5. The AAMC supports a long-term, hospital-specific transition from the capital passthrough to prospective payments for plant and fixed equipment.
6. The AAMC supports a transition period which allows each hospital its choice of (1) cost reimbursement for depreciation and interest on adjusted base period capital or (2) a prospective percentage add-on that is no less than Medicare's current percentage of hospital payments for facilities and fixed equipment.

The Administration has recently published a proposed capital payment policy which is summarized in attachment 2. The Administration's proposal incorporates some features similar to the AAMC principles, including the separation of major movable and plant capital, the more rapid introduction of movable equipment into prospective payments, and the inclusion of the resident-to-bed adjustment in setting payment rates. As a result, the current AAMC principles are more similar to the HCFA proposal than the prevailing hospital association policy which favors continuing cost based reimbursement at less than full cost. Despite, the AAMC principles, the Association recently signed a "hospital-industry letter," attachment 3, requesting a continuation of cost based reimbursement at less than full costs.

When the COTH Administrative Board last discussed capital, it was generally agreed that the AAMC should be part of the debate and supportive of the general position, but that the AAMC should not attempt to be the industry leader. In the current circumstance, where the AAMC principles differ substantially from the industry's general position, the COTH Administrative Board is requested to discuss how extensively the AAMC should participate in the capital debate and what position the AAMC should advocate.

MEDICARE PAYMENT OF CAPITAL COSTS:
AN AAMC POLICY POSITION

Background

In adopting the Medicare prospective payment system, Congress expressed a strong interest in eliminating retrospective cost reimbursement for capital expenses.

- o Congress indicated capital projects initiated on or after March 1, 1983 may be paid differently from projects initiated before that date;
- o Congress required HHS to complete a major study of alternative methods of paying for capital; and
- o Congress provided that if retrospective cost payments continued beyond September 30, 1986, no payment shall be made for major new capital expenses unless the project is approved by a Section 1122 planing agency.

Since the Congressional action, a number of organizations have developed proposals for paying capital costs, including the American Hospital Association, the Healthcare Financial Management Association, the Healthcare Financing Study Group, and the National Committee for Quality Health Care. Given the developments of these and other proposals, it is apparent that there is no clear consensus among hospitals for a single method of paying for capital under Medicare. While the AAMC could take the lack of hospital consensus as a sign that no strong statement on this issue should be made, the high capital costs of teaching hospitals and their dependence on capital for tertiary care services and new technologies require the AAMC to be an active participant in this debate.

Two empirical reports on capital costs have major implications for teaching hospitals. One is the American Hospital Association's April 16, 1984 paper, "Capital-Related Cost Variation Across Hospitals," which has three major conclusions:

- o capital costs as a percentage of operating expenses vary substantially across hospitals even when hospitals are grouped by region, bed size, ownership, case mix, medical education activity, location and age of plant;
- o because of the variation in capital costs, capital payments based on peer groups create as many "winners" and "losers" as capital payments based on a single national rate; and
- o because of the variation in capital costs, a transition mechanism from cost reimbursement for capital to prospective payment for capital is crucial.

Second, AAMC staff prepared a separate report reviewing the capital costs of COTH members. The analysis, "Toward an Understanding of Capital Costs in COTH Hospitals," resulted in three major findings:

- o while capital costs of COTH members are a smaller percentage of total expenses than they are of non-member hospitals, COTH members do have greater absolute capital costs per unit of workload (i.e., per day or per admission);
- o the physical facilities of COTH hospitals are 12% older than those of non-COTH hospitals; and

- o recently increased capital spending by COTH hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980's.

The report concludes by stating, "given these conclusions and the 'lumpy' capital cycle of major facility projects, COTH hospitals must give particular attention to the impacts of proposed capital payment policies on hospitals which have recently constructed or are planning in the next few years to begin construction of major plant replacements. Special care must be taken to ensure that incorrectly interpreted or past trends are not used to restrict the financial viability and competitive attractiveness of major teaching hospitals which are presently involved in major plant projects."

Policy Positions

Using this information and the recommendations of the AAMC's Ad Hoc Committee on Capital Payments for Hospitals, the AAMC Executive Council adopted the following six principles as a recommended policy on Medicare payment of capital costs.

I. THE AAMC SUPPORTS REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS.

The Part A Medicare trust fund, which is used to make payments for inpatient services, is headed for insolvency. Continuing the present open-ended cost passthrough for capital seems unlikely because it is philosophically inconsistent with prospective payment, is perceived to stimulate capital expansion and an over-investment in capital goods, and is likely to be under-funded or capped as Congress weighs service benefits for current beneficiaries against facility investments for future beneficiaries.

II. THE AAMC SUPPORTS SEPARATING CAPITAL COSTS INTO TWO COMPONENTS -- (1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT.

This separation, which has historically been maintained in accounting records, recognizes that expenditures for movable equipment are constantly made by hospitals and that the useful life of the items purchased is generally rather short. Expenditures for fixed equipment and plant, on the other hand, tend to aggregate into more infrequent major projects which have a relatively long useful life. Given these different characteristics, a transition period is not necessary for movable equipment but is necessary for fixed equipment and plant.

III. THE AAMC SUPPORTS INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD ON" TO PER CASE PAYMENTS.

Because movable equipment purchases are a regular and ongoing component of hospital operations, no transition period or phase-in is required in order to include movable equipment in the per case price. Incorporating movable equipment into the prospective price would encourage managers to consider the relative advantages of capital and labor intensive alternatives. With both payroll costs and movable equipment incorporated into a single payment rate, a hospital would have the flexibility to select the labor-equipment mix most suitable to its particular circumstances.

IV. THE AAMC SUPPORTS A PERCENTAGE ADD-ON TO PER CASE PRICES FOR CAPITAL COSTS OF FIXED EQUIPMENT AND PLANT THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS.

In enacting the Medicare prospective payment system, Congress recognized that the operating costs of teaching hospitals are higher than those of non-teaching hospitals and included a resident-to-bed adjustment in the DRG payments to recognize this difference.

This adjustment is provided in the light of doubts ... About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

Thus, the patient care costs of teaching hospitals are met by combining the basic DRG payment with the resident-to-bed adjustment. The AAMC believes capital payments made to teaching hospitals should be computed as a percentage add-on to the combined DRG and resident-to-bed payments. A single percentage add-on for all hospitals has been selected because no analysis to date has identified a more equitable approach.

V. THE AAMC SUPPORTS A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT.

In considering capital costs for plant and fixed equipment, it must be recognized that different hospitals are at various points in their capital cycles: some have new plants with high construction and financing costs; others have old plants and low costs but need to rebuild. Given this variability, the transition period should be long enough to recognize current obligations and make

adjustments for plant additions approved by health planning agencies and alterations/modernizations required by life safety codes and licensing and accreditation agencies.

VI. THE AAMC SUPPORTS A TRANSITION PERIOD WHICH ALLOWS EACH HOSPITAL ITS CHOICE OF (1) COST REIMBURSEMENT FOR DEPRECIATION AND INTEREST ON ADJUSTED BASE PERIOD CAPITAL OR (2) A PROSPECTIVE PERCENTAGE ADD-ON THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT.

Under prospective payments, change is the order of the day. Hospitals are examining long-standing operational practices and altering those found inconsistent with the incentives and requirements imposed by the new payment system. While changes in daily operating practices may be difficult, the everyday nature of these activities provides numerous opportunities for changing practices. The construction and financing of major facilities offer less flexibility: planning the project and obtaining all necessary approvals is a multi-year effort, the asset itself has a long useful life, and the permanent financing often is for 15 to 30 years. As a result of these long term dimensions of major facility changes, the AAMC believes a change in capital payments must include adjustments honoring (1) the depreciation and interest originally anticipated for ongoing construction and recent plant additions; (2) new projects in the final planning stages; and (3) expectations of bondholders, lenders and donors.

Under this transition policy, a hospital could elect to be paid on a cost reimbursement basis (depreciation and interest) for (1) existing capital, (2) capital projects under active construction, and (3) capital projects for which a certificate of need was sought prior to a given date. These "base period" capital costs would be increased only for mandatory life safety or accreditation requirements approved by a planning agency. Capital payments would not be

increased for facility modernizations, expansions, or replacements undertaken after the base period. At any time during the allowed transition period, a hospital receiving depreciation and interest payments could elect to change and receive the prospective capital add-on to DRG payments. Once a hospital elected the prospective add-on, it could not subsequently receive payments based on depreciation and interest.

The AAMC recognizes that hospitals with above average capital costs will probably select the depreciation and interest option initially while hospitals with below average capital costs will select the percentage add-on from the beginning. This pattern of choice, which increases Medicare expenditures from 1 to 2%, will help ensure the continued viability of hospitals with recent or ongoing construction projects and maintain access to the capital market for hospitals generally. The small increase in expenditures is a reasonable price to pay for converting hospitals from a capital system based on recovery of past expenditure to one based on capital formulation and the prudent investment of capital assets.

DRAFT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #87-

June, 1987

To: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

From: Robert Petersdorf, M.D.

Subject: Proposed Regulations for Capital Payment Under PPS

 HCFA has published proposed regulations to incorporate capital-related costs into the Medicare prospective payment system. Payments to hospitals eventually will be based on an average of 1984 capital costs, trended forward to account for inflation but there is a ten year transition period for plant and fixed equipment and a two year transition for movable equipment. During the transition period, hospitals payments will be based on a blend of a federal capital rate and a hospital-specific capital rate. There are no provisions for an exceptions process for hospitals with high costs due to construction or penalties for low occupancy. The regulations, barring any Congressional intervention, will be effective for cost reporting periods beginning on or after October 1, 1987.

The proposed HCFA regulations for incorporating capital costs into prospective payment were published in the May 19 Federal Register. A copy is enclosed for your use. The regulations will affect those hospitals and units currently paid on a prospective basis with cost reporting periods beginning on or after October 1, 1987. Hospitals excluded from PPS will continue to be reimbursed for capital on a reasonable cost basis. Comments on the proposal are invited by HCFA but must be received by 5:00 on July 20, 1987. Address all comments to:

Health Care Financing Administration
Department of Health and Human Services
Attention: BERC - 403 - P
P.O. Box 26676
Baltimore, Maryland. 21207

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Plant/Fixed Equipment

The transition period for incorporating plant and fixed equipment capital costs completely into the prospective payment system is ten years. The proposed schedule for the phase-in period for plant and fixed equipment is as follows:

Plant & Fixed Equipment

<u>Cost Reporting Period Federal Fiscal Year</u>	<u>Hospital Specific</u>	<u>Federal</u>
1988	95%	5%
1989	90%	10%
1990	85%	15%
1991	80%	20%
1992	75%	25%
1993	70%	30%
1994	60%	40%
1995	50%	50%
1996	35%	65%
1997	20%	80%
1998	0%	100%

The federal capital payment rates are calculated using FY 1984 Medicare cost reports and are then standardized and updated as separate national averages for urban and rural hospitals. These estimated federal rates for plant and fixed equipment are \$171.83 for urban hospitals and \$160.59 for rural hospitals. The national average figures do not reflect any extraordinary costs associated with teaching hospitals such as the indirect medical education adjustment, the factor for disproportionate share utilization and case mix variations. They describe the average non-teaching hospital with a case mix index of 1.0. To calculate the federal portion of a hospital's payment for plant/fixed equipment, the appropriate national average is multiplied by the area construction index, the DRG weight, and applicable adjustments (i.e., indirect medical education adjustment and the disproportionate share adjustment). All of this is then multiplied by the federal portion of the blending percentage for that year of the transition.

$$\text{[(Nat'l Avg. * Area Construction Index * DRG Wt. * Applicable Adjustments)] * Federal Transition \%}$$

The hospital-specific portion of the capital payment is based on each hospital's allowable capital-related costs in each year of the transition reduced by the capital reduction enacted in OBRA. Thus, the hospital-specific payment rate is a rolling base - it incorporates the hospital's capital expenditures made during the year. Therefore, the hospital-specific portion of the payment for plant/fixed equipment is: Medicare's share of the hospital-specific costs multiplied by the applicable percentage reduction mandated by OBRA and then multiplied by the hospital-specific blending proportion for that year. (In year one, this is 95 percent.)

[(Medicare's portion of) * (Appropriate)] * Hospital-Specific
 hospital's allowable (OBRA) Transition
 plant/fixed equipment costs Reduction Percentage

The total capital payment for plant/fixed equipment is the sum of the federal portion of plant/fixed equipment costs and the hospital-specific portion. (Figure I)

Major Movable Equipment

The proposed payment for movable equipment operates in much the same manner as the plant/fixed equipment but over a shorter period of time. The transition period is only 3 years with the following transition percentages:

Cost Reporting Period Federal Fiscal Year	<u>Movable Equipment</u>	
	<u>Hospital-Specific</u>	<u>Federal</u>
1988	67%	33%
1989	33%	67%
1990	0%	100%

The calculation for the federal portion of the movable equipment rate is the national average, \$108.53 for urban hospitals and \$87.11 for rural hospitals, multiplied by the DRG weight, appropriate adjustments and then the federal transition percentage, which in 1988 will be 33 percent. The only difference between this calculation and the federal portion of plant/fixed equipment is that there is no adjustment for area construction costs.

The calculation of the hospital-specific portion of the movable capital rate is exactly the same as fixed equipment - Medicare's portion of a hospital's movable equipment costs multiplied by the OBRA reduction and then by the appropriate transition percentage. Once again, the total payment is the sum of the federal portion of costs plus the hospital-specific portion each times its transition percentage.

Observations

The final pages of the regulations present HCFA's analysis of the impact of these proposed changes on various types of hospitals. Teaching hospitals with a resident to bed ratio greater than .25 are shown to benefit as a group. Their capital payments, for the first three years of transition, increase an average 3 percent a year. These optimistic figures are based on 1984 data and do not reflect capital expenditures that may have occurred in the interim. Furthermore, these are "net" changes for the group as a whole. Individual hospitals may receive payments greater or less than their actual costs.

PropAC recommended an exceptions policy, with strict criteria, to assist hospitals harmed by the proposal that provide "accessible" high-quality hospital

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services but this suggestion was not included. HCFA believes that the cost outlier portion of the proposed policy and the heavily weighted hospital-specific transition percentages are adequate protection for hospitals and obviate the need for a separate exceptions policy.

The final point of concern is that there are still numerous methodological questions unresolved in this proposal. HCFA is still analyzing data to determine whether a hospital's directly assigned capital-related costs are more appropriately included as fixed or movable equipment. They are also examining alternative methodologies to later refine the system and apportion ancillary equipment into both fixed and movable as well inpatient and outpatient services. Of particular concern is HCFA questioning the evidence for standardizing capital-related costs by indirect costs of medical education and disproportionate share and using these adjustments to compute payments. They could choose to use non-standardized rates which would substantially reduce teaching hospitals' payments under the regulations. Therefore, AAMC members writing comments to HCFA should strongly recommend including both the indirect medical education and disproportionate share adjustments in computing capital payments. If you have any questions regarding these regulations, please contact Sonia Kohan or Linda Fishman in the Division of Clinical Services at (202) 828-0490.

Figure I
 Calculation of Hospital's
 Capital Payments

[(Nat'l Avg. * Area * DRG * (Fed.)] + [M'Care % * OBRA) * Hosp.]
 for plant/fixed * Constr. Index * Wt. * Adjs.) * Trans. % plant/fixed * Reduction * Trans.
 costs %

American Hospital Association
 American Healthcare Institute
 American Protestant Health Association
 Association of American Medical Colleges
 Catholic Health Association
 Federation of American Health Systems
 Healthcare Financial Management Association
 American Osteopathic Hospital Association
 Healthcare Financing Study Group
 National Association of Private Psychiatric Hospitals
 National Association of Public Hospitals
 National Council of Health Facilities Finance Authorities
 National Association of Rehabilitation Facilities
 National Council of Community Hospitals
 Voluntary Hospitals of America
 Volunteer Trustees of Not for Profit Hospitals

Dear Senator Mitchell

The members of the undersigned hospital coalition which represents all of our nation's hospitals oppose the Administration's proposal to incorporate Medicare hospital capital payments into the prospective payment system (PPS). We believe that the current payment methodology should be maintained. In order to retain the current approach, however, Congress must act before September 1987 to prohibit the Secretary of Health and Human Services (HHS) from issuing regulations that would incorporate capital related costs into PPS.

In the four years that have passed since 1983, despite the best collective efforts of the hospital industry, Congress, and the Administration, no workable system has been developed. Difficult problems remain in developing an allocation formula that equitably continues payment for capital committed under the existing system while at the same time providing sufficient resources for new projects. We have carefully reviewed the proposals recommended by the Administration and the Prospective Payment Assessment Commission and find serious inadequacies in both plans.

Further, since the entire amount of anticipated reductions in Medicare outlays for capital sought by the Administration has already been achieved as a result of actions taken last year under the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) which reduced Medicare capital payments by 3.5, 7 and 10 percent between fiscal years 1987 and 1989, we do not believe it is necessary to change capital payment policy.

We believe that it makes little sense for Congress to proceed at this time with a policy which creates tremendous inequities among hospitals, achieves no net additional savings for the Medicare program and results in tremendous uncertainty in the financial markets which raise such a large portion of hospital capital.

The coalition believes that on the basis of all currently available information, the only method of paying for capital that provides reasonable assurances of equity is a continuation of the current payment methodology. This position has the broad support of the hospital field and reflects a strong consensus among hospitals across the country.

In summary, we request that you defer legislative action to incorporate capital into the prospective payment system and block the Administration's authority to issue regulations on the capital issue without Congressional guidance.

Sincerely

The Health Care and Hospital Associations
Listed Above

Defining a COTH Member

BACKGROUND

The Council of Teaching Hospitals of the AAMC includes two kinds of members: (1) full or teaching hospital members and (2) corresponding members. Attachment A lists the requirements for each membership category. For hospitals, the difference in membership status is based on the number of residency programs. If the hospital participates in four or more programs, it is a full member; otherwise, it is a corresponding member. Foundations, consortia and other non-hospitals providing hospital-based residency programs are eligible only for corresponding membership.

When the Council of Teaching Hospitals was formed in 1967, most hospitals were stand-alone, independent institutions. As a result, COTH membership was established on the basis of the individual hospital. In the past twenty years, hospitals have merged, consolidated, reorganized, and formed multi-hospital systems. To date, these new arrangements have been handled on an ad hoc individual basis. This has led to a number of inconsistencies and problems:

- o Some hospitals composed of more than one distinct facility have joined in the name of the parent and paid a single annual dues. Other hospitals have joined as individual facilities each paying dues. For example, the University of Washington Hospitals is a single member which includes the University Hospital and the Harborview Hospital. In contrast, the two hospitals owned by Emory University -- Crawford Long Hospital and Emory University Hospital -- each belong and pay dues. In a recent request, the Mayo Foundation has asked that its present dues for St. Mary's Hospital also include membership for Rochester Methodist; see Attachment B.
- o When the hospital is organized as a subordinate unit of a system, holding company or foundation, there is no membership opportunity for the parent CEO. Thus, when the Johns Hopkins Health System was established, Dr. Owens became the COTH representative instead of Dr. Heyssel.
- o When a system joins, each of its members may promote itself as full COTH member, even though only the "flagship" hospital meets the criteria. As an example, Alliance Health System of Norfolk belongs to COTH. Norfolk General meets the criteria for full membership but Leigh Memorial Hospital would only be a corresponding member.

In addition to issues of membership equity, each of these examples has implications for COTH dues revenues. The dues implications are significant in the cases of municipal hospitals in New York City and the VA medical centers. They could also become significant if a hospital alliance (i.e., VHA, AHS, UHC, or Premier) sought to join in lieu of its individual members.

RECOMMENDATION

While a number of possible membership alternatives could resolve the present situation, staff believe it is important to establish a process which leads to a set of membership policies which can be uniformly applied. Therefore, it is recommended:

that the COTH Administrative Board appoint a small membership committee to review and recommend criteria and categories for COTH membership.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

I. MEMBERSHIP

Section 1. There shall be the following classes of membership:

- A. Institutional Members - Institutional Members shall be medical schools and colleges located within the United States and its territories.
- B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.
- C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.
- D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges located within the United States and its territories.
- E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.
- F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.
- G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.
- H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.
- I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Mayo Foundation

Rochester, Minnesota 55905 Telephone 507 284-2511

Mayo Clinic Mayo Medical School
Mayo Graduate School of Medicine
Mayo School of Health-Related Sciences

April 27, 1987

Franklyn G. Knox, M.D., Ph.D.
Director for Education
Dean, Mayo Medical School

James D. Bentley, Ph.D.
Vice President
Division of Clinical Services
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, DC 20036

Dear Jim:

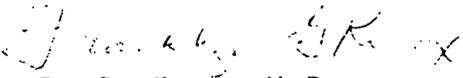
As you are aware, the organization structures of St. Marys Hospital, Rochester Methodist Hospital, and Mayo Foundation were recently integrated, and all three organizations are now under the corporate umbrella of Mayo Foundation.

St. Marys is currently a member of the Council of Teaching Hospitals, and Methodist is not. We propose that Mayo Foundation be accepted as the Mayo member of COTH. Mayo Foundation would represent and act on behalf of both hospitals.

Dues and an appropriate listing in the COTH Directory, to include the hospitals as well as Mayo Foundation, are details that would need to be addressed.

We appreciate your consideration of this proposal. Please let me know if you have any questions.

Sincerely,


F. G. Knox, M.D.

FGK:srs



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Georgia Baptist Medical Center
Hospital Address: (Street) 300 Boulevard, N.E.
(City) Atlanta, (State) Georgia (Zip) 30312
(Area Code)/Telephone Number: (404) 653-4600
Name of Hospital's Chief Executive Officer: William C. Brown, FACHE
Title of Hospital's Chief Executive Officer: President & CEO

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>523</u>	Admissions:	<u>23,371</u>
Average Daily Census:	<u>390</u>	Visits: Emergency Room:	<u>31,501</u>
Total Live Births:	<u>3200</u>	Visits: Outpatient or Clinic	<u>28,835</u>

B. Financial Data

Total Operating Expenses: \$ 98,649,000

Total Payroll Expenses: \$ 49,771,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,800,000
 Supervising Faculty: \$ 690,000

C. Staffing Data

Number of Personnel: Full-Time: 2,148
 Part-Time: 742

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 208
 With Medical School Faculty Appointments: 30

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>14</u>	<u>14</u>	<u>Required</u>
Surgery	<u>18</u>	<u>12</u>	<u>Required</u>
Ob-Gyn	<u>12</u>	<u>6</u>	<u>Required</u>
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: <u>Ortho</u>	<u>12</u>	<u>12</u>	<u>Elective</u>
_____	<u>6</u>	<u>6</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 (Transitional)	9	9		1981
Medicine	15	15		1953
Surgery	15	14		1958
Ob-Gyn	12	12		1953
Pediatrics				
Family Practice				
Psychiatry				
Other: Ortho	12	12		1958

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: Medical College of Georgia

Dean of Affiliated Medical School: Francis J. Tedesco MD

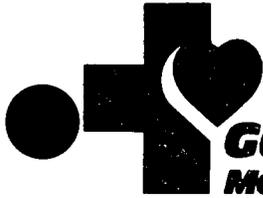
James S. Maughon MD
Information Submitted by: (Name) James S. Maughon, M.D.

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

William C. Brown (Date) 3 12 87
William C. Brown, FACHE

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Georgia Baptist Medical Center

A TEACHING AFFILIATE OF THE MEDICAL COLLEGE OF GEORGIA

DIVISION OF MEDICAL EDUCATION

GEORGIA BAPTIST MEDICAL CENTER: A TRADITION OF SERVICE

Len G. Broughton, minister, doctor and founder of Georgia Baptist Medical Center, must have been a visionary, but even he could hardly have anticipated the scope of GBMC today. It was Thanksgiving Day, 1901 when Dr. Broughton and a group of women from the Tabernacle Baptist Church in Atlanta established the Tabernacle Infirmary and Training School for Christian Nurses. They began with three beds in a rented house, deep dedication to the care of the sick and injured and a great deal of faith.

Today, Georgia Baptist Medical Center has 523 beds and 65 bassinets, making it one of the biggest private hospitals in the state. In 1902, the year after its founding, four students enrolled in the first class at the Training School. The School of Nursing is one of the largest diploma schools of nursing in the nation.

As a teaching hospital, GBMC has clinical affiliation with Mercer University Schools of Pharmacy and Nursing, Emory's School of Medicine and the Medical College of Georgia. Residencies in four medical specialties, transitional internships for physicians, a vascular surgery fellowship and training in allied health fields ranging from hospital chaplaincy to histo-technology all affirm GBMC's teaching mission.

In its eighty-five year history, GBMC has logged many "firsts". The first cancer clinic in Georgia - Sheffield Clinic - opened at Georgia Baptist in 1934. The Stroke Unit, emphasizing a team approach to the care of stroke victims, was the first in the Atlanta area. The first in vitro fertility surgery in the city and the first nuclear pacemaker implantation in the state were both performed at GBMC. GBMC was the first facility in the metro Atlanta area to offer a comprehensive program for overweight youngsters. Called "The Body Shop", the program teaches good nutrition and exercise habits to children and adolescents.

Life flight is yet another dramatic "first" at GBMC. Life Flight is what its name implies - an airborne emergency care system. The two helicopters currently used in the Life Flight program

President and
Chief Executive Officer
William C. Brown, FACME

Medical Education Department
James S. Maughon, MD,
FACS
Director of Medical Education
Assistant Dean, Medical
College of Georgia

Amir H. Ansari, MD,
FACOG, FACS
Director of Obstetrics-
Gynecology
Clinical Professor, Medical
College of Georgia

John D. Cantwell, MD, FACP
Director of Internal Medicine
Associate Clinical Professor,
Medical College of Georgia

George W. Lucas, MD, FACS
Director of Surgery
Associate Clinical Professor

W. David Hammed, MD,
FAAP
Director of Pediatrics

Richard E. King, MD, FACS
Director of Orthopedic
Residency
Clinical Professor
Emory, Tulane

David Rosenthal, MD
Director, Vascular Surgery
Assistant Clinical Professor
Medical College of Georgia

have the sophisticated equipment necessary to begin treatment immediately. Life Flight is virtually a mobile hospital which goes to the victim, saving precious time.

GBMC is a Georgia pioneer in the application of high technology to medicine with its procedure for eliminating kidney stones without surgery. The lithotripter, which uses shock waves generated by an electrode to disintegrate kidney stones, offers the patient many advantages, running from the speed of recovery to the reduction of expense.

Other recently developed programs include osteoporosis screening, addiction treatment, magnetic resonance imaging, preventive medicine, older adult services, brain injury rehabilitation, reconstruction surgery and replantation services.

Yes, 85 years have meant many changes at GBMC. Yet, one thing that has remained constant and unchanging is its founders' spirit of caring, compassion and dedication. If Dr. Len Broughton returned today, he would find that alive, well and guiding the ministry of this great Medical Center.



Medical College of Georgia
Augusta, Georgia 30912-0067

School of Medicine
Office of the Dean
(404) 828-2231

February 19, 1987

Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, DC 20036

Dear Sir:

The Georgia Baptist Medical Center is a major teaching hospital for the Medical College of Georgia. We are pleased to endorse the membership of the Georgia Baptist Medical Center in the Council of Teaching Hospitals. The Medical Center meets all of the requirements for membership in COTH.

As a major affiliated teaching hospital, the Georgia Baptist Medical Center is involved in teaching core clerkships in Medicine, Surgery and Obstetrics and Gynecology for Junior students and electives for Senior students from the Medical College of Georgia. The Georgia Baptist Medical Center and the Medical College of Georgia have a combined vascular fellowship which has existed for several years. In many instances, the two teaching institutions are combined in involvement in future planning and state teaching hospital policies.

If I can provide further information in support of the GBMC's application for membership in COTH, please let me know.

Sincerely,

A handwritten signature in cursive script that reads "Francis J. Tedesco M.D.".

Francis J. Tedesco, M.D.
Interim Dean

sg



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: The Staten Island Hospital

Hospital Address: (Street) 475 Seaview Avenue

(City) Staten Island (State) New York (Zip) 10305

(Area Code)/Telephone Number: (718) 390-9000

Name of Hospital's Chief Executive Officer: Barry T. Zeman

Title of Hospital's Chief Executive Officer: President

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>471</u>	Admissions:	<u>16,484</u>
Average Daily Census:	<u>374.5</u>	Visits: Emergency Room:	<u>36,476</u>
Total Live Births:	<u>2672</u>	Visits: Outpatient or Clinic	<u>58,276</u>

B. Financial Data

Total Operating Expenses: \$ 83,710,655

Total Payroll Expenses: \$ 38,965,716

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 3,795,247
 Supervising Faculty: \$ 690,870

C. Staffing Data

Number of Personnel: Full-Time: 1144
 Part-Time: 614

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 354
 With Medical School Faculty Appointments: 85

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

<u>Medicine</u>	<u>Surgery</u>	<u>Pathology</u>	<u>Obstetrics/Gynecology</u>
<u>Pediatrics</u>	<u>Radiology</u>	<u>Psychiatry</u>	<u>Neonatology</u>
<u>Radiation Oncology</u>	<u>Dentistry</u>	<u>Physical Medicine</u>	<u>(Rehab)</u>

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

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>40(3rd year)</u>	<u>40</u>	<u>required</u>
Surgery	<u>4 per month</u>	<u>48</u>	<u>required</u>
Ob-Gyn	<u>24</u>	<u>24</u>	<u>required</u>
Pediatrics	<u>4</u>	<u>1</u>	<u>elective</u>
Family Practice	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>
Other: <u>Dentistry</u>	<u>variable 0-7</u>	<u>5</u>	<u>elective</u>
<u>4th year elective (Med)</u>	<u>70</u>	<u>70</u>	<u>elective</u>
<u>2nd year physical diag.</u>	<u>42</u>	<u>42</u>	<u>required</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	46	43	3	1969
Surgery	15	15	none	1971
Ob-Gyn	8	0	6	1966
Pediatrics	12	2	10	1985
Family Practice				
Psychiatry				
Other:				
Dentistry (general practice)	5	5	none	1970
Med/Peds	8	8		1983

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

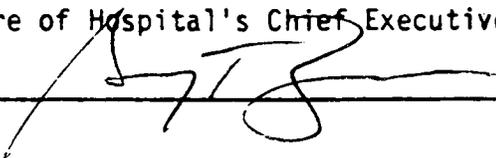
To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should 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: State University of New York-Health Science Center at Brooklyn
Dean of Affiliated Medical School: Richard H. Schwarz, M.D.

Information Submitted by: (Name) David Dibner
(Title) Assistant to the President

Signature of Hospital's Chief Executive Officer:  (Date) 6/2/87



RECEIVED
MAY 15 1987
PRESIDENT

COLLEGE OF MEDICINE

May 11, 1987

Barry T. Zeman
President
Staten Island Hospital
475 Seaview Avenue
Staten Island, NY 10305-3498

Dear Barry:

This is to support your application for membership in the Council of Teaching Hospitals. Staten Island Hospital, as a major affiliate of the State University of New York-Health Science Center at Brooklyn, plays a major role in the educational programs of the College of Medicine. Our Third Year Students are involved in clerkship experience in the Departments of Medicine, Obstetrics and Gynecology, and Surgery, at the Staten Island Hospital, and these clinical rotations have been universally evaluated as being of high quality. In addition, there are clinical elective offerings as well.

Not only is Staten Island Hospital classified as a major affiliate, we certainly consider the hospital an essential part of our educational network, and enthusiastically recommend Staten Island Hospital for membership in the Council of Teaching Hospitals.

Sincerely,

Richard H. Schwarz, M.D.
Dean of the College of Medicine
Vice President for Academic Affairs

RHS:dl

cc: Dr. Donald J. Scherl