ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COUNCIL OF TEACHING HOSPITALS
SELECTED ACTIVITIES REPORT

November 1988

A A M C
Division of Clinical Services

AAMC
COUNCIL OF TEACHING HOSPITALS
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SELECTED ACTIVITIES REPORT

Teaching hospitals are the primary training sites for the clinical education of the full spectrum of health professionals. Although approximately 1,300 hospitals are involved in graduate medical education in this country, the 440 Council of Teaching Hospitals (COTH) member institutions train over 80% of the residents in the United States.

COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges was formally established in 1965. Its purpose is to provide representation and services related to the special needs, concerns, and opportunities facing major teaching hospitals in the United States. The Council of Teaching Hospitals, governed by a fourteen-member administrative board, is the principal source of hospital input into overall Association policy and direction.

COTH MEMBERSHIP CRITERIA

There are two categories of membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school.

Teaching hospital membership is limited to hospitals which sponsor, or significantly participate in, at least four approved, active residency programs. At least two of the approved residency programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, or psychiatry. In the case of specialty hospitals, such as children's, rehabilitation, and psychiatric institutions, the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Those institutions with teaching missions in their communities that do not meet the above criteria may seek corresponding membership in the Council of Teaching Hospitals. Corresponding members are eligible to attend all open AAMC meetings and enjoy many of the privileges of full members, but have no vote in the AAMC Assembly. Hospitals that are eligible for full COTH membership are not eligible for corresponding membership.

COTH GOVERNANCE

The Council of Teaching Hospitals Administrative Board represents the interests of the Council as a whole in the deliberations and policymaking of the AAMC. This Board also provides representation to the Association's Executive Council. The nine

The nine at-large members of the Administrative Board serve three year terms. Board membership also includes the chair, chair-elect, immediate past chair, secretary and COTH "at large" representative to the AAMC Executive Council. Mr. Gary Gambuti, President, St. Luke's-Roosevelt Hospital Center in New York City, will serve as Chairman of the Council of Teaching Hospitals in 1988-89, succeeding outgoing chair, J. Robert Buchanan, MD, General Director of the Massachusetts General Hospital in Boston. The members and officers of the 1987-88 Administrative Board are listed in Appendix A. The Administrative Board is elected at the COTH Business Session held during the AAMC Annual Meeting. The COTH Administrative Board has met four times over the past year to conduct business and discuss issues of interest and importance. Such issues as the impact of AIDS on the teaching hospital, the nursing shortage issue, and the recent JCAHO academic medical center survey trial were discussed at these meetings and at the 1988 COTH Spring Meeting in New York City. Appendix B contains a listing of the COTH representatives to the AAMC Assembly; they are also elected at the Annual Meeting.

COTH ACTIVITIES

Medicare Issues

Medicare Payments to Hospitals. The first AAMC positions on prospective payment (PPS) were adopted in January 1983 in a broadly worded document aimed at the original debate over how to implement a prospective payment system (Appendix D-1). In 1986, following the first two years of PPS implementation, the AAMC adopted additional policies to address emerging issues (Appendix D-2), and specific policies on direct medical education payments (Appendix D-3). While these documents provide broad guidelines for the AAMC to use in developing policies on specific proposals, they do not address some of the issues likely to be raised in 1989. Therefore, in September 1988, the COTH Administrative Board recommended and the AAMC Executive Council adopted the following positions on Medicare payment issues.

- The AAMC supports a tiered rate structure for Medicare PPS payments which recognizes cost differences between urban and rural hospitals until adequate and tested indices for both wage and non-labor components of hospital cost are available.

- The AAMC supports, as a floor, the October 1988 formula (yielding 7.7% per 0.1 resident per bed) for the indirect medical education adjustment. This is in recognition of the multiple roles and accompanying costs teaching hospitals have in the nation's health care system, including caring for the most severely ill patients, introducing new diagnostic and treatment services, caring for patients in the high cost core cities of urban areas, and providing clinical education programs in the health professions.

- The AAMC supports increasing the percentage of Medicare PPS payments used to compensate hospitals for high cost and long stay outliers as a means of more fully recognizing differences in patient severity of illness.

- The AAMC supports the inclusion of a disproportionate share adjustment in the Medicare PPS and supports efforts to develop better measures of the impact of treating the poor, including the aged poor, on a hospital's overall costs and financial status.

- The AAMC supports rebasing PPS prices, but only when rebasing includes full, public documentation and release of methodology and data; contemporary hospital cost data; and a rulemaking process with comment and appeal. If these conditions are not met, the AAMC Executive Council supports an annual increase in PPS prices at least equal to the annual increase in the price of goods and services purchased by hospitals.

- All health care payers, including Medicare, should continue to provide their appropriate share of support for graduate medical education. Medicare may be a keystone in assuring this support since Medicare policies are determined by Congress and the Department of Health and Human Services (DHHS), bodies which are intended to guard the public interest. Accordingly, the AAMC supports the following policies:

  - residents in approved training programs should be funded largely by payments to teaching hospitals by patient care payers at least through the number of years required to achieve initial board eligibility in their chosen discipline;

  - one additional year of funding beyond initial board eligibility should be provided from teaching hospital revenues for fellows in accredited training programs to the extent that the hospital funded such training in 1984;

  - an individual should be supported from patient care payers' payments to teaching hospitals for a maximum of six years of graduate medical education;

  - while public and private organizations may adopt positive financial incentives to encourage physicians to train in particular disciplines, they should not adopt financial disincentives for a particular discipline during the period of its initial board eligibility.

Nursing Issues

The nursing shortage is a major problem affecting a large number of teaching hospitals in this country today, and many COTH members are unable to support a preferred number of inpatient beds as a result of this shortage. This is a significant teaching hospital issue because while COTH member institutions comprise 6% of the total hospitals nationwide, they employ approximately 29% of hospital-based registered nurses. In seeking solutions various proposals have arisen, including the scouting of high school students for nursing school, the formation of specialized high schools with a strong emphasis on healthcare, and the creation of scholarships for students pursuing careers in this field. In an effort to educate the staff and the membership on new developments in nursing, a number of individuals prominent in the nursing leadership were featured speakers at the 1988 COTH Spring Meeting. These individuals, Joyce Clifford, Vice President of Nursing at Beth Israel Hospital in Boston; Vivien DeBack, Director of the National Commission on Nursing Implementation Project; Barbara Donaho, Vice President for Nursing, Shands Hospital in Gainesville; and Sheila Ryan, Dean of the University of Rochester School of Nursing, addressed the issue of "Primary Nursing and its Attraction for Nurses," "Addressing Today's Problems While Preparing for Tomorrow," "Attracting and Retaining Nurses in a Small City Medical Center," and "Does the Nursing Education Model Fit Nursing Service Roles and Expectations?"

Since that time the nursing issue has been an agenda item at the Administrative Board meetings, and in September, several representatives of the leadership of the Nursing Tri-Council, comprised of the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing, joined the Board for dinner in an informal forum to establish a dialogue with Board members about the problems contributing to the nursing difficulties being faced today. Following this encouraging exchange, the Association has decided to form an ad hoc Committee on Nursing in an effort to help the Association and member institutions address nursing issues more successfully. This committee will be staffed by the Division of Clinical Services and will be comprised of CEOs and nursing directors from various COTH member institutions, in addition to a faculty chairman and dean.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Survey

In 1987, the JCAHO, under the aegis of their Standards and Survey Procedures Committee, spearheaded an effort to identify the special survey problems presented by academic medical centers in complying with the Commission's standards of monitoring and evaluation (M&E). This study, a pilot with an eye to implementation of a more extensive test of a modified survey process for academic health centers in late 1988, involved four

COTH member institutions and was addressed at the 1988 COTH Spring Meeting. Mr. Donald Avant of the JCAHO began the discussion with an overview of the survey process and the history of the pilot program. He described the degree to which the following academic health center activities met the intent of M&E: clinical research, bench research which improves methods of diagnosis or treatment, local epidemiological research which prevents or moderates adverse outcomes, patient care given by or under the direction of subspecialists, multiple independent consultations on patients, consensus decision-making by clinical experts, and concurrent or prospective control mechanisms intended to assure quality and appropriateness of patient care. Dr. Paul Sanazaro, a field representative for the JCAHO, described the modified survey process planned for 1988 and elaborated on the draft final protocol and scoring guidelines for the anticipated survey process. He anticipated that results of this modified survey process would be available at the end of 1988.

John A. Reinertsen of the University of Utah Hospitals, J. Durwood Bradley, MD, University of Alabama at Birmingham, and Barbara McNeil, MD of the Harvard Medical School, who had acted as a surveyor consultant on this study, examined the cost and benefit of implementing the modified survey process, and the difficulty of including clinical research in a Joint Commission survey process. This endeavor was addressed at ensuing Administrative Board meetings, and in September, the Board recommended that the modified survey process be terminated. Consequently, the JCAHO has agreed to halt further efforts to test and implement the proposed modified survey process.

AIDS in the Teaching Hospital

The impact of AIDS on the teaching hospital varies greatly across the nation; however, those institutions in the areas of greatest concentration are encountering a new class of problems that range from the current controversy over infectious/toxic waste disposal and community image to "Ethical Responsibilities in the Face of an Epidemic." This facet of the epidemic was addressed specifically by Abigail Zuger, MD, of New York University Medical Center, at the 1988 COTH Spring Meeting. Dr. Zuger, a self-described member of the "first generation" of AIDS physicians, presented the paradoxes encountered in treating the AIDS patient and the ethical questions that arise when a physician refuses to treat these patients. She stressed that the responsibilities of a teaching institution include education, counseling, and appreciation for all employees at all levels. Dr. Zuger's remarks coincided with the statement on professional responsibility in treating AIDS patients drafted by the AAMC Committee on AIDS. This statement re-enforces the imperative of up-to-date information on the modes and risk of transmission of the virus, and training in protective measures to be employed in the clinical setting. These points will be incorporated in the Committee's final report to be available by the winter of 1988; COTH representatives to the Committee are James Farsetta of the

Veterans Administration Medical Center, Brooklyn; William H. Johnson, Jr. of the University of New Mexico Hospital; and Robert G. Newman, MD, Beth Israel Medical Center, New York.

During the past year, published papers on the organizational and financial impact of AIDS on public hospitals and teaching hospitals were presented in JAMA and Health Affairs. These reports drew on a 1985 membership questionnaire sponsored jointly by the AAMC and the National Association of Public Hospitals. In addition, a 1987 followup survey on the impact of AIDS on hospitals was launched as joint effort of several associations, including the AAMC.

COTH MEMBER SERVICES

COTH members receive a full range of AAMC and Council-specific services and publications. AAMC services include: legislative and regulatory monitoring of Federal health initiatives in the areas of reimbursement, biomedical research, technology, medical education, and manpower; representation and testimony at key congressional hearings; access to the Association's numerous databases; and staff support in the interpretation and analysis of national policy issues.

The Council sponsors occasional educational seminars and at least two meetings annually where CEOs can hear the latest on planned government changes, relevant research, and problems facing teaching hospitals. The meetings generally spotlight nationally recognized experts in the health care field and provide CEOs with the opportunity to gain useful information and exchange ideas with peers.

As needed, information memoranda which summarize or analyze a current topic of interest are distributed. A Legislative and Regulatory Update, coordinated by the AAMC Office of Government Relations, is also distributed several times a year. It updates and summarizes many of the health issues being debated during current congressional sessions.

Four AAMC publications are regularly provided to COTH members. They are the Journal of Medical Education (to be replaced in January by Academic Medicine), the President's Weekly Report, the Annual Report on Medical School Faculty Salaries, and the Association's Annual Report.

The Council of Teaching Hospitals is primarily supported by personnel in the Division of Clinical Services. These individuals concentrate on changes in the Medicare hospital payment program, physician payment issues and their implications for hospitals, and collecting and analyzing data on member institutions. Data are distributed in annual publications such as : the COTH Survey of Housestaff Stipends, Benefits, and Funding; the COTH Executive Salary Survey, and the COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data. The Division also publishes a membership directory, various bibliographies,

and a monthly newsletter, the COTH Report, which highlights current topics of interest to teaching hospitals' chief executive officers.

COTH Survey of Housestaff Stipends, Benefits, and Funding

This annual survey has an 85% response rate and provides constituents with the following data on COTH member institutions:

1/ Stipends paid in the reporting year and projected stipend levels for the next year;

2/ Health and non-health benefits provided to housestaff and their dependents; and

3/ Teaching hospital expenditures and sources of funding for housestaff stipends and benefits.

Nationwide mean and median stipend data are reported and are aggregated by region, type of affiliation relationship with the medical school, hospital ownership, and specific bed size. Information on resident-to-bed ratios and distribution of minority residents and fellows is also included.

Council of Teaching Hospitals Executive Salary Survey

This is an annual survey of salaries and fringe benefits for chief executive officers, senior administrative staff, and departmental executives. It includes a limited section on CEO characteristics, including age and educational data. This is a confidential report sent only to CEOs of member institutions.

Council of Teaching Hospitals Executive Salary Survey: Special Analysis of the Academic Medical Center Hospitals

This annual survey is a special analysis of academic medical centers' chief executive officers' salaries. It is a confidential report sent only to CEOs of academic medical center hospitals. Data are presented by categories of ownership; i.e., public, private, and university-owned, and freestanding non-university. This report includes salary data on the CEO as well as the five most senior administrative positions.

COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data

This annual survey reports on operational, financial, and staffing characteristics of academic medical center hospitals for purposes of institutional comparison. It is a confidential report sent only to CEOs of participating institutions and serves as one of several sources for the AAMC Commonwealth Fund supported study to build a teaching hospital database. This survey reports operating statements from most recently available fiscal year, data on government appropriations, calculations of

operating and total hospital margins, and ranked hospital expenses per discharge standardized by the Medicare wage and case mix indices. In addition, data are reported on the impact of Medicare prospective payment, case mix and DRGs, graduate medical education (costs and resident counts), Medicare outlier cases, hospital-based research, service and clinical unit availability, and utilization and personnel statistics.

AAMC Directory of American Medical Education

This directory lists the 127 member (institutional) medical schools in the United States, Canada, and Puerto Rico as well as affiliate and graduate affiliate schools. Each school entry includes enrollment, type of support, clinical facilities, as well as university officials, medical school administrative staff, and departmental chairmen in the clinical and basic sciences. The 1989 edition of this directory will include a separate section for the Council of Teaching Hospitals that results from an effort to consolidate the former COTH Directory within the AAMC Directory. This section will provide an alphabetical listing by city and state of COTH member institutions, including hospital name, address, CEO and their title and telephone number. Additionally, the same information will be provided for the each institution's chief operating officer, chief financial officer, medical director, and nursing director.

COTH Report

The COTH Report is a monthly newsletter designed to highlight current events of interest to COTH member institutions with primary focus on pertinent legislation and regulation affecting teaching hospitals. This past year it has highlighted such issues as the resident supervision and hours debate, Prospective Payment Assessment Commission (ProPAC) and Physician Payment Review Commission (PhysPRC) developments, and recent AAMC testimony on behalf of the AAMC on the Veterans Administration (VA) appropriations. In addition, the COTH Report serves as a common forum for member specific news such as the appointment of a CEO or receipt of a prestigious award.

Issue Updates (Blue memoranda)

In-depth analysis and reporting on current policy issues and agency actions such as

- Medicare Prospective Payment regulations
- Legislative Activities
- Prospective Payment Assessment Commission (ProPAC)
- Council on Graduate Medical Education (CoGME)
- HHS Commission on Nursing

are provided to members in a series of issue-specific "blue" membership memoranda. These have included coverage of such activities as the recent publication of HCFA's 1986 Medicare

mortality data; proposed regulations to revise Medicare PPS for federal FY89, increasing DRG prices and modifying the calculation of the wage index and outlier payments; the effect of the Senate's 1988 NIH reauthorization bill on fetal research; as well as proposed HHS regulations on misconduct or fraud in science; House and Senate proposed tax code amendments; and proposed regulations on Medicare's payment for direct graduate medical education costs.

Additionally, the AAMC collaborated in a coalition effort to increase support for the medical care and health research programs at the Veterans Administration. Entitled the "Friends of VA Medical Care and Health Research," a document setting forth a proposal for FY89 funding for medical care research at the VA was sent to all members of the Congress and formed the basis of Congressional testimony on behalf of the coalition. This document was distributed to COTH CEOs at the 1988 COTH Spring Meeting.

DIVISION OF CLINICAL SERVICES

The AAMC Division of Clinical Services (Appendix E) is the component within the Association with primary responsibility for staffing the Council of Teaching Hospitals. The Division develops specialized policy analyses, membership meetings, and membership services for teaching hospitals and other patient care organizations significantly involved in the clinical education of physicians and/or in biomedical research. The primary goal of the Division is the development of programs and services which enable hospital and other clinical entities to provide high quality, personalized services to patients while supporting the clinical education and biomedical behavioral research missions of academic medicine.

The Division of Clinical Services is involved in a number of special projects pertinent to the activities of its members.

Task Force on Physician Supply
Committee on Physician Supply Issues for Resident and Fellow Education

Issues associated with the supply and deployment of physicians in the United States will hold a prominent position on the health policy agenda over the next decade. United States medical schools are now experiencing a decline in their applicant pool and are concerned that this may portend a decline in the quality of future physicians and biomedical scientists.

The AAMC Executive Council established the Task Force on Physician Supply with the charge of reviewing physician supply and production, considering the necessary manpower mix for provision of services in teaching hospitals, facilitating access to health care services, and assuring a sufficient number of appropriately trained researchers in biomedical and behavioral sciences.

Toward that end, the Committee on Physician Supply Issues for Resident and Fellow Education, one of four Task Force committees, was convened in July 1987. The committee's charge included the evolving societal demand for training in various disciplines and for geographic distribution of physicians; the examination of different sets of forces which influence the nature of graduate medical education opportunities and the production of trained physicians; the consideration of the economics of graduate medical education from the viewpoint of both the hospital and the resident; and the consideration of the implications of future changes in (1) the number and type of residents in training, and (2) the requirements and sites of training programs for the delivery of patient care services provided by teaching hospitals.

The Committee met several times in 1987 and 1988 and submitted its draft report to the Task Force in May 1988, recommending that the AAMC enlarge its capacity to monitor developments and trends in graduate medical education; assist in the development of manpower by issuing periodic reports on the number of graduates and their characteristics; develop, evaluate and report on specialty-specific estimates of future physician requirements; improve its capability to advise governmental and private bodies having an interest in or responsibility for graduate medical education policies; report on and monitor appropriate funding; and develop annual reports to medical schools and students on career opportunities and the likelihood of achieving institutional and personal choices. These recommendations will be reviewed by the Task Force with the intent of incorporating them into the final Task Force report planned for release at the end of 1989. This Committee has been chaired by Mitchell Rabkin, MD of Beth Israel Hospital in Boston. Complete committee membership is listed in Appendix C.

AAMC/Commonwealth Fund Project
Better Policy Analysis for Teaching Hospitals

Teaching hospitals carry a very special burden and responsibility for the nation's health care. They provide primary sites for clinical education for undergraduate medical students and residents, fellowship training programs, and a significant share of the nursing and allied health programs. Additionally, they are important partners in the conduct of clinical research, the testing and development of drugs, medical devices and new technologies and advanced treatment methods of patients.

Teaching hospitals are major providers of medical care, offering regionalized tertiary care services and specialized support for community hospitals in addition to essential backup and routine patient care. Although accounting for only six percent of the nation's hospitals, members of the Council of Teaching Hospitals have 22% of admissions, 28% of all outpatient visits, and 21% of all surgical operations.

These institutions also provide care to a disproportionately

large share of the nation's poor and medically indigent. In 1986, short-term general, non-federal COTH members incurred 54% of the charity care charges and 33% of the bad debts of all US hospitals. The average COTH member deducted 11.8% of revenues for charity care compared to the community hospital average deduction of 7.1% of revenues.

Today's teaching hospitals face major challenges as a more diverse and competitive health care system evolves. The growing number of patients with inadequate or no health insurance strains the ability of teaching hospitals to cope in a competitive environment. Governments, confronted with fiscal deficits and necessary program cutbacks, have instituted fixed and prospective payment systems which may affect the financing of medical education. Health care cost inflation continues and cost containment pressures from public and private sectors may threaten quality of patient care in the nation's hospitals.

To analyze and address how these emerging forces will affect teaching hospitals, the AAMC's Division of Clinical Services, with support from The Commonwealth Fund, has developed a database on teaching hospital costs and operating characteristics, composed of data from the American Hospital Association, Health Care Financing Administration, other secondary data sources, and AAMC primary data on academic medical centers. Information from the database forms the foundation for three research efforts: trends in teaching hospital profitability, variation in the costs of graduate medical education, and the identification and distribution of high cost patients among types of hospitals. These research topics are areas of national policy concern and must be examined so that teaching hospitals can continue to fulfill their unique missions of medical education and patient care in the face of a rapidly changing health care environment.

AAMC Recommendations on Housestaff Supervision and Hours

During this decade, changes in the medical care system have had major effects on the environment of teaching hospitals. These changes have included sicker patients, shorter hospital stays, and dramatic technological advances in diagnostic tools. These changes in environment have had a striking effect on the course of present-day residencies and presented an urgent need for review. As an organization representing medical schools, faculties, and teaching hospitals, the AAMC has attempted to address these changes in environment and has adopted a statement setting forth a number of guidelines for members to consider on housestaff supervision and hours.

These recommendations were approved by the COTH, Council of Deans (COD) and Council of Academic Societies (CAS) Administrative Boards as well as the AAMC Executive Council, and were summarized in a blue memorandum this past Spring. Among these recommendations were the proposals that:

- Teaching hospitals and residency programs have policies and procedures specifying the level of supervision which faculty and other supervising physicians exercise over residents at each level of training; and

- Every teaching hospital adopt general guidelines for residents' working hours according to specialty, intensity of patient care responsibilities, level of experience, and educational requirements. In order that decisions about the care of patients are not impaired by fatigue, residents' hours actually worked should not exceed 80 hours per week when averaged over four weeks.

Other recommendations addressed the role of accrediting agencies in the support of these guidelines and policies, phasing in the implementation of policies, and the impact of moonlighting.

Study and Comparison of Transition of Medical Education Programs from Hospital Inpatient to Ambulatory Training Programs

As the emphasis on patient care shifts from inpatient to the ambulatory setting, the need has arisen to examine how this trend affects the graduate medical education process. With the support of the Bureau of Health Professions of the Health Resources and Services Administration (HRSA), the federal agency responsible for assuring the adequacy of the nation's health manpower, the AAMC undertook such a study.

In an effort to assess alternatives for ambulatory training that might be appropriate for educating physicians and for developing strategies to organize the education experience, a research team, headed by a member of the Division of Clinical Services, visited nine academic medical centers and looked at training programs in internal medicine, family medicine, general surgery, family medicine, pediatrics, psychiatry, and ophthalmology. The study addresses questions involving critical issues for medical schools such as the prospect of additional costs, quality of education in ambulatory sites, and existing affiliation agreements. It further examines the issues involved in adapting the educational process, the appropriateness of clinical sites, and the actual financing of ambulatory education. This study delineates key factors influencing the choice of how ambulatory settings are used as well as identifies barriers to developing such programs.

Copies of the publications, surveys, and recommendations covered in this report may be obtained through the AAMC Division of Clinical Services by calling 202/828-0490.

APPENDIX A

COTH ADMINISTRATIVE BOARD
1987-1988

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THREE YEAR TERM, Expiring 1990
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COTH REPRESENTATIVES TO AAMC ASSEMBLY 1987-1988

1990

Peter Baglio
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W. Daniel Barker
Emory University Hospital, Atlanta, GA

Jerry Boyd
Veterans Administration Medical Center, Tucson, AZ

Paul Broughton
Children's Hospital of Michigan, Detroit, MI

J.L. Buckingham
LA County-USC Medical Center, Los Angeles, CA

Robert Condry
Foster G. McGaw Hospital, Maywood, IL

Phillip Dutcher
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Gary Gambuti
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Jerome Grossman, MD
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Larry Mathis
The Methodist Hospital, Houston, TX

Robert Newman, MD
Beth Israel Hospital, New York, NY

Max Poll
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Raymond Schultze, MD
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Richard Uhrich, MD
Good Samaritan Medical Center, Phoenix, AZ
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The Children's Hospital, Boston, MA
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John Buckley, Jr.
St. Joseph Hospital, Phoenix, AZ
Judge Calton
Methodist Hospital of Memphis, Memphis, TN
James Dooley
Veterans Administration Medical Center, Bronx, NY
Paul Griner, MD
Strong Memorial Hospital, Rochester, NY
Gregory Haag
Veterans Administration Medical Center, New Orleans, LA
John Ives
St. Luke's Episcopal Hospital, Houston, TX
Terrence Johnson
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Veterans Administration Medical Center, Minneapolis, MN
Charles O'Brien, Jr.
Georgetown University Hospital, Washington, DC
Howard Peterson
PennState University Hospital, The Milton S. Hershey Medical Center, Hershey, PA
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Veterans Administration Medical Center, Durham, NC
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APPENDIX C

1987-1988
AAMC COMMITTEE APPOINTMENTS

The following individuals are COTH representatives to AAMC standing and ad hoc committees.

AIDS and the Academic Medical Center Committee

James J. Farsetta
Veterans Administration Medical Center
Brooklyn, NY

William H. Johnson, Jr.
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Robert G. Newman, MD
Beth Israel Hospital
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Audit Committee

J. Robert Buchanan, MD, Chair
Massachusetts General Hospital
Boston, MA

Flexner Award Selection Committee

Andrew G. Wallace, MD
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Durham, NC

Investment Committee

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Journal of Medical Education Editorial Board

Paul F. Griner, MD
Strong Memorial Hospital
Rochester, NY

John E. Ives
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Houston, TX

Liaison Committee on Medical Education

J. Robert Buchanan, MD, Chair, Co-Chair
Massachusetts General Hospital
Boston

Management Education Programs Planning Committee

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

William B. Kerr
University of California, San Francisco,
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Nominating Committee

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Resolutions Committee

John A. Reinertsen
University of Utah Hospital
Salt Lake City, UT

Task Force on Physician Supply

Committee on Implications of Physician
Supply Issues for Medical Student Education

Spencer Foreman, MD
Montefiore Medical Center
Bronx, NY

Committee on Implications of Physician
Supply Issues on Programs for the Education
of Biomedical Scientists

Paul F. Griner, MD
Strong Memorial Hospital
Rochester, NY

The following AAMC Committees are staffed by the Division of Clinical Services

Task Force on Physician Supply

Committee on Implications of Physician
Supply Issues for Resident and
Fellow Education

Mitchell T. Rabkin, MD, Chair
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Frank A. Riddick, Jr., MD
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Stefan Stein, MD
The Payne Whitney Clinic
Cornell Medical Center
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W. Donald Weston, MD
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Frank C. Wilson, Jr., MD
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Commonwealth Fund Project Advisory Committee
Better Policy Analysis Capability for
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Carol M. McCarthy, PhD, JD
American Hospital Association
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James H. Sammons, MD
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Health Insurance Association of America
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Bernard R. Tresnowski
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ad hoc Committee to Review the Academic Medical Center Hospital Survey

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Michael J. Bradley
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The Milton S. Hershey Medical Center
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Peter Van Etten
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Kenneth Yerington
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The following are COTH Committee appointments also staffed by the Division of Clinical Services

COTH Nominating Committee

Spencer Foreman, MD, Chair
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Bronx, NY

J. Robert Buchanan, MD
Massachusetts General Hospital
Boston, MA

Earl J. Frederick
Children's Memorial Hospital
Chicago, IL

COTH Spring Meeting Planning Committee

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Phillip C. Dutcher
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David J. Handel
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Nashville, TN

APPENDIX D-1

AAMC Principles for Prospective Payment of Hospital Services

Adopted: January 1983

Prospective payment systems should:

a. fully recognize the impact of the hospital's approved scope of services, its patient mix, and the intensity of care required on operating costs,

b. recognize regional differences in the costs of goods and services purchased by hospitals.

c. calculate operating costs on a "going concern" basis with full recognition of hospital capital requirements,

d. recognize physician costs for personal medical services and for medical program supervision and administration,

e. recognize costs resulting from manpower training programs which are accredited by an appropriate organization. Costs recognized should include those for educational instruction and supervision, student stipends where provided, program support and institutional overhead, and the decreased productivity accompanying training in the hospital setting,

f. recognize increased costs associated with clinical research to bring advances in biomedical knowledge to the improvement of medical care,

g. recognize increased costs accompanying the use of new diagnostic and treatment technologies,

h. permit hospitals to charge patients for the differences between the program payment and the posted charges for services used, and

i. provide hospitals with a statutory right to obtain administrative and judicial review of program policies and payment computations.

AAMC Policy Positions on the Medicare Prospective Payment System

Adopted: January 1986

-- The AAMC vigorously opposes any freezes in Medicare payments to hospitals.

-- The AAMC strongly recommends that Congress amend the prospective payment system so that payments are based on a DRG specific, blended rate of hospital-specific and federal component prices.

-- If Congress is unwilling to enact DRG specific price blending, then the AAMC recommends that Congress amend the DRG price formula so that it is based on a blend of 50% hospital-specific costs and 50% regional average costs.

-- The AAMC supports recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices and a regression equation which incorporates only variables used in determining DRG payments. The most recent analyses by the Congressional Budget Office support a curvilinear adjustment of 8.7% per 0.1 resident per bed.

-- The AAMC strongly supports including the same types of residents in the payout of the indirect medical education adjustment as are included in the statistical formulation of the adjustment.

-- The AAMC supports eliminating Medicare funding for residents who are not graduates of accredited medical or osteopathic schools located in the United States or Canada.

-- The AAMC supports retaining explicit Medicare funding of graduate medical education for at least the number of years required to attain board eligibility in various specialties (to a maximum of five years) plus one additional clinical year for advanced specialty and subspecialty positions in hospitals in which the position are supported by Medicare in FY 1984.

-- For any foreign trained resident presently in training and for any resident presently in a specialty which would not be included in the passthrough, the AAMC supports a phase-in of Medicare payment changes.

-- The AAMC supports establishing an adjustment in prospective payments to recognize the generally higher costs incurred by hospitals serving a disproportionate number of indigent Medicare patients. The AAMC recognizes that implementation of a disproportionate share adjustment may lead to a recalculation of the percentage used for the indirect medical education adjustment.

-- The AAMC recommends that Congress require HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment.

AAMC Policies on Financing Graduate Medical Education

Adopted: April 1986

1. Teaching hospital revenues from patient care payers should continue to be the principal source of support for graduate medical education, but modifications should be made in what they are expected to fund.

2. All health care payers, including Medicare, should continue to provide their appropriate share of support for graduate medical education. Medicare may be a keystone in assuring this support since Medicare policies are determined by Congress and the Department of Health and Human Services, bodies which are supposed to guard the public interest.

3. In addition to patient care payers, other sources currently providing funds for health care training need to continue to participate in funding residency training. Or, in fact, may be called upon to provide greater support in the future. These other sources include state and local governments, special purpose Federal government programs, and private organizations that provide support to meet specific needs.

4. The medical education community should continue to monitor the quality of its residency training and provide assurances that graduates of its residency programs are adequately prepared for practice.

5. The institutions receiving funding should recognize their obligations to train the types of physicians needed by society.

6. These institutions also must recognize their obligation to operate the training programs in a cost-effective manner.

7. Funding for graduate medical education should be limited to graduates of medical schools approved by the Liaison Committee on Medical Education or the American Osteopathic Association's Committee on Postdoctoral Training should be funded.

8. Only residents in programs approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association's Committee on Postdoctoral Training should be funded.

APPENDIX E

1988

AAMC
DIVISION OF CLINICAL SERVICES

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