

COTH ADMINISTRATIVE BOARD
Sunday, August 19, 1973
Palmer House
PDR #6
Chicago, Illinois
9:00 a.m. - 3:00 p.m.

AGENDA

- I. Call to Order
- II. Approval of Minutes TAB A
- III. Membership Applications TAB B
 - A. Morristown Memorial Hospital
 - B. Christ Hospital
- IV. Discussion of the Report of the Committee on Financing Medical Education Entitled "Undergraduate Medical Education: Elements -- Objectives -- Costs" TAB C
- V. Research Memo: "Selected Comparisons Of Hospitals With Graduate And Undergraduate Training Programs And Those With Graduate Training Only" TAB D
- VI. "The Patient In The Teaching Setting" TAB E
- VII. COTH Research Awards TAB F
- VIII. Proposed Regulations on Section 221 of P.L. 92-603 Entitled "Limitation On Federal Participation For Capital Expenditures" TAB G
- IX. Representation in the AAMC Assembly TAB H
- X. Other Business
- XI. Adjournment

NEXT MEETING OF THE ADMINISTRATIVE BOARD
Wednesday Evening, September 12, 1973
Thursday, September 13, 1973
Dupont Plaza Hotel
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH Administrative Board Meeting
Thursday, June 21, 1973
Embassy Row Hotel
Washington, D.C.

PRESENT:

Leonard W. Cronkhite, Jr., M.D., Chairman
Robert A. Derzon, Chairman-Elect
John H. Westerman, Secretary
Daniel W. Capps
David H. Hitt
Arthur J. Klippen, M.D.
Sidney Lewine
Stuart M. Sessoms, M.D.
Eugene L. Staples
David D. Thompson, M.D.
Charles B. Womer
Thomas H. Ainsworth, Jr., M.D., AHA Representative

STAFF:

Richard M. Knapp, PH.D.
Robert H. Kalinowski, M.D.
Dennis D. Pointer, Ph.D.
Grace W. Beirne
Catharine A. Rivera

EXCUSED:

George E. Cartmill
Herluf V. Olsen, Jr.

I. Call to Order:

Dr. Cronkhite called the meeting to order at 9:00 a.m. in Envoy C of the Embassy Row Hotel.

II. Consideration of Minutes:

The minutes of the meeting of March 15, 1973 were approved as distributed.

III. Membership Applications:

ACTION # 1

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE APPROVED:

VETERANS ADMINISTRATION HOSPITAL
TAMPA, FLORIDA

VETERANS ADMINISTRATION HOSPITAL
SAN DIEGO, CALIFORNIA

MOUNT SINAI HOSPITAL
MINNEAPOLIS, MINNESOTA

IV. The Patient in the Teaching Setting:

Dr. Knapp presented a draft of a statement regarding the patient in the teaching setting (full text in Appendix A) prepared by staff at Dr. Cooper's request. The need for such a statement from the AAMC was stimulated by a resolution passed by the American Public Health Association. It was noted that the AAMC statement will be presented for consideration to the Executive Council on June 22, 1973. Discussion centered around the draft statement vis a vis the AHA Patient Bill of Rights. Questions were raised regarding the enforcibility of several sections of the AHA Statement as well as the AAMC draft since the actions required were to a large degree within the purview of individual practicing physicians. It was suggested that the first two paragraphs of the statement delineated a general policy with which all could comply.

ACTION # 2

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD RECOMMEND ADOPTION OF THE FIRST TWO PARAGRAPHS OF THE STATEMENT AND ENDORSE THE AMERICAN HOSPITAL ASSOCIATION'S STATEMENT ENTITLED "PATIENT BILL OF RIGHTS."

V. Regional Meetings:

Dr. Sessoms, Mr. Westerman, Mr. Derzon and Dr. Cronkhite each presented a brief report on the recently concluded COTH regional meetings. A list of topics and respective speakers for the four sessions can be found in Appendix B. It was concluded that the meetings were well accepted and should be continued in a similar format next year. Much success of the meeting was credited to having regional coordination engaged in planning and executing arrangements.

VI. AAMC/AHA Liaison Committee Meeting:

Dr. Cronkhite reported on the AAMC/AHA Liaison Committee Meeting held June 10-11 in Chicago, Illinois. The meeting focused primarily on discussing federal regulations pertaining to Section 227 of P.L. 92-603. It was noted that a draft of the regulations received by the committee would be entered into the Federal Register by July 1, 1973. Agreement was reached that emphasis should be placed on efforts to delay publication of the regulations in the Federal Register. It was suggested that all three organizations (AHA, AAMC and AMA) obtain advice from legal counsel regarding either separate or joint legal action with respect to the various issues posed by the regulations.

The liaison committee felt that there appears to be considerable foundation for a class action suit instigated by selected classes of patients. If the regulations come out as presently written the freedom of medicare-eligible patients to choose the physicians and/or hospitals from which they wish to receive care will be limited.

Dr. Knapp indicated that a meeting of the AAMC H.R. 1 Task Force will be held on June 10. The Association's legal counsel has had an opportunity to review a draft of the proposed federal regulations and will make a presentation to the Executive Council on June 22, 1973.

VII. Annual Meeting:

Dr. Knapp stated that Dr. Cronkhite has agreed to speak at the Plenary Session of the AAMC Annual Meeting on the topic, "Control and Regulation of the Health Industry." Dr. Knapp requested that the four individuals who coordinated the COTH regional meetings (Dr. Cronkhite, Mr. Derzon, Dr. Sessoms, and Mr. Westerman) form a committee to assist the staff in selecting speakers and topics for the COTH program at the annual meeting. A specific agenda for the program will be presented at the next administrative board meeting on August 19 in Chicago, Illinois.

VIII. Future of the Freestanding Internship:

The future of the freestanding internship was discussed in reference to a letter received by Dr. Marjorie Wilson, Department of Institutional Development, AAMC, from Robert Buchanan, M.D., Dean, Cornell University Medical College. (See Appendix C) No action was taken on this item, however, the group felt that the phase-out of such internships posed several significant problems. It was noted that many residency directors are urging applicants to take a year of general mixed or rotating internships before entering specialty training; the reduction of freestanding internships would appear to inhibit the potential for meeting this requirement. It appears that the problem should be addressed from three perspectives: (1) the effect on hospitals that have freestanding internships; (2) the impact on students who are not placed through the NIRMP, and: (3) the impact on teaching hospitals themselves. Dr. Thompson agreed to present these points at a future meeting of the Coordinating Council on Medical Education.

IX. OSR-NIRMP Proposal:

A paper was distributed to the board regarding the role of OSR and GSA representatives in monitoring procedures of the NIRMP (See Appendix D). The proposal sets forth specific suggestions regarding NIRMP improvement with respect to enforcement of the "all or none" principle for hospitals participating in the program. The AAMC Organization of Student Representatives (OSR) adopted a resolution to establish a system of investigating NIRMP violations and reporting them to appropriate authorities. It was noted that COTH should have no objection to this type of consumer monitoring, however, no structure presently exists for dealing with medical students who violate contracts with a hospital for an internship or residency position. It is noted that if a structure for monitoring hospital performance under the NIRMP is developed, the same type of system should be implemented to monitor violations by students.

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED THAT
THE PROPOSAL SHOULD INCLUDE PROCEDURES
FOR MONITORING STUDENT RESPONSIBILITIES
WITH REGARD TO SIGNING A HOSPITAL CONTRACT.

X. Report on Physician Assistant Programs:

Thomas Piemme, M.D. of Georgetown Medical School made a presentation regarding physician assistant programs. Dr. Piemme's discussion centered upon: (1) development of the physician assistant concept; (2) a history of the development of physician assistant education programs; (3) the development of physician assistant accreditation procedures, and; (4) legislation regarding practice rights of physician assistants. Dr. Piemme noted that

there now appears to be developing a three class categorization of physician assistants: (1) Class A are those individuals that are broadly trained (a Duke model); (2) Class B are those individuals trained in a narrow area with no breadth outside that area, and; (3) Class C are those individuals broadly trained with limited skills and no knowledge of underlying pathophysiological mechanisms. Dr. Piemme noted that while the physician assistant concept is growing in both acceptability and potential contribution, there are significant problems regarding certification and accreditation. He noted that in 1966 no legislation existed for supervising the activities of physician assistants. The first state to enact such legislation was North Carolina in 1967, and now twenty-eight jurisdictions have some form of legislation regarding this issue.

Several members of the board expressed concern regarding the status of the physician assistant in the hospital setting. It was noted that there was considerable confusion regarding to whom the physician assistant is responsible in the institution; lines of authority and responsibility have yet to be established. Dr. Piemme noted that the AHA has stated that if the physician assistant is working in the hospital setting, then he should be employed by the hospital medical staff and not the hospital administration. Several members of the board indicated that the direct responsibility for action to the physician assistant in this instance is extremely diffuse.

XI. Institute of Medicine Staff Report: Educational Costs of Teaching Hospitals:

Kersey B. Dastur of the Institute of Medicine staff presented a review of ongoing efforts by the Institute to document the educational costs of teaching hospitals (See Appendix E). The objectives of the study are to: (1) gain further understanding of the role of teaching hospitals in medical education; (2) estimate the additional expenses incurred (if any) by teaching

hospitals in the support of education, and relate these costs to the appropriate beneficiary; (3) anticipate impending changes in medical school-teaching hospital relationships -- especially how such changes would affect the costs and financing of medical education, and; (4) report to the Congress on the costs of resources essential for medical education.

The IOM study staff proposed to employ incremental cost analysis leading to identification, description and quantification of those costs attributable to education in teaching hospitals. The methodology employed will assume that patient care is the primary role of such institutions and limit inquiry to major educational cost centers (outpatient clinics, supportive services, space and facilities, administration and overhead, and diagnostic services). Staff anticipates completion of methodological design by August, 1973. The execution of field study (four teaching hospitals) will take place December, 1973 through March, 1974. A formal report will be prepared for the Congress before April, 1974. The IOM staff solicited reactions from the board regarding: (1) possible distortions in findings and costs through the adoption of incremental analysis approach; (2) the validity of assumptions underpinning the methodology; (3) the feasibility of modeling an ideal teaching hospital and using that model to derive resulting educational costs; (4) problems associated with analysis of only eight cost centers, and; (5) delineation of other associations or organizations who would be willing to participate with the IMO in the development and/or execution of the methodology.

The board took no action on this matter but directed the staff to monitor the activities of the IOM staff closely.

XII. Information Items:A. Ad Hoc Committee to Review Pertinent Sections of H.R. 1 (P.L. 92-603)

Dr. Knapp reviewed briefly the meeting of the Ad Hoc Committee to Review Pertinent Sections of H.R. 1 (S. David Pomrinse, M.D., Chairman, John W. Colloton, John M. Stagl, Charles B. Womer). During its meeting in New York, the Committee discussed pending federal regulations pursuant to Section 221 and 223 of P.L. 92-603. Regulations regarding Section 223 have not been drafted by the Social Security Administration, and are not expected for some time. Regulations regarding Section 221 are available in draft form and the greatest proportion of the committee's time was directed toward examining these regulations. A copy of a letter prepared by the committee to Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration, regarding criticisms of regulations relating to Section 221 is presented in Appendix F.

B. Intermediary Manual Revision Transmittal Number 320

Dr. Knapp discussed briefly intermediary manual instructions recently forwarded by the Social Security Administration regarding intern and resident moonlighting. Section 6102.7 has been revised to include within the definition of "physician services" services performed by interns and residents outside their regular training program in a hospital other than the hospital in which they are training, provided that they are fully licensed to practice medicine in the state in which the services are rendered and are not compensated by the provider. Any services rendered in the hospital with the approved teaching program under which the intern or resident is in training continue to be reimbursable only as provider services. The full text of this intermediary manual revision can be found in Appendix G.

III. Undergraduate Medical Education: Elements - Objectives - Costs:

A general discussion ensued regarding the final report of the Task Force on Financing of Medical Education entitled, "Undergraduate Medical Education: Elements - Objectives - Costs."

ACTION #4

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD RECOMMEND THAT THE REPORT NOT BE PUBLISHED AND THAT FURTHER DISTRIBUTION OF THE REPORT SHOULD BE DISCOURAGED AT THIS TIME.

The Board directed staff members of the Department of Teaching Hospitals to prepare a point-by-point critique of the report for consideration at its August meeting in Chicago. Members of the Board were requested to forward their individual comments regarding the report to the staff by early August.

XIV. Adjournment:

There being no further business, the meeting was adjourned at 3:30 p.m.

AAMC POLICY STATEMENT
THE PATIENT IN THE TEACHING SETTING

The medical faculties and staff of the nation's medical schools and teaching hospitals are committed to the provision of the highest quality of personal health services. The interrelationships between the health care, educational and research functions of these institutions contribute to the assurance of these high standards of patient care. Patients seeking care in the teaching setting are not only provided high quality health services, but also an opportunity to share in the training of the nation's future health care professional personnel through participation in clinical education.

It is the policy of the Association of American Medical Colleges that all patients, regardless of economic status, service classification, nature of illness or other categorization should have the opportunity to participate in the clinical education program of the hospital, clinic or other delivery setting to which they are admitted or from which they seek care.

In order to assure a single standard of high quality patient care, and to reinforce student perspectives and attitudes regarding patient rights and responsibilities, the AAMC reaffirms that:

- Selection of patients for participation in teaching programs shall not be based on the race, or socio-economic status of the patient.
- Responsible physicians have the obligation to discuss with the patient both general and specific aspects of student participation in the medical care process.

(2)

- Provision of patient care is a confidential process. Relationships between the patient, health professional and student, regarding examinations, treatment, case discussion and consultations should be treated with due respect to the patient's right to privacy.
- Each patient has the right to be treated with respect and dignity. Individual differences, including cultural and educational background, must be recognized in designing each patient's care program.
- Every teaching institution should have programs and procedures whereby patient grievances can be addressed in responsive and timely fashion.

The Association of American Medical Colleges believes that the reaffirmation of these principles in medical schools and teaching hospitals will contribute to the best interests of patients and ensure the most appropriate educational environment for the training of future health professionals.

APPENDIX B

COTH REGIONAL MEETINGS

Topics and Speakers

WESTERN REGION (April 27, 1973)

"The Implication of H.R. 1 on the
Provision of Professional Services
in Teaching Settings"

John Kasonic
Arthur Young & Company

MIDWEST-GREAT PLAINS REGION (April 30, 1973)

"Operating Experiences of a Foundation
Plan"

Al Whitehall
New Mexico Medical Care
Foundation

"Impact of a Foundation Plan on a Teaching
Hospital"

Thomas McConnell, M.D.
University of New Mexico

"An Analysis of the Issues Involved in
Quality Assurance Proposals"

Vernon E. Weckworth, Ph.D.
University of Minnesota

"Federal Shifts in Programs and Implications
for Teaching Hospitals"

Robert Laur, Ph.D.
Health Services and
Mental Health Administration

NORTHEAST (May 14, 1974)

"The Control of Health Care Costs Under
Phase III"

John D. Twiname
Executive Director, Health
Cost of Living Council

SOUTHERN (May 4, 1973)

"Federal Cutbacks on Medical School Funding:
Implications for The Teaching Hospital"

John Lynch
North Carolina Baptist Hospitals

"Certificate of Need Legislation:
The North Carolina Decision"

George Stockbridge
Health Planning Council
of Central North Carolina

"Rate Review Legislation: Special
Implications for Teaching Hospitals"

Lawrence E. Martin
Massachusetts General Hospital

CORNELL UNIVERSITY
MEDICAL COLLEGE

1300 YORK AVENUE
NEW YORK, N. Y. 10021

MAY 9 1973

APPENDIX C

OFFICE OF THE DEAN

May 4, 1973

Marjorie P. Wilson, M.D.
Director
Department of Institutional Development
Association of American Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Marjorie:

Several recent events have focused my attention on the need to review the closeout of the freestanding internship scheduled for 1975. These events include:

- a. This year we experienced a sharp increase in the number of our students who did not match for internships. This also occurred at several other established and respected schools with which I am familiar.

In the course of our efforts to place these individuals, we discovered far fewer unmatched hospital positions than in former years. This undoubtedly reflects the influx of American citizens from foreign medical schools and the accomplished closure of many internships of the freestanding variety.

- b. Many specialty residency directors are urging applicants to take a year of general, "mixed" or rotating internships before entering specialty training. This creates a special demand for one-year programs more commonly found in the "freestanding" state than in major teaching centers where the first and second postdoctoral years of general surgery and internal medicine programs are commonly coupled.
- c. The requirements of the Academy of Family Practice are presently so inflexible as to threaten well-established mixed internships in many of the larger community hospitals where a family practice residency would otherwise be the logical solution to the problem. This situation exists in Duluth, Minnesota and though it is critical to the new medical school there, a satisfactory outcome probably cannot be negotiated before the 1975 deadline.

Marjorie P. Wilson, M.D.

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- d. The demise of NIH support for clinical fellowships will increase the demand for residency openings which are not likely to be made available in our university medical teaching centers because of the current fiscal crisis. Thus, a solution we should be seeking is the establishment of more residency programs, the majority geared to produce "generalists" rather than simply to abolish freestanding internships. This would, of course, require our community hospitals to spend money on staffing such programs but it would also greatly improve the quality of medicine in those communities while meeting a growing national need in medical education.

The foregoing is but a partial discussion of a very important constellation of issues related to the future of freestanding internships. I would, therefore, request that this item be placed on the agenda for the June 1973 meeting of the COD Administrative Board.

Thank you.

Sincerely,



J. Robert Buchanan, M.D.
Dean

JRB:hw

ROLE OF OSR AND GSA REPRESENTATIVES IN MONITORING PROCEDURES
OF THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM (NIRMP)

Background

At its business meeting in November 1972, the AAMC Group on Student Affairs (GSA) adopted a resolution urging that the National Intern and Resident Matching Program (NIRMP) improve its enforcement of the "all or none" principle for hospital participation in the program. Similarly, at its November business meeting, the AAMC Organization of Student Representatives (OSR) adopted a resolution to establish a system of investigating NIRMP violations and reporting them to appropriate authorities.

In response to these actions, staff of the Division of Student Affairs developed a proposal for the role of OSR and GSA representatives in monitoring the procedures of NIRMP. This staff proposal was approved in principle by Western OSR and GSA members at their regional meeting in Asilomar, California, in March.

The program outlined below, which is a modification of the original staff proposal, was drafted and approved by the Southern region of OSR at its meeting in Williamsburg in April. This program was subsequently supported in principle by Southern GSA at the same meeting.

The basic elements of the Southern region's NIRMP monitoring program were also approved by the Central region of OSR at its meeting in Starved Rock, Illinois, in May. Just prior to this meeting, the NIRMP Board of Directors had agreed that one of its three student members could be appointed by the OSR Administrative Board, so the Central region version of these procedures included the concept that the OSR National NIRMP Monitor would also be a member of the NIRMP Board. Central region OSR also suggested that the Coordinating Council for Graduate Medical Education be included among the recipients of violation reports in lieu of the AAMC Executive Committee and developed a procedure under which CCGME could eventually deny accreditation to any institution of graduate medical education having a program found to be in repeated violation of NIRMP rules. Central GSA approved the Central OSR version of the basic monitoring program but did not act on those portions of the Central OSR proposal concerning accreditation.

It is presently planned that AAMC will assume all staffing responsibility for the functions of the OSR National NIRMP Monitor. Reports of violations will be sent to the Monitor at AAMC Headquarters and AAMC staff will conduct correspondence and take action as appropriate in his/her name, with copies of all materials forwarded to the Monitor.

At its meeting on June 8, the OSR Administrative Board expects to develop a final proposal for OSR monitoring of NIRMP violations, based on the versions approved by OSR and GSA in the three regions which have met this spring, and to select an OSR National NIRMP Monitor for the coming year. Assuming Executive Council approval of this program, the final proposal and the name of the Monitor would be promptly circulated to GSA and OSR members, so implementation of the OSR role in monitoring NIRMP violations may begin this summer.

Program

(1) The role of the AAMC Organization of Student Representatives and Group on Student Affairs in assisting in the maintenance of the NIRMP should be mainly one of channeling student reports of non-compliance to a committee established to review such problems by the dean of each medical school.

(2) The membership of this committee shall include a representative of the OSR and of the GSA as well as any other members appointed by the dean.

(3) When the NIRMP is explained to the rising seniors, the importance of working within established procedures should be stressed to them by this committee. Students shall be asked to report to any member of this committee evidence of any internship or first-year graduate program trying to seek contract agreements outside of the established arrangement for matching.

(4) The committee shall (a) guarantee anonymity to a complaining student, and (b) be responsible for securing all pertinent data in a form pre-established by the complaint review committee. As necessary, any committee member may request a meeting of the committee to determine whether data submitted merit follow-up. If it is agreed that violations exist and that the hospital program in question does not intend to abide by its contract agreements, the committee will (a) advise the dean, and (b) report the violating hospital and department to the OSR National NIRMP Monitor.

(5) The OSR Monitor shall send a report of such violations to the NIRMP Board of Directors and to the AAMC Executive Committee. This report shall state only that X number of various types of violations have been reported concerning Institution Y, Department Z. The Monitor will request that NIRMP acknowledge receipt of such reports and advise him that appropriate action will be taken. It shall then be up to the NIRMP to see that prompt appropriate action is taken by them and/or by the AAMC Executive Committee as needed.

(6) If the National Monitor has reason to believe that appropriate action on a reported violation is not being taken by NIRMP, the Monitor may at his discretion resubmit the report in question to the NIRMP Board of Directors, indicating that this is a second notice.

(7) The National Monitor shall determine, by the time of the AAMC annual meeting, whether (a) all reports of violations forwarded to the NIRMP Board of Directors and AAMC Executive Committee have been received, and (b) the NIRMP has taken action on them. The Monitor shall report these results at the OSR annual meeting.

(8) The OSR Monitor shall be selected by a majority vote of the OSR Administrative Board during the annual meeting. Assuming agreement with this procedure by the Central and Northeast GSA and OSR at their 1973 regional meetings, a temporary National Monitor will be appointed by the OSR national chairman to serve until the 1973 OSR annual meeting.

(9) This procedure shall be reviewed every three years.

PROPOSED STUDY OF
THE EDUCATIONAL COSTS
OF
TEACHING HOSPITALS

1. PRIOR STUDIES
2. BACKGROUND
3. PURPOSE
4. ALTERNATIVE APPROACHES
5. PROPOSED IOM METHODOLOGY
6. STUDY PLAN
7. ISSUES

SUMMARY OF
PRIOR STUDIES

PRIOR STUDIES OF EDUCATIONAL COSTS OF TEACHING HOSPITALS:

- HARTFORD HOSPITAL STUDY
- BUSBY, LEMING & OLSON: "UNIDENTIFIED COSTS IN A UNIVERSITY TEACHING HOSPITAL"
- GLASER: THE TEACHING HOSPITAL
- AAMC STUDIES DESIGNED BY A.T. CARROLL AND T.J. CABELL

WHILE EACH HAS ADVANCED THE STATE OF THE ART, THEY HAVE SHORTCOMINGS:

1. LIMITED COVERAGE -- OFTEN ONE HOSPITAL
2. ADDRESS ONLY PORTIONS OF POTENTIAL COSTS

MAJOR CONCEPTUAL AND PRACTICAL DIFFICULTIES:

- DEFINING EDUCATION, PATIENT CARE AND JOINT ACTIVITIES
- VALUE OF QUALITY CARE
- LACK OF RELIABLE AND AVAILABLE FINANCIAL AND PATIENT CARE DATA
- RELUCTANCE ON PART OF HOSPITALS TO PARTICIPATE

THE IOM APPROACH WILL STRIVE TO OVERCOME THESE DIFFICULTIES AND THE MAJOR LIMITATIONS IN PAST STUDIES.

BACKGROUND

1. NATIONAL COMPARISONS OF COMPARABLE SIZE TEACHING AND NON-TEACHING HOSPITALS SHOW FOR TEACHING HOSPITALS:
 - ⊙ PER DAY COSTS ARE 35% HIGHER
 - ⊙ IN-PATIENT DAYS PER CARE ARE 9% LONGER
 - ⊙ OUTPATIENT VISITS AND EXPENSES ARE 5 TIMES GREATER
2. MOREOVER, INCOME SOURCES, AREAS OF EXPENDITURES AND INTERNAL ORGANIZATION ARE DIFFERENT FOR TEACHING VS. NON-TEACHING HOSPITALS.
3. SOME OF DIFFERENCE IS CAUSED BY TEACHING HOSPITALS SERVICE IN PATIENT CARE AND PUBLIC SERVICE:
 - ⊙ TERTIARY CARE
 - ⊙ TRAUMA AND EMERGENCY CARE
 - ⊙ INDIGENT CARE
 - ⊙ CONTINUING EDUCATION

PURPOSE FOR IOM STUDY

THE PURPOSE FOR STUDYING TEACHING HOSPITALS IS:

- ⊙ GAIN FURTHER UNDERSTANDING OF THE ROLE OF
TEACHING HOSPITALS IN MEDICAL EDUCATION
 - UNIVERSITY OWNED
 - MAJOR AFFILIATES
 - MINOR AFFILIATES
- ⊙ ESTIMATE THE ADDITIONAL EXPENSES INCURRED (IF ANY)
BY TEACHING HOSPITALS IN SUPPORT OF EDUCATION AND
RELATE THESE COSTS TO APPROPRIATE BENEFICIARIES
(STUDENT CATEGORIES)
- ⊙ ANTICIPATE IMPENDING CHANGES IN MEDICAL SCHOOL/
TEACHING HOSPITAL RELATIONSHIPS, ESPECIALLY HOW
SUCH CHANGES WOULD AFFECT THE COSTS AND FINANCING
OF MEDICAL EDUCATION
- ⊙ REPORT TO CONGRESS ON THE COST OF RESOURCES
ESSENTIAL FOR MEDICAL EDUCATION.

ALTERNATIVE
APPROACHES

WE HAVE EXAMINED FOUR ALTERNATIVE APPROACHES FOR CONDUCTING THE
STUDY:

1. QUANTITATIVE ANALYSIS - USING REGRESSION ANALYSIS AND H.A.S.
COST ACCOUNTING DATA TO DERIVE AGGREGATE COST DIFFERENCES
BETWEEN TEACHING AND NON-TEACHING HOSPITALS:
 - USEFUL FOR IDENTIFYING POTENTIAL AREAS OF
INQUIRY
 - SERIOUS LIMITATIONS
2. TRADITIONAL PROGRAM COSTING - USING ACTIVITY ANALYSIS,
EFFORT REPORTS ON STAFF; DISTRIBUTING OTHER COSTS BASED
ON STAFF:
 - POTENTIALLY USEFUL FOR SELECT PORTIONS OF STUDY
 - DOES NOT IDENTIFY EXTRA COSTS (IF ANY)
 - LIMITATIONS POSED BY ACCOUNTING STRUCTURES
3. COMPARATIVE ANALYSIS - USING LIMITED NUMBER OF INDIVIDUAL
CASE STUDIES TO IDENTIFY DIFFERENCES BETWEEN TEACHING AND
NON-TEACHING HOSPITALS:

- HELPS NARROW POTENTIAL COST CENTERS
- BEGIN TO CONSTRUCT (MODEL) DIFFERENCES IN PROCEDURES
- PROVIDES "BENCHMARKS"
- NOT INTENDED FOR CONTROL STANDARDS

4. INCREMENTAL ANALYSIS - LEADING TO IDENTIFICATION, DESCRIPTION AND QUANTIFICATION OF INCREMENTAL COSTS ATTRIBUTABLE TO EDUCATION:

- ASSUME PATIENT CARE IS PRIMARY ROLE
- ASSUME EXISTING LEVELS OF CARE AND MIX OF PATIENTS
 - LENGTH OF STAY
 - QUALITY OF CARE
 - SEVERITY OF CASES
 - SOCIO/ECONOMIC STATUS OF PATIENTS
- LIMIT INQUIRY TO MAJOR EDUCATIONAL COST CENTERS
 - OUTPATIENT CLINICS
 - SUPPORTIVE SERVICES (MEDICAL RECORDS)
 - SPACE AND FACILITIES
 - ADMINISTRATION AND OVERHEAD
 - LABORATORIES, DIAGNOSTIC ROOMS
- INQUIRE INTO "HIDDEN COSTS" SUCH AS LEVEL OF HOUSE STAFF, NON-ECONOMICAL "TEACHING" DEPARTMENTS, VALUE OF HOUSE OFFICER AND MEDICAL STUDENT OUTPUT

WE PROPOSE TO CONCENTRATE ON ALTERNATIVE 4 - INCREMENTAL ANALYSIS,
USE THE COMPARATIVE AND QUANTITATIVE ANALYSIS (ALT. 1 & 3) TO
IDENTIFY AREAS OF INQUIRY.

PROPOSED IOM
METHODOLOGY

THE METHODOLOGY IS STILL BEING DEVELOPED. THEREFORE, YOUR INPUTS AND GUIDANCE WILL BE ESPECIALLY APPRECIATED. IN GENERAL WE PROPOSE TO PROCEED AS FOLLOWS:

1. REVIEW ALL PAST STUDIES, LITERATURE, ETC.
2. USE COMPLETED FACULTY ACTIVITY ANALYSIS, SUPPORT STAFF AND HOUSE OFFICER STUDIES
3. IDENTIFY MAJOR COST CENTERS WHICH SUPPORT EDUCATION:
 - ANALYZE CHANGE AS SERVICE HOSPITAL BECOMES A TEACHING HOSPITAL (E.G., UC-DAVIS)
 - USE NATIONAL DATA AND STUDIES TO IDENTIFY AREAS OF INQUIRY
 - USE COMPARATIVE ANALYSIS TO DEFINE POTENTIAL INCREMENTAL COST AREAS
4. CONSTRUCT PROGRAM STRUCTURE; SPECIAL ATTENTION TO MEDICAL STUDENT AND HOUSE OFFICER PROGRAMS (SEE ATTACHMENT 1)
5. APPLY APPROPRIATE INCREMENTAL COST FINDING APPROACH TO OBTAIN QUANTITATIVE COST DATA

6. DESCRIBE OR "MODEL" THE MAJOR TEACHING/PATIENT CARE
PROCESSES:

-- QUALITATIVE UNDERSTANDING

-- VARIABILITY

7. SUMMARIZE DATA BY TYPES OF HOSPITALS FOR REPORT TO
CONGRESS

STUDY PLAN

WE PROPOSE TO PROCEED IN FIVE MAJOR PHASES OVER THE NEXT 11 MONTHS:

<u>PHASE</u>	<u>TIMING</u>
I. DEVELOP PILOT METHODOLOGY	JULY - AUGUST
II. CONDUCT PILOT TEST (2 SITES)	SEPTEMBER - OCTOBER
III. COMPLETE DEVELOPMENT OF METHODOLOGY	NOVEMBER
IV. CONDUCT FIELD STUDY (4 SITES)	DECEMBER '73 - MARCH '74
V. PREPARE REPORT TO CONGRESS	APRIL '74

ISSUES FOR
CONSIDERATION

1. WHAT DISTORTIONS IN FINDINGS AND COSTS SHOULD WE EXPECT BY ADOPTING THE "INCREMENTAL ANALYSIS" APPROACH (ASSUMING TEACHING CAN BE "MARGINED" ON TOP OF PATIENT CARE)? DOES THIS DIFFER BY TYPE OF HOSPITAL?

2. HOW SERIOUS IN TERMS OF ACCEPTABILITY AND PROPORTION OF CAPTURED COSTS ARE OUR ASSUMPTIONS TO ACCEPT AS GIVEN (AND THEREFORE NOT TO COST DIRECTLY):
 - LENGTH OF STAY
 - SEVERITY OF CASES
 - QUALITY OF CARE
 - SOCIO/ECONOMIC STATUS OF PATIENTS

3. HOW FEASIBLE AND TIME CONSUMING WOULD BE AN ATTEMPT TO "MODEL" OR "CONSTRUCT" AN IDEAL TEACHING HOSPITAL AND FROM THAT DERIVE THE RESULTING EDUCATIONAL COSTS?

4. GIVEN OUR INTENT TO ADDRESS ONLY THE MAJOR COST CENTERS, WHAT IS YOUR REACTION TO OUR PROPOSED FIELD STUDY TIMETABLE AND STAFFING LEVELS: 4 PEOPLE FOR 8 WEEKS TO STUDY A SET OF HOSPITALS (INCLUDING THE UNIVERSITY OWNED, THE MAJOR TEACHING AND A NON-TEACHING)

5. WHAT OTHER GROUPS, ASSOCIATIONS OR ORGANIZATIONS WOULD YOU RECOMMEND COULD ASSIST US IN THE DEVELOPMENT OF OUR METHODOLOGY?

PROPOSED PROGRAM STRUCTURE

1. Patient Care
 - A. In-Patient
 - B. Out-Patient
2. Medical Education for the M.D. Degree
3. Intern and Resident Education
4. Graduate Education for Master or Doctoral Degrees Other Than Nurses
5. Nursing Education
 - A. Undergraduate Nursing Educ. (B.S. in Nsg.)
 - B. Graduate Education (M.S. Degree)
 - C. Graduate Education (Ph.D. or Ed.D.)
 - D. Continuing Education
6. Allied Medical Professions
 - A. Medical Dietetics
 - B. Physical Therapy
 - C. Occupational Therapy
 - D. Medical Technology
 - E. Medical Illustrations
 - F. Radiology Technician
 - G. Medical Records Administration
 - H. Respiratory Technology
 - I. Medical Communications
 - J. Circulation Technology
 - K. Nurse Anesthesia
 - L. Hospital Administration
7. Other Hospital Education Programs
8. Research
 - A. Federally Supported
 - B. Non-Federally Supported
9. Community Services
10. Other Programs (specify)

AD HOC COMMITTEE TO REVIEW PERTINENT SECTIONS OF H.R. 1 (P.L. 92-602)

APPENDIX F

S. David Pomrinse, M.D., CHAIRMAN
Director
The Mount Sinai Hospital
11 East 100th Street
New York, New York 10029

John W. Colloton
Director
University of Iowa
Hospitals and Clinics
Newton Road
Iowa City, Iowa 52240

John M. Stagl
Executive Vice President
Northwestern Memorial Hospital
303 East Superior Street
Chicago, Illinois 60611

Charles B. Womer
Director
Yale New Haven Hospital
New Haven, Connecticut 06511

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

May 15, 1973

Thomas M. Tierney
Director
Bureau of Health Insurance
Social Security Administration
East Building Room 700
Baltimore, Maryland 21235

Dear Mr. Tierney:

As requested in your letter of April 19, we have reviewed the proposed policies for implementing section 1122 (Limitation on Federal Participation for Capital Expenditures). Our comments concerning the "Discussion Paper" are set forth as follows:

.. In reviewing the language of the law as well as the Committee reports, the intent to review projects which do not exceed \$100,000 is not clear. From the standpoint of efficient administration, it would appear burdensome for designated planning agencies to review projects which require the expenditure of less than \$100,000. This is particularly important for large teaching hospitals which constantly are in the process of changing bed distribution as well as clinic and other service components. In most instances, these changes entail relatively minor capital expenditures.

.. In regard to the point above, the sentence beginning on the bottom on page nine, is important, and reads as follows: "The 'change in capacity' is defined as any change in the facility's total number of beds or any change in the total number of beds assigned for a specific type of patient care." We would hope that some guidance would be provided in the regulations so that designated planning agencies would not make an unnecessarily narrow interpretation of this sentence. It would seem worthwhile to include an example which demonstrates that the redistribution of beds between sub-specialties (e.g., from cardiology to gastroenterology) are not included within the intent of this sentence.

.. Nowhere in the regulations are the terms project or program specifically defined, except by example on page three of the "Implementing Section." The definition of these terms is particularly important in instances where a facility is proposing a large number

of capital expenditures. These proposed expenditures could be reviewed on either a case by case or a total program basis. In this regard we would hope that designated planning agencies would be encouraged to approach these multiple expenditures from an overall perspective. For example, one large midwestern teaching hospital expects to have 41 identifiable capital expenditures over the next three years which would most likely require approval. If reviewed individually, the energy of the planning agency would almost be totally consumed in reviewing the proposed expenditures of this facility.

.. In administering the regulations, we would hope that designated planning agencies would exclude from review the normal replacement of capital equipment in excess of \$100,000 dollars which does not substantially change the services provided. For instance, many teaching hospitals would engage in the replacement of over \$500,000 dollars worth of capital equipment each year. Example B on page three of the "Implementing Section" makes no distinction between normal replacement and the acquisition of equipment which would substantially change the capacity or type of service. Additionally, we assume that if the three separate and independent pieces of equipment referred to in the example are in three different departments (e.g., laundry, laboratory and x-ray), the expenditures would not be subject to review.

.. With the exception of the Reconsideration Determination on page 22, each step of the review process sets forth time limits for decision making. To ensure an orderly and efficient process, we would suggest that a time limit also be included for reconsideration determinations by the Secretary.

.. On page 16 of the draft regulations four guidelines are cited on which designated planning agencies may base decisions, the first of which states that "...the project is needed in the community in terms of health services required." Decisions based upon considerations of community of need or the community served varies considerably according to the mix of specialized services provided by the facility. For example, the community of need for primary care services may be the city or county in which the hospital is located, whereas the community of need for highly specialized services most frequently extends beyond local jurisdictions and is interstate and regional in character. Thus, our concern is focused on the possibility of local agency denial of capital projects for highly specialized services having a community of need which extends beyond the local community and is referral in nature.

.. Related to the above is the fact that institutions providing highly specialized services are most frequently engaged in manpower training and clinical research. Therefore, we would suggest that an additional

Mr. Tierney
Page Three

guideline be added which recognizes that the manpower training and research functions of teaching hospitals are essential to their role as regional tertiary care centers.

We appreciate very much the opportunity to review the "Discussion Paper" and I hope that our comments are of some assistance to you. If I can in any way provide further clarification of our comments, please let me know.

Sincerely,

John A.D. Cooper, M.D.
President

cc: Maurice Hartman
Division of State Operations



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21285

APPENDIX G

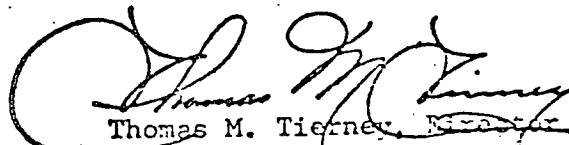
PART
B

March 1973

INTERMEDIARY MANUAL
REVISION TRANSMITTAL NO. 320

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Sec. 6102.6-6102.8	21-21.1 (2 pp.)	21-21.1 (2 pp.)

Section 6102.7, Interns and Residents, has been revised to include within the definition of "physicians' services" services performed by interns and residents outside their regular training program in a hospital other than the hospital in which they are in training under such program provided that they are fully licensed to practice medicine in the State in which the services are rendered and are not compensated by a provider. Any services rendered in the hospital with the approved teaching program under which the interns or residents are in training continue to be reimbursable, if at all, only as provider services. This policy is effective on receipt and is applicable to claims not yet adjudicated as well as to adjudicated claims coming to the carriers' attention. Files should not be searched, however, to locate previously denied claims.


Thomas M. Tierney
Bureau of Health Insurance

Action Note: Add to the last paragraph of § 6012, "(See, however, § 6102.7B regarding circumstances under which services of certain moonlighting residents are reimbursable on a reasonable charge basis.)"

6102.6 Provider-Based Physicians' Services.--The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, etc., whether or not they bill patients directly) include two distinct elements: the patient-care component, and the provider component. (The services of interns and residents are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.)

A. The Professional Component.--The patient-care component of provider-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) When such services are performed by a faculty member of a medical, osteopathic, dental, or podiatry school billing may be by the school with the physician's authorization. See § 6330 for form and procedures for billing for services of provider-based physicians. See § A6015 for limitations on reassignment under the 1972 Amendments.

B. The Provider Component.--Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where they relate to outpatient services and inpatient ancillary services where there are no benefits payable under Part A. (See § 6852.2 on distinguishing between professional and provider components for reimbursable purpose.)

C. The Roles of the Fiscal Intermediary and Carrier.--The provider's Part A intermediary will obtain from the provider information it and the Part B carrier need to make payment determinations where the services of provider-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between provider and physician on the allocation of physician compensation (received from or through the provider) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the provider and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue (§ 6852.6). The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of provider-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, the uniform percentage if the optional method of determination is used, or the unit charge if the per diem or per visit method is used (§§ 6856ff.).

Group practice prepayment plans which deal directly with the Social Security Administration may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan members entitled to Part B. These claims will not be processed by carriers.

6102.7 Interns and Residents.—

A. General.—For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting (e.g., unlicensed graduates of foreign medical schools). As a general rule, services of interns and residents are reimbursed on a reasonable cost basis by the Part A intermediary. However, the services of an intern or resident are reimbursable by the carrier on a reasonable charge basis as physicians' services where the individual: (1) renders the services off provider premises (however, see also B below, regarding certain "moonlighting" interns and residents); (2) is not compensated by a provider; and (3) is fully licensed to practice medicine by the State in which the services are performed. (See §§ 6704.5 and 6806 regarding the reasonable charge determination.)

See §§ 3101.6 and 3115 of the Part A Intermediary Manual (HIM-13) regarding approved programs and coverage as a provider service under hospital and medical insurance.

B. "Moonlighting" Interns and Residents.—Services a moonlighting intern or resident performs in the outpatient department or emergency room of the hospital which has the training program in which he is participating are reimbursable only on a Part B reasonable cost basis (i.e., all services performed in the hospital with the training program are treated as part of the training program). In addition, any services a "moonlighting" intern or resident furnishes in the hospital other than the one with the approved training program under which the intern or resident is in training are reimbursable on a Part B reasonable cost basis if he is paid for such services on a salary or other fixed compensation basis by the hospital in which such services are rendered (or by another hospital). However, such services are reimbursable by the carrier on a reasonable charge basis as physicians' services if the intern or resident is not so compensated and if he is fully licensed to practice medicine in the State in which the services are performed.

6102.8 Supervising Physicians in the Teaching Setting.—Medical insurance covers the services attending physicians (other than interns and residents) render in the teaching setting to individual patients.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Morristown Memorial Hospital
Morristown 100 Madison Avenue
City Street
New Jersey 07960 07960
State Zip Code

Principle Administrative Officer: _____
Name

Title

Date Hospital was Established November 19, 1892

Approved Internships:

<u>Type</u>	<u>Date Of Initial Approval by CME of AMA*</u>	<u>Total Internships Offered</u>	<u>Total Internships Filled</u>
Rotating	<u>Prior to 1950</u>	<u>12</u>	<u>12</u>
Straight	_____	_____	_____

Approved Residencies:

<u>Specialties</u>	<u>Date Of Initial Approval by CME of AMA*</u>	<u>Total Residencies Offered</u>	<u>Total Residencies Filled</u>
Medicine	<u>January 1973</u>	<u>16</u>	<u>New Program</u>
Surgery	<u>1955</u>	<u>4</u>	<u>4</u>
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Psychiatry	_____	_____	_____
Other	_____	_____	_____
Radiology	<u>1968</u>	<u>6</u>	<u>5</u>
Pathology	<u>1953</u>	<u>6</u>	<u>5</u>

Information Submitted By:

Robert G. Boyd Executive Vice President
Name Title of Hospital Chief Executive
February 8, 1973 _____
Date Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Rutgers Medical School

Name of School of Medicine College of Medicine & Dentistry of New Jersey

Name of Dean James Mackenzie, M. D.

Address of School of Medicine University Heights, Piscataway, N.J. 08854

FOR COFH OFFICE USE ONLY	
Date _____	Approved _____ Disapproved _____ Pending _____
Remarks _____	

Invoiced _____	Remittance Received _____

AFFILIATION AGREEMENT

AGREEMENT made this 6th day of December 1972,

BETWEEN,

MORRISTOWN MEMORIAL HOSPITAL (hereinafter referred to as the
"Hospital")

AND

THE COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY, a body corporate and
politic in the Department of Higher Education, State of New Jersey (hereinafter
referred to as the "College").

WITNESSETH THAT:

WHEREAS, The College and the Hospital are desirous of cooperating in the
use of their respective facilities and staffs to develop high quality medical education
programs, and (a) whereby students of the Rutgers Medical School of the College
can participate in the care of patients of the Hospital as an integral part of their
medical education, and (b) where by quality internships and residency programs can
be developed for graduate education and clinical training, and

WHEREAS, the College and the Hospital are desirous of using their facilities
and staffs jointly to provide the highest possible quality patient care for the
community served by the College and the Hospital, and

WHEREAS, the College and the Hospital are desirous of providing on a cooperative
basis programs of community service designed to sustain and improve the delivery
of good medical care and to develop programs of preventive medicine, and,

WHEREAS, the College and the Hospital are desirous of using the combined
resources of their respective facilities and staff in joint programs of biomedical
and clinical research, within the limitations of their existing respective facilities,
and

WHEREAS, to implement the foregoing, the College and the Hospital desire
to enter into an affiliation agreement,

NOW, THEREFORE, in consideration of the mutual promises, covenants and agree-
ments hereinafter contained, the parties hereto do hereby covenant and agree as
follows:

1. The members of the Hospital's Medical Staff who, in accordance with the standards and procedures prescribed by the Rutgers Medical School of the College for appointment to the College, qualify by training and performance will be given appropriate appointments to the Rutgers Medical School of the College's Faculty of Medicine as described below. Physicians who are members of the Hospital staff as of the date of this Agreement who do not so qualify by training and/or performance for an appointment to the faculty of the Rutgers Medical School of the College, or who by choice prefer not to be so appointed, will continue as members of the Hospital staff, without loss of rank or privilege. Full-time Hospital Medical Staff members will receive clinical titles at the Rutgers Medical School of the College and have the same rights and privileges as clinical appointees of the faculty of the Rutgers Medical School of the College. Full-time Hospital Medical Staff appointments will be renewed in accordance with the customary practices of the Hospital. The Hospital shall review with the Dean of Medicine of Rutgers Medical School of the College, before any action is taken, any decision to rescind a contract or failure to renew the appointment of any full-time Hospital Medical Staff member holding a clinical appointment on the College faculty. Qualified voluntary members of the Hospital Medical Staff, who so desire, will receive clinical appointments to the faculty of the Rutgers Medical School of the College for a term of one year, subject to renewal, on the approval of the Hospital and the College through the usual appointment mechanisms of both the Hospital and the College.

2. After the effective date of this Agreement, all physicians newly appointed to the Hospital staff shall qualify for simultaneous appointment to the faculty of the Rutgers Medical School of the College in accordance with standards jointly prescribed by the College and the Hospital. Exceptions to this rule may be made for general and/or family practitioners, emergency service physicians, and for physicians in specialties who do not have counterparts on the College's faculty. In addition, other exceptions may be made upon the recommendation of the Affiliation Review Committee. All nominations for appointment and for staff advancement shall originate in the Hospital in accordance with the regular procedures of the Hospital and professional staff. Before final approval of any nomination for appointment is given by the Hospital, the nomination or recommendation shall be submitted to the Chairman of the respective Department at the Rutgers Medical School and through the Dean of the School, who shall process the appointment through the School's and College's regular appointment mechanisms. It is expected that ordinarily these appointments will be approved or disapproved within 45 days after credentials are complete. No physicians who are members of the Hospital staff as of the date of this Agreement

or subsequently may lose such membership except in accordance with action of the Hospital.

3. The Hospital agrees to employ full-time Hospital based chiefs-of-service of the following services: medicine, pediatrics, radiology, and pathology; and agrees to employ a full-time Hospital based chief-of-service in surgery within nine months. In addition, the Hospital agrees to employ full-time chiefs in psychiatry, obstetrics and gynecology, and family practice when, in the sole discretion of the Hospital, it is feasible to do so. The Rutgers Medical School of the College agrees to assist the Hospital, if requested, in recruiting qualified personnel to be appointed as chiefs of the designated services, according to mutually acceptable procedures. Final appointment of full-time chiefs-of-services shall be subject to the approval of the Dean of the Rutgers Medical School of the College, who shall refer such appointments through the School's and College's regular appointments mechanisms. These mechanisms shall include recommendation for faculty appointment by the Chairman of the respective Department, approval of the Dean of the School and subsequent processing through the School's and College's regular appointment mechanisms. The appointment of the Hospital's Medical Director shall be subject to the approval of the Dean of the Rutgers Medical School of the College, the President of the College, and the Board of Trustees of the College, as well as the Hospital.

4. An Affiliation Review Committee will be formed to consist of the Dean of the Rutgers Medical School of the College (or his representative, whom he may designate) and two representatives from the faculty of the Rutgers Medical School of the College, the Medical Director of the Hospital (or his representative), and two other representatives designated by the Hospital. This Committee will have the authority to review and recommend educational programs and policies developed for purposes of this affiliation. It will also serve as an appeals committee in the event of individual disagreements as to questions of academic or educational character. It will be asked to formulate and present matters of policy for consultation by the respective governing bodies. It will meet annually or more often as is necessary. At each annual meeting, progress of the affiliation will be discussed and future plans will be developed, discussed and approved. The Chairmanship of this Committee will alternate between the Dean and the Medical Director of the respective institutions or their delegates.

5. All patients admitted to the affiliated departments of the Hospital for medical care shall be admitted with the understanding of the patients that they will participate in the teaching program of the Hospital house staff and medical students of the College under the guidance of the appropriate service chief and his teaching staff. Professional responsibility for the care and management of all patients will remain with the Hospital's Medical Staff. Patients may be excluded from participating in the teaching programs only if the attending physician determines that such participation might be harmful to the patient, or if the patient declines to participate. Patients excluded from the medical student training program may also be excluded from receiving services of Hospital house staff members as determined by the Chief of the appropriate department except in cases of medical emergency. Any member of the teaching staff of the Hospital excluding an excess of ten (10) percent of his patients in any twelve (12) month period from the teaching program shall have all such excluded cases reviewed by the Chairman of the Department at the Hospital before his annual Hospital staff appointment is renewed.

6. The Hospital will accept and the College will provide students of the Rutgers Medical School of the College for clerkships in those services where the Hospital has appointed a full-time chief of service. These students shall abide by all of the policies, rules, and regulations of the Hospital. The Hospital may continue to provide elective or advance clerkships in accordance with its existing commitments. The number of students to be assigned and retained to clerkships in any year or fraction thereof shall be determined by the Rutgers Medical School of the College and with the concurrence of the Hospital. The College agrees to transfer any student from the Hospital at the reasonable request of the Hospital. In such instances, students may appeal to the Affiliation Review Committee through the Dean of the Medical School of the College. Each Hospital service chief shall be responsible for the supervision of those students assigned to his service. The students' association with patients of the Hospital shall be through their participation with the house staff and assigned teaching attending physicians holding appointments on the faculty of the College. Student clerks shall participate in patient care by taking medical histories, doing physical examinations, recording differential diagnosis, making recommendations for diagnostic and therapeutic procedures, making recommendations for disposition of patients after discharge from the Hospital, and in participation in other activities as requested by the Hospital Service Chiefs.

The patients' histories, physical examinations and other notes as recorded by students participating in the hospital's teaching program will become a part of the patient's temporary hospital record, and of the permanent record if not in conflict with other policies of the hospital. These entries shall be on separate pages and shall be identified by the student's signature and Medical School class, and shall be reviewed and countersigned by a supervising resident or teaching attending physician.

7. Subject to mutual agreement between the authorized representative of the Hospital and the Dean of the Rutgers Medical School of the College, the Hospital will provide necessary educational facilities for all College students serving clerkships and electives within the Hospital.

8. The members of the Hospital house staff shall participate under the direction of the appropriate Hospital service chief in the teaching program to be carried on at the Hospital. Students assigned to the Hospital will be working directly under members of the house staff.

9. Attending staff members participating under this agreement in the educational program shall not accept any appointment in another medical school without the approval of the Dean of the Rutgers Medical School of the College.

10. Subject to the approval of the governing board of the Hospital, the Hospital may appoint to its staff, with appropriate privileges, members of the College faculty.

11. The College shall assist the Hospital in developing quality internship and residency programs and assist in recruiting interns and residents.

12. The Hospital agrees that it shall not enter into any affiliation agreement other than agreements now in effect or renewals thereof with any other medical school without the prior approval of the Rutgers Medical School of the College. The Hospital also agrees to phase out any affiliation it may have with other medical schools as comparable replacement programs are developed by the College.

13. It is understood that the Rutgers Medical School of the College will require affiliations with other hospitals to carry out its purposes and that the College alone shall determine the number and content of such affiliations. However, the College agrees to refrain from contracting any affiliations which would interfere with the College's obligations under this agreement without agreement of the Affiliation Review Committee and the knowledge of the Hospital.

14. Under this Agreement both the College and the Hospital shall continue to be autonomous and shall be governed independently by the respective governing bodies and administrations except insofar as this Agreement specifically states to the contrary.

15. This Agreement may be modified or amended by mutual consent of the parties and shall be subject to annual review. Either party may terminate the Agreement by giving one (1) year's written notice of such intention to the other party.

16. The College will not compensate the Hospital on account of any of the activities, services, or facilities provided for in this affiliation.

17. The Hospital's status shall be that of an independent principle and not as agent or employee of the College and/or the State of New Jersey.

18. This agreement shall be governed and construed and the rights and obligations of the parties hereto shall be determined in accordance with the laws of the State of New Jersey.

19. If it becomes necessary for the Hospital, either as principle or by agent or employee, to enter upon the premises or property of the State of New Jersey in order to construct, erect, inspect, make delivery or remove property hereunder, the Hospital hereby covenants and agrees to take, use, provide and make all proper, necessary and sufficient precautions, safeguards and protections against the occurrence of happenings of accidents, injuries, damages or hurt to any person or property during the progress of the work herein covered, and to be responsible for and to indemnify and save harmless the State of New Jersey from the payment of all sums of money by reason of all, or any, such accidents, injuries, damages or hurt that may happen or occur upon or about such work and all fines, penalties and loss incurred for or by reason of the violation of any city or borough ordinance, regulation, or the laws of the State of New Jersey or the United States, while the said work is in progress.

20. There shall be no discrimination against any employee engaged in the work required to produce the services and programs covered by this agreement, or against any applicant for such employment because of race, creed, color, national origin, sex, or ancestry. This provision shall include, but not be limited to the following: employment upgrading, demotion, transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Hospital shall insert a similar provision for all sub-contracts.

21. The New Jersey Prevailing Wage Act, T.L.-1963, Chapter 150, is hereby made a part of every agreement entered into on behalf of the State of New Jersey through the College of Medicine and Dentistry of New Jersey, except those agreements which are not within the contemplation of the Act.

22. The parties to this agreement do hereby agree that the provisions of N.J.S.A. 10;2-1 through 10;2-4, dealing with discrimination in employment on public agreements, and the rules and regulations promulgated pursuant thereto, are hereby made a part of this agreement and are binding upon them.

23. The undersigned does hereby warrant and represent that this agreement has not been solicited or secured, directly or indirectly, in a manner contrary to the laws of the State of New Jersey and that said laws have not been violated and shall not be violated as they relate to the procurement or the performance of this agreement by gift, gratuity or consideration of any kind, directly or indirectly, to any State employee, officer or official. The Hospital also agrees that it shall not advertise or use the fact of the agreement for any promotional program without the approval of the Dean of Rutgers Medical School of the College. Such approval shall not be unreasonably withheld.

24. The Hospital does hereby warrant and represent that it is qualified by training and experience to perform the required services and programs in the manner and on the terms and the conditions set forth herein.

IN WITNESS WHEREOF, the parties hereto, duly authorized, have caused these presents to be assigned by their proper corporate officers and caused their proper corporate seals to be hereto affixed the day and year first written above.

WITNESS:

Maebelle B. Wiley
Secretary

By Stanley S. Bergen, Jr.
Stanley S. Bergen, Jr.
President
COLLEGE OF MEDICINE AND DENTISTRY
OF NEW JERSEY

Robert M. Smith

By Robert M. Smith
President
BOARD OF TRUSTEES
MORRISTOWN MEMORIAL HOSPITAL

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Christ Hospital
Cincinnati Name 2139 Auburn Avenue
City Street
Ohio 45219
State Zip Code

Principle Administrative Officer: Alexander Harmon
Name
Executive Director
Title

Date Hospital was Established 1889

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1952</u>	<u>15</u>	<u>5</u> 2 - affiliated - U.C.
Straight	<u>1959</u>	<u>7</u>	<u>3</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery	<u>1951</u>	<u>17</u>	<u>13</u>
OB-Gyn			<u>3 (affiliated - U.C.)</u>
Pediatrics			
Psychiatry			<u>4 (affiliated - U.C.)</u>
Other Plastic Surgery	<u>1958</u>	<u>2</u>	<u>2</u>
Orthopedic			<u>1 (affiliated - U.C.)</u>
Radiology			<u>2 (affiliated - U.C.)</u>
Urology			<u>4 (affiliated - U.C.)</u>
Neurosurgery			<u>2 (affiliated - Good Samaritan)</u>

Information Submitted By:

Thoracic Surgery Alexander Harmon Executive Director 2 (affiliated) (U.C.)
Name Title of Hospital Chief Executive

Date

Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine University of Cincinnati College of Medicine
Name of Dean Robert S. Daniels, M.D.
Address of School of Medicine Eden and Bethesda Avenues
Cincinnati, Ohio 45219

FOR COTH OFFICE USE ONLY	
Date _____	Approved _____ Disapproved _____ Pending _____
Remarks _____	

Invoiced _____	Remittance Received _____

THE CHRIST HOSPITAL

SUMMARY OF TEACHING PROGRAMS

The Christ Hospital is a 700-bed voluntary general hospital, located in the inner city of Cincinnati. Its basic service area encompasses Greater Cincinnati, with only 6 percent of the patients coming from the inner city itself. In 1972, 20,254 patients were admitted, and 206,171 patient days of service were rendered.

All of the major specialties are represented on the medical staff. In addition, a hemodialysis unit and a cardiovascular surgical team have been developed. The Hospital has become increasingly specialized over the years and has been moving away from primary care into secondary and tertiary care.

The Christ Hospital has been active in medical education for a number of years. Many of the members of the medical staff have appointments at the University of Cincinnati Medical Center, and many members of the full-time staff at the University have appointments on the consulting staff of the Hospital. In 1967, the Hospital and the University signed an agreement which laid the groundwork for joint activities in teaching, patient care, and research. The number of joint ventures between the two institutions has been growing steadily. Collaborative programs are expected to expand considerably beginning in 1975 when the University will double its present medical student enrollment.

The Christ Hospital Institute of Medical Research Library, located on the Hospital campus, has a well-developed collection and is one of the University

of Cincinnati Medical Center Libraries. The Hospital has closed circuit television linked with the University so that the house staff at The Christ Hospital may view grand rounds, special programs, and so forth at the University of Cincinnati Medical Center. The Hospital also subscribes to the Network for Continuing Medical Education.

A detailed account of the various medical education programs at The Christ Hospital, and a list of the department directors follow.

INTERNAL MEDICINE

The Department of Internal Medicine supports a full-time director who is also Professor of Medicine at the University of Cincinnati. Of the 45 active members of this department, 36 have teaching appointments at the University, including two professorships of medicine and three clinical professorships of medicine.

Undergraduate Programs In Cooperation with the University of Cincinnati Medical Center.

Sophomore Medical Students. A required course in clinical physical diagnosis is offered at The Christ Hospital. The sophomore class is divided into groups, some students going to Cincinnati General Hospital, the Veterans Administration Hospital, and community hospitals. The Christ Hospital has 36 students. Each preceptor is assigned two students who receive their first experience in totally analyzing the patient.

Junior Medical Students. At present no juniors have been assigned to The Christ Hospital. Future plans call for approximately six third-year students per year to receive their basic exposure to the field of internal medicine at The Christ Hospital. The course, one quarter in length, will provide the student with clinical responsibility under a preceptorial arrangement. In addition there will be conferences and lectures by the staff here.

Senior Medical Students. Every senior must take one quarter in a junior internship. Almost all of the students take this internship in internal medicine. Six students per quarter are serving their junior internship at The Christ Hospital.

During the quarter the student serves as an intern but has much more individual supervision of his activities than a regular intern. This program serves as an extension of the student's basic training in internal medicine and increases his responsibility within legal limits. It is based on a preceptorial arrangement together with conferences, ward rounds, didactic teaching sessions, and lectures. After 1975, the number of students per quarter will probably increase to 12.

The Christ Hospital offers elective courses in several subspecialties, namely, cardiology, hematology, and nephrology. The program will be expanded to include infectious diseases and gastroenterology. Six students per year are taking advantage of this preceptorship type opportunity.

Graduate Programs.

Rotating Internships. The Christ Hospital has a free-standing, approved rotating internship for a quota of 15 positions. The house staff now has five interns. The Hospital also participates in the rotation internship program at the University of Cincinnati Medical Center. Two or three interns from the Center rotate at a time for a period of two to three months at the Hospital. A minimum of four positions and a maximum of eight are rotated through internal medicine in the course of a year.

Residency. The Christ Hospital participates in the straight surgical residency at the University of Cincinnati by providing a two-month rotation on internal medicine. Throughout the year, two residents are assigned to The Christ Hospital.

The Christ Hospital is applying for a free-standing medical residency with the endorsement of the University of Cincinnati Department of Medicine.

Fellowships. The Christ Hospital is planning to expand its educational activities to include fellows in subspecialties, such as infectious diseases, cardiology, nephrology, gastroenterology and hematology, in an integrated program with the University of Cincinnati. A fellow in infectious diseases is currently at the Hospital; next year a second-year fellow in cardiology will be here.

ONCOLOGY

The Department of Oncology supports a full-time director who also has a teaching appointment at the University of Cincinnati. This department is active in both undergraduate and graduate medical education.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center.

Those freshmen taking the clinical opportunities elective under the Hospital Director of Surgical Education observe the Oncology Department as part of their coursework. These medical students taking their gynecology rotation spend one day per week in Oncology. In addition, the department offers an elective in oncology to junior or senior medical students who spend one day a week for six weeks in this program to gain wide experiences in the diagnosis and modes of treatment of cancer.

Graduate Programs.

All residents have teaching contact with the director of Oncology on individual service cases.

School of Radiation Therapy Technology.

In cooperation with the University of Cincinnati and the Good Samaritan

Hospital, the department has planned a training program for therapeutic radiologic technologists, beginning July 1, 1973. This will be a one-year program open to registered nurses and registered diagnostic radiologic technologists.

GENERAL SURGERY

The Department of General Surgery supports a full-time Director of Surgical Education, who also has a teaching appointment at the University of Cincinnati. This department is active in both undergraduate and graduate medical education.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center .

Freshman Medical Students. Twenty students spend one day per week at The Christ Hospital participating in an elective clinical opportunities course offered through the Dean's Office. These students learn basic surgical skills, participate in surgical procedures, and become more involved in the clinical problems facing house staff and the attending physician.

Senior Medical Students. A junior internship in general surgery is offered at The Christ Hospital as an elective. This year two students will participate in this program.

Graduate Programs.

Straight General Surgery Internship. This is a free-standing, approved program in which three interns are currently enrolled. The program is approved for seven positions.

General Surgery Four-Year Residency. This is a free standing, approved program, which is loosely affiliated with the University of Cincinnati. Seventeen positions are approved. At present, The Christ Hospital has seven first year residents and one fellow, three second-year residents, two third-year residents, and one chief resident. All first-year residents rotate to the Emergency Room at the Cincinnati General Hospital for one month; all second-year residents rotate to Children's Hospital for three months; and all third-year residents rotate to the Trauma Unit at Cincinnati General Hospital for three months. In addition to its complete four-year program in general surgery has provided two years of basic surgical training to physicians in preparation for entering specialty residencies in otolaryngology, urology, and orthopedics at the University of Cincinnati Medical Center.

OBSTETRICS AND GYNECOLOGY

The Department of Obstetrics and Gynecology supports a full time director who is an Associate Clinical Professor of Obstetrics and Gynecology at the University of Cincinnati and is active in the teaching program at The Christ Hospital as well as at the University. The active members of the department number 16, 14 of whom have teaching appointments at the University. One staff member is a Professor of Obstetrics and Gynecology, and another is a Clinical Professor of Obstetrics and Gynecology. University faculty members have consulting appointments to The Christ Hospital medical staff. Joint seminars sponsored by the University and the Hospital are held at The Christ Hospital.

Undergraduate Programs in Cooperation with the University of Cincinnati
Medical Center.

Freshmen Medical Students. Four students spend one afternoon a week in obstetrics, working with the house staff and nurses to get an overview of the total care of a maternity patient.

Junior Medical Students. Throughout the year two to six students rotate, participating in both the obstetrical and gynecological services, as part of their regular rotation. The students spend two weeks of their six weeks at The Christ Hospital; they spend the remaining four weeks at the Cincinnati General Hospital.

Senior Medical Students. A junior internship in Obstetrics and Gynecology is offered at The Christ Hospital as an elective. These students work with the residents and attending staff, participate in the clinics and in inpatient care, and serve in the Operating Room and Delivery.

Graduate Programs.

Rotating Internship. This is a free-standing, approved program with which the Department of Obstetrics and Gynecology cooperates.

Rotation Residency Program. Three residents, one at the first-year level, one at the second - year level, and one at the third-year level, rotate on a three-month basis, through a combined obstetrics-gynecology program with the University of Cincinnati Medical Center.

ORTHOPEDICS

Seven orthopedic surgeons are active members of the medical staff; five of them have teaching appointments at the University of Cincinnati.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center.

The department offers an elective (preceptorship) in orthopedic surgery to junior and senior medical students at the University.

Graduate Programs.

Rotating Residency Program. Orthopedic residents from the University rotate through The Christ Hospital for a period of three months. One resident is assigned to the hospital at all times.

NEUROSURGERY

The Director of the Department of Neurosurgery at The Christ Hospital holds the same position at The Good Samaritan Hospital, another voluntary general hospital. All active members of the department at The Christ Hospital hold teaching positions at the University of Cincinnati, the director being a Clinical Professor of Neurosurgery.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center.

The two voluntary hospitals offer an elective in neurosurgery, either six or twelve weeks in length, to medical students of the University.

Graduate Programs.

Neurosurgical Residency. The two voluntary hospitals have a combined free-standing residency, fully accredited by the American Board of Neurological Surgery. This four-year residency program includes specific rotations in neurology, the basic sciences, and pediatric neurosurgery. One new resident each year is added. Five residents are in the combined program this year.

Graduate Fellowships. The two voluntary hospitals also offer two types of graduate fellowships in neurosurgery. The clinical fellowship may be taken by students from other countries who want clinical training in this country, by American neurosurgical residents who desire greater experience, or by orthopedic residents. The microneurosurgery fellowship is open to individuals who desire to learn and perfect techniques with the surgical microscope. This year two graduate fellows are in the program.

Research. The department engages in limited research activities at The Christ Hospital Institute of Medical Research.

PLASTIC SURGERY

The Director of the Department of Plastic Surgery holds an appointment as Associate Clinical Professor of Surgery at the University of Cincinnati. Three plastic surgeons are active members of the medical staff.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center.

A six-week elective course in plastic surgery is offered to senior medical students.

Graduate Programs.

Straight Surgical Internship. At all times one straight surgical intern from the University of Cincinnati is assigned to The Christ Hospital Department of Plastic Surgery on a two to three month rotation basis.

Plastic Surgery Two Year Residency. The department has a fully approved free-standing residency in plastic surgery. Each year the hospital has one junior resident and one senior resident.

Surgical Fellowships. The department also supports two surgical fellows.

THORACIC AND CARDIOVASCULAR SURGERY

The two departments of Thoracic Surgery and Cardiovascular Surgery have six active staff members, four of whom have teaching appointments at the University. The Department of Cardiovascular Surgery supports two full time surgeons.

Graduate Programs.

Rotating Residency Program. At all times two senior residents are assigned to The Christ Hospital by the Department of Surgery of the University of Cincinnati: one in thoracic surgery and one in cardiovascular surgery. The rotation period is usually three months.

UROLOGY

The teaching program of this department is totally integrated with that of the University of Cincinnati Medical Center. The director of the Department of Urology at The Christ Hospital is also Professor of Surgery and Director of the Urologic Division at the University.

Undergraduate Programs in Cooperation with the University of Cincinnati Medical Center.

Medical Students. A three-, six-, or twelve-week elective in urology is available to medical students. Several students are assigned to The Christ Hospital at all times. They participate, under supervision, in the active workup and treatment of urologic patients and in all staff conferences, grand rounds, and teaching seminars.

Student Exchange. The department also participates in student exchange with other universities. This year one medical student from the University of New Jersey took an elective course at The Christ Hospital.

Urologic Assistants Training Program. This is a two-year program in which most of the students are college graduates. Four urologic assistant trainees are assigned to The Christ Hospital at all times, one in sternal therapy, and three in urology. In their second year, they rotate through the Urologic Service at the Cincinnati General Hospital.

Graduate Programs.

Rotating Residency. All urologic residents at Cincinnati General Hospital rotate through The Christ Hospital Department of Urology. Rotations

are usually on a three-month basis. At all times there are two rotating residents on urology, one on nephrology and one on pathology.

RADIOLOGY

The director of the Department of Radiology has an appointment as Associate Clinical Professor of Radiology at the University of Cincinnati. The other two radiologists in the department also have teaching appointments at the University.

Rotating Residency Program. Radiology residents from the University of Cincinnati Medical Center rotate through The Christ Hospital for a period of four months. Two residents are assigned to the Hospital at all times.

Other Activities. - The department conducts weekly meetings on x-ray diagnosis each week for the benefit of junior interns, interns, and residents. A two-year school of x-ray technology, approved by the American College of Radiology, the American Registry of Radiologic Technologists, and the American Medical Association, provides a program for 20 students. Application is being made to increase the enrollment to 24.

AGREEMENT

This agreement, entered into by and between the Board of Trustees of the Elizabeth Gamble Deaconess Home Association, operating The Christ Hospital hereinafter called "The Hospital" and the Board of Directors of the University of Cincinnati (hereinafter called "The University"), the third day of October, 1967.

WITNESSETH, as follows:

Both the Hospital and the University recognize the potential values inherent in joint activities in teaching, in patient care and in research. Both recognize also the difficulties inherent in the interrelation of two complex organizations. Hence, this agreement covers only certain general principles, with its major goal being one of making possible the exploration of specific areas of potential collaboration or association. If such exploration leads to the definite development of an area of joint activity, that arrangement shall be covered by a detailed "Agreement".

Further, in consideration of the mutual promises herein made, it is agreed:

1. That the Hospital shall be associated with the University as hereinafter set forth, for the purpose of exploring and if possible, of establishing further informal professional linkages between the Hospital and University Departments or groups, and further formal affiliations between the two for the advancement of patient care, medical education, and research in selected programs or projects of the Hospital and the College of Medicine of the University.
2. The professional director of the selected program or project may be appointed by the Hospital only from a list of one or more candidates for the position, which list had been submitted to the Hospital by its Director following recommendation of the Executive Committee of The Christ Hospital Medical Staff and the Department is concerned and which list also had received prior endorsement in writing by the Dean and the appropriate Department Director of the University of Cincinnati.
3. Upon written notification by the Hospital that it has taken such action, of appointing the professional director of a selected program or project in accordance with paragraph 2 above, the University will appoint him to an appropriate academic rank in the College of Medicine as recommended by the Dean and the appropriate Department Director of said College.

4. The professional director of the program or project, having such a joint appointment, shall supervise and be responsible for the professional activities of his program or project. He shall be responsible to the Hospital in the areas usually regarded as hospital functions, and to the University in the areas usually regarded as academic. These shall be specified if necessary in the Agreement governing the specific program or project. The goal can be of coexistent congenial and cooperative bilateral lines of responsibility and authority plus extensive autonomy for a competent director.

If he plans to appoint an individual in his program who would have academic rank as well as hospital status, the program or project director must have prior endorsement in writing from the Dean of the College of Medicine before appointment is made by the Hospital.

5. Upon written notification by the Hospital that it has appointed persons to the professional staff of a program or project, in accordance with paragraph 4 above, the University will appoint such persons to appropriate academic rank in the College of Medicine as recommended by the Dean and appropriate department head of the said College.
6. For the purpose of implementing this agreement, the Hospital shall adopt rules, regulations and provisions for a policy relating to tenure of appointment in such selected programs or projects. The Hospital thereupon shall forward said rules, regulations, and provisions for tenure for consideration, suggestions, or approval of the University. These regulations shall have evolved from previous discussion between the relevant Departments of the College of Medicine of the University and the Hospital. Upon approval by the University, said rules, regulations and provisions shall have full force and effect. Said rules and regulations and provisions may be revised and amended from time to time through the same procedure by which they are originally adopted and approved, as set forth above.

Concerning the provisions for tenure, it is agreed that the rules shall include the following: If the individual has not only a university title but also a university salary, the University will follow its usual rules with regard to tenure. The Hospital policy will be that the professional head shall be appointed by the Hospital Board with indefinite tenure, within the age limit set forth (to be defined by the Hospital). If the Board of Trustees of the Hospital should deem it necessary to consider terminating the appointment of the professional head previous to the normal expiration of the term of the appointment or after he has been accorded indefinite tenure, the following will apply:

A standing committee, made up of representatives of the University and the Hospital, shall conduct a hearing, at which the professional head will be entitled to present evidence and argument in his own defense. The final recommendation by the Committee shall be made via closed ballot. A two-thirds (2/3) vote is required for dismissal, and such recommendation will be reported through its Chairman to the Hospital and University Boards.

Nothing herein contained shall prevent the termination of an appointment by vote of the Hospital Board of Trustees in case of financial exigency requiring closing of the area and function involved.

- 7. The question of whether the director or staff members of a selected program or project shall be fulltime paid or parttime paid or non-paid, is to be covered by the Agreement covering the specific program or project.
- 8. This agreement may be terminated by the Hospital or the University upon written notice given not less than one year in advance

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed by the officers thereunto duly authorized as of the day and year first aforesaid.

Board of Trustees of
The Elizabeth Gamble Deaconess Home Association

By: *Yvonne Hill*
President //

Jane H. ...
Secretary

Board of Directors of
The University of Cincinnati

By: *M.R. Dodson*
~~Secretary~~ M.R. Dodson, Vice Chairman

Ralph C. Bursiek
~~Secretary~~ Ralph C. Bursiek, Clerk

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POINT BY POINT REVIEW OF "UNDERGRADUATE
MEDICAL EDUCATION: ELEMENTS-OBJECTIVES-COSTS"

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

Dennis D. Pointer, Ph.D, Assistant Director
Department of Teaching Hospitals

Robert J. Carow, Staff Associate
Division of Operational Studies

1. Statement five on page iii of the summary notes that "this [dependence upon individual education program cost data] will, in the long run, be detrimental to all the public interests now rooted in the programs of the medical schools." Paraphrasing this sentence one could note that this study in the long run could be detrimental to the interests of both the public and the medical schools. This point is underscored in the final page of the report through the assertions that:

"Such data may offer opportunities for adverse and critical judgements concerning the need for such variations and may engender misguided efforts to correct or compress such differences into a smaller range or permit seizing upon the lowest cost figures as the standard for all." (p.42)

"The use of cost data for individual education programs ignores and is destructive of the integrity and coherence of the institutional structures essential to the conduct of the programs being supported." (p.43)

Is the Association willing to publicly defend these findings given serious methodological difficulties (note elaboration provided in items that follow) and given its own doubts about misinterpretations?

2. On page iii of the summary the report states that "the committee believes that the entire framework of federal support aimed at national objectives in the education of health professionals in medical research and patient care must be reexamined." The thrust of this statement leads one to believe that the AAMC is dissatisfied with the concept of capitation support for medical education. Is this a true reflection of Association policy with respect to this issue?
3. The report notes on page three of the forward that "federal programs concerned with these objectives [the financing of the education of health

professionals in medical research and patient care] should have as a common base a program of support for these institutions, as such, which is integrated rather than diffuse, and which does not diminish the whole in the pursuit of the parts." This is obviously a financing statement rather than a cost observation. Taken literally, the statement would suggest that educational funding of medical education per se should not be allocated directly to the dean of the medical school but rather total training dollars (for all educational programs) should be channeled through an individual such as the vice president for health or medical affairs and then be disbursed by him based upon health center wide priorities. Is this an accurate reflection of Association policy?

4. The summary statement provided in pages i through iii is inadequate in several respects. First, and most importantly, the summary statement should provide the potential reader with a concise overview of the entire report; clearly this is not accomplished. The summary statement should be in abstract form and include: 1) a description of the data base, 2) a brief discussion of methodology including assumptions employed, 3) a delineation of primary findings and 4) a concise discussion of the implications of the report from the perspective of potential use. Second, the summary states that the main body of the report will include a critical review of the underlying data base and the implications of using the generated data as a basic instrument for establishing the levels of federal support for medical education programs. Neither of these two tasks are accomplished within the main body of the report (see specifically items numbered twelve, thirty-one and thirty-two of this review).

5. The section entitled "The Need For Cost Measurement" beginning on page five attempts to detail the rationale underlying the necessity for engaging in cost allocation studies. The second paragraph of this section delineates this rationale most succinctly when it states that "the directive to the Secretary of the Department of Health, Education and Welfare contained in the legislation to determine the average annual per student cost of education in the health professions, to prescribe standards for determining such costs and to recommend how the federal government can most equitably make capitation awards based upon these costs . . ." Thus, the objective of the cost allocation study is pragmatic in the sense that it hopes to provide baseline data to be used in developing capitation formulas. However, in developing empirical estimates of the per student cost of undergraduate medical education the study sets out to identify total resource engery consumed (direct costs, indirect costs and imputed costs). It appears unreasonable to assume that total resource "costs" could be captured through federal capitation formulas. As noted elsewhere in this review, the report does not state the manner in which such estimates should be employed in developing capitation requests. Are the range of total "resource costs" estimates the association's proposal in this regard?

6. "Undergraduate Medical Education - Elements and Objectives" beginning on page six provides a discussion of the undergraduate medical education process. It notes in part that "the essential parts of this educational process are universal for all medical schools supporting the M.D. degree but emphasis and manner of presentation differ, reflecting the character and objectives of the medical school and of the individual medical student."

This universal process, differing only in "emphasis" and "manner of presentation" (realizing that this reflects the character and objectives of the school) demonstrates a fourteen thousand dollar variation in the per student costs of medical education (see page twenty-seven of the report). Is such a large variation defensible given the discussion of general factors that are presumed to influence costs (note item seven below)?

7. The section entitled "Manifold Characteristics of Medical Education and Institutions" beginning on page eleven attempts to detail several factors that might be associated with variation in the per student costs of medical education across different settings. The factors listed are as follows: 1) variations in medical student capability and career aspirations, 2) varying institutional arrangements, 3) differences in medical school faculty capabilities and interests, and 4) varied health needs of the community in which the medical school operates. In actuality the study is attempting to construct a production function for M.D. graduates. Viewed in this light it would appear beneficial to entertain the notion that variation in the per student costs of M.D. education is a function of: 1) differences in the production process per se, and 2) qualitative variations in the product produced. Little attention is devoted to either of these factors in the main body of the report when evaluating cost differences between various medical schools.

8. There appears to be considerable redundancy in developing and discussing certain ideas and/or concepts in the report. For example, the report notes that: 1) undergraduate medical education is intimately related with graduate post doctoral and continuing medical education; 2) undergraduate medical education is embedded in a matrix of other health training

programs; and 3) both of these trends are increasing in importance and in intensity. These assertions are mentioned either directly or indirectly fully twelve times in the first sixteen pages of the report.

9. The section entitled "Faculty Effort Reporting" beginning on page eighteen suggests that "much attention" will be focused upon the validity of this measurement technique. Fulfillment of this objective is as necessary as it is laudible as the technique of faculty effort analysis has been highly criticized and since the believability of the report findings is intimately related to the validity of this technique. In Appendix B of the report four problems are specified with regard to the faculty effort reporting technique, they are: 1) joint production, 2) time frame, 3) adequate boundaries, and 4) funding bias. The discussion presented in the appendix denotes that these problems can be mitigated and the validity of effort analysis increased by engaging in an educational program directed to faculty members and by employing an interview approach to gathering baseline data. However, it appears that none of the eight centers involved in the study reported here employed either of these techniques. In the appendix there is considerable confusion between the concepts of reliability and validity. The writer assumes that if a measurement instrument possesses reliability it will also be valid; this however is not the case. A valid measurement instrument must of necessity be reliable but a reliable measurement instrument is not necessarily valid. The appendix provides a discussion of the reliability (not validity) of faculty effort reporting in three settings (University of California, Irvine; State University of New York at Syracuse; and Case Western Reserve University School of Medicine). At Irvine, two different approaches were utilized

to allocate faculty resources across programs. However, both instruments were filled out at exactly the same time -- any variation between the two instruments at all would, indeed, be surprising. At the State University of New York and at Case Western Reserve similar effort reporting questionnaires were completed by faculty members separated by varying amounts of time. In these studies the "validity" of the technique was "demonstrated" by noting that faculty time in aggregate allocated across various programs showed small degrees of variability. It is impossible to determine, however, whether or not individual faculty members reports were nonvariable across the periods or whether variations among individual faculty members cancelled out intergroup differences. Thus, the validity (of which there are four types: content, concurrent, construct, and face) of the faculty effort reporting technique was not addressed and the discussion of the technique's reliability appeared to be seriously deficient.

10. In discussing "Conceptual Issues Surrounding Joint Costs" on page nineteen, the study notes that "the derivation of estimates of the costs of these instructional activities ["the training of the student in clinical practices in the direct presence of the patient"] is not inhibited by problems of the conceptual or theoretical nature". This clearly is not the case. Estimating undergraduate medical educational instructional costs (not final program costs) through the faculty effort reporting techniques is where the joint product problem is most critical. That is, there is a joint cost problem involved in the individual physician-faculty member allocating his effort and/or time between undergraduate M.D. instruction (a function) and patient care (a program).

11. No significant discussion of the joint cost problem is provided in the section entitled "Conceptual Issues Surrounding Joint Cost" (pp. 19-20). At a minimum, previously completed work in this area should either be cited in a footnote or included (abstract or full text) as an appendix item. This is particularly important since the costing of the research and patient care functions accounts for approximately forty percent of the total cost of undergraduate medical education.
12. In the section entitled "Methodology for Estimating Costs of Undergraduate Medical Education Program" beginning on page twenty-one no attention whatsoever was accorded the methodology underlying the preparation of baseline data (the allocation of faculty effort across activities and the quantification of other cost components) in the eight medical centers. The reader is unable to discern whether or not a consistent methodology was employed in identifying and allocating costs (expensed and imputed) across both activities and programs in the study sites (specific comments noted below will indicate that the medical schools employed highly variable criteria in assigning different cost elements to various functions), rather a considerable amount of attention is focused upon the manner in which the baseline data from the eight study sites was consolidated (i.e., matching criteria and cost study conferences).
13. Discussion provided on page twenty-two indicates that it was the objective of the cost dialogue between paired institutions to: 1) better understand the complex flow of resources to programs, and 2) "identify the differences in procedure or approaches in the methodology in deriving cost, to adjust for these differences, and to derive, thereby, cost estimates reflecting

valid variations in the institutional component of the undergraduate medical education program." It has been our experience, from participating in an extension of the original eight center study, that the cost dialogue conducted by the paired institutions centered only upon identifying differences between costs as noted on the summary report form. If a cost "difference" was observed between the two paired centers considerable time was expended in either attempting to explain the difference or in adjusting for it (through subtractions, additions or allocations to other cost components). However, little attention was paid to those subcomponents on the summary reporting form where no difference was observed in the costs between the paired settings. It is highly conceivable that "differences in procedure or approaches in the methodology in deriving costs" (i.e., measurement error) could cause similarities as well as differences in the generated cost estimates.

14. On the bottom of page twenty-two the report notes that "once the real differences in the use of resources between these centers was determined other variances could be caused by: 1) the level of use of these resources, 2) the price of value of these resources, and 3) the differences in the content or essentials of programs." Two comments appear appropriate here. First, "the differences in the content or essentials of programs" should be viewed as a real difference (see aforementioned criticism number seven). Second, the list of factors associated with "other variances" leaves out a particularly important item -- measurement error. Based on criticisms provided elsewhere in this report, it appears that this latter factor is particularly important (i.e., initial analysis indicates that measurement error is the primary

source of variability and the differences between affiliated teaching hospital costs as reported in the eight centers). That is, specific costs in different study sites were not pursued with the same intensity (see item twenty three below).

15. The section entitled "Methodology for Estimating Cost of Undergraduate Medical Education Program" concludes with the statement that "after a more thorough examination and discussion with representatives of the institutions, it was found, for instance, that one organization had heavy financial commitments because of recently acquired buildings, whereas the other has relatively small capital costs due to the use of older buildings." This is a particularly inappropriate way to end up a general discussion of those factors that are associated with per student cost variability in the eight centers as it would appear that this element is of relatively minor importance.
16. Assumption number two on page twenty-four states that "in no way should the quantitative results for any one of these centers alone or in aggregate be interpreted in terms of typical, average, the result of high or low quality program content, the result of high or low efficiency of program content." The question arises: how should the data then be viewed? One could easily ask, given this caveat, "how can the AAMC be willing to base financing requests on such results?" Additionally, the aforementioned statement assumes away many possible sources of variability without providing any rationale for doing so.

17. Assumption four noted on page twenty-four states that "every reasonable precaution was made by each center during its cost study to minimize faculty bias." As specifically discussed in point number nine, above, it appears that no uniform guidelines were employed by the eight centers in preparing effort reporting data.
18. Assumption seven noted on page twenty-five indicates that "all cost figures have been adjusted to 1972 dollars." The text contained in the main body of the report nowhere indicate how this adjustment was executed. Discussions with the study staff indicated that cost data were adjusted on the basis of a faculty salary inflator. This procedure would assume that all components of the per student undergraduate medical instructional costs are increasing at exactly the same rate. This is an extremely hazardous assumption with respect to the primary and affiliated hospital component of the cost figure. Available data indicates that house staff salaries (the major component of primary and affiliated hospital costs) is increasing at a significantly higher rate than faculty salaries. At a minimum, a footnote should have been included that detailed the precise manner in which this adjustment was accomplished (basis, rate and compounding method).
19. Assumption nine listed on page twenty-five notes that "legitimate methodological variations should not imply poor management or thoughtless protocol." Given the nature of this sentence it is difficult to determine just exactly what is considered to be a "legitimate methodological variation." It must be noted, however, that "legitimate methodological variations" could cause potentially significant variations in the resultant per student cost of undergraduate medical education across schools participating in the study (i.e., methodological variations cause measurement error).

20. Assumption number thirteen on page twenty-six states that "one of the more significant imputed costs in the study resulted from placing a value on the effort of voluntary faculty involved with instructing medical students." Given the "federal capitation objectives" noted elsewhere in the document, imputing value (rather than costs) severely obfuscates the analysis. It appears reasonable to assume that these contributed services could be viewed as "free goods." That is, if such services were denied to the medical schools it is possible that they would not have to be purchased (such volunteer effort might represent beneficial although not necessary inputs). Additionally, one could take the position that the imputed value of volunteer services is offset (or even exceeded) by imputed payment for such services. For example, the value of volunteer teaching (and the imputed costs attributable to the individual volunteer) might well be offset by continuing education benefits received by the volunteer in the process of teaching. The significance of including an imputed cost for volunteer effort in the faculty salary component is demonstrated in the table below.

VOLUNTEER IMPUTATION AS A PERCENT
OF TOTAL FACULTY COSTS*

CENTER	TOTAL FACULTY COSTS	VOLUNTEER IMPUTATION	VOLUNTEER IMPUTATION AS A PERCENT OF TOTAL FACULTY COSTS
A	\$3,337	--	
B	4,432	\$440	9.9
C	2,397	272	11.3
D	2,762	490	17.7
E	3,305	503	15.2
F	2,535	401	15.8
G	3,916	287	7.3
H	2,209	240	10.8

*per student undergraduate M.D. instruction

21. Page twenty-seven marks the dividing point between two separate and somewhat conflicting subcomponents of the total report. Pages one through twenty document, in considerable detail, the need for viewing undergraduate medical education as a component of both: 1) other segments of the medical education process (graduate, postgraduate and continuing); and 2) as an integral component of other health education training programs. This part places considerable emphasis on the fact that the cost considerations, and indeed the process of undergraduate medical education, cannot be separated from these other factors. Part two of the report beginning on page twenty-eight completely discards the material developed in part one and proceeds to execute what previously was said to be both detrimental and impossible. These problems are compounded by the fact that statement B on page i of the summary indicates that the definitional approach developed in the first part of the study will form the basis for developing a "set of cost estimates of undergraduate medical education programs." Clearly this is not the case.
22. The table and associated text on page twenty-seven provides a summary of the empirical results of this study. Several general comments (all of which will be elaborated on in items contained later in this review) appear warranted. First, the table indicates that the total costs of undergraduate M.D. education vary from \$10,770 to \$24,760. Given the methodological problems delineated in this review the question becomes: can we believe such data? If it can be assumed that the data is believable, the question then becomes: how can we account, explain and/or understand such large amounts of variability? If the variability is accounted for, explained and/or understood the final question becomes: given the large amounts of variability how can the developed data be employed to produce a capitation figure --

to what uses can the cost estimates (individually or in aggregate) be put? Second, as indicated in the table provided below, dollar amounts attribut-

IMPACT OF ENVIRONMENTAL COMPONENTS
UPON TOTAL COST OF UNDERGRADUATE MEDICAL EDUCATION

CENTER	TOTAL COST	RESEARCH COST (% OF TOTAL COST)	PATIENT CARE COST (%OF TOTAL)	ENVIRONMENTAL COMPONENTS (% OF TOTAL)
A	24,760	8,650 (34.9)	6,520 (26.3)	15,170 (61.2)
B	22,490	8,750 (38.9)	4,200 (18.6)	12,950 (57.5)
C.	10,770	3,060 (28.4)	2,100 (19.4)	5,160 (47.8)
D	11,710	3,030 (25.8)	2,090 (17.8)	5,093 (43.6)
E	11,240	2,390 (21.2)	1,850 (16.4)	4,240 (37.6)
F	10,880	2,350 (21.5)	1,410 (12.9)	3,760 (34.4)
G	23,730	8,300 (34.9)	5,710 (24.0)	14,010 (58.9)
H	16,500	4,400 (26.6)	3,280 (19.8)	7,680 (45.4)

able to the "environmental cost" transfer methodology (research and patient care) account for a significant proportion of the total cost of undergraduate medical education. Thus, it appears that the most dubious component of the cost finding methodology (note specific review items provided below) account for the greatest proportion of total costs. Third, the greatest proportion of the total variability of undergraduate medical education costs at the eight medical centers is due to the variability of these two components (environmental costs) rather than to the estimates of the instructional cost component which is fairly homogeneous across the eight centers (coef-

ficients of variation for the three components and total cost are as follows: "instruction" = 5.33, "research" = 1.86, "patient care" = 1.90 and "total" = 2.83). Fourth, it appears that employing the title "patient care" for that component of the total costs of undergraduate medical education attributable to the need of physician-faculty members to maintain clinical skills could be subject to some misinterpretation. A heading designation should be developed which emphasizes the fact that this is not a hospital patient care component (and as such be viewed by third party payors as an educational cost attributable to the hospital). Rather this category should be perceived as a professional service component (as specifically addressed in item number thirty of this review).

23. Pages twenty-eight through thirty-four of the report discuss, in some detail, individual costs related to undergraduate medical education. Several general comments regarding this section of the report will be provided here while specific criticisms of individual components follow. First, data provided in the table presented on page twenty-eight are misleading. Text should be associated with the table indicating that the upper and lower range per student cost data associated with each item listed are not necessarily extracted from the same medical center. That is, one cannot legitimately total the four items listed under "upper range" and obtain the per student cost of that medical center that has the highest total. Second, this section is organized so that for each component a series of factors associated with both high and low per unit costs are delineated. A considerable amount of redundancy occurs here because if a given factor is associated with a high per unit cost for a specific component its inverse will of necessity be

associated with a low per student cost with respect to the same component. That is, if a relatively high number of faculty is delineated as contributing to greater costs it will of necessity be true that a relatively small number of full time faculty will be related to somewhat lower costs (see item one on pp. 29-30 of the report). Second, it appears that there is some inconsistency with respect to the manner in which specific elements of costs are included in the four general cost components. For example, in one center faculty salaries in affiliated hospitals are included within the category of affiliated hospital costs, while in another center such salaries are included within the faculty salary component. This situation causes severe problems for a meaningful analysis of intra-category cost variations (i.e., the level of inclusion across different study sites varies within each cost category).

24. The discussion regarding faculty salary costs beginning on page twenty-nine suggests that two factors contributing to greater costs are: "(1.b) extensive commitments to other educational research and service programs" and "(2) a comparatively high percentage of faculty assigned to all instructional programs (not necessarily M.D. instruction)." The objective of the faculty effort reporting technique was to allocate such effort to other programs so that only effort associated with the undergraduate M.D. instructional program was included in the category "instructional costs." Therefore, how can such factors now be stated as reasons for variation in per student instructional costs? The costs associated with such effort should be charged to the respective programs (other educational and research) other than to undergraduate M.D. instruction.

The subsection entitled "Direct Instructional Costs in Teaching Hospitals" beginning on page thirty-three denotes that such costs vary from \$2,414 to \$95 per student. The table provided below demonstrates that principal

PRINCIPAL TEACHING HOSPITAL CONTRIBUTION
TO TOTAL UNDERGRADUATE INSTRUCTIONAL COSTS

CENTER	TOTAL INSTRUCTIONAL COSTS	PRINCIPAL TEACHING HOSPITAL COSTS	PERCENT
A	\$9,588	\$1,527	15.9
B	9,540	1,324	13.8
C	5,611	716	12.7
D	6,590	95	1.4
E	7,006	482	6.8
F	7,121	202	2.8
G	9,716	2,414	24.8
H	8,823	1,035	11.7

teaching hospital costs expressed as a percentage of total instructional costs varies from a high of 33% in Center G to a low of 1.4% in Center D. On the face this amount of variability between the eight centers with respect to this component appears totally unbelievable. An examination of Table A entitled "Consolidated Program Cost Profiles - Eight Centers Study" in Appendix C of the report indicates that the prime source of variability in these costs is due to measurement error (i.e., the rigor with which such costs were pursued). An analysis of individual cost profiles indicates that while most principal teaching hospitals identified housestaff salary and fringe benefit costs the methodology associated with capturing costs associated with other cost centers varied from rigorous pursuit (one

setting identified \$2,057 in this area) to nonexistence (one hospital had no costs associated with this component while another estimates an allocation of \$10). This problem is compounded when one examines the costs associated with affiliated hospitals. Fully five centers chose not to pursue the determination of these costs whatsoever. When such large amounts of measurement error exist, it is impossible to interpret variations between settings with any degree of validity and/or reliability. Additionally, due to the large amounts of measurement error present, the inclusion of principal and affiliated hospital costs in the total cost of undergraduate instruction produces a situation whereby differences between study sites is due not so much to substantive variations as it is to inadequate methodology and poor measurement techniques. Such difficulties make it impossible to either analyze or utilize such data.

26. Beginning on page thirty-five the report discusses costs associated with "research" and "patient care" components. As such, the study in its attempt to report findings, switches radically from an empirical to a normative methodology. That is, in pages twenty-one through twenty-four the methodology is directed toward identifying those costs that are observable in the real world ("what is"). However, beginning on page thirty-five the study attempts to generate cost data based upon normative criteria (i.e., "what should" be rather than "what is"). The two sections are relatively independent and nonadditive. Acceptance of the normative (environmental) cost calculations requires a shared world view between the authors of the report and its potential consumers. Since neither group is prepared to demonstrate, empirically, the correctness of these calculations, one "estimate" is as

good as any other. It appears hazardous to assume that those funding medical education are so naive as to accept any one set of calculations on their face value (this problem is adequately developed in: Milton Friedman, Essays In Positive Economics, Chicago: University of Chicago press, 1953, pp. 3-46).

27. On page thirty-six of the report it is stated that, "... every faculty member, in order to maintain his competence as a scientist and educator, should devote a minimum of 20% of his effort in scholarly activities, such as biomedical research." On page forty of the report it is stated that "... every member of the medical school clinical faculty should, at a minimum, devote 10% of his effort to independent clinical practice, in order to maintain his competence as a faculty member." It appears reasonable that readers of the report will note the two fold difference in these percentages. Rationale was provided for each percentage but not for the difference between the two.
28. As noted in the table associated with item twenty-two above, the proportion of the total costs of undergraduate M.D. education accounted for by the "research" and "patient care" components in the individual study centers is as high as sixty percent. Due to the significance of these components (both in terms of allocated dollars and conceptually) it appears reasonable that considerably more space should have been allocated to: 1) discussing the methodology upon which the estimates were based, and 2) analyzing the various estimates per se. While fully thirteen pages of the study report were allocated to discussing instructional cost estimates, only six pages were devoted to both the "research" and "patient care" components. A

significant portion of the total cost estimate is based upon a highly questionable methodology -- these findings would be difficult to defend.

29. In the section entitled "Cost of Patient Care Component" beginning on page thirty-eight, the Task Force noted that it viewed the patient care aspects of undergraduate medical education from the following perspectives: 1) direct activities of clinical faculty and other staff in instructing the student in clinical acts and procedures, 2) additional costs associated with management of the patient that may result from instruction, 3) the delineation of those hospital costs of a patient who is involved in the educational process that should be allocated to the educational program, and 4) costs associated with that level of clinical activity deemed essential for a clinical faculty member to be engaged in (although without the presence of undergraduate students) in order to maintain competence. Each of these items however, is dealt with in a distinctly different manner by the study. The first cost item is included within the hospital budget and has been treated as an incremental cost previously allocated to instruction. Rationale provided in the study suggests that the second cost item does not exist for the purposes of undergraduate medical education. The third item, allocation of hospital costs to the undergraduate medical education function, is rejected on the basis of rationale provided on page thirty-nine. Only the fourth element of cost, that level of clinical activity deemed essential to maintain faculty competence, is amenable to some allocation to the educational program. Items three and four can both be considered as joint cost problems, however, each was addressed in a different manner. This methodological inconsistency should be developed more thoroughly to avoid confusion.

30. On page forty the report notes that "it was the view of the Task Force, however, that educational costs are associated with the requirements that the clinical faculty must be engaged in a certain level of patient care activity without the presence of undergraduate medical students in order to maintain their competence and skill in patient care and thereby their effectiveness as members of the medical school faculty." Given this statement it is unreasonable to assume that individual medical school faculty members or the Association could argue that clinical faculty members should be allowed to bill on a reasonable charge basis for care provided to patients under this classification of effort (i.e., 10% of the total amount of time allocated to patient care activities).
31. "Implications for the Future Development of Public Policy" beginning on page forty-four of the report notes that the use of cost measurements of educational programs: 1) will become "increasingly meaningless", 2) "pose grave hazards to maintaining the differential characteristics, objectives and distinguishing qualities of American medical education programs", 3) "neglect the relationship to, and adversely cultivate division among, the essential integral functions and activities that underly the several programs of the academic medical centers", and 4) "will in the long run be basically detrimental to all public interests now rooted in the programs of the academic medical centers." A great deal of attention is addressed to the manner in which the data can be misused but no suggestions are forwarded as to how the data can be used.
32. Flowing from the aforementioned comment, the reader is provided with no suggestions regarding the manner in which the estimates generated in the

study could be employed by those charged with developing public policy in this area. That is, what are the implications of the findings? For example, should policymakers, engaged in developing capitation formulas, employ the low, high or average cost estimate? Should they base capitation rates upon the total estimate of undergraduate medical education cost or should they utilize only portions thereof (i.e., total direct expenditures, total costs less imputations, total costs less environmental transfer, etc.)?

33. The final two paragraphs of both the summary and implication sections of the report conclude with the same statements, noting that:

In summary, the Committee believes that the entire framework of federal support aimed at national objectives in the education of health professionals in medical research and in patient care must be reexamined. The necessary premise under which this reexamination should be initiated is that a strong, vigorous, and diverse set of academic medical centers is a vital national asset to be cultivated and sustained by virtue of their innate and critical value to the attainment of any and all of the national purposes in health, the emphasis on purposes, however, may shift over time.

Federal programs concerned with these objectives should have as a common base a program of support for these institutions as such, which is integrated rather than divisive, and which does not diminish the whole in the pursuit of the parts. Such support should be in substantial amounts and on a continuing stable basis, separate from and in addition to the special targeted actions needed to achieve particular national objectives in education, research, or health care. Only through viewing academic medical centers as a national resource and providing stable and substantial support for their basis operations can this structure of vital institutions and their indispensable functions be sustained and the problems of determining the appropriate levels of government and private support be resolved.

These statements lead one to believe that: 1) the AAMC is dissatisfied with capitation mechanisms for financing medical education by indicating that the entire framework of support needs reexamination (see item number two of this

review); and 2) the present arrangement of channeling financial support to the medical school directly rather than through the health center is detrimental. These are not observations regarding educational costs that flow directly from the main body of the report, rather they are statements of financing policy.

The nature, placement, and indeed, repetition of these points takes on added significance due to the fact that many, if not most, consumers of this report will read only the summary and implications sections of the report. The question becomes: do these two financing statements, standing alone, accurately reflect AAMC policy on these issues?

RESEARCH MEMO: SELECTED COMPARISONS OF HOSPITALS
WITH GRADUATE AND UNDERGRADUATE TRAINING PROGRAMS
AND GRADUATE TRAINING PROGRAMS ONLY*

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Department of Teaching Hospitals
Association of American Medical Colleges

* Basic data for use in this study were supplied by the Commission on Professional and Hospital Activities (CPHA), Ann Arbor, Michigan. In these data the identities of individual hospitals were not revealed in any way. Any analysis, interpretation, or conclusion based on these data is solely that of the Association of American Medical Colleges, and CPHA specifically disclaims responsibility for any such analysis, interpretation, or conclusion.

Several studies have been executed to estimate the impact of the teaching function upon hospital costs; these investigations have employed a wide range of methodologies and have produced highly variable findings. Given the current interest in this area, it is surprising that no attention has been focused upon attempting to isolate the relationship between engagement in physician clinical education and certain operating characteristics of the medical care provision process in teaching hospitals. The data briefly reported here is an initial effort in that direction.

This study reports a comparison of the utilization of diagnostic services and selected characteristics of the patient population between hospitals with both undergraduate and graduate training programs and hospitals with graduate training programs only for 6 specific disease classifications. All eight (8) of the hospitals with undergraduate and graduate training had residencies in both surgery and medicine. For those facilities with graduate training only, 5 had residencies in both specialties, 2 hospitals had residencies in only surgery and 1 hospital had a residency in medicine only.

Data for this analysis were provided by the Commission On Professional and Hospital Activities (CPHA) and is based upon 14,188 patients discharged in two groups of 8 hospitals during fiscal year 1971. The scale of hospitals comprising the two study groups were as follows:

Total Discharges	Number of Hospitals Included in the Analysis	
	<u>Graduate only</u>	<u>Grad. & Undergraduate</u>
15,000 +	7	5
10,000 - 14,999	0	2
5,000 - 9,999	1	1

The following six groups of patients were studied: diabetes mellitus (H-ICDA 250), acute myocardial infarction (H-ICDA 410), peptic ulcer (H-ICDA 531-534); cholecystectomy (H-ICDA 53.5); appendectomy (H-ICDA 49.1) and inguinal hernia (H-ICDA 57.01-57.1). All medical diagnoses were final and all surgeries were noted as primary. All patients studied in the three medical groups were discharged from the adult medicine service; all patients included in the three surgical categories were discharged from the adult surgery service.

The attached table provides information regarding patient profile, care process characteristics and the intensity of selected adjunct services provided for hospitals with undergraduate and graduate training (A) and graduate training only (B). Due to the small study pool and the absence of a rigorous matching procedure, inferential analyses are extremely tenuous. The following observations are meant to be indicative rather than exhaustive.

The data on diagnostic services appear, generally, not to support the notion that adjunct services are provided with significantly greater intensity in hospitals with both graduate and undergraduate training as compared with hospitals having graduate training only. The variety index denotes the average number of different diagnostic tests ordered per patient as a percentage of a possible total of seventy such tests. No differences are noted between groups in the medical categories. Only

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SELECTED COMPARISON BETWEEN EIGHT PAS HOSPITALS WITH UNDERGRADUATE AND GRADUATE TRAINING
AND EIGHT PAS HOSPITALS WITH GRADUATE TRAINING ONLY
JULY 1971-JUNE 1972

Measures	MEDICAL						SURGICAL					
	Diabetes C		Acute Myocardial Infarction		Peptic Ulcer		Cholecystectomy		Appendectomy		Inguinal Hernia	
	A*	B**			A	B						
Multichannel Chemistry	83.9%	87.7%	84.2%	86.3%	88.9%	89.7%	83.8%	83.9%	62.8%	46.4%	73.2%	67.8%
Variety Index	17.7	17.8	17.3	17.7	18.1	18.0	17.2	16.4	11.4	11.1	12.6	11.7
EKG ¹	70.9%	79.4%	92.4%	98.0%	68.1%	66.6%	72.0%	62.5%	18.3%	13.9%	64.0%	49.2%
Repeat EKG	14.8	17.9	84.1	92.0	11.4	13.0	16.2	14.4	4.3	3.2	7.4	4.8
X rays:												
Chest	53.5	83.5	73.8	91.8	55.1	73.0	64.1	71.3	29.6	20.9	57.6	58.6
Skeletal	23.2	27.0	6.8	7.9	15.1	14.9	8.6	6.1	2.9	2.1	5.3	3.9
Digestive	25.4	31.0	9.3	10.6	79.2	93.4	75.1	63.7	12.3	9.6	15.3	10.1
Genitourinary	15.0%	18.8%	4.4%	3.4%	15.5%	18.7%	11.0%	14.8%	12.3%	13.0%	6.9%	5.4%
Average Stay	10.1	11.9	18.7	20.5	8.9	9.5	12.8	13.0	7.1	7.5	6.7	7.0
Number of Patients	1,005	1,566	706	2,021	457	957	353	2,300	415	1,019	712	2,097
Rate per 1,000 discharges	7.4	7.9	5.2	10.2	3.4	4.8	6.3	12.1	3.1	5.2	5.3	10.0
Males	39.5%	39.5%	70.5%	67.8%	58.2%	60.6%	22.6%	25.7%	57.8%	56.4%	50.0%	51.1%
Deaths	1.3%	3.1%	18.6%	18.5%	0.9%	1.9%	2.1%	1.4%	0.5%	0.5%	0.4%	0.1%
Patients 65 and over	22.6	28.7	37.0	43.4	22.1	27.1	24.2	21.1	6.0	4.2	25.7	20.7
WBC 10,000 (Admission)	26.5	25.9	41.4	46.6	25.6	25.9	22.0	20.7	74.2	73.9	10.4	12.4
Temp 100°F (Admission)	5.0	5.7	4.0	4.8	2.0	3.9	7.0	4.5	26.7	25.8	1.3	2.1
Operated	16.4	10.7	16.6	7.8	33.7	14.4	100.0	100.0	100.0	100.0	100.0	100.0
Transfused	2.8	1.8	3.3	1.6	23.6	28.0	12.3	6.3	5.1	2.7	1.1	0.4
Consultations	43.7	30.7	24.2	27.4	38.7	31.2	28.6	33.0	10.3	13.2	13.2	11.3
ICU or CCU ²	7.7%	4.3%	78.8%	77.5%	8.5%	4.3%	21.6%	5.8%	13.3%	2.9%	4.9%	0.9%
Minimum Lab Not Met ³	8.7%	4.1%	12.2%	9.2%	7.4%	6.3%	2.5%	1.9%	9.2%	6.5%	2.2%	2.1%

¹Excluding deaths

²Includes patients treated in an intensive care unit, cardiac (coronary) care unit, or both

³Minimum laboratory work (urinalysis and hemotocrit) was not done at any time during hospitalization.

*A refers to hospitals with undergraduate and graduate training

**B refers to hospitals with graduate training only

slight differences are observed for the three surgical classifications; hospitals with graduate and undergraduate training have slightly higher variety indexes than facilities with graduate training only for appendectomies and inguinal hernias. Almost uniformly hospitals with graduate training only show a higher intensity of x-rays taken or denote no pronounced differences between the two groups of facilities. This relationship does not hold, however, in the single instance of surgical categories for skeletal and digestive x-rays. Supportive of the aforementioned findings one may note that the average length of stay across all diagnosis is longer in hospitals providing only graduate training than in facilities having both graduate and undergraduate training programs.

The remaining data presented in the table provides the basis for a rough comparison of the characteristics of patients treated in the two settings. Available demographic data (percentage of males and percentage of patients exceeding 65 years of age) show no striking differences between the two groups.

The percentage of patients admitted to intensive care or cardiac care, transfused or provided consultations provides an approximate indication of case complexity-severity. The percentage of patients transfused and admitted to intensive or cardiac care is uniformly and pronouncedly greater in hospitals with undergraduate and graduate training programs; this difference is particularly significant in the three surgical classifications. Consultations demonstrated no particular pattern between the two study groups across the six disorder classifications.

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Minimum lab not met is included here as a first approximation quality measure since it signifies that two basic tests (urinalysis and hemoglobin or hematocrit) were not performed at anytime during the patient's stay. In every instance hospitals with both undergraduate and graduate training programs had a higher percentage of patients with the minimum lab not met than those hospitals with graduate training programs only. It must be noted that the proportion of deaths may have a positive effect upon this measure, particularly if a high proportion of the deaths occurred soon after admission so that the basic lab test could not be performed.

Given the nature of the data, meaningful and valid general conclusions cannot be drawn. However, for the facilities studied it appears that hospitals with both graduate and undergraduate training programs do not provide a marginally greater amount of selected adjunct services than hospitals with graduate programs only (in fact, the data suggest the opposite relationship). This is the case in spite of evidence that the complexity-severity of patients in such facilities (for six specific primary diagnoses) may well be greater than that experienced in hospitals with graduate training programs only.

Hopefully, the preliminary findings reported here will stimulate more refined investigative efforts in this area.

AAMC POLICY STATEMENT

THE PATIENT IN THE TEACHING SETTING

The medical faculties and staff of the nation's medical schools and teaching hospitals are committed to the provision of the highest quality of personal health services. The interrelationship between the health care, educational and research functions of these institutions contribute to the assurance of these high standards of patient care. Patients seeking care in the teaching setting are not only provided high quality health services, but also an opportunity to share in the training of the nation's future health care professional personnel through participation in clinical education.

It is the policy of the Association of American Medical Colleges that all patients, regardless of economic status, service classification, nature of illness or other categorization should have the opportunity to participate in the clinical education program of the hospital, clinic or other delivery setting to which they are admitted or from which they seek care.

In order to assure a single standard of high quality patient care, and to reinforce student perspectives and attitudes regarding patient rights and responsibilities, the AAMC reaffirms that:

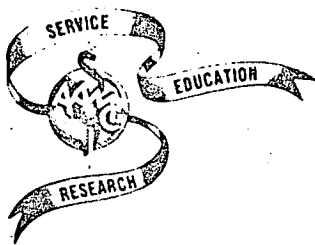
- Selection of patients for participation in teaching programs shall not be based on the race or socio-economic status of the patient.
- Responsible physicians have the obligation to discuss with the patient both general and specific aspects of student participation in the medical care process.

- Provision of patient care is a confidential process. Relationships between the patient, health professional and student, regarding examinations, treatment, case discussion and consultation should be treated with due respect of the patient's right to privacy.
- Each patient has the right to be treated with respect and dignity. Individual differences, including cultural and educational background, must be recognized in designing each patient's care program.
- Every teaching institution should have programs and procedures whereby patient grievances can be addressed in a responsive and timely fashion.

The Association of American Medical Colleges believes that the reaffirmation of these principles in medical schools and teaching hospitals will contribute to the best interests of patients and ensure the most appropriate educational environment for the training of future health professionals.

COTH ADMINISTRATIVE BOARD ACTION
June 21, 1973

It was moved, seconded and carried that the COTH Administrative Board recommend adoption of the first two paragraphs of the statement and endorse the American Hospital Association's statement entitled "Patient Bill of Rights."



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202/466-5127

ANNOUNCEMENT

Council of Teaching Hospitals Research Award Program

The Association of American Medical Colleges has recently made available funds to establish two or more Council of Teaching Hospitals (COTH) Research Awards.

The COTH awards are designed to assist doctoral candidates in health and health related disciplines conducting research (or portions thereof) directly related to some aspect of the financing, organization and/or delivery of health services in academic medical centers. Applicants should have an approved dissertation proposal and should be no more than eighteen months away from its defense. Although any reasonable topic will be considered, priority will be accorded those individuals conducting research regarding: 1) the management of complex professional services enterprises operating in rapidly changing technological environments; 2) the effect of medical education programs on hospital costs; and 3) the dynamics of ambulatory care delivery in an academic medical center environment.

Awards will be made in the amount of \$2,500 for a one year non-renewable term. The stipend is unencumbered and may be spent in any manner the recipient deems appropriate. Receipt of the award is in no way affected by other income sources (e.g., grants, fellowships) of the applicant. The award recipient will be expected to provide the Association of American Medical Colleges with a distillation of the research suitable for publication in a monograph format (although publication is not guaranteed).

Applications for the awards are due in this office no later than August 1, 1973. Applications should consist of a declaration of intent from the candidate, a letter of recommendation from the candidate's departmental chairman or dissertation supervisor and one copy of the approved dissertation proposal. In certain instances applicants may be asked to travel to Washington in order to meet with the staff of the Association; all expenses associated with such travel will be reimbursed. All applicants will be reviewed by the staff of the Council; final selection will be made by the COTH Administrative Board.

Formal announcement and conference of the awards will be made at the Association's annual meeting in November. However, it is anticipated that individual applicants will be notified of their status in early September.

DENNIS D. POINTER, PH.D.
Assistant Director
Department of Teaching Hospitals

Background

Title: "Utilization Patterns Among Physicians in a Prepaid Group Practice Setting"

Applicant: Raynald Pineault, M.D.

Affiliation: Ph.D. candidate, Department of Medical Care Organization, the University of Michigan

Sponsor: Benjamin J. Darsky, Ph.D.

Evaluation

Relevance to COTH mission: Moderate

Methodology: Excellent

Usability of Findings: Theoretical in nature, no immediate direct application

Abstract

The study proposes to investigate the utilization behavior of physicians in a group practice. It seeks to investigate: 1) the extent of variation in physician behavior concerning the use of office visits, telephone, laboratory and radiology; 2) the factors that account for such variation; and 3) the consequences of such variation for the organization.

Staff Recommendation: Deserves consideration

Background

Title: "Effects of Physician Education and Administrative Support on Hospital Ambulatory Care"

Applicant: Michael Pozen, M.D.

Affiliation: D.Sc. candidate, Department of Medical Care and Hospitals,
School of Public Health, The Johns Hopkins University

Sponsor: Philip D. Bonnet, M.D.

Evaluation

Relevance to COTH mission: Moderately high

Methodology: Excellent

Usability of findings: Moderate

Abstract

Proposes to assess the effect of medical education supervision and administrative controls in ward follow-up clinics of the Baltimore City Hospitals. Dependent variables are process and outcome measures. Six clinics are studied -- two with "education changes"; two with "administrative changes and two controls.

Staff Recommendation: Deserves Consideration

Background

Title: "A Model for Evaluating the Performance of Health Maintenance Organizations"

Applicant: Robert G. Shouldice

Affiliation: D.B.A. candidate, Department of Hospital Administration,
The George Washington University

Sponsor: Leon Gintzig, Ph.D.

Evaluation

Relevance to COTH mission: Related

Methodology: Good-excellent

Usability of findings: Direct, pragmatic

Abstract

The objective of the study is to develop a model for evaluating the performance of HMO's in the period through which they progress from planning through development to operations and the build-up in enrollment to the point of financial break even.

Staff Recommendation: Deserves consideration

Background

Title: "Short Run Variations in Bed Availability and the Process of Hospital Care: A Comparative Analysis of Teaching and Nonteaching Hospitals"

Applicant: Roice D. Luke

Affiliation: Ph.D. candidate, Department of Medical Care Organization, the University of Michigan

Sponsor: William L. Dowling, Ph.D.

Evaluation

Relevance to COTH mission: Very high

Methodology: Excellent

Usability of findings: Direct and immediate

Abstract

An analysis of the responsiveness of the process of hospital care (case mix, length of stay, intensity of care and approach to care) to short-run fluctuations in hospital occupancy rates in a small sample of teaching and non teaching hospitals.

Staff Recommendation: Make award

Background

Title: "Gynecological Services and the Women's Movement: Comparisons of Self-Help Clinics and Other Modes of Delivery"

Applicant: Helen I. Gates

Affiliation: Dr. P.H. candidate, Department of Health Services Administration, School of Public Health, University of California - Los Angeles

Sponsor: Milton I. Roemer, M.D.

Evaluation

Relevance to COTH mission: Nonexistent

Methodology: Lacks precision

Usability of findings: Nonexistent

Abstract

The study proposes to compare the outcome (as measured by consumer knowledge, consumer attitudes and effectiveness of care) of obstetrical and gynecological services provided in three settings: self help (NOW Clinics), paramedical (county clinic staffed with paramedics) and traditional (hospital OB-GYN service).

Staff Recommendation: Reject

Background

Title: "A Comparative Study of Health Program Design Strategies"

Applicant: Paul C. Nutt

Affiliation: Ph.D. candidate, Department of Industrial Engineering,
the University of Wisconsin - Madison

Sponsor: David H. Gustafson, Ph.D.

Evaluation

Relevance to COTH mission: Very indirect

Methodology: Excellent

Usability of findings: Remote

Abstract

Proposes to study the development and execution of program design strategies in four settings: university family practice, state division of public health, student health service and area wide planning agency. A "design method" is defined as "an explicit and formally structured strategy to identify and to elaborate cost-effective solutions that meet a prescribed purpose".

Staff Recommendation: Exceptionally well developed study but has no direct relevance to COTH mission - reject

Background

Title: "An Exploratory Study of the Delivery of Health Care to Adolescents in Hospital-Based, Out-patient Clinics in N.Y.C.; and the Rationale of Providers"

Applicant: Eleanor Kostant

Affiliation: Ph.D. candidate, program in social medical sciences, School of Public Health, Columbia University

Sponsor: Jack Elinson, Ph.D.

Evaluation

Relevance to COTH mission: Indirect

Methodology: Adequate

Usability of findings: Indirect and remote

Abstract

The study proposes to examine the development of "adolescent medicine" as a specialty. Theoretical structures are based upon earlier sociological work completed by George Rosen. Funding sources, perceptions of physicians regarding adolescents and clinic characteristics will be investigated as correlates of the adequacy of services provided.

Staff Recommendation: Interesting and well developed but little relevance to COTH objectives or programs - reject

Background

Title: "An Analysis of the Relationship of Organization to Hospital Effectiveness"

Applicant: S. Kelley Moseley

Affiliation: Ph.D. candidate, program in health services and planning, School of Public Health, the University of Texas - Houston

Sponsor: Richard M. Grimes, Ph.D.

Evaluation:

Relevance to COTH mission: Not specifically applicable to teaching hospitals per se

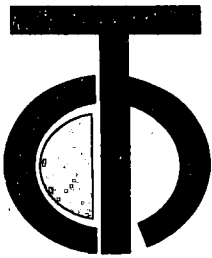
Methodology: Poor

Usability of findings: Nonexistent

Abstract

Objective of the study is to determine if there are a set of effectiveness indices acceptable to a "defined group of consumers and providers" and to determine if organizational patterns (which is not organizational-ized) have an "effect on these indices".

Staff Recommendation: Reject



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5127
(202) 466-5127

General Membership Memorandum

No. 73-8G

August 6, 1973

Subject: Proposed Rules Implementing
Limitation on Federal Par-
ticipation For Capital
Expenditures

1. Social Security Amendments of 1972 (P.L. 92-603):

The Social Security Amendments enacted in October, 1972 included Section 221, entitled "Limitation on Federal Participation in Capital Expenditures." Under this provision, designated planning agencies are required to review all capital expenditures which (1) exceed \$100,000, or (2) change the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially change the services of the facility with respect to which such expenditure is made. Where a designated planning agency disapproves a capital expenditure, the Secretary HEW is required to exclude from Federal payments made under Titles V, XVIII, and XIX to the facility those expenses related to such capital expenditure.

2. Federal Register Publication of Proposed Rules:

The Federal Register of August 3, 1973 contains a notice of the proposed regulations to implement the provisions of section 1122 of the Social Security Act, as added by section 221 (a) of the Social Security Amendments of 1972. As set forth in the proposed regulations, the Secretary HEW is directed to make an agreement with any State which is able and willing to do so under which a designated planning agency will submit to the Secretary findings and recommendations relating to whether capital expenditures proposed by or on behalf of health care facilities and health maintenance organizations in the State are consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Act of 1963. The regulations set forth requirements governing the agreements to be entered into pursuant to section 1122, including those relating to the agency to be named as the designated planning agency, criteria and procedures for review of proposed capital expenditures and submission of findings and recommendations to the Secretary HEW and review of such findings by the Secretary.

General Membership Memorandum

No. 73-8G

August 6,, 1973

3. Copy of Proposed Rules Attached:

A copy of the Proposed Rules contained in the Federal Register is attached for your information. Interested persons are invited to submit written comments, suggestions, or objections to the Comprehensive Health Planning Service, 5600 Fishers Lane, Rockville, Maryland 20852, on or before September 4, 1973. COTH headquarters would be interested in receiving a copy of any comments you may have.

4. Interim Guidance for Review of Capital Expenditures Proposals:

On June 5, 1973 the then Director of Comprehensive Health Service addressed a memorandum to the Directors of 314 (a and b) Agencies, State Hill-Burton Agencies, and other reviewing agencies, setting forth some guidance as to the review of capital expenditures proposals during the period before final regulations are published and State agreements are signed. These will be the "ground rules" to be observed until the final regulations are published some time after September 4, 1973 when comments on the Proposed Rules have been received and reviewed. A copy of this memorandum also is attached for your information.

RICHARD M. KNAPP, PH.D.
Director
Department of Teaching Hospitals

Attachment:

federal register

FRIDAY, AUGUST 3, 1973
WASHINGTON, D.C.

Volume 38 ■ Number 149

PART II



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CAPITAL EXPENDITURES

Proposed Limitation on
Federal Participation

**DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE**

Office of the Secretary

[42 CFR Parts 51, 81]

CAPITAL EXPENDITURES

**Proposed Limitation on Federal
Participation**

Notice is hereby given that the Assistant Secretary for Health of the Department of Health, Education, and Welfare, with the approval of the Secretary of Health, Education, and Welfare, proposes to issue a new Part 81 of Title 42, Code of Federal Regulations, entitled "Limitation on Federal Participation for Capital Expenditures", and to amend Part 51, Subpart A, of Title 42, Code of Federal Regulations, entitled "Grants to States for Comprehensive Health Planning".

The purpose of the proposed Part 81 is to implement the provisions of section 1122 of the Social Security Act, as added by section 221(a) of the Social Security Amendments of 1972 (86 Stat. 1386-89; 42 U.S.C. 1320a-1). The purpose of section 1122 is to assure that Federal funds appropriated under titles V, XVIII, and XIX of the Social Security Act are not used to support unnecessary capital expenditures made by or on behalf of health care facilities of health maintenance organizations which are reimbursed under any of such titles. Under section 1122, the Secretary of Health, Education, and Welfare is directed to make an agreement with any State which is able and willing to do so under which a designated planning agency will submit to the Secretary findings and recommendations relating to whether capital expenditures proposed by or on behalf of health care facilities and health maintenance organizations in the State are consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Act of 1963. Where the designated planning agency finds that a proposed capital expenditure is not in conformity with such standards, criteria, or plans, or where timely notice of such an expenditure has not been provided to such agency, the Secretary is required, subject to certain exceptions set forth in the statute, to exclude from the Federal payments made under titles V, XVIII, and XIX to the facility or organization expenses related to such capital expenditure.

The proposed new Part 81 sets forth requirements governing the agreements to be entered into pursuant to section 1122, including those relating to the agency to be named as the designated planning agency, criteria and procedures for review of proposed capital expenditures by the designated agency and other appropriate agencies in the State, and submission of findings and recommendations to the Secretary; and procedures for review of such findings and recommendations by the Secretary. Regula-

tions relating to payment by the Secretary to States for the reasonable cost of performing the review functions (pursuant to section 1122(c)) and to the computation by the Secretary of the amounts to be excluded from reimbursement under titles V, XVIII, and XIX, are in preparation and will be published separately.

The proposed amendment to Subpart A of Part 51 would require that State plans for comprehensive health planning make provision for assisting health care facilities and health maintenance organizations to develop programs for capital expenditures in accordance with criteria to be established by the Secretary after consultation with the States, and set forth criteria to be considered for such purpose.

Interested persons are invited to submit written comments, suggestions, or objections regarding the proposed new 42 CFR Part 81 and the proposed amendment to Part 51, Subpart A, to the Comprehensive Health Planning Service, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852, on or before September 4, 1973. Comments will be available for public inspection at Room 7-43, Parklawn Building, between the hours of 8:30 a.m. and 5 p.m., Monday through Friday.

It is therefore proposed to issue a new Part 81 of Title 42, and to amend Part 51, Subpart A, of Title 42, as set forth below.

Dated: July 18, 1973.

CHARLES C. EDWARDS,
Assistant Secretary for Health.

Approved: July 23, 1973.

FRANK CARLUCCI,
Acting Secretary.

**PART 81—LIMITATION ON FEDERAL
PARTICIPATION FOR CAPITAL EXPEND-
ITURES**

1. Title 42, CFR, is amended by the addition of a new Part 81, to read as follows:

- Sec.
- 81.101 Applicability.
 - 81.102 Definition.
 - 81.103 Expenditures covered.
 - 81.104 Agreement; general.
 - 81.105 Agreement; designated agency.
 - 81.106 Agreement; procedures for agency review.
 - 81.107 Agreement; criteria for agency review.
 - 81.108 Determination by the Secretary.
 - 81.109 Continuing effect of determinations.

AUTHORITY: Sec. 1122, Social Security Act; 42 U.S.C. 1320a-1.

§ 81.101 Applicability.

The provisions of this part are applicable to agreements entered into by the Secretary with the various States pursuant to section 1122 of the Social Security Act (42 U.S.C. Chap. 7), and to determinations made by the Secretary thereunder, for the purpose of assuring that Federal funds appropriated under titles V, XVIII, and XIX of the Social Security Act are not used to support un-

necessary capital expenditures made by or on behalf of health care facilities or health maintenance organizations which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

§ 81.102 Definitions.

(a) "Act" means the Social Security Act, as amended (42 U.S.C. Chap. 7).

(b) "State" means any of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(c) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved may be delegated.

(d) "Person" means an individual, a trust or estate, a partnership, or a corporation (including associations, joint-stock companies, and insurance companies).

(e) "Health care facility" includes hospitals, psychiatric hospitals, tuberculosis hospitals, skilled nursing facilities, home health agencies, and providers of outpatient physical therapy services (including speech pathology services) as defined in section 1861(e), (f), (g), (j), (o), and (p), respectively, of the Act (except that such term shall not apply with respect to outpatient physical therapy services performed by a physical therapist in his office or in a patient's home); kidney disease treatment centers, including freestanding hemodialysis units; intermediate care facilities as defined in section 1905(c) of the Act; and organized ambulatory health care facilities such as health centers, family planning clinics, and facilities providing surgical treatment to patients not requiring hospitalization (surgicenters), which are not part of a hospital but which are organized and operated to provide medical care to outpatients.

(f) "Health maintenance organization" means a public or private organization, organized under the laws of any State, which

(1) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: Usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;

(2) Is compensated (except for co-payments) for the provision of the basic health care services listed in subparagraph (1) of this paragraph to enrolled participants solely on a predetermined periodic rate basis; and

(3) Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

§ 81.103 Expenditures covered.

Any capital expenditure proposed by or on behalf of any health care facility or health maintenance organization, the obligation for which is incurred by or on behalf of a health care facility or health maintenance organization after December 31, 1972, is subject to this part: *Provided, that*, In the case of a health care facility providing health care services as of December 18, 1970, which on such date is committed to a formal plan of expansion or replacement, this part shall not apply with respect to such expenditures as may be made or such obligations as may be incurred for capital items included in such plan where preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of \$100,000 or more, had been made during the three-year period ended December 17, 1970.

(a) (1) For purposes of this part, a "capital expenditure" is an expenditure, including a force account expenditure (i.e., an expenditure for an internal work force employed by the facility), which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (i) exceeds \$100,000, or (ii) changes the bed capacity of the facility with respect to which such expenditure is made, or (iii) substantially changes the services of the facility with respect to which such expenditure is made.

(2) (i) For purposes of paragraph (a) (1) (i) of this section, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds \$100,000.

(ii) For purposes of paragraph (a) (1) (i) of this section, where the estimated cost of a proposed project, including cost escalation factors appropriate to the area in which the project is located, is, within 60 days of the date on which the obligation for such expenditure is incurred, certified by a licensed architect or engineer to be less than \$100,000, such expenditure shall be deemed not to exceed \$100,000 regardless of the actual cost of such project: *Provided, that*, In any such case where the actual cost of the project exceeds \$100,000, the health care facility or health maintenance organization on whose behalf such expenditure is made shall provide written notification of such cost to the designated planning agency not more than 30 days after the date on which such expenditure is incurred. Such notification shall include a copy of the certified estimate.

(iii) For purposes of paragraph (a) (1) (ii) of this section, the term "bed ca-

capacity" means licensed capacity under applicable State or local law, or, if there is no such law, the number of beds in a given facility as of January 1, 1973, as determined by the designated planning agency.

(iv) For purposes of paragraph (a) (1) (iii) of this section, a capital expenditure which "substantially changes the services" of a facility means a capital expenditure which results in the addition of a clinically related (i.e., diagnostic, curative, or rehabilitative) service not previously provided in the facility or the termination of such a service which had previously been provided in the facility.

(v) Any change in a proposed capital expenditure which itself meets the criteria set forth in this paragraph, shall, for purposes of this part, be deemed a capital expenditure.

(b) Where a person obtains, under lease or comparable arrangement, or through donation, any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure and subject to exclusion from reimbursement under titles V, XVIII, and XIX of the Act pursuant to this part if the person had acquired it by purchase, such acquisition shall be deemed a capital expenditure by or on behalf of such facility and the Secretary shall, subject to section 1122(d) of the Act:

(1) In the case of a donation which is carried by such person as a capital asset, or in computing such person's rental expense, in determining the Federal payments to be made under such titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or equipment by purchase. The amount to be excluded pursuant to this subparagraph shall be based upon.

(i) The fair market value, as determined by the Secretary, in the case of real property; and

(ii) The Estimated Useful Lives of Depreciable Assets as set forth in the American Hospital Association Chart of Accounts for Hospitals, or comparable table for the computation of equipment values acceptable to the Secretary, in the case of equipment.

(2) In computing such person's return on equity capital, deduct any amount deposited under the terms of the lease or comparable arrangement.

(c) Obligation: An obligation for a capital expenditure shall be deemed to have been incurred by or on behalf of a health care facility or health maintenance organization

(1) When an enforceable contract is entered into by such facility or organization or by a person proposing such capital expenditure on behalf of such facility or organization for the construction, acquisition, lease or financing of a capital asset; or

(2) Upon the formal internal commitment of funds by such facility or organization for a force account expenditure which constitutes a capital expenditure; or

(3) In the case of donated property, the date on which the gift is completed in accordance with applicable State Law.

§ 81.104 Agreement; general.

The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate public officials, shall make an Agreement with any State which is able and willing to enter into such an agreement under which a designated planning agency (which shall be an agency described in § 81.105) will submit to the Secretary, together with such supporting materials as the Secretary may require, the following:

(a) With respect to each capital expenditure proposed by or on behalf of a health care facility or health maintenance organization in such State, the findings of such designated planning agency as to whether

(1) The designated planning agency or any other agency described in § 81.105 had been given notice of such proposed capital expenditure (in accordance with such procedure or in such detail as may be required pursuant to § 81.106) at least 60 days prior to obligation for such expenditure; and

(2) Such expenditure is or is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(i) In reaching such findings, the designated planning agency shall consult with, and take into consideration the findings and recommendations of, the other agencies described in § 81.105.

(ii) Where the designated planning agency finds that such expenditure is not consistent with such standards, criteria, or plans, it shall submit to the Secretary the findings and recommendations of all such other agencies with which it has consulted.

(b) With respect to each proposed capital expenditure which is found by the designated planning agency to be not consistent with the standards, criteria, or plans described in paragraph (a) of this section, its recommendation as to whether the Secretary should either

(1) Exclude, in determining the Federal payments to be made under titles V, XVIII, and XIX of the Act with respect to services furnished in the health care facility or health maintenance organization for which such capital expenditure is made, any amount which is attributable to a depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure (in accordance with section 1122(d) (1) of the Act; or

(2) Not exclude such expenses, on the ground that such facility or organization has demonstrated proof of capability to provide comprehensive health care services efficiently, effectively, and economically, and that such an exclusion would discourage the operation or expansion of such facility or organization, or of any facility of such organization.

(c) With respect to each proposed capital expenditure which is found by any other agency described in § 81.105 of this part to be not consistent with the standards, criteria, or plans described in paragraph (a) of this section within the field of responsibilities of such other agency, the findings and recommendations of such other agency.

(d) With respect to each proposed capital expenditure as to which the designated planning agency reaches a finding contrary to that reached by the local area planning agency described in § 81.105(a)(3), a statement of the reasons for such a contrary finding.

§ 81.105 Agreement; designated agency.

(a) The designated planning agency designated in the Agreement shall be one of the following:

(1) The State agency designated or established pursuant to section 314(a) of the Public Health Service Act as the sole agency for administering or supervising the administration of the State's health planning functions under the plan developed pursuant to such section 314 (a).

(2) The State agency designated pursuant to section 604(a) of the Public Health Service Act as the sole agency for the administration of the State plan developed pursuant to Title VI of the Public Health Service Act.

(3) The public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is or is proposed to be located or, if there is no such agency covering such area, such other public or nonprofit private agency or organization which is found by the State agency referred to in paragraph (a)(1) of this section and by the Secretary to be performing similar functions.

(b) The designated planning agency shall have a governing body or advisory board at least half of whose members represent consumer interests.

§ 81.106 Agreement; procedures for agency review.

(a) The Agreement shall provide for the following notification and review procedures:

(1) The designated planning agency shall establish and maintain procedures under which timely written notice of the intention to make a capital expenditure subject to this part is required to be given (i) to the designated planning agency, in which case such agency shall distribute copies of such notice to those

other agencies described in § 81.105 whose respective fields of responsibility cover the proposed expenditure, or (ii) simultaneously to the designated planning agency and to those other agencies described in § 81.105 whose respective fields of responsibility cover the proposed expenditure. Such notice shall set forth the date on which the obligation is expected to be incurred, and must be received by the designated planning agency not less than 60 days prior to such date.

(2) Such notice shall be submitted in such form and manner and shall contain such information as may be required by the designated planning agency to meet the needs of all the agencies whose respective fields of responsibility cover the proposed expenditure. The designated planning agency shall promptly publicize its receipt of such notice through local newspapers and public information channels.

(3) If the notice under this paragraph is found by the designated planning agency to be incomplete, such agency shall notify the person proposing the capital expenditure within 15 days of its receipt of such incomplete notice, advising such person of the additional information required. Where such timely notification of incompleteness is provided, the period within which the agency is required to notify the person proposing such expenditure that such expenditure is not approved, as required by section 1122(d)(1)(B)(i) of the Act and paragraph (a)(4) of this section, shall run from the date of receipt by the agency of a notice containing such additional information.

(4) Except as provided in paragraph (a)(3) of this section, or unless the person proposing the capital expenditure agrees to a longer period, the designated planning agency shall, prior to the date set out in the written notice of intention submitted pursuant to paragraph (a)(1) of this section as the expected date for the obligation of the proposed expenditure (but, subject to the provisions of paragraph (a)(3) of this section in no event later than 90 days after the receipt of such notice), provide written notification to the person proposing such capital expenditure (i) that such capital expenditure has been determined by such agency to be in conformity with the standards, criteria and plans described in § 81.104(a)(2), or (ii) that such agency has elected not to review the proposed capital expenditure (which election shall constitute a determination by such agency and plans); or (iii) that such agency after having consulted with, and taken into consideration the findings and recommendations of, the other agencies described in § 81.105 (to the extent that such proposed capital expenditure is within the respective fields of responsibility of such other agencies), has determined that the proposed capital expenditure would not be in conformity with the standards, criteria, or plans described in § 81.104(a)(2). The notification described in paragraph (a)(4)(iii) of this section shall be accompanied by a statement of the designated plan-

ning agency's proposed recommendation to the Secretary and the reasons therefor, a summary of the findings and recommendations of the other agencies with which such agency has consulted pursuant to paragraph (a)(4)(iii) of this section and shall provide an opportunity for a fair hearing with respect to the findings and recommendations of the designated planning agency at the request of the person proposing such capital expenditure.

(5) Copies of the findings and recommendations of the designated planning agency shall also be sent to the other agencies consulted, and shall be publicized through local newspapers and public information channels.

(b) Any person proposing a capital expenditure may withdraw his previously filed notice of proposed capital expenditure, without prejudice, by filing simultaneous written notification of such withdrawal with those agencies to which he gave notification pursuant to paragraph (a)(1) of this section, at any time prior to his receipt of notice pursuant to paragraph (a)(2)(i), (ii), or (iii) of this section.

(c) In addition to any other hearing which may be provided by an agency described in § 81.105 in connection with the review of a proposed capital expenditure under this part, the Agreement shall provide that the designated planning agency will grant to a person proposing a capital expenditure an opportunity for a fair hearing with respect to the findings and recommendations of the designated planning agency, and will establish and maintain procedures for such appeal. Such procedures shall include the following:

(1) The request for a hearing must be made in writing, to the designated planning agency, within 30 days after the date on which the person proposing the capital expenditure receives notice of an adverse finding or recommendation of the designated planning agency.

(2) The hearing shall be held as promptly as practicable consistent with the provision of adequate notice to the person requesting the hearing in accordance with the applicable requirements of State law, and shall be conducted by such agency or person, other than the designated planning agency, as the Governor (or other chief executive officer of the State) may designate for that purpose.

(i) The hearing shall be open to the public and shall be publicized through local newspapers and public information channels.

(ii) The person proposing the capital expenditure, the other agencies described in § 81.105, and other interested parties, including representatives of consumers of health services, shall be permitted to give testimony and present arguments at the hearing.

(iii) The record of the proceedings shall be transcribed and copies of the transcription, together with copies of all documents received in evidence, shall be available to the public for inspection and copying: *Provided*, That any person who

requests copies of such material may be required to bear the costs thereof.

(3) As soon as practicable, but not more than 45 days after the conclusion of a hearing, the hearing officer shall notify the person who requested the hearing, the designated planning agency, the other agencies described in § 81.105 who participated in the hearing, and other interested parties at the discretion of the hearing officer, of his decision and the reasons therefor. Such decision shall be publicized through local newspapers and public information channels.

(4) Any decision of a hearing officer, arrived at in accordance with this paragraph, shall, to the extent that it reverses or revises the findings or recommendations of the designated planning agency, constitute the findings and recommendations of the designated planning agency: *Provided*, That where judicial review of such decision is obtained, the final decision of the reviewing court, to the extent that it modifies the findings and recommendations of the designated planning agency, shall to such extent constitute the findings and recommendations of the designated planning agency.

§ 81.107 Agreement; criteria for agency review.

The Agreement shall set forth the criteria under which the designated planning agency and the other agencies described in § 81.105 shall evaluate proposals for capital expenditures for purposes of this part to determine their conformance with the applicable standards, criteria and plans referred to in § 81.104 (a) (2). Such criteria, to the extent provided for under such standards, criteria, or plans, shall include the following:

(a) Whether the proposed project is needed or projected as necessary to meet the needs in the community in terms of health services required: *Provided*, That projects for highly specialized services (such as open-heart surgery, renal transplantation, or radiation therapy) which will draw from patient population outside the community in which the project is situated will receive appropriate consideration;

(b) Whether the proposed project can be adequately staffed and operated when completed;

(c) Whether the proposed capital expenditure is economically feasible and can be accommodated in the patient charge structure of the health care facility or health maintenance organization without unreasonable increases; and

(d) Whether the project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, and design and construction economies.

§ 81.108 Determination by the Secretary.

(a) Except as provided in paragraph (b) of this section, if the Secretary determines that (1) the designated planning agency has not been given timely notice of intention to make a capital ex-

penditure in accordance with § 81.106, or (2) that the designated planning agency has, in accordance with the requirements of section 1122 of the Act and this part, submitted to the Secretary its finding that such expenditure is not consistent with the standards, criteria, or plans described in § 81.104(a) (2) then, for such period as he deems necessary to effectuate the purpose of section 1122 of the Act, he shall, in determining the Federal payments to be made under titles V, XVII, and XIX of the Act to such health care facility or health maintenance organization, exclude expenses related to such capital expenditure.

(b) Notwithstanding the provisions of paragraph (a) of this section, if the Secretary, after submitting the matters involved to the National Advisory Health Council on Comprehensive Health Planning Programs (established pursuant to section 316 of the Public Health Service Act, 42 U.S.C. 247a) and after taking into consideration the recommendations of the designated planning agency and the other agencies described in § 81.105 with respect to such expenditure, determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of titles V, XVIII, or XIX of the Act, he shall include such expenses in Federal payments under such titles.

(c) Upon making a determination under this section the Secretary will promptly notify the person proposing such capital expenditure, the designated planning agency, and the other agencies described in § 81.105 with which the designated planning agency has consulted, of such determination and the basis for such determination.

(d) Any person dissatisfied with a determination by the Secretary under section 1122 of the Act or this part with respect to a particular capital expenditure may, within six months following the date of such determination, request the Secretary to reconsider such determination.

(1) Such request for reconsideration shall be in writing, addressed to the Secretary of Health, Education, and Welfare or to any officer or employee of the Department of Health, Education, and Welfare to whom the Secretary has delegated responsibility to receive such requests, and shall set forth the grounds based upon the record of the proceedings and any issues of law, upon which such reconsideration is requested.

(2) Reconsideration will be based upon the record of the proceedings, which shall consist of the findings, recommendations and supporting materials submitted to the Secretary by the designated

planning agency (including the findings and recommendations of other agencies) which relate to the findings and recommendations involved, the record of the hearing provided by the designated planning agency, if any, and of any judicial proceedings, the materials submitted in connection with such request, and such comments as the Secretary may request from the designated planning agency.

(3) Notice of any reconsidered determination under this paragraph shall be sent to the designated planning agency and the person requesting such reconsideration.

(4) A determination by the Secretary is, under section 1122 of the Act, not subject to administrative or judicial review.

§ 81.109 Continuing effect of determinations.

(a) Except in the case of a long-term construction plan of the type described in paragraph (b) of this section, where the designated planning agency has found that a proposed capital expenditure is in conformity with the standards, criteria, and plans described in § 81.104(a) (2), the obligation for such capital expenditure shall be incurred not less than one year following the date of such finding, or such shorter period as may be required by applicable State law: *Provided*, That in the absence of any State law to the contrary, the Secretary may, pursuant to a showing of good cause by the person proposing such expenditure, extend the period during which such obligation must be incurred for up to an additional six months. If no such obligation is incurred within such period, the designated planning agency's approval shall, for purposes of this part, be deemed to be terminated upon the expiration of such period.

(b) In the case of any capital construction plan proposed by or on behalf of a health care facility or health maintenance organization under which a series of obligations for capital expenditures for discrete components of the plan is to be incurred over a period longer than one year, the designated planning agency may review and approve or disapprove, for purposes of this part, those of such capital expenditures which it estimates will be incurred within three years following the date of such approval or disapproval.

(c) (1) In any case in which the Secretary has determined pursuant to a finding by the designated planning agency that a proposed capital expenditure is not in conformity with the standards, criteria, or plans described in § 81.104 (a) (2), that expenses related to such capital expenditure shall not be included in determining Federal payments under titles V, XVIII, and XIX of the Act the health care facility or health maintenance organization to whom such payments are made shall be entitled, upon its request to the designated planning agency in such form and manner and supported by such information as such agency may require, to a reconsideration by the designated planning agency of such finding:

PROPOSED RULES

(1) Whenever there is a substantial change in existing or proposed health facilities or services, of the type proposed, in the area served by such facility or organization;

(ii) Upon a substantial change in the need for facilities or services, of the type proposed, in the area served by such facility or organization, as reflected in the standards, criteria or plans referred to in § 81.104(a)(2); or

(iii) At any time following the expiration of three years from the date of the finding of the designated planning agency or of its last reconsideration of such finding pursuant to this paragraph, whichever is later.

(2) (i) If, upon reconsideration of its finding pursuant to this paragraph, and after consulting with and taking into consideration the findings and recommendations of the other agencies described in § 81.105, the designated planning agency finds that the facilities or services provided by such capital expenditure are in conformity with the standards, criteria, and plans described in § 81.104(a)(2) it shall promptly so notify the Secretary and the person submitting such request.

(ii) If the designated planning agency, upon such reconsideration, reaffirms its previous finding, the procedure set forth in § 81.106 following an initial determination shall be followed.

(3) Upon notification by a designated planning agency of a revised finding in accordance with paragraph (c)(2) of this section, the Secretary will include, in determining future payments under titles V, XVIII, and XIX of the Act, expenses related to such capital expenditure. Such expenses will be included for periods following the date of such notification only, and amounts previously excluded shall not be taken into account in determining Federal payments under titles V, XVIII, and XIX of the Act.

2. Paragraph (i) of 42 CFR 51.4 is amended to read as follows:

§ 51.4 State program requirements.

(i) *Program for capital expenditures.*

(1) The State program must incorporate by reference a written program providing for assisting, through consultation, pro-

vision of information, and advice, each health care facility and health maintenance organization in the State to develop a program for capital expenditures for replacement, modernization, and expansion in accordance with criteria which will meet the needs of the State for health care facilities, equipment and services without duplication and otherwise in the most efficient and economical manner. Such criteria will be established by the Secretary after consultation with the State, and will be based on the following considerations:

(i) Whether a proposed project is needed or projected as necessary to meet the needs in the community in terms of health services required: *Provided*, That projects for highly specialized services which will draw from patient population outside the community will receive appropriate consideration;

(ii) Whether a proposed project can be adequately staffed and operated when completed;

(iii) Whether a proposed capital expenditure is economically feasible and can be accommodated in the patient charge structure of the health care facility or health maintenance organization without unreasonable increases; and

(iv) Whether a project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, and design and construction economies.

(2) The State agency furnishing such assistance shall periodically review such capital expenditure program of each health care facility or health maintenance organization in the State and recommend appropriate modification thereof.

(3) The assistance and review required under this paragraph may be provided either by the State comprehensive health planning agency itself, or, under such State agency's control and supervision, by a local public or private nonprofit agency, or by another State agency qualified and authorized to provide such assistance and designated in the State program as the agency with the primary responsibility therefor.

(4) For purposes of this section, the term "health care facility" includes hospitals, psychiatric hospitals, tuberculosis hospitals, skilled nursing facilities, home health agencies, and providers of outpatient physical therapy services (including speech pathology services) as defined in section 1861(e), (f), (g), (j), (o) and (p), respectively, of the Social Security Act (except that such term shall not apply with respect to outpatient physical therapy services performed by a physical therapist in his office or in a patient's home); kidney disease treatment centers, including freestanding hemodialysis units; intermediate care facilities as defined in section 1905(c) of the Social Security Act; and organized ambulatory health care facilities such as health centers, family planning clinics, and facilities providing surgical treatment to patients not requiring hospitalization (surgicenters), which are not part of a hospital-but which are organized and operated to provide medical care to outpatients.

(5) For purposes of this section, the term "health maintenance organization" means a public or private organization, organized under the laws of any State which

(i) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician's services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;

(ii) Is compensated (except for copayments) for the provision of the basic health care services listed in subsection (i) of this subparagraph to enrolled participants solely on a predetermined periodic rate basis; and

(iii) Provides physicians' services primarily (A) directly through physicians who are either employees or partners of such organization, or (B) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(Sec. 314(a), Public Health Service Act; 42 U.S.C. 246(a)).

[FR Doc.73-15674 Filed 8-2-73;8:45 am]

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

TO : Directors, 314(a) and 314(b) Agencies;
State Hill-Burton Agencies;
Other Agencies designated for Section 1122,
Social Security Act (Sec. 221, P.L. 92-603)

DATE: JUN 5 1973

FROM : Director,
Comprehensive Health Planning Service

SUBJECT: Section 1122, Social Security Act (Section 221, P.L. 92-603)

The purpose of this memorandum is to give you some guidance as to review of capital expenditures proposals falling within the scope of Section 1122 during this period before regulations are published and State agreements are signed. The Secretary of Health, Education, and Welfare has assigned full responsibility for Section 1122 to the Comprehensive Health Planning Service.

First, I would like to give you a capsule sketch of where we stand:

Regulations are being prepared for the Federal Register. We hope to have them ready in June. They are now with the General Counsel.

Training programs in Section 1122 (law, procedures, how to review, appeals, etc.) will be conducted across the country between now and October. Representatives of all designated State agencies and 314(a) agencies will be asked to attend.

Guideline materials needed for the entire process will be ready in June - July.

Formulae for reimbursement to States for Section 1122 activities are being worked out and will be negotiated by Regional Offices at the time of agreement negotiations. Reimbursement will be available for the fiscal year beginning July 1, 1973.

We hope and expect to have regulations, signed agreements, and all other aspects of the program in full effect by Labor Day.

Now for some guidance on reviews in 314(a) during this interim period:

1. If a provider submits a capital expenditures proposal to the State-designated agency, or the appropriate (b) or H-B, and 60 days

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elapse with no action or clear guidance to the provider (i.e. approval, informal negative finding or written postponement to a definite date not to exceed 30 additional days), then the provider may proceed to build, expand, change, etc., with no risk that reimbursement for such capital expenditure will be withheld by the Secretary under Titles V, XVIII and XIX. A positive finding by such State agency or by such other agency during this interim period will stand as a positive finding under Sec. 1122 as long as the proposal is carried out without substantial change.

2. If a provider submits a proposal to the State-designated agency during this pre-agreement period and the State agency develops a negative finding in accordance with the statutory procedures or, in the absence of the DPA to the 314(a) or (b) agency or Hill-Burton (604), we have been told by our General Counsel that the provider should be advised to govern the initiation of his project in accordance with this negative finding.

3. If a provider develops a proposal during this pre-agreement period, but does not submit it to the State-designated planning agency, he is in danger of losing reimbursements. (All providers have been made aware of the January 1 effective date.)

4. In any event, if reviews are made during this pre-agreement stage by a State-designated agency, all other appropriate agencies (Hill-Burton, 314(a), 314(b)) must be contacted for comment before response is given to providers.

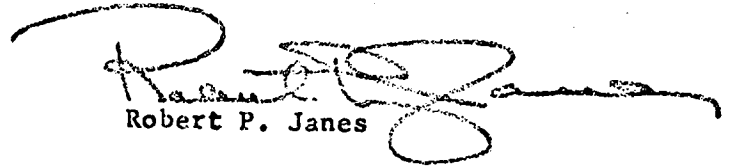
5. Our advice to State-designated planning agencies, until an agreement is negotiated with your State this summer: If you are prepared now to implement Section 1122, announce your readiness to all providers and make reviews and advise providers of the hazards of proceeding in the face of negative findings or failure to give the required notice.

6. 314(b) Agencies are advised to communicate with and work with providers to the extent possible and insure that proposals a) get sent to the correct State agency, and b) generate specific replies as to whether the agency is prepared to make reviews and develop findings.

I am sending copies of this memorandum to national provider organizations and asking them to communicate its contents to their constituents by newsletter, etc.

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Please call your Regional CHP Director for further guidance and answers to questions.



Robert P. Janes

Distribution:

Attached

REPRESENTATION IN THE AAMC ASSEMBLY

The AAMC Assembly presently consists of all U.S. members of the Council of Deans (114), 35 designated representatives of the Council of Academic Societies, 35 designated representatives of the Council of Teaching Hospitals, and ten (10) percent of the members of the Organization of Student Representatives (11). The Association Bylaws further indicate that all other members shall have the privileges of the floor without vote.

Since the adoption of this formula for Assembly representation, the voting membership of the COD has expanded with the addition of new medical schools, while the representation of both CAS and COTH has remained fixed. At the most recent meeting of the CAS Administrative Board this pattern of representation was questioned.

At its meeting on June 21, 1973 the CAS Administrative Board adopted a motion requesting that CAS representation in the Assembly be increased to reflect one vote for each constituent society, not to exceed the representation of the COD. The Association's Executive Council discussed this issue at its meeting on the following day and requested that each Administrative Board at its next meeting reassess the pattern of representation in the Assembly. Recommendations of the Administrative Boards are to be forwarded to the Executive Council for consideration at its September 14 meeting.