

PN-ABP-011
ISN 82196



HEALTH SECTOR FINANCING PROJECT

**Ministry of Health
Republic of Indonesia**

CONSULTANT REPORT SERIES

Hospital Study Tour, October 2 - 24, 1989
Indonesian Health Sector Financing Project

No. 29

Author: Albert C. Baker



A USAID-Sponsored Project in Collaboration with
The International Science and Technology Institute, Inc.

HOSPITAL STUDY TOUR, OCTOBER 2 - 24, 1989
INDONESIAN HEALTH SECTOR FINANCING PROJECT

No. 29

Author:
Albert C. Baker

September 1990

Prepared for:

Health Sector Financing Project
Ministry of Health
Republic of Indonesia
Under USAID Contract No.
ANE-0354-C-00-8030-00

Prepared by:

International Science and Technology Institute, Inc.
Suite 800
1129 20th Street, NW
Washington, D.C. 20036
Tel: (202) 785-0831
Telex: 272785 ISTI UR
FAX: (202)223-3865

TABLE OF CONTENTS

LIST OF ACRONYMS	iii
I. BACKGROUND	1
II. STUDY TOUR OBJECTIVES	1
III. STUDY TOUR PARTICIPANTS	2
IV. TOUR DOCUMENTATION	3
V. FORMAT OF AGENCY/FACILITY VISITED OR PRESENTATIONS	4
VI. LIST OF AGENCIES/ORGANIZATIONS VISITED	4
VII. SUMMARIES	6
APPENDIX A Selected Expanded Biographies	

LIST OF ACRONYMS

AAMC	Association of American Medical Colleges
AHA	American Hospital Association
AMA	American Medical Association
CAT	Computerized axial tomography scanner
DOD	Department of Defense
DRG	Diagnostic Related Groups
FDA	Federal Food and Drug Administration
FTE	Full-time Equivalents
GOI	Government of Indonesia
HCA	Hospital Corporation of America
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
HSQ	Bureau of Health Standards and Quality
ISTI	International Science and Technology Institute Inc.,
JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
M.B.A.	Master of Business Administration
M.H.A.	Master of Health Administration
MC	Medical Corps.
MOH	Ministry of Health
M.P.H.	Master of Public Health
NAPH	National Association of Public Hospitals
OP	Out Patient
PPO	Preferred Provider Organization
PPS	Prospective payment system
PRO	Peer Review Organization, Professional Review Organization
ProPac	Prospective Payment Assessment Commission
PTC, P&T	Pharmaceutical and Therapeutic Committee
RN	Registered Nurse
TAMC	Tripler Army Medical Center
UCLA	University of California - Los Angeles
USAID	United States Agency for International Development
VA	Veterans Affairs
VAMC/WLA	Veterans Administration Medical Center - West Los Angeles
VCR	Video Cassette Recorder

I. BACKGROUND

The Government of Indonesia (GOI) and the U.S. Agency for International Development (USAID) are jointly funding a multi-year project to improve the efficiency of, increase cost recovery for, and expand alternative financing arrangements for health services in Indonesia. The hospital component for this project is to conduct a diagnostic study to ascertain management, service, financing, and delivery problems in the government-owned and operated hospitals in Indonesia. The results will be used to identify programmatic and policy changes needed to improve hospital efficiency, increase revenues and cost recovery, and reduce government subsidies to the hospitals. The International Science and Technology Institute, Inc., (ISTI), Washington, D.C., is the prime A.I.D. contractor for the project.

To broaden and enhance the knowledge about U.S. hospitals for the benefit of several Indonesian physicians who are participating in the hospital component of this project, a study tour was developed to bring these doctors to the United States in October 1989. This report incorporates the results of that tour.

II. STUDY TOUR OBJECTIVES

The general objective is to introduce the participants to the innovations in hospital financing and management that have been and are continuing to be developed in the United States. The specific objectives of the study tour are:

- To understand how U.S. hospitals, particularly those operated by federal, state, and local governments, are governed and policy-making changes are developed and implemented;
- To understand how U.S. hospitals are accredited, with particular emphasis on the accrediting agencies, and how the standards and criteria are applied as well as how quality of care is measured and monitored;
- To understand how U.S. hospitals financially manage their revenues and expenditures, with special need to examine cash versus accrual accounting;
- To examine the techniques used to control costs in hospitals to include an understanding of the Diagnostic Related Groups (DRGs) system used by Medicare (the federal program to provide health care for the elderly) for inpatient acute care patients as well as the use of hospital rate setting at the state level;
- To understand the operation of hospital pharmacies to include the use of formularies and generic drug substitution;
- To understand the relationships between hospital administrators and hospital medical staffs, including the relationships between the administrators of teaching hospitals and the teaching faculties of medical schools who practice in the teaching hospitals;
- To review personnel hiring and discharge policies, particularly the issues surrounding the shortage of nurses;
- To understand the process of hospitalization of patients enrolled in health maintenance organizations (HMOs);
- To understand how patient medical records are maintained and utilized within hospitals;
- To understand how U.S. hospitals cope with malpractice issues that threaten the

financial viability of both hospitals and the physicians who practice in them; and

- To understand the extent to which computers and automated management information systems are being utilized within U.S. hospitals.

III. STUDY TOUR PARTICIPANTS

A. Members

The six Indonesian physicians who participated as members in the tour are:

- Dr. H. Boedihartono, M.D. and M.H.A., currently Director of General and Teaching Hospitals for the Indonesian Ministry of Health (MOH) in Jakarta.
- Dr. Soedibjo Sardadi, M.D. and M.P.H., currently Director of the Project Implementation Office for Hospitals in the MOH in Jakarta.
- Dr. Adji Muslihuddin, M.D. and M.H., currently Director of the Fatmawati Hospital in Jakarta.
- Dr. Nazaroedin Bakar, M.D. and M.P.H., currently Director of the Achmad Mughtar Hospital in West Sumatra.
- Dr. I.G.A. Gde Oka, M.D. and M.P.H., currently Director of the Sanglah Teaching Hospital in Denpasar, Bali.
- Dr. Soenarso, M.D. and M.P.H., currently Director of the Syaiful Anwar Teaching Hospital in Malang, East Java.

An expanded biography for each of these physicians can be found in Appendix A.

B. Tutor/Facilitator/Tour Guide

Albert (Al) C. Baker, M.S. (Public Admin), an ISTI health care consultant (expanded biography in Appendix A) from Vienna, VA.

C. Other Major Participants

The following persons also provided active direction and assisted in facility, hotel, and local travel arrangements:

- Elizabeth J. Connell, MBA, Senior ISTI Associate and the Washington Deputy Director for the project. Ms. Connell was instrumental in developing the tour itinerary, making contacts with federal officials, hospital administrators and management company officers, and actively participating in several tour visits in Washington, DC, Los Angeles, CA, and Honolulu, HI (expanded biography in Appendix A).
- Paul Zukin, M.D., an ISTI consultant who heads the Health Management Group, Ltd., in Piedmont, CA. Dr. Zukin was responsible for developing the Los Angeles area itinerary and facility contacts, for assisting in travel and hotel arrangements in the area, and for participating actively during each facility visit.
- Robert T. Eonham, M.D., an ISTI consultant who is Chief of the Emergency Department for the Waianae Coast Comprehensive Health Center in Hawaii and

is also an international health/communications specialist with the Omega Rose Foundation in Honolulu. Dr. Bonham worked tirelessly to assure that the tour's visit to Hawaii was productive and useful. He provided for all our local transportation needs, made facility contacts prior to and during our visit, and actively participated in the facility visits. He also arranged for a visit to the Office of the Governor of Hawaii which culminated in a session with the State's Lieutenant Governor, Benjamin Cayetano. Further, he arranged for and accompanied the tour group to the campus of the Kapiolani Community College, a unit of the University of Hawaii, which offers a number of courses in the allied health professions area which could be a resource for training Indonesian health and hospital professionals. Dr. Bonham on Saturday, October 21, conducted an island tour of Oahu, accompanied by his friend, William D. Souza, an Hawaiian native and Information Officer with the Department of Commerce and Consumer Affairs in Honolulu. Mr. Souza provided the tour group with cultural insights and historical anecdotes about Hawaii. Finally Dr. Bonham, who is also a glider pilot and instructor, concluded the island tour at the Dillingham Glider Airport on the north shore of Oahu where glider rides were provided for all tour members who desired. Most took advantage of the opportunity, and those who did were thrilled by ten to fifteen minute glider rides, piloted by instructor pilots who took the glider craft to between two and three thousand feet above sea level, affording passengers an outstanding and panoramic view of the mountains, land, and sea.

IV. TOUR DOCUMENTATION

The prime record of the tour will be this report. However, several other sources of documenting the trip were employed and are available at ISTI's Washington, DC, office for further detailed analysis and reference, except for those documents furnished to or notes taken by the tour group members who have them currently in their possession in Indonesia. In addition to this report, other documentation include:

- The two-inch, three-ring notebook prepared by Elizabeth Connell and Al Baker for each tour member. The notebook contains a tour itinerary, information on hotel accommodations, biographical data, study tour objectives, and 75 pages of U.S. hospital systems and health care data, to include statistics on health manpower, Medicare and Medicaid, HMO enrollments, health care expenditures, numbers of hospitals and beds, and on physicians, dentists, and nurses.
- Facility, agency, and association brochures, pamphlets, operating procedures, organizational charts, and other documents supplied by the organization visited either at the time of the visit or sent to ISTI's Washington office at a later date. Most of these types of documents were also furnished to each of the tour members at the time of the visit. However, for reference purposes, the summary description of each organization visited which follows later in this report will cite the documents received.
- Audio Tapes - Most of the oral presentations to the tour group were audio taped on cassette recorders by the tour facilitator, Al Baker, and comprise eleven standard-size 90 minute tapes; nineteen 60 minute microcassette tapes, and four 90 minute micro tapes. At appropriate points in this report, a reference will be made to the specific tape number and tape side that pertains to the segment under discussion.
- Video Tapes - The tour facilitator also videotaped selected segments of the tour, using his personal Sony 8mm Model CCDF40 camcorder which produces both a color and audio output. Approximately 150 minutes (two and one-half hours) were recorded of usable tape and then converted from the 8mm format to standard two hour VHS tapes at the SP (fast speed) level for best fidelity. Each segment of the report, at appropriate

points, will cite the VHS tape number and tape counter numbers to facilitate reference to the video record. For the information of the Indonesian and ISTI officials located in Indonesia, another and more electronically complicated conversion is necessary to produce a videotape that can be viewed on video cassette recorders (VCRs) and television sets available in Indonesia. Practical Technologies Inc., 7032 Golden Ring Road, Baltimore, MD, 21237, (phone: 800-227-0042 or 301-682-4013) offers such conversion services.

- Word Perfect Floppy Disc (5 1/4 Inch, IBM Formatted, MD 2-HD) containing the complete report and visit summaries written in Word Perfect 5.0 version.
- Personal handwritten notes and memos taken by the tour members and the other participants during the visit also provide a personal documentation. However, since each individual's handwriting, style of note-taking, abbreviations or shorthand used, are generally only interpretable by that individual (including those of the tour facilitator) inclusion of such notes and memos will not be a formal part of the documentation. Each person, though, who participated in the tour will find such reference material useful and should file and retain them in an accessible location for future needs.

V. FORMAT OF AGENCY/FACILITY VISITED OR PRESENTATIONS

The "Agency/Facility Visited or Presentations" segment of the report which follows as Section VI has been formatted for each visit or presentation in a standardized manner to facilitate reference in the order described below:

- Name and address of agency, facility, or association,
- Contact person, title, and telephone number within the agency of the individual who coordinated the visit.
- Date and time of visit or presentation (and location if other than at the agency address).
- Names of those in attendance, excluding personnel of the agency being visited who also may have been present. Note: Rather than naming the six visiting Indonesian physicians in attendance at each visit, the phrase "the six Indonesian tour group members" has been used to denote their presence.
- Names and titles of agency presenters.
- Summary of presentations. Note: No attempt has been made to correlate the information being presented or the documentation received during each visit with the specific objectives of the tour which are stated in Section II of this report. It may prove useful though as a later task to be undertaken by ISTI to prepare a matrix that would display which agencies addressed which objectives.
- Documentation pertaining to the visit to include audio tape references, video tape identification, and a listing of other documentation received or obtained.

VI. LIST OF AGENCIES/ORGANIZATIONS VISITED

- A. Tour Orientation Session, ISTI's Washington Office
- B. National Public Hospital Association, Washington, DC
- C. Prospective Payment Assessment Commission, Washington, DC
- D. Dr. Randy Teach, former Deputy Assistant Secretary for Health Policy, Department of

- E. Health and Human Services, Washington, DC
- E. American Pharmaceutical Association, Washington, DC
- F. Health Care Financing Administration, Bureau of Health Standards and Quality, Washington, DC
- G. Department of Veterans Affairs, Washington, DC
- H. U.S. Naval Medical Center, Bethesda, MD
- I. Georgetown University Hospital, Washington, DC
- J. State of Maryland, Department of Health, Baltimore, MD
- K. Hospital Corporation of America, Nashville, TN
- L. HCA Park View Medical Center and HCA West Side Hospital, Nashville, TN
- M. Ohio County Hospital, Hartford, KY
- N. American Hospital Association, Chicago IL
- O. Veterans Administration Lake Side Medical Center, Chicago IL
- P. Joint Commission on Accreditation of Healthcare Organizations Chicago, IL
- Q. American Medical Association, Chicago, IL
- R. Cedars-Sinai Medical Center, Los Angeles, CA
- S. Kaiser-Permanente Regional Office, Pasadena, CA
- T. Veterans Administration West Los Angeles Hospital, Los Angeles, CA
- U. Harbor General Hospital, Torrance, CA
- V. Straub Hospital and Burn Center, Honolulu, HI
- W. Tripler Army Medical Center, Honolulu, HI
- X. Kapiolani Community College Campus, Honolulu, HI
- Y. Office of the Governor of Hawaii, Honolulu, HI
- Z. Tour Cultural and Recreational Events

VII. SUMMARIES

A. Tour Orientation Session

Presented by:

International Science and Technology Institute Inc. (ISTI)
1129 - 20th Street, NW - Suite 800
Washington, D.C., 20036
Phone: 202-785-0831
Fax: 202-223-3865

Date, Time, and Location:

Monday, October 2, 1989, 9:00 a.m. to Noon, ISTI main conference room

Introductions and Welcoming:

Nihal W. Goonewardene, President and Chief Operating Officer of ISTI, welcomed the tour group on behalf of E.K. Wesley Copeland, ISTI's Chairman and Chief Executive Officer, emphasizing his pleasure in having the tour group visit ISTI's Washington, D.C., office as their first stop on the tour. He pledged full support of his staff and facilities at all times during their stay in the United States and anytime in the future after their return to Indonesia.

Robert Pratt, Senior ISTI Associate, and ISTI's Washington, D.C. Director for the Indonesian Health Sector Financing Project, introduced several members of the ISTI administrative staff who were present as well as Elizabeth J. Connell, ISTI's Washington, D.C., Deputy Project Director for the project. Al Baker, the tour facilitator and tour guide was also introduced.

Summary of Tour Orientation Presentations:

Ms. Connell and Mr. Baker jointly presented an overview of the tour itinerary. Then to provide for the tour members a better understanding of the U.S. health care and hospital delivery systems, they discussed the various kinds of private and public health benefit programs available in the United States for the employed population, for the elderly, for the disabled, and for the unemployed and poor. The Federal Medicare program for the elderly and the Federal/State Medicaid program for "qualified" poor were described, as well as private not-for-profit insurance plans such as the Blue Cross and Blue Shield plans and those offered by life insurance companies such as Aetna Casualty and Life and the Prudential Life. An explanation of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) was provided, describing these as innovative and often less costly alternatives to other health benefit programs, which in part has explained their phenomenal growth rate over the last several years.

Ms. Connell explained how health care services are regulated in the United States by licensing and accreditation; through rate setting on hospital payments and physician fees; and by utilization and peer review programs to assure that quality of care is provided. Mr. Baker provided data on the size of the U.S. hospital industry by numbers of hospitals, beds, average bed size, ownership, geographic locations, admissions and days of care, average lengths of stay, and the numbers of personnel employed to provide hospital services. He also described the different types of hospital ownership and governance in the United States: some are private not-for-profit, some are private for-profit, others are affiliated with religious orders or organizations, others belong to state, county, and local governments, and finally some are federal hospitals primarily for military personnel, retired personnel and their dependents, and for veterans of military service who have no other forms of health insurance.

Ms. Connell and Mr. Baker also reviewed the relationship between medical schools that train physicians and the teaching hospitals that are associated with the medical schools and that provide the

clinical environment for medical students, interns, and residents.

They also explained the contents of the ISTI "Hospital Study Tour" notebook furnished to each member, reviewing in particular the 75 page section devoted to U.S. Hospital Systems that provides detailed and specific data which had only been covered in summary form during the orientation.

The orientation session was concluded by Ms. Connell and Mr. Baker with a more detailed and specific description of the planned itinerary for the tour members so they could be preparing questions for or asking for more detailed explanations from the agencies, facilities, and organizations to be visited. An in-house lunch followed the morning session, providing an opportunity on a more informal basis for the tour members and the ISTI staff to become better acquainted.

Documentation:

1. Audio: Standard Tapes 1, Sides A and B, and 2, Side A.
2. Video: None
3. Other:
 - ISTI's three-ring notebook, "Hospital Study Tour - October 2-24, 1989"

B. National Association of Public Hospitals

Agency/Organization Visited:

National Association of Public Hospitals (NAPH)
1001 Pennsylvania Avenue, NW - Suite 635
Washington, D.C., 20004

Contact and Phone:

Angie (Mr. Gage's secretary) 202-347-0066

Date and Time of Visit:

Monday, October 2, 1989, 2-3:30 p.m.

Persons Attending Excluding Personnel from Organization Visited:

The six Indonesian tour group members, Elizabeth Connell, and Al Baker

Presenter:

Mr. Larry S. Gage, President and General Counsel
National Association of Public Hospitals

Summary of Remarks:

Mr. Gage opened his remarks by stating that U.S. public hospitals had several common problems with international public hospitals -- use of medical technology, how much is available, how much you can afford; quality of care issues; staffing ratios; but not necessarily financing health care because the U.S. has its own peculiar system. However, management and communications problems within hospitals are similar. He stated that starting next September or early October 1990 a series of international conferences on the problems of government-owned hospitals were being planned, with the first to take place in Western Europe, primarily because of the 25 public hospital system in Paris, France, where some comparison analyses could be made with U.S. public hospitals. Mr. Gage also stated he was scheduled to be in Tokyo the week of October 9, to attend a comparative symposium on the U.S./Japanese health care systems and then over to Hong Kong to examine their public hospital system.

Mr. Gage stated that his NAPH had a membership of 65 public hospital systems that represent 90 hospitals with about 45,000 beds with revenues in 1988 of US\$ 9 billion. NAPH member hospitals are generally very large in size, averaging 500 beds, and tend to be located in large urban areas, and also include all twelve public hospitals in the state of Hawaii, some being rather small. He also stated that there are another 1,400 state, county, and local government owned hospitals in the U.S. that are not his members. Most of these tend to be small, rural hospitals operated by a county. There are also a number of public hospitals associated with state universities that are not his NAPH members, although he does represent several in this category. Many of the smaller public hospitals including even some of his own are also looking at the possibility of "privatizing" their facilities; that is, restructuring the ownership by converting to a private not-for-profit or for-profit hospital with community ties but separate and apart from the local government political and tax structure. He said several conversions had already taken place. (Parenthetical Note: The tour group visited one of these "converted" hospitals on Tuesday, October 10, the Ohio County Hospital, Hartford, Kentucky -- see details in a later section of this report).

Mr. Gage used the term "safety net" many times in referring to U.S. public hospitals. He defined "safety net" to mean a catchment facility to provide health care regardless of the means of the patient to

pay for it; that is, no one who genuinely needed care would "fall through the cracks" because of lack of any or inadequate health benefits insurance. He stated that the average non-government hospital in the U.S., excluding Medicare and Medicaid programs, which cover certain elderly and qualified poor patients, have an average of 45 percent of their other patients covered by private commercial health insurance. His public hospital members average about 11 percent privately insured patients. His NAPH hospital members also provide a much higher percentage of outpatient (OP) services than other hospitals, because the indigent population uses these services for primary health care, not having the ability to pay for the services of private physicians. Two of his hospital members, the Dallas Parkland Hospital, and the Los Angeles County Medical Center, deliver more babies in one year (13,000-15,000 each) than any other hospital in the world, with the exception of the Singapore Hospital, and most of the mothers are unable to pay for their obstetrical services. Costs also tend to be higher in his members hospitals because they generally provide tertiary services for large areas, such as burn centers and spinal cord regeneration units. Moreover, his patients tend to be sicker when admitted because most lack the economic ability to eat properly; to maintain healthful environmental conditions; or to take preventive measures to maintain a healthy body.

Occupancy tends to be significantly higher in his hospitals, averaging 95 percent in 1988, compared to 62 percent for other U.S. hospitals. Many of the NAPH hospitals are major teaching facilities, directly associated with medical schools. This has both favorable and unfavorable aspects. On the negative side hospital costs are higher because a teaching environment often requires a higher than average number of diagnostic tests. On the plus side, the teaching faculty that practice in their facilities are often the most expert in the country in their specialties. In response to a tour member's question, Mr. Gage discussed the relationship between and often the difficulties that arise as a result of the hospital administrator's policies and those of the teaching faculty staff from the medical school that practice in the hospital. The administrator is concerned with costs, yet does not admit patients, order diagnostic tests, prescribe therapies, nor even have the authority to order a patient's discharge. Difficulties that are often encountered can only be resolved at the governing board level.

Mr. Gage also in response to a question discussed the use of generic drug usage in his hospitals. He said that as recently as ten years ago, most physicians resisted any pressures on them to prescribe other than brand name pharmaceuticals. However, because of current budget squeezes, higher labor costs, and the need for modernization of facilities and new high-tech medical equipment, very few physicians today object to generic substitution. Mr. Gage also commented that because of the enormous buying power of his large institutions, most major pharmaceutical companies are now offering prices for brand name drugs that compare favorably with generics. He was also asked about the employment status of the physicians that practice in his member hospitals. He replied that there's a wide variety of arrangements. In a few of his hospitals, all or most of the doctors are on the hospital's payroll. However, in the majority of cases, only a few are full time -- the medical director and department heads. In his teaching hospitals, many hold dual appointments, receiving a salary for their medical school teaching duties and another salary for supervising students, interns, and residents as well as performing administrative duties in the hospital. Many physicians also maintain private practices and can bill their patients or insurance carriers on a fee-for-service basis. Mr. Gage also discussed the malpractice risk in his hospitals. He indicated that threat was always present because the hospital administrator and his governing board are ultimately responsible for any mistakes and errors of commission or omission that occur in the hospital, even when a non-hospital employed physician who has admitting privileges is found guilty of malpractice. The hospital is almost always sued jointly and held jointly responsible, courts holding that the hospital should have exercised greater care in its credentialing process, or by more closely monitoring a physician's personal conduct and practice when in the hospital.

Documentation:

1. Audio: Standard Tapes 2, Side B, and 3, Side A
2. Video: None

3. Other:

- **"Strengthening American's Health Safety Net", a description of the NAPH.**
- **The Safety Net (Spring and Summer 1989 issues) -- quarterly publication of NAPH activities.**
- **Descriptive brochure on NAPH's National Public and Hospital Institute.**

C. Prospective Payment Assessment Commission

Agency/Organization Visited:

Prospective Payment Assessment Commission (ProPAC)
Reporters Building - 7th and D Streets SW
Washington, D.C., 20024
Phone: 202-453-3986

Contact Person:

Jay Younes, Admin. Assistant to Dr. Young
Phone: 202-453-3986

Date and Time of Visit:

Tuesday, October 3, 1989, 9:30 a.m. to Noon

Attendees:

The Indonesian tour group members; Elizabeth Connell, Deputy Project Director; Al Baker, Tour Facilitator, and Jay Merchant from the Federal Health Care Financing Administration which administers Medicare.

Presenter:

Donald A. Young, M.D.,
Executive Director of ProPAC

Summary of Presentation:

Dr. Young began his presentation with a description of the Federal Medicare program. He stated that it was authorized by an act of the U.S. Congress in 1965 to provide health care primarily for retired persons after their employment ceased and upon reaching the age of 65 and who by reason of their employment were eligible for Social Security retirement benefits. Currently more than 30 million persons are eligible for Medicare benefits. Ninety percent are 65 or older. The remaining 10 percent are eligible by reason of another part of the Social Security law, pertaining to employed persons who become permanently disabled (unable to work because of illness or injury) with a special provision to allow persons with end stage renal disease (kidney failure) to qualify. The Medicare Part A program provides hospital inpatient benefits, a limited number of days in a skilled nursing facility, and home health services. Part B of the program provides for physicians services, furnished either in the hospital as an inpatient or in a hospital outpatient setting, in a physicians office, or at an ambulatory surgery center. Part B will also pay for ambulance services and for certain types of durable medical equipment such as wheel chairs that may be needed for a Medicare beneficiary at home. However, Medicare will only pay for pharmaceuticals and drugs when prescribed for a beneficiary while in an inpatient facility.

Dr. Young explained how the Medicare program was financed: through a combination of employer and employee payroll taxes for Part A (hospital) benefits with some limited cost sharing and for Part B (physician) benefits, through funds appropriated annually by Congress and with patient cost sharing. When the Medicare program began in 1965 and continuing through most of 1983, hospitals were paid on a cost basis; that is, if Medicare patients accounted for 30 percent of the patient days in a year, Medicare would reimburse the hospital 30 percent of its total costs. Because this cost reimbursement provided no incentive for hospitals to cut costs, Congress changed the system in late 1983 to a prospective payment system (PPS) which established a series of 470 Diagnosis Related Groups (DRGs) for Medicare acute care hospital inpatients. The DRG rates were based on historical

hospital costs for treating each DRG, then averaged for all hospitals, by geographical region, and further adjusted for area wage differences. Initially DRG rates were scheduled to increase annually at a rate of increase related to the increase in the hospital industry's "market basket" (the input prices hospitals pay for salaries, goods, and services). However, during the first two years of the program in 1984 and 1985, hospitals were averaging 14 percent profits on their Medicare inpatients because for the first time hospitals had an incentive to reduce their own operating costs. In 1986 and thereafter, the U.S. Congress revised the DRG law to provide for a rate of increase to be determined annually. Dr. Young pointed out that since 1986, hospitals have been complaining that the established rates of increase by Congress has not only not kept up with hospital inflation (the market basket) but that in 1990 more than 50 percent of hospitals in the U.S. will be providing Medicare inpatient hospital services at a loss.

Dr. Young also discussed the Peer Review Organization (PRO) program which was authorized concurrently with introduction of DRGs in 1983. PROs were initially established by the Health Care Financing Administration (HCFA), the agency that administers Medicare, in each of the fifty states by contracting with local groups, primarily physician organizations, to review the quality of care furnished by hospitals under DRGs. The Medicare program wanted to be assured that hospitals under DRGs would not be admitting patients who did not need hospitalization, and second, once admitted, they wanted to be assured that hospitals would not be discharging the patient too quickly or providing inadequate quality of care in the hospital. PROs can prohibit a hospital from being paid under the DRG program if it finds the hospital admitted a patient who did not need hospitalization or when admitted was provided inadequate care.

Dr. Young concluded his presentation by explaining why ProPAC was created at the same time that DRGs were established in 1983. He said that Congress wanted an independent group of health care experts outside of the federal government and free of political influence to advise the Secretary of Health and Human Services (HHS) and the U.S. Congress on an annual basis of charges that should be made in the DRG system and to recommend annually what the rate of increase should be in DRG rates. The legislation authorized and funds were appropriated for a 17-member commission who would meet six or seven times a year for one or two day sessions and who would be staffed with permanent federal employees, not to exceed 25 in number. The staff which Dr. Young explained he heads provides the statistical analyses, research, and issues identification that are then presented to the 17 Commissioners for their review and recommendations. Dr. Young commented that by law the Secretary of HHS must respond in writing to ProPAC's recommendation but the Secretary is not bound to accept them. To date, though, Dr. Young estimates that about 75 percent of the Commission's recommendations have been favorably acted upon by HHS. Dr. Young emphasized to the tour group that ProPAC is an advisory group only with no authority to change Medicare policy or regulations.

Documentation:

1. Audio: Standard Tapes 3, Side B, 4, Side A and half of Side B
2. Video: VHS Tape I, Tape Counter 156 to 269
3. Other: Documents furnished directly to ISTI

D. Dr. Randy Teach

Special Guest Speaker:

Randy Teach, Ph.D. (Medical Information Systems, Stanford University)

Current Position and Address:

Senior Vice President for Government Liaison and Programs
National Association of Chain Drug Stores
413 North Lee Street
Alexandria, VA 22313
Phone: 703-549-3001

Date, Time, and Place of Presentation:

Tuesday, October 3, 1989, Noon to 1:30 p.m. in the reserved meeting/luncheon room at the Market Inn, 2nd and E Streets, SW, Washington, D.C.

Speaker's Background:

Dr. Teach served as a political appointee from 1981 to 1988 during President Reagan's administration, first as Director of Legislation and Policy in the Health Care Financing Administration which administers the Medicare and Medicaid programs for the Department of Health and Human Services (HHS) and for the last five years of his federal service as Deputy Assistant Secretary for Health Policy in the Office of the Assistant Secretary for Planning and Evaluation, HHS. In this latter position he had a wide variety of responsibilities ranging from developing departmental policies for AIDS and generic drugs to recommending changes in the Medicare program including how capital payments to hospitals should be treated under the prospective payment DRG system. Prior to coming to Washington in 1981, Dr. Teach served in a number of health care research, policy, and delivery programs in California's Department of Health as well as being a health care consultant. Both Ms. Connell, during her service with HHS as Deputy Executive Director for Health Policy, and Mr. Baker, during his service with the Federation of American Health Systems, became well-acquainted with Dr. Teach and strongly felt he would be an ideal speaker to give insight into federal health care and hospital programs from the viewpoint of a former senior government official and as a senior officer in a national health care related organization.

Attendees at Meeting/Luncheon:

The six Indonesian tour group members, Elizabeth Connell, Al Baker, and Jay Merchant from the Office of Professional and Scientific Affairs, HCFA.

Summary of Presentation:

Dr. Teach initially discussed the rising costs of malpractice insurance for both hospitals and physicians. He said that insurance companies have had to raise their premiums tremendously over the past several years to pay for extremely high awards that have been made to patients. The Medicare and Medicaid programs as well as commercial health benefit insurers have charged that physicians are driving up health care costs by practicing defensive medicine; that is, ordering a much wider range of diagnostic tests than before as a defense in case the physician is later charged with failure to diagnose properly a disease or injury. One of his projects when at HHS was to look at what some state legislatures have done to reduce malpractice costs. He cited Indiana as an example that limited the dollar amount of malpractice awards, taking the physician somewhat off the hook. Did that change their behavior? No, he observed. There was no noticeable difference in the number of tests on average being ordered before the Indiana legislation was enacted than afterward. His conclusion: defensive

medicine exists as a real economic fact and no one has yet come forward with a workable solution.

In response to a question from one of the tour physicians as to how one measures the appropriateness of health care, Dr. Teach said it was very difficult, although more careful peer monitoring and second opinions have proved somewhat helpful. He cited a RAND Corporation study on coronary by-pass surgery frequency, with a panel of independent physicians being given for review the medical case histories of a number of patients as candidates for by-pass surgery. In 30 percent of the cases, the panel physicians unanimously agreed that by-pass surgery was not indicated; nevertheless the patient cases reviewed already had the surgery. In a Stanford University Medical Center study on frequency of medical tests being ordered by residents in training, it was determined that the residents who had attended medical schools in the Northeastern part of the United States (Massachusetts, New York, Pennsylvania) ordered 30 percent to 40 percent more tests than residents who went to medical schools in the West (California, Oregon, Washington) -- and there were no significant difference in patient outcomes for any of the residents. He said that studies of this sort and the analyses that follow are providing greater insight into why health care costs are so greatly accelerating in many parts of the U.S. This will provide ammunition for federal and state health policy makers to become more demanding in their regulatory strategy.

Dr. Teach also discussed the explosion of medical knowledge and expansion of high tech medical equipment. He commented that many physicians who have been out of medical school as recently as 15 years ago have a difficult time in maintaining currency in new developments in the practice of medicine. Efforts must be initiated to assure the continuing medical education of all practicing physicians, even taking away their credentials to practice in a hospital unless certain regular and specified training programs are attended.

He concluded his presentation with a discussion of why the United States Congress has never enacted a national health insurance program that would assure that every person in the country had at least minimum health care benefits. Provisions have already been made for the elderly and the disabled who are eligible for Medicare if covered by Social Security and certain categories of poor (mothers unable to work because there are dependent children in the home and no father is present, for example) that are covered by Medicaid. Also most large companies and many smaller ones provide health insurance benefits for their employees because they are given a break for the cost of such insurance as a deduction when calculating their income tax liability. However, many other smaller companies cannot afford to pay for any health insurance for their employees and there are many unemployed who do not qualify for Medicaid who are not covered. The basic problem is one of financing a national health insurance program. The present Republican administration is adamant against raising taxes, and the Congress which has a majority of Democrats in each house are reluctant to do so, fearing they may not be reelected.

Documentation:

1. Audio: Standard Tape 4, Side B (last half)
2. Video: VHS Tape 1, Tape Counters 300 to 499
3. Other: None

E. American Pharmaceutical Association

Agency/Organization Visited:

American Pharmaceutical Association
2215 Constitution Avenue, NW
Washington, D.C., 20037

Note: This organization is the national professional society of pharmacists in the United States

Contact Person:

Michele, secretary to Dr. Webb
Phone: 202-429-7538 or 202-628-4410

Date, Time, and Place of Presentation:

Tuesday, October 3, 1989, 2:30 p.m. to 4:00 p.m. in the ISTI Conference Room

Attendees:

The six Indonesian tour members, Elizabeth Connell, and Al Baker

Presenter:

C. Edwin Webb, Pharm.D., M.P.H.
Director of Professional Affairs
American Pharmaceutical Association

Summary of Presentation:

Dr. Webb opened his presentation by citing his academic and experience credentials (a complete biography is included in the documentation). He has a Bachelor of Science in Pharmacy and a Doctor of Pharmacy degrees from the University of Tennessee and a Master of Public Health degree from the University of North Carolina. He has been a practicing staff pharmacist in a 450 bed teaching hospital in Ohio; was both a faculty member as well as a practicing clinical pediatric pharmacist in the University of North Carolina's teaching hospital; and was Director of Pharmacy at a 300 bed private hospital in North Carolina, prior to joining his present organization in 1987.

Dr. Webb stated that 65 percent of the hospitals in the United States have a pharmaceutical formulary system in place. The 35 percent of those that do not are primarily small, rural hospitals where there are few attending physicians in the hospital, usually less than thirty, and where there is no great adherence or interests among them, that is, few are in group practices. He said that there are between 12,000 to 15,000 individual prescription drug items available from pharmaceutical manufacturers. The number of items in any hospital's formulary depends upon its size and degree of specialization; for example, a hospital that specializes in obstetrics or orthopedics will have significantly fewer items than a large acute care general teaching hospital. The formulary makes a reasonable attempt to have on hand the drugs needed without duplicating generic or therapeutic substitutions. He said that the Federal Food and Drug Administration (FDA) has approved only about 30 percent of the total drugs available for generic substitution. These become available when the patent held by the original manufacturer expires, and other manufacturers get into the market with their own chemical/biological equivalents, that of course, must receive FDA approval with respect to quality, equivalency, etc. In some cases, even when a patent expires, some generic manufacturers do not choose to produce an equivalent because of expensive capital investment, quality control problems, or the long and costly process of getting FDA approval. Still, he mentioned that 70 percent of the drugs are available from only a single source.

Dr. Webb explained that hospitals that do have formularies establish a Pharmaceutical and Therapeutic Committee or Council (PTC). The PTC membership includes the hospital's pharmacy director, medical staff members, nurses, and representation from hospital administration. The PTCs meet regularly – monthly or quarterly to determine what drugs should be included in the formulary, which new drugs should be considered, which obsolete ones should be dropped, which manufacturer of a generic should be selected by the hospital, and which therapeutic equivalents for the formulary should be established. Therapeutic equivalents, he explained are not the same as generic equivalents where the chemical/biological composition are the same but where research has determined that one drug, perhaps cheaper in price, may produce the same therapeutic results as a higher costing one or ones that have been found to cause more severe patient reactions. In response to a question from one of the tour physicians regarding the selection of a product from a generic manufacturer, Dr. Webb explained that price was not the only consideration. What has been the reputation of the manufacturer in the past; is the company able to supply orders on time; is the quality of their drugs high – that is, you do not receive bottles of tablets with many of them crumbled in the bottom; what is their return policy with respect to shelf life and obsolescence? Dr. Webb also explained the unit dose system for dispensing drugs to inpatients; also the types of organizational structure for pharmacies: degrees of decentralization or centralization; the way drugs are marked-up for billing purposes to produce a profit. He admitted though that since Medicare introduced DRGs in 1983, hospitals have to look more carefully at the number and costs of the drugs being prescribed because the cost is now included in the overall DRG payment that the hospital receives for the Medicare patient, so closer liaison exists between hospital pharmacists and physicians. It is not unusual for some pharmacists to accompany physicians on rounds and make suggestions to the doctors. In fact he said that many doctors often turn to the pharmacist and ask what he would recommend, feeling that the pharmacist may have more current knowledge of new drugs.

Dr. Webb also emphasized the need for the general public to be educated on generic drug substitution so that when a patient receives a prescription from his physician, he can ask about less expensive substitution equivalents that may be available. His concluding remark was in response to a question from one of the tour physicians about how much cheaper generic drugs in general might be. Dr. Webb said on average they should be at least 50 percent less expensive.

Documentation:

1. Audio: Standard Tapes 5, Side A, and half of Side B
2. Video: VHS Tape 1, Tape Counter 500 to 584
3. Other: Biographical sketch and curriculum vitae of Dr. Webb

F. Health Care Financing Administration

Agency Presentation:

Bureau of Health Standards and Quality
Health Care Financing Administration
Department of Health and Human Services
East High Rise Building
6201 Security Boulevard
Baltimore, MD 21235

Contact Person:

Jay Merchant, Office of Professional and Business Affairs
Health Care Financing Administration, Department of HHS
Phone: 202-472-7416

Date, Time, and Location of Presentation

Tuesday, October 3, 1989, 4:30 p.m. to 5:15 p.m., ISTI Conference Room, Washington, DC

Attendees:

The six Indonesian tour group members; Jay Merchant, HCFA; Elizabeth Connell, and Al Baker

Presenter:

John Spiegel, Deputy Director
Bureau of Health Standards and Quality (HSQ)
Health Care Financing Administration

Summary of Presentation:

Mr. Spiegel described HSQ as the bureau within the Health Care Financing Administration (HCFA) responsible for assuring that Medicare and Medicaid patients receive quality health care. HSQ has three major offices:

- The Office of Standards and Certification, is responsible for seeing that Medicare and Medicaid facilities meet established standards of quality established by law and regulation. Hospitals can be certified as Medicare providers by either passing an accreditation survey conducted by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), a private certifying agency, funded by the health care industry, or by passing a survey conducted by one of the 50 state departments of health with whom HSQ contracts for this service. Of the approximate 6,000 Medicare approved hospitals, about 75 percent have received certification through the JCAHO. The remaining 1,500 hospitals have been approved through the state survey process. The latter hospitals tend to be small, rural hospitals who cannot afford the JCAHO survey costs (average cost US\$ 15,000). The JCAHO certification is generally good for three years, unless some major faults have been reported. In such cases, the hospital may be given a temporary accreditation for up to twelve months in which time it must correct the deficiencies. JCAHO also now surveys home health agencies, makers of durable medical equipment, and skilled nursing facilities for Medicare and Medicaid.
- The Office of Professional Review Organizations (PROs) was established in 1983 as part of the Medicare prospective payment DRG system for inpatient hospitalization. The law required a PRO to be established by a contracting organization for each of the 50 states.

The PRO would be responsible for assuring that hospitals were providing quality care for Medicare patients; that Medicare patients were not being admitted to a hospital unless there was a medical necessity for the admission; that once in the hospital, the diagnoses and treatment were proper for the injury or illness; and finally that the patient was not being discharged too soon.

These safeguards were established because Congress when enacting the DRG program became concerned that hospitals might encourage more admissions to increase revenues; and might give inadequate care and discharge the patient sooner since the hospital would be paid an established rate for each admission according to the DRG classification. PROs review cases on a sample basis -- about 20 percent of all Medicare hospital admissions in a year or about 2.5 million. Less than 3 percent of the cases reviewed are rejected in which case the hospital is denied payment for the services rendered. There is an appeal mechanism, though, which the hospital industry claims is inadequate. The majority of the reviews also are conducted after patients have been discharged from the hospital by a review of the patients medical records. In response to a question from a tour member regarding setting of criteria for review, Mr. Spiegel indicated that each local PRO whose professional staff are physicians and nurses have the responsibility to determine its own criteria, although the Office of PRO does specify in its Scope of Work when contracting with a PRO the general types and percentages of cases that should be reviewed.

- The Office of Program Assessment and Information is the last major functional segment of HSQ. It is responsible for producing the annual mortality report which is a statistical document listing each of the 5,000 acute care hospitals which participate in Medicare by name, location, and the number of deaths by selected categories that occurred in the hospital (or within 30 days of the date of admission if the patient had been discharged and died at another location). The report also indicates for each hospital the expected range of deaths that should occur for each category so the hospital and the public (the report is widely distributed to consumer groups, news media, and other interested parties) can analyze how each hospital performed relative to others in its community, state, or nationwide. Hospitals are also given the opportunity before the report is made public to have included letters of explanation in the report which might be useful in evaluating the data presented.

Mr. Spiegel concluded his presentation by citing other issues that HSQ has been given responsibility for implementing. The first, a 1985 law that would deny payment to both hospitals and physicians that provide "sub-standard" care. The PROs already examine for unnecessary care or inadequate care, but the definition of "substandard" care is a much more difficult area to interpret. HSQ has issued proposed regulations for public comment and hundreds of responses have been received, pointing out problems with the proposed rule. In particular, physicians are concerned about an overwhelming increase in malpractice claims since a finding of "sub-standard" quality of care against a physician would be on the face of it an invitation for entering a malpractice suit against the doctor. Mr. Spiegel was unable to speculate as to when final regulations might be issued on this 1985 law.

Another law change requires Medicare patients who have been recommended for surgery to get a second medical opinion. Research has found that many physicians do not agree among themselves on treatment protocols. HSQ has the responsibility for drafting the regulations that will spell out the conditions under which a second opinion would be required. Medicare would pay for the second opinion, or for a third if the first two did not agree. The patient, however, has the choice after the second opinion of accepting either one, or of getting a third, even if there is disagreement.

Documentation:

1. Audio - Standard Tape 5, Side B (last half)

2. Video - VHS Tape 1, Counter Nos. 585 to 774

3. Other:

- Sample PRO Scope of Work (Note: Mr. Spiegel promised to send a copy to ISTI'S Washington office.)
- Sample copy of one volume of the HCFA mortality report

G. Department of Veterans Affairs

Agency/Organization Visited:

U.S. Department of Veterans Affairs (VA)
810 Vermont Avenue, NW
Washington, D.C., 20420

Contact Person:

Donna Pringle, Office of Public Affairs
Phone: 202-233-6651

Date and Time of Visit:

Wednesday, October 4, 1989, 8:30 a.m. to 11:00 a.m.

Attendees:

The six Indonesian tour group members, Elizabeth Connell and Al Baker

Major Presenters:

Honorable Edward J. Derwinski, Secretary of the Department
R. Eugene Konik, Deputy Regional Director for Great Lakes Area
Elizabeth Short, M.D., Deputy Director, Office of Academic Affairs
Betsy Dillard, Special Assistant, Office of Healthcare Staff Development and Retention
Leonard Bourget, Director, Information Integration Services
Al Furlan, Deputy Director, Office of Resource Management
John Bott, Resource Management Service, Office of Procurement and Supply
John Ogden, Director, Pharmacy Service

Summary of Presentation (Note: The order of the presentations will not be in the same order as listed above in every case):

- Secretary Derwinski, who became the first Secretary of the newly created Department of Veterans Affairs, was sworn in on March 15, 1989, the day the department became officially established. It absorbed the activities of the Veterans Administration which had been functioning as an independent but not cabinet level federal agency since 1930. A biography of the Secretary is listed in the documentation identified at the end of this section.

The Secretary welcomed the tour group in his office, stating he was glad to have an opportunity to visit with the Indonesian physicians. He stated that he had visited Indonesia when he was with the U.S. Department of State and as a Congressman from Illinois. He said his major function as Secretary of a newly created department was to represent the veterans of U.S. military services in presenting their needs to the President and to Congress in recognition of the services, patriotic duty, and injuries, illnesses, and death that had been inflicted upon them and their families in the service of our country. His biggest challenge would be to convince the President, the Office of Management and Budget, and the Congress on the amount of money required for providing health care, benefit programs, and other needs of the veterans. This would be particularly difficult because of the current budget crisis.

- Mr. Konik, the deputy regional director from the VA Great Lakes Region, who recently had been detailed to work in the Office of the Secretary, chaired the meeting and introduced the presenters. He gave an overview of the department, stating that it has more than 245,000 employees, the federal government's second largest civilian work force. Its current annual

operating budget will exceed US\$ 30 billion, of which more than 95 percent goes for direct benefits and services. He said the three major activities of the department were health care, with the VA operating 172 hospitals, 231 outpatient clinics, 119 nursing homes, and 27 domicillaries. Second, the department administers monetary benefit programs for service-disabled veterans, pensions for low-income veterans and dependent survivors, as well as education and vocational training programs. VA also guarantees over 12 million home loans and operates the fifth largest life insurance program in the country. The last major activity of the department is the operation and maintenance of memorials for veterans, that includes 112 national cemeteries.

- Dr. Short, the deputy assistant chief medical director for academic affairs, stated that this year about US\$ 11 billion or a little more than one-third of the department's total budget of US\$ 30 billion would be for the provision of health care services. She said that of the 172 hospitals in the VA system, 142 of them were teaching hospitals, affiliated directly with accredited medical schools. They operated 8,000 intern/residency programs in the last fiscal year. She continued that 50 percent of physicians currently completing their medical training in the United States, have sometime during their academic, intern, or residency programs been associated with a VA hospital.
- Ms. Dillard, a special assistant in the Office of Healthcare Staff Development and Retention, discussed the registered nurse shortage and some of the steps VA has or will be taking to improve this problem, including a legislative proposal for increased pay for VA nurses and providing scholarships for nurses training with tuition assistance payback waived, if the nurse agrees to work for the VA upon graduation for a specified number of years. There are also shortages in VA hospitals of physicians, licensed practical nurses, and nursing assistants.
- Mr. Ogden, the director for pharmacy services, stated that the VA pharmacy services overall employ about 6,300 persons with about 3,300 of them being registered pharmacists. Getting down to the hospital level as an example he cited the 500 bed Dallas, Texas, VA hospital that has a pharmacy staff of 60 with about 30 of them being registered pharmacists. He said the hospital was a teaching facility with a large outpatient volume. Ambulatory care (outpatient) services accounted for 58 million prescriptions last year and took about 60 percent of the US\$ 650 million VA drug budget. On average he said that each OP visit generates three prescriptions. He commented that of the 58 million OP prescriptions, 33 million of them were filled by the VA mail out program; that is, a patient who has been discharged as an inpatient or who has completed an OP visit may upon returning to his home order refills by mailing in a reorder form to the VA pharmacy. When queried about the use of generic drugs, he stated that it was an overall VA policy to substitute approved chemical/biological equivalents whenever possible and that VA physicians accepted this policy, although in some cases there are no generic drugs manufactured or approved, and in other cases, brand name drugs can be obtained from the pharmaceutical manufacturer as cheaply as generics because of the large national volume of the drugs being ordered.
- Mr. Bott, with the Office of Procurement and Supply, said his office was responsible for a US\$ 4.7 billion annual budget for purchasing supplies, services, and equipment for the VA. It is the fourth largest in the federal government, being surpassed only by the Army, Navy, and Air Force that have larger procurement budgets associated with weapon systems. His largest customer within the VA is the health care services and research area that accounts for US\$ 3.5 billion of his overall budget. The procurement staff has 634 employees in the central and regional offices and depots and another 6,500 in other divisions within the department and in individual VA facilities. Federal procurement regulations are quite rigid. Just to buy aspirin, as an example, he described a complex specification, bidding, and evaluation process that had to be completed within the prescribed rules.

Mr. Bott commented that standardization was a key factor in reducing procurement costs. As an example, he cited needle and syringe sets used in each of the 172 VA hospitals. By standardizing centrally the type and model to be used through the VA system, millions of dollars

annually are saved through large volume orders, as opposed to perhaps 30 or 40 different types, models, and vendors that would be selected if left to the individual hospital. He also stated that the VA is the central procurement agency for all drugs and pharmaceuticals used by any U.S. federal activity – Army, Navy, Air Force, and Indian Health Service hospitals, and other health care facilities. The overall savings to the federal budget is significant by such volume purchasing. He cited the drug, Motrin, as an example, where the unit cost for the federal government was US\$ 5, compared to a range of US\$ 9 to US\$ 28 when procured by HMOs or Medicare patients going to a local pharmacy.

- Mr. Bourget, Director for Information Integration Services, described the VA Decentralized Hospital Computer Program (DHCP) for which his office is responsible. It is a computerized management information system that ties together both the clinical and administrative applications of their 172 hospital system. Its scope includes a patient data base with admission, discharge, transfer, diagnoses, procedures, therapies, laboratory tests, drugs/pharmaceuticals prescribed, and other related patient administrative/clinical data. It includes software to track medical records, patient location, scheduling of appointments for surgery, medical, and ambulatory services. When fully operational, it will require 50,000 computer terminals for use in the VA central office, regional offices, and individual hospitals. Currently 20,000 terminals are in use, with another 30,000 on order. Note: Two items listed in the documentation below provide further details and descriptions of DHCP.
- Mr. Furlan, deputy director, Office of Resource Management, was the final speaker. His discussion centered on the VA central and hospital budgeting process. He stated that Congress had three different appropriations for the VA: the largest for the delivery of health care services; the next was for construction and renovation of health care facilities; and the last was for health care and medical research.

He said that the budgeting process starts at the local hospital level, with each facility preparing next year's budget based on current costs, and reflecting any changes expected in patient population; types of new services being offered or old ones discontinued; staffing; and other variables including inflation that would impact the budget. His office also uses three computerized resource allocation models to evaluate budgets that are submitted. For inpatient care, elements of inpatient occupancy, case mix, staffing, etc. are considered. The outpatient model looks at the individual patient population on a capitation basis; that is, how many persons were serviced in the past period and what were the total costs. There is also a long-term care model that uses nursing hours of care as the prime factor in the analyses. A fourth model, Education, to evaluate the teaching hospital's educational costs is not yet operational. Hospitals are also evaluated on their efficiency, with credit being awarded for staying within or below the current budget, reducing lengths of stay, etc., and penalties assessed for high staffing ratios, cost overruns, etc. Central VA maintains a pool of about 1.5 percent annually of the overall hospital operating budget to reward efficient hospitals. With respect to the construction budget, although this starts as a wish list at the local VA hospital level, history has demonstrated that decisions are made more on a political basis than on need. Powerful Congressman often want new or larger VA facilities in their districts because it will bring money into the community.

In response to a question from a tour member about whether there is enough money appropriated for health care needs of veterans, Mr. Furlan responded that there is never enough to satisfy the needs of all the veterans and the veterans organizations that are out there trying to compete for more federal dollars among all the federal programs for education, health care, transportation, defense, etc. However, he said they make do with what they get and hope for the future.

Documentation:

1. Audio: Standard Tape 6, Sides A
2. Video: VHS Tape 1, Tape Counter 870 to 1018
3. Documentation:
 - Meeting agenda and schedule
 - Biography and photo of Secretary Derwinski
 - News Feature - Facts and Figures - Department of VA
 - U.S. Map with Location of VA Facilities
 - Organizational Charts of the Department
 - VA Today 1989 - Descriptive Brochure
 - Annual Report, 1988, Department of VA
 - Medical Advances: VAs Contribution to Health Care
 - Great Lakes Region Descriptive Brochure
 - VA Medical Center Indianapolis, IN - Descriptive Brochure
 - Decentralized Hospital Computer Program (2 documents)
 - Income Assessment for VA Medical Treatment
 - Therapeutic Equivalent Guidelines
 - Resource Allocation Principles Document

H. U.S. Naval Medical Center

Agency/Facility Visited:

U.S. National Naval Medical Center
8901 Wisconsin Avenue
Bethesda, MD 20814
Phone: 301-295-2266

Contact Persons:

Lt Col Shiela Bowman, Office of the Assistant Secretary of Defense for Health Affairs, The Pentagon, phone: 202-697-0626 and Lt. Commander Thomas Hatcher, Office of Public Affairs, Bethesda Naval Medical Center, phone: 301-295-5727

Date and Time of Visit:

Wednesday, October 4, 1989, 2:00 p.m. to 4:30 p.m.

Attendees:

The six Indonesian tour member members and Al Baker

Presenters:

Rear Admiral Donald F. Hagen, M.D., Commanding Officer
Captain James Potts, USN, Director of Fiscal Management
Captain Jean Loughney, USN, RN, Director of Nursing Services
Commander David Butler, Assistant Director, Pharmacy
Lt. Commander Daniel Sahler, Director, Medical Records

Summary of Presentations:

- Admiral Hagen, the medical center and hospital commander, welcomed the tour group in his office. He said the Bethesda Naval Medical Center came about during President Franklin Delano Roosevelt's first term in office in the early 1930s. The President, a former Assistant Secretary of the Navy, decided that the Washington, D. C. area needed another major military medical facility to augment the Army's Walter Reed Medical Center. Today, the hospital is a 468-bed acute care facility, associated as a teaching hospital with the U.S. Armed Services Medical School, which is co-located on the campus of the medical center. The hospital provides for both inpatient and outpatient services in the Washington, D.C. area for active duty military personnel, retired military personnel, and their dependents. It includes several VIP (very important people) suites, including one for the President and his family with special security features, for high level federal officials, congressmen, and visiting dignitaries from foreign countries.
- Captain Potts, the director of fiscal management, described the budgeting process for the hospital, which is built basically on historical costs, and then takes into consideration changes in expected case mix, bed census, outpatient population, addition or deletion of services, and inflation factors. The budget then goes up to the Center's next level of authority, the Department of Navy's Bureau of Medicine and Surgery, and ultimately is incorporated into the entire Department of Defense budget which is presented to Congress. Captain Potts stated that appropriations are never as high as those requested, particularly in recent years with the budget deficit facing the entire federal government. In response to a question from a tour member about how much internal flexibility the Center has in shifting funds from one function to another, he said that in recent years such flexibility was becoming much more obtainable. However, there are still some restrictions. He mentioned that the budget for civilian labor costs cannot be

exceeded, nor can the money be shifted to non-civilian payroll elements such as labor-saving devices. They do have the authority to mix the grades of and types of personnel, such as between or among contract services versus employed persons, or between nurses and therapists.

He cited some management areas that the Center was either instituting or had been implementing over the last several years to improve efficiency. One, for example, was the study of the use of DRGs used by Medicare as a resource allocation tool for inpatient hospital services. Although not yet mandated by the Department of Navy or the Department of Defense, the Medical Center has been working on the coding of patient medical records so cases can be classified, and cost findings by diagnoses more closely identified, than previous methods of determining such costs. He also mentioned the sharing of very expensive medical equipment between or among adjacent or relatively close-by federal medical facilities, such as sharing the use of an MRI (magnetic resonance imager), a very expensive piece of diagnostic equipment, between the Army's Walter Reed Medical Center and the Bethesda Naval Hospital or the U.S. Veterans Hospital. At the present time there are no requirements for transfer of funds between the military departments or the VA when such sharing takes place.

- Commander Butler, assistant pharmacy director, told the group that the Center drug formulary contains about 1,300 items. A copy was furnished to the group and is part of the report documentation identified below. He said the Center has a Pharmacy and Therapeutics Committee with membership that includes physicians, nurses, pharmacists, and supply procurement personnel. It meets monthly to review new drugs to be added to the formulary, to delete obsolete ones, to review problems that have developed such as adverse drug reactions among patients, and errors that have been reported in filling or administering drugs. He said there is a central procurement center for all Department of Defense (DOD) military pharmaceutical requirements, operated by the Defense Personnel Support Center, which consolidates all the services orders and then by reason of extremely large quantity buying can go directly to the manufacturer for the best possible price. Note: In our visit to the Department of Veterans Affairs (VA) on October 3, the group was told that VA is the central procurement agency for all federal pharmaceutical needs, including DOD. Perhaps the federal bureaucracy is so large that at a hospital level officials are not certain as to who does what in the overall picture.

When asked about generic substitution, Commander Butler replied that it was a DOD policy that any military or contract physician working in a military medical facility must agree to prescribe generic equivalents whenever possible. There is some flexibility though such that a physician may insist on a specific brand-name drug by getting approval from his department head. At Bethesda, perhaps 30 such cases a month occur. He said his pharmacy department had a total of 70 persons on its payroll with 25 of them being registered pharmacists. To minimize the establishment of decentralized pharmacies within the hospital, they make use of a pneumatic tube delivery device whenever possible. For example, prescriptions needed in the Emergency Department are sent to Central Pharmacy in a pneumatic tube and the filled prescription is returned to the Emergency Room by the same method. When asked if the hospital would fill a prescription for an authorized military person or dependent that was written by a private physician who had no association with the hospital, the answer was in the affirmative, so long as the pharmacy had the prescribed drug in its inventory. Note: This policy conflicts with that of the VA who informed the group that only prescriptions written by a physician associated with a VA facility would be honored.

Commander Butler concluded his presentation by walking the group through the Central Pharmacy. He was asked whether pharmaceutical "detail persons" (drug salesmen) ever visited the hospital and how they were handled. He said they often try to see physicians and leave with them descriptions of the new or current drugs their company manufacture. However, they may not leave samples, because of a recent federal law prohibiting such practices to preclude the illegal or unauthorized distribution of drugs without a proper accounting for them.

- Captain Loughney, the director of nursing services, met with the group in her conference room. She introduced her three deputy directors, also all registered nurses and navy captains. The three deputies were responsible respectively for general nursing inpatient hospital services; for ambulatory nursing services (outpatient department, emergency room, and several clinics operated by the Bethesda Medical Center for naval facilities in the Washington area not large enough to have their own hospital); and the third deputy for supervision of the six operating rooms of the hospital. The hospital's nursing staff consists of 700 persons of whom 370 are registered nurses and the remaining navy corpsmen. The latter are active duty personnel who receive 14 weeks of training either at Bethesda or at another naval medical facility and then continue working at the Center under the supervision of an RN, until they are scheduled for shipboard duty. Of the RN total, 200 are active duty navy nurses, 100 are federal civilian employees, and the remaining 70 are contract nurses hired from a central civilian nurses registry. Contract nurses are expensive. They pay the registry US\$ 22 to US\$ 33 an hour for such services, depending upon the specialty needed. Although the hospital has almost 500 licensed beds, there is such a shortage of nurses that less than 400 are staffed. Captain Loughney commented that the Commanding Officer's objective was to have a minimum of nurses on board to care for at least 350 patients per day. The present census was 371 patients.

Captain Loughney also discussed physician/nurse relationships within the Medical Center, concluding that such relationships were in general more cordial and less tense than in civilian hospitals where she had spent the first 10 years of her nursing career. The military officer ranks for the navy nurses were also a favorable aspect of the relationship, giving more equality between the physicians and nurses. Even the civilian nurses and the contract nurses preferred working in a military facility for they felt that nurses were more highly respected. Captain Loughney meets every Wednesday morning with about 25 of her senior staff: deputies, department chiefs, and division heads. In addition to the clinical nurses the hospital employs, there are many other nurses including those in central supply (not under Nursing Services) and in quality assurance.

- Lt. Commander Sayler, the medical records director, said his function was almost 100 percent computerized. His presentation was made in the medical records work area, so the tour group members were able to see first hand how the entire system functioned from data entry into computer terminals from handwritten patients charts to output reports of delinquent records that not yet been completed by attending physicians. Commander Sayler stated that they had recently purchased (US\$ 13,000) a new computer software program for their medical records system that was the most sophisticated on the market. A demonstration to the tour group was quite enlightening as to what the system could accomplish. However, as to its usefulness in Indonesia hospitals, it may be so complex that its value may be lost when attempts are made to convert present medical records manual systems into something so complicated.

Documentation:

1. Audio: Standard Tapes 6, Side B, and 7, Side A
2. Video: VHS Tape 1, Counter Nos. 1068 to 1299
3. Other:
 - National Naval Medical Center Formulary

I. Georgetown University Hospital

Agency/Facility Visited:

Georgetown University Hospital
3800 Reservoir Road, NW
Washington, DC, 20007

Contact person:

Charyl A. Kiger, Assistant Administrator for Planning and Marketing Phone: 202-784-3007

Date and Time of Visit:

Thursday, October 5, 1989, 9:30 a. to 12:30 p.m.

Attendees:

The six Indonesian tour group members, Ms. Connell and Mr. Baker

Facility Description:

The Georgetown University Hospital, formerly called the Georgetown University Medical Center, is a 526-bed acute care general and teaching hospital, associated with the Georgetown University Medical School. Both are major subsidiaries of the Georgetown University, a prestigious national institution of higher education in the United States, operated by the Society of Jesus (Jesuits) of the Roman Catholic faith.

Major Presenters:

Charles M. O'Brien, Hospital Administrator
Donald F. Leon, M.D., Medical Director
Robert Peck, Director, Medical Records
Bart Metzger, Director, Human Resources
Edra Shellner, Director, Admitting
Richard Brodeur, Director, Pharmacy
Charlotte Ritchie, Director, Dietary
Edward Heinrich, Director, Engineering
William Curran, Manager, Clinical Engineering

Summary of Presentations:

- Mr. O'Brien, the hospital administrator, described the structure of Georgetown University, stating that there is an overall Board of Directors of the University but no separate Board for the hospital as is the general case in community hospitals. The President of the University is the Chief Executive officer with three principal academic officers reporting to him: an Executive Vice President/Provost for the undergraduate and main campus programs; an Executive Vice President/Dean for the Law Center; and an Executive Vice President/Dean for the Medical Center. The Hospital Administrator and the Medical Director both report to the Executive Vice President/Dean of the Medical Center. The Medical Center consists of a medical school, the hospital, a school of nursing, and a dental school. The dental school is closing because of a diminished need for dentists in the United States. The University Board of Directors is a policy body meeting only three or four times a year. Mr. O'Brien said that the hospital's medical staff, headed by Dr. Leon, is of two types: those who are full time faculty at the medical school (about 65 percent) and those physicians who practice in the community and also hold non-full

time faculty appointments at the medical school (35 percent). Mr. O'Brien, as Administrator, interfaces with Dr. Leon, the Medical Director, on a daily basis, meeting regularly to review issues and resolve problems. The major issues include capital allocation; program priorities; technical support personnel; internal hospital space changes; and cost containment. On the administrative side, revenue and expense elements must be forecast, building renovations must be considered, and personnel recruiting and training must be planned for operation and maintenance of the equipment, all within an environment of current budget restraints. On the clinical side, the medical staff want the newest developed technology and latest equipment for treatment of the hospital patients and for the training of medical students, interns, and residents. When an acceptable resolution cannot be made between the Administrator and the Medical Director, the issue moves up to the University level and to the Executive Vice President/Dean of the Medical Center.

Mr. O'Brien also discussed the impact of the DRG payment system for Medicare inpatients since 1984. Because Georgetown is a teaching hospital, additional payments are received to recognize the higher costs involved in training physicians. The hospital has been fairly treated under DRG, compared to non-teaching hospitals, although the DRG rates for the last two years and the projected increase for next year are not keeping up with the increase of the goods and services the hospital buys and the salary increases that are necessary to maintain quality personnel. He said Medicare's planned restructuring of the DRG categories, expanding the number from 470 to about 1,250 should help a teaching hospital. The expanded numbers will provide more revenues for treatment of complex cases that teaching hospital by their nature tend to get.

Dr. Leon, the Medical Director, discussed the dual appointment policy that exists between the medical school and the hospital. For example, the Chairman of the Department of Surgery in the Medical School is also Chairman of the Department of Surgery at the hospital. Below the department level, you have divisions where the Neurosurgery Division Chief in the Medical School holds the same appointment in the hospital. Some surgery specialties, such as obstetrics-gynecology and orthopedics, are at the department level. He contrasted this to Medicine which is a department in both the medical school and hospital with no other medicine subspecialties having their own department. He commented that this was generally true throughout the United States. He also discussed his relationship with Mr. O'Brien, the Hospital Administrator, saying that the two of them or their staff resolve most issues themselves. Furthermore, the two of them meet every Tuesday morning with the University Executive Vice President/Dean of the Medical Center.

He also commented that in his opinion physicians in general were responsible for the overexpenditure of health care funds in the United States, because physicians do not generally know enough about their patients' medical history nor about choosing the right diagnostic tests. He said this was a fault of the training of medical residents and it is one of his priorities as Medical Director in the hospital to address this.

Dr. Leon discussed also the education of residents in the hospital who are primarily on duty and on call physicians, training under a physician who is a faculty member in the medical school and who also is credentialed to practice in the hospital. The department heads and division chiefs in the hospital tends to be very authoritative in managing their resident training programs. In response to a question from a tour member on standards for resident training, he replied that he would send to ISTI the "Green Book" published by the Council of Graduate Medical Education, that includes standards for managing the medical education process in a teaching hospital.

He also discussed the Medicare DRG system, commenting that the Indonesian physicians should also look at other patient classification systems for possible use back home. He recommended in particular the Patient Management Categories system, developed in Pittsburgh, PA by the Pittsburgh Research Institute, Wanda Yount, Ph.D., President. This is a subsidiary of the Blue Cross Association of Western Pennsylvania, Eugene Barone, President.

- Mr. Peck, the Director, Medical Records, stated that the hospital medical records system is almost entirely automated. The newest development under study is the use of an optical disc system whereby medical records can be read into a computer and then brought up on a terminal screen and coded directly. The major problem in his medical records department and generally with most U.S. hospitals is the retention of trained coders. There are shortages all over the country, and turnover is high as hospitals will compete with one another to entice coders to move by offering higher salaries and perks. Hospital policy calls for physicians to complete a patient's medical record as soon as possible after discharge because payment from the patient's insurer cannot be received until the claim is submitted, and this is dependent upon a completed medical record. The medical records system produces periodic reports of physicians who are delinquent in completing their records, so the Hospital Administrator and the Medical Director can exert pressure on the late filers. The policy is to have no more than 1,000 records delinquent more than 30 days. He commented that in September there were only 892 records in that late category. His department maintains more than 100,000 records on a current basis for two-and-one-half years. Then the records are transferred to microfilm for permanent storage, although still accessible.

Mr. Peck also discussed the impact of DRGs on medical records accuracy. Because many reviews of medical records will be made by Medicare and other insurers to ascertain the need for hospitalization, the modes of diagnoses and treatment, and the lengths of stay as well as the accuracy of the coding to reflect the actual narrative description of the diagnoses and procedures involved, he as the director must stress quality in record maintenance. He concluded by stating he has a staff of 44 full-time equivalents (FTEs) with a total of 60 persons on his payroll.

- Mr. Metzger, Director, Human Resources, commented on the personnel problems in the Washington, D.C. area, his biggest problem being the inability to fill existing vacancies for skilled medical technicians and skilled mechanics and repair personnel to maintain equipment. Because U.S. federal hospitals in the area -- the army, navy, air force, veterans, and the national institutes of health facilities -- employ a large number of the same types of skilled personnel Georgetown Hospital use and because federal wage and salary levels are relatively higher than can be paid by non-federal hospitals, other methods must be utilized to attract and maintain such personnel. Some of the methods established at the Georgetown hospital include the availability of a child care center which soon will be increased to care for 125 small children whose mothers work in the hospital; institution of award programs to recognize outstanding workers with their pictures in the hospital's newsletter, bonuses, and award banquets.

Mr. Metzger concluded his remarks by responding to a question from one of the tour member physicians on the process of discharging unsuitable employees. He commented that the most important recommendation was the maintenance of an accurate record by the supervisor of the problems caused by the employee -- lateness, unauthorized absences, insubordination, etc. -- and the actions taken by the supervisor to notify, in writing preferably, the employee of these faults. In this way a case file is built which is difficult for the employee to refute.

- Ms. Ritchie, the Dietary Director, described the food service operations of her department which employs 73 FTEs (85 on the payroll). She provides a kitchen which can supply three meals a day for an average of 350 patients, although not all patients because of illness or tests, are fed on a regular basis. Employees of the hospital who normally are also fed in the cafeteria of a hospital must use the University cafeteria and dining facilities used by faculty and students. Patients use a restaurant type menu to select their meals daily, subject to physician and nutritionist approval or guidelines.
- Mr. Brodeur, the Pharmacy Director, has 32 FTEs, including 21 pharmacists. His annual budget is US\$ 8.2 million of which US\$ 6.9 million goes for the purchase of drugs. Four pharmacy locations are maintained: main, operating room, cancer center, and outpatient department. The

pharmacy system is also entirely computerized. When a physician writes a prescription for an inpatient, a copy is sent to the pharmacy where it is entered into the computer to check for adverse reaction notations in the patient's history; for other drugs the patient may be taking that would unfavorably react with the current prescribed drug; for determining unit dose schedules; and finally for entering on the patient's bill. In response to a question about drug mark-ups, he responded that cost to the hospital of each tablet or capsule prescribed is marked up by 75 cents. For injections and ointments, etc., the markup is cost plus US\$ 3.50. In 1988 the hospital dispensed 2.9 million units. Eighty percent of their drugs are purchased from one wholesaler. Georgetown is a member of a group of 33 teaching hospitals that have entered into a consortium for the purpose of making group purchases with the drug wholesaler and are able to get extraordinary cost savings as a result. Mr. Brodeur described the hospital's Pharmacy and Therapeutic Committee (PTC) which meets regularly to review new drugs being marketed or requested by physicians. Physicians, nurses, pharmacists, and administrative staff are on the committee. The PTC also recommends the stop-use of certain drugs which may have become obsolete or proven ineffective. They also review adverse drug reactions of patients, and make corrective recommendations for changes. The hospital's formulary contains 2,800 line items although only 1,800 are prescribed for inpatients. The outpatient department and the medical schools which uses drugs for research account for the remainder.

- Ms. Shellner, the Admitting Director, has a staff of 20 FTEs (30 on the payroll). They have someone on duty 24 hours a day, 365 days a year. They control assignment of patients to beds and make use of a visual Bed Control Board for this purpose. However, this function is currently in the process of being computerized. Admitting also deals directly with the admitting physicians' offices that must be called a specified number of days in advance, depending on the diagnoses or procedure, to reserve a bed. Admitting then notifies the patient's insurer at least two days in advance for clearance on any pre-authorization requirements such as preadmission tests. Admitting also creates the master patient record used for billing and other information system purposes.
- Mr. Heinrich and Mr. Curran from the Engineering Department described their functional responsibilities for building maintenance, mechanical repairs, and clinical engineering. The Department has 50 FTEs, and a budget of US\$ 5.5 million annually. Mr. Curran who has five clinical engineering technicians working for him stated that the hospital has more than 3,000 items of medical equipment. The most valuable advice to take back to Indonesia would be to standardize as much as possible the purchase of equipment used in a hospital; that is, the same type and model of cardiac monitors, for example. If it is not possible to obtain the same type and model, then try at least to use the same manufacturer. This will minimize the numbers of different spare parts that must be kept on hand to maintain the equipment and will also be useful in getting one working unit out of two that are out of commission by interchanging parts. By using the same manufacturer, even though of a different model, you again minimize the number of phone calls or letters you write for parts or repair information. Mr. Curran in response to a question from a tour member on how to choose medical equipment replied that Georgetown uses a company called ECRI, that publishes an objective evaluation of various kinds of medical equipment. They do not advertise in their publications so they have no motive to favor one manufacturer over another.

Documentation:

1. Audio - Standard Tapes 8, Sides A and B, and 9, Side B (half)
2. Video - VHS Tape 1, Tape Counter Nos. 1300 to 1394
3. Other:
 - Patient Guide to the Georgetown University Hospital
 - Pre-admission Guide to the Georgetown University Hospital

- A.M. (Before Noon) Admission Guide
- Guest Information, Hotels and Transportation
- Medical Record Department Profile

J. State of Maryland Department of Health

Agency/Organization Visited:

Maryland State Department of Health and Mental Hygiene
201 West Preston Street - Room 525
Baltimore, MD 21201

Contact Person:

Diane Rich, Secretary to Mr. Sabatini
Phone: 301-225-6535

Date and Time of Visit:

Wednesday, October 6, 1989, 10:00 a.m. to Noon

Attendees:

The six Indonesian tour group members and Al Baker

Presenter:

Nelson J. Sabatini
Deputy Secretary for Health Care Policy, Finance, and Regulation

Summary of Presentation:

Mr. Sabatini asked Dr. Budihartano to describe the Indonesian healthcare and hospital system so he could better understand what types of information would serve the group best. Mr. Sabatini stated that the state of Maryland no longer had any government-owned acute care hospitals, although there were some long-term mental facilities in the state. Even the University of Maryland hospital had been converted into a private independent corporation. All but four of the 70 hospitals in Maryland are not-for-profit. These four are for-profit facilities. He continued that Maryland has one of the most heavily regulated healthcare industries in the United States. He said that currently Maryland is the only remaining state that has been exempted from Medicare's prospective payment DRG (diagnostic related group) system. Hospitals that serve Medicare patients receive the same rate per patient as for other patients who are covered by commercial insurance or self-pay. The state has two primary regulating commissions to control hospital costs: (1) a hospital rate setting commission and (2) a health planning commission that controls capital expenditures, new beds, and expansion of services.

The rate setting commission, composed of 16 members appointed by the Governor, with representatives from the hospital industry, medical profession, and the public, perform their functions on a part-time basis. They are supported by a state-employed staff that does research, statistical analyses, audits of hospital accounts, and develops recommendations for the commissioners. He stated that their "All Payor System" guarantees access by anyone in the state who requires acute care hospitalization. Built into each hospital's rate is an allowance for charity care which averages 6.25 percent overall for the state but ranges from 2 percent in some hospitals to as high as 19 percent in some of the inner city facilities. The rates are reviewed each year and adjusted to assure that each hospital has not been making too large a surplus (average is 2 percent) nor suffering a loss. However, if a hospital makes a poor management decision such as selling its facility and leasing it back for operation that creates higher debt payments than previous capital costs allowed, the hospital must suffer the consequences even though it may have to close. He said rates vary by hospital but within an individual hospital, all payers pay the same rate.

While costs for capital are built into the rates, control of capital spending rests with the health planning commission. When a hospital wants to add new beds, buy new medical equipment in excess of US\$ 1.5 million, or add a new service, it must apply to the commission for approval. In this latter case, Mr. Sabatini cited as an example applications by hospitals to perform open-heart surgery. The commission examines the geographic area to be served and then grants approval for only one hospital to be the area open-heart surgery facility. This minimizes and reduces duplication of both capital expenditures and professional requirements.

Mr. Sabatini said that the hospital association in the state fully backed their regulatory system and that physicians for the most part, although their individual fees were not regulated, had no major problems with the hospital rate setting commission. Even hospital based physicians such as radiologists and pathologists were not complaining. However, since length of stay is an important cost element for hospitals, they must monitor physician treatment patterns closely and apply pressure to assure that each physician who treats a patient realizes the cost of additional days of hospitalization. This has caused some tension but not of a major proportion.

In response to a question about state certification of hospitals, Mr. Sabatini stated that all 70 hospitals were JCAHO accredited, including rural hospitals. His Department of Health further makes independent spot reviews of hospitals to assure that JCAHO standards are being maintained. Often patients will complain about a condition or problem at a particular hospital and his audit team will conduct a review.

Documentation:

1. Audio: Standard Tapes 10, Sides A and B, 11, Sides A and B
2. Video: VHS Tape 1, Tape Counter 1533 to 1563
Editor's Note: Following the visit to the Department of Health in Baltimore, the group toured the Baltimore inner harbor area. A record of this tour can be found at Tape Counter 1564 through 1780.
3. Other: Mr. Sabatini promised to send a number of documents to the ISTI Washington office following our visit. However, several other documents were distributed directly to the Indonesian physicians who should have them in their personal files.

K. Hospital Corporation of America

Agency/Organization Visited:

HCA (HOSPITAL CORPORATION OF AMERICAN) International Company
One Park Plaza, P.O.Box 550
Nashville, TN 37202-0550
Phone: 615-327-9551 or 800-251-2561

Contact Person:

Karen Fleming, Office of Public Affairs, HCA Intr'l
Phone: 615-320-2440

Date and Time of Visit:

Monday, October 9, 1989

Attendees:

The six Indonesian tour group members and Al Baker

Presenters:

Ronald C. Marston, President, HCA International
Gregory Brough, Vice President, Finance and Admin., HCA Intr'l
and President, AMICO, Brazil's largest HMO
Luther Ramsey, Director of Finance, HCA International
Charles Neuman, Vice President, Operations, HCA International
Douglas Smith, President HCA Management Company

Summary of Presentations:

The four HCA International officials discussed the capabilities of their organization to assist foreign governments and private companies outside the United States in providing the entire range of health care delivery services, including the planning, design, construction, and operation of hospital facilities and services. In particular, they emphasized their experience in Australia since 1978 where they established a hospital accreditation program as well as the ownership and/or management of hospitals. They also stated that they are working under the direction of a private Board of Directors to assist in the conversion of Singapore's largest acute care government hospital to a privately operated hospital with expected decreases in hospitalization costs. Their financial officials reviewed the process and advantages of converting a hospital accounting system from a cash accounting basis to an accrual accounting basis. The use of computerized management accounting and information systems was emphasized for these conversions and continued operation of the accrual basis.

Mr. Smith, President of the HCA Management Company, discussed the role of quality assurance and improvement in hospital operations. He also mentioned that he was recently appointed as one the 24 Commissioners of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in the United States.

Documentation:

1. Audio: Micro Tapes 1 A through 4 B

2. Video: VHS Tape I, Tape Counter 1780 through 1915

3. Other:

- Descriptive brochure of HCA International's mission
- Descriptive brochure of HCA International's operations, services, and experience
- List of HCA International consulting services
- HCA Quality Policy Framework Card

L. HCA Park View Medical Center and HCA West Side Hospital

Agency/Organization Visited:

HCA Park View Medical Center
230 - 25th Avenue, North
Nashville, TN 37203
Phone: 615-340-1000
and
HCA West Side Hospital
2221 Murphy Avenue
Nashville, TN 37203
Phone: 615-329-6000

Contact Person:

Frances A. Rajotte, Manager, Public Relations

Date and Time of Visit:

Monday, October 9, 1989

Attendees:

The six Indonesian tour members and Al Baker

Presenters:

See Documentation Item 3 a for a tour agenda of these hospitals which lists the presenters.

Summary of Presentations:

The HCA Park View Medical Center is a 441 bed acute care general hospital and is considered HCA's "showcase" facility. The HCA West Side Hospital is a 199 bed facility. The visits to these two facilities have been combined into one report since they were conducted by the same person, Ms. Rajotte, and no duplicate services were covered.

The Director of the Park View Medical Center walked the group through the admitting, discharge, patient records, accounting, and fiscal areas, explaining the interrelationships of the operations of these functions. He reviewed the computerized management information system that brought the data from all of these functions together and explained how certain reports and data that were needed by HCA corporate headquarters were generated and transmitted. Walk-throughs of the hospital laboratory, food service and nutritional planning services were conducted. Of particular interest to the Indonesian physicians was the visit to the Cancer Center and its radiation/oncology Magnetic Resonance Imager. The tour of the HCA West Side Hospital focused on its unique family birthing unit, a full description of which is included in the documentation. Also of interest was West Side's neo-natal unit.

Documentation:

1. Audio: Micro Tape 4 B
2. Video: VHS Tape 1, Tape Counter 1920 through 1919 (Park View) and 1920 through 1964 (West Side)

3. Other:

- **Tour Agenda for Park View and West Side Hospitals**
- **Descriptive brochure of the HCA Park View Medical Center which contains additional printed materials on food and nutritional services, policy monitors for anesthesia, medical records review, surgery services, and imaging, as well as medical staff generic screens**
- **Descriptive brochure of the HCA West Side Hospital's family birth unit**

M. Ohio County Hospital

Agency/Organization Visited:

Ohio County Hospital
1211 Main Street
Hartford, KY 42347

Contact Person:

Debbi Robinson
Director of Public Relations/Personnel
Phone: 502-298-7411

Date and Time of Visit:

Tuesday, October 10, 1989

Attendees:

The six Indonesian tour members and Al Baker

Presenters:

Blaine Piper, Administrator
Lloyd Spivey, Chairman, Board of Trustees

Summary of Presentations:

The Administrator, Mr. Piper, explained that the Ohio County Hospital was a 68 bed acute care hospital, the only such facility within a 25 mile area. Until two years ago, it was an Ohio County, State of Kentucky-owned municipal hospital with all of its personnel being employed by the county. Several years ago the county's governing body decided to study the possibility of converting the facility from a county-owned to a not-for-profit private institution because the day-to-day operation of a health care facility created major problems for the administration of a small rural county. Local politics became involved in the hiring and firing of the personnel, even to include the lowest level workers such as janitors. The physicians were not happy with the budget process to get modern medical equipment and competent medical technicians. The tax payers in the county complained that the county supervisors were not monitoring closely enough the costs of hospital operations. Finally in 1984, the county governing body agreed to convert the hospital to a private not-for-profit facility but to assure that its management would be most efficient, it was to be managed by a nationally recognized hospital management company. The Hospital Corporation of America was awarded the management contract and has operated that facility since its initial conversion. Mr. Spivey, the Chairman of the Board, who is also a local businessman in the county, explained his role and that of the other trustees in establishing hospital operating policy and in their relationships with the county supervisors who are also represented on the governing body of the hospital. Mr. Spivey stated that the conversion proved to be an ideal decision with the physicians in the county much more satisfied. Employee morale has been high since politics has been removed from the hiring/discharge process. And finally, under HCA management, costs have been reduced. A walk-through conducted by Mr. Piper and Mr. Spivey included visits to the medical and surgical wards, the hospital's laboratory and pharmacy, and to their proudest new medical technology, a CAT (computerized axial tomography) scanner.

Documentation:

1. Audio: Micro Tapes 5 A and B and 6 A and B
2. Video: VHS Tape 1, Tape Counter 2044 to 2129
3. Documentation:
 - HCA Management Company's Report of Progress, 1987-88
 - CommuniCare, the hospital's newsletter to the community
 - By-laws for the practicing medical staff
 - Patient Handbook
 - Employee Handbook
 - Brochures: Day surgery, mammography, family celebration, and hospice of Ohio County

N. American Hospital Association

Agency/Organization Visited:

American Hospital Association
840 North Lake Shore Drive
Chicago IL, 60611
Phone: 312-280-6000

Contact Person:

Patricia M. Victor, Coordinator, International Visitors Program
Phone: 312-280-6350

Date and Time of Visit:

Wednesday, October 11, 1989, 9:30 a.m. to Noon

Attendees:

The six Indonesian tour members and Al Baker

Presenters:

Carol M. McCarthy, Ph.D., J.D., President
Shelly Johnson, Acting Director, American Society for Hospital Materials Management
Tom Granitar, Program Manager, Division of Health Policy
Linda Brooks, Program Director, Division of Medical Affairs

Summary of Presentations:

Although Dr. McCarthy, the AHA President, was scheduled to spend some time with the group, an unexpected but urgent meeting permitted her to visit with us for only a few minutes. She welcomed the Indonesian physicians, and apologized for not being able to stay longer. However, she assured us that her staff had done a great deal of work in preparing for the briefings and that we could certainly follow-up with her directly if we had any questions in the future.

Ms. Johnson spoke on the subject of the purchase of medical equipment. She cited a not-for-profit organization called ECRI in Philadelphia, PA, (phone 215-825-6000) where hospitals might inquire about receiving objective evaluations of such equipment. She offered some suggestions when purchasing medical equipment: check on its history of breakdowns; also when negotiating to purchase, find out the availability of parts and service, how quickly they can be expected, how much they cost, will the manufacturer fly over technicians to repair and service; and will they train technicians at your site.

Mr. Granitar spoke on the issues of quality of hospital care, how it is measured (not very well!); it should be internal hospital staff who does the monitoring but the federal and state governments become involved as does the Joint Commission for Accreditation of Healthcare Organizations. Further under the Medicare program, Professional Review Organizations have been established as private reviewers under contract by the federal government to determine the medical necessity of hospitalizing Medicare patients, to review their stay for quality of care; and finally recommend nonpayment for substandard care and/or suspension from the Medicare program.

Ms. Brooks discussed relationships between hospital administrators and the medical staff. She explained the general organizational structure that in general leaves clinical decisions to the physicians, and non-clinical functions -- finance, purchasing, hiring/discharge, maintenance, and food service to

the administrative staff. However, she said that conflicts arise when physicians demand the newest medical equipment and the hospital's budget cannot afford all requests at the same time. She indicated that in recent years, the administrative staff seems to be getting more powerful in making such decisions because of rising costs, smaller revenues from government purchasers of hospital services, and complaints from other insurers about getting costs shifted to them when the government does not pay its full share.

Documentation:

1. Audio: Micro Tapes 7 A and B
2. Video: VHS Tape 1, Tape Counter 2130 through 2243. Note: Dr. Carol McCarthy, the President, is at 2146 to 2176.
3. Other:
 - AHA Annual Report for 1988
 - Brochure: Introducing the American Hospital Association
 - The Complete AHA Catalog (Publication and other Resources)
 - Economic Trends, Summer 1989 issue
 - Brochure: Associate Membership in AHA
 - Brochure: Introducing the AHA Resource Center
 - Brochure: AHA Hospital Literature Index
 - AHA Personal Membership Groups
 - Brochure: A Guide to Health Care Terms for Seniors
 - Brochure: The AHA Advantage
 - Dear Colleague Letter from Dr. McCarthy on Medicare's hospital mortality information data to be released in December 1989
 - Member Briefing Memo on Medicare Hospital Mortality Data: 1989
 - Public Relations Advisory "Early Warning System" Mortality Data Advisory

O. Veterans Administration Lakeside Medical Center

Agency/Organization Visited:

Veterans Administration Lakeside Medical Center
333 East Huron Street
Chicago, IL 60611
Phone: 312-943-6600

Contact Person:

Harold Rhein, Office of Public Affairs
Phone: 312-943-6600 Extension 571

Date and Time of Visit:

Wednesday, October 11, 1989, 2:00 p.m. to 4:00 p.m.

Presenters:

Joseph L. Moore, Director, V.A. Lakeside Medical Center
Irving Singer, M.D., Medical Director and Chief of Staff
Richard Rooney, Chief of Pharmacy Services

Summary of Presentations:

Mr. Moore, who has been Director of the Center for the past eleven years, described his organization as a 514-bed acute care hospital in a 19-story building in downtown Chicago that provides outpatient services not only locally but also through the Crown Point Clinic, an ambulatory outpatient service department, located 50 miles away, which services veterans in northern Indiana and southern Chicago. Two wards of the hospital are currently closed for renovation but this is a continuous process since the basic facility is old and modernization will proceed on a year to year basis. Currently 471 beds are staffed, with an average daily occupancy of 72 percent to 75 percent. Although 8,000 discharges will occur in 1989, there will be fewer total days than produced by the 7,000 discharges in 1988 because of reduction in average length of stay. Over 200,000 outpatient visits are expected during 1989, almost double the amount five years ago. Chicago has three other Veterans Administration hospitals all of which have some long-term care patients but Lakeside has none. He said that Lakeside operates on a fixed budget, with funds coming from the Veterans Administration in Washington, D.C., based on previously submitted requests for funding. With a fixed budget, priorities have to be set as to personnel, equipment, pharmaceuticals, maintenance, training, etc. He also described the budget development process, using current years expenditures, staffing, patient load, equipment needs, and the like to determine requests for the next budget cycle. The hospital's budget then goes to its VA regional office for review and finally to VA in Washington where it is consolidated into the overall VA budget.

Dr. Singer, the Chief of Staff, described Lakeside's relationship with the Northwestern University Medical School which is located directly across the street from Lakeside and is joined to the school by a second story bridge which permits direct access from the school to the hospital. Dr. Singer is also an Associate Dean and Professor of Medicine at the medical school. Most of the physicians on the Lakeside staff -- federal employees -- also hold teaching appointments at the medical school which is a private institution. He also explained the problems of operating under a fixed budget where resources are limited. Patients cannot be billed, although recently some who have private insurance coverage through a change in federal law can have their insurance companies billed. However, any payments from the insurer goes directly to the U.S. Treasury, so the VA system cannot directly benefit from additional revenues received.

Dr. Singer, when questioned about the use of generic drugs, stated that they are used as much as possible within the Medical Center. He said they have an active Pharmaceutical and Therapeutic Committee (P&T) that is composed primarily of physicians with pharmacists and nurses on it. Their formulary is broad as to the types and kinds of drugs but limited in brand names. As soon as generic drugs are approved by the Food and Drug Administration, they replace brand names unless there is some question as to the effectiveness of a particular generic drug. If a staff physician wants to prescribe a brand name, he must get the approval of the chief physician specialist for the disease being treated. The P&T Committee reports to the Medical Executive Committee with its recommendations, and those approved go to the Medical Center Director for final decision.

Dr. Singer stated that when operating under a fixed budget, you must first determine a priority of goals for the organization. Soon after his arrival as Chief of Staff he had the Clinical Executive Committee, which he chairs, to determine current goals for the Center. He was not surprised when improvements in ambulatory services and geriatrics came up as numbers one and two but was shocked at improvement in information management as the number three priority. Medical and surgery services received lower priorities. On a more interesting note, Dr. Bujihartano asked Dr. Singer if the Delphi method was used in making such determinations. Dr. Singer replied: "exactly!"

Dr. Singer commented on the patient characteristics of Lakeside: the average age of the patient was 60, with 75 percent of the patients being treated for substance abuse or alcohol, chronic lung disease, or cancer -- or a combination of them. Dr. Singer accompanied the group in a walk-through of both medical and surgical wards, with special comments about their coronary care unit. They recently installed the latest state-of-the-art equipment for treating coronary patients, including a US\$ 2 million CAT scanner. He said, however, that open-heart surgery was not performed at Lakeside, since one of the other VA hospitals in Chicago was equipped and staffed for such operations. The federal government in its budget review process minimizes duplication of facilities and equipment within areas whenever possible.

Mr. Richard Rooney, the Chief Pharmacist, walked the group through his areas of responsibility. He said VA hospitals nationwide order drugs from a central VA pharmacy depot which consolidates orders from all hospitals in the VA system, and then places orders directly with pharmaceutical manufacturers. By federal law, the manufacturer may be barred from federal contracts if it sells its products at a lower price to any non-federal organization. He said that more than half of his formulary consisted of generic drugs. They do a great deal of automated packaging of drugs for use by inpatients on a daily basis with computerized equipment that has recently become available. Mr. Rooney also described their system for refilling prescriptions for outpatients on an automated basis. Each prescription may be filled up to six times without seeing a physician and is good for six months. When originally filled, the patient receives six mail-in reorder forms that are bar coded with the original prescription number. When the patient mails in the form, a laser scanner reads the bar codes, prints a mailing label, a pharmacist fills the order, and the refilled prescription is mailed to the patient the same day. The system can handle 800 refills an hour.

Documentation:

1. Audio: Micro Tapes 8, Sides A and B
2. Video: VHS Tape I, Tape Counter 2244 to 2322
3. Other:
 - Ward Rounds, Fall 1989, a Northwestern University Medical School publication, which contains starting on page 28 a profile of the VA Lakeside Medical Center.
 - Mr. Moore promised to send additional documents to ISTI's Washington office. However, no record of what has been received is available for inclusion in this report.

P. Joint Commission on Accreditation of Healthcare Organizations

Agency/Organization Visited:

Joint Commission for the Accreditation of Healthcare Organizations
875 North Michigan Avenue
Chicago, IL 60611
Phone: 312-642-6061

Contact Person:

Marita Gomez, Communications Manager
Phone: 312-642-9349

Date and Time of Visit:

Thursday, October 12, 1989, 9 a.m. to Noon

Attendees:

The six Indonesian tour members and Al Baker

Presenters:

Dennis S. O'Leary, M.D., President JCAHO
Henry Woodson, Associate Director, Standards Development, JCAHO
Deborah Nodzam, R.N., PhD (Nursing), Project Manager, Indicator and Database Development
Marita Gomez, Communications Manager

Summary of Presentations:

Ms. Gomez, the Communications Manager, provided the group with an overview of the Joint Commission, its governing body consists of 24 commissioners, and indicated that the average time for an accrediting team to be at a hospital site was two days for a small hospital (up to 150 beds), and longer if the hospital was larger and offered additional services such as home health, hospice, etc. Hospitals are required to pay for accreditation services, with the cost about US\$ 10,000 for the average hospital. Once accredited, the certification is good for three years.

Dr. O'Leary, the President, explained the mission of the JCAHO as an organization to enhance the quality of health care provided to the public by establishing contemporary standards, evaluating health care organizations, rendering accreditation decisions, and providing educational and consultative support to health care organizations. It was founded in 1951 as the Joint Commission for the Accreditation of Hospitals, but changed its name to the Joint Commission for the Accreditation of Healthcare Organizations in 1987 when it broadened its scope to accredit providers other than hospitals: nursing homes, home health care organizations, outpatient surgery centers, drug abuse and mental health centers, and other deliverers of health care. He described the organization structure of the JCAHO, a chart of which is included in the documentation. Dr. O'Leary stated that the federal Medicare program which provides health services for the elderly and disabled accepts a JCAHO accreditation for a hospital as having met Medicare's "conditions of participation". Of the approximate 5,500 hospitals in the United States that participate in Medicare, more than 4,000 are reviewed for JCAHO accreditation. The remaining hospitals which tend to be small (under 100 beds) and rural choose not to use JCAHO because of the cost. These hospitals, to participate in Medicare, must receive a certification of meeting the "conditions of participation" by applying to and being reviewed by an agency of the Department of Health in the state in which they are located.

Mr. Woodson, the Associate Director of Standards Development and a former hospital administrator himself, explained the development of standards and criteria used by the evaluators during the accrediting process. Proposed changes in standards are submitted to national associations of healthcare organizations for comment before being adopted.

Dr. Deborah Nodzam, who is project manager for the JCAHO's "Agenda for Change" explained that this new initiative was launched in late 1986 to develop an outcome-oriented monitoring and evaluation process that would assist healthcare organizations in improving the quality of care they provide. Initially three task forces were appointed to develop clinical and organizational indicators related to obstetrical care, anesthesia care, and organization and management functions of hospitals. Other task forces are now getting under way for radiology, medical services, and general surgery. Eventually JCAHO hopes to establish such an outcome-oriented monitoring and evaluation process for all departments and services of hospitals. The documentation cited below contains three Agenda for Change Update issues which more fully explain this new initiative. Also included in documentation are several clinical indicator information forms to illustrate the process.

Note: Upon completion of the visit, Ms. Gomez and other staff of the JCAHO hosted luncheon for the visiting group at a Chinese restaurant near their office.

Documentation:

1. Audio: Micro Tapes 9 A and B
2. Video: VHS Tape 1, Tape Counter 2223 through 2570
3. Other:
 - A History of the Joint Commission (magazine article)
 - JCAHO 1989 Publications Catalog
 - Organization Chart
 - Board of Commissioners -- 1990
 - Department Heads
 - Mission Statement
 - Facts about Joint Commission Accreditation
 - Twelve Reasons for Maintaining JCAHO Accreditation
 - Three Issues Agenda for Change Update
 - Blank Clinical Indicator Development Form
 - Clinical Indicator Information Form for Tumors
 - Clinical Indicator Information Form for Coronary ByPass
 - Summary Lists (3) for Oncology, Trauma, and Cardiovascular Indicators

Q. American Medical Association

Agency/Organization Visited:

American Medical Association
535 North Dearborn Street
Chicago, IL 60610
Phone: 312-645-5000

Contact Person:

Ms. Patricia Hutar, Director
Office of International Relations
Phone: 312-645-4381

Date and Time of Visit:

Friday, October 13, 1989, 9:45 a.m. to Noon

Attendees:

The six Indonesian tour members and Al Baker

Presenters:

James S. Todd, M.D., Senior Deputy Executive Director
Harry Jonas, M.D., Director, Division of Undergraduate Medical Education
Michael R. Vitek, Director, Department of Medical Staff Services
Patricia Hutar, Director, Office of International Relations
Paula K. Andreoli, J.D., Assistant Director, International Relations

Summary of Presentations:

Ms. Hutar welcomed the group, stating that AMA has six small projects currently underway in Indonesia, funded by the U.S. State Department/A.I.D. She is working with the central headquarters of the Indonesian Medical Association and has visited several areas of the country, where she is working as Project Director with local physicians. One of her projects has taken her to West Sumatra. Dr. Nazaruddin recalled that he had met Ms. Hutar on her last visit. She described briefly the projects underway, citing the names of physicians and other officials she has been working with. She has also visited the Ministry of Health, spending an hour with the Minister on her next to last visit to Jakarta. Editors Note: Micro Tape 10, Side A, includes a more detailed explanation of these projects and it may be worthwhile to transcribe that portion.

Mr. Vitek, Director of AMA's Medical Staff Services Department, stated that he has been with AMA only one year. Previously, though, he had been a hospital administrator at a 52 bed hospital and later at a 127 bed facility. His department is responsible for policies and procedures relating to physicians roles in hospital medical staffs. In response to a question from Dr. Budihartano about conflicts between the administrator and the medical staff, he replied that a recent JCAHO study indicated that 80 percent of hospital governing boards, administrators, and medical directors were satisfied with their relationships. However, that left the remaining 20 percent or about 1,400 hospitals that acknowledged major problems. Mr. Vitek commented that often there was tension rather than conflict involved, primarily because the physician is concerned about care for his individual patient while the governing body and administrator have a broader view of concern for the needs of the entire community. The problem arises now more frequently because of budget restrictions so resources have to be allocated on priority basis. Mr. Vitek described the organization of the medical staff at a typical hospital

with legal by-laws adopted that specify the qualifications of physicians and other practitioners who will be granted admitting privileges and the extent to which their practice will be limited within the hospital. The by-laws also establish a medical executive committee; clinical departments within the facility; and state the procedure for electing or designating department chairpersons and other clinical positions.

Ms. Andreoli, Assistant Director, International Relations, discussed AMA's involvement with the World Medical Association and distributed to the visitors a copy of the World Medical Association Handbook of Declaration. In particular, she referred the group to pages 65, 66, and 67 (See Documentation Item 3b) concerning a Statement of Policy on Infant Health adopted by the 39th World Medical Assembly in October 1987, which states that the Indonesian Medical Association and the Medical Association of Thailand were selected to implement pilot projects in their respective countries, with funding provided by USAID.

Dr. Jonas, Director of the Division of Undergraduate Medical Education, said that he was also Secretary of the Liaison Committee on Medical Education, a joint committee of AMA members and members of the Association of American Medical Colleges (AAMC), which is responsible for accrediting the 127 medical schools in the United States and 16 medical schools in Canada. He stated that AMA was started in 1847 not primarily out of concern for health care but for medical education. Generally, medical schools are accredited for a term of seven years. He described the accrediting process which costs the schools no fee, the costs being absorbed by the two parent associations, AMA and AAMC. He indicated that there are diverse arrangements between medical schools and teaching hospitals in the United States. For example, he cited the University of Arizona medical school that owned its own teaching hospital. The Harvard University medical school is private and does not own its own teaching hospital but has arrangements with Massachusetts General Hospital, Brigham & Women's Hospital, Boston Childrens Hospital, and others in the Boston area. Dr. Jonas asked how many medical schools were in Indonesia. Dr. Budihartano replied there were sixteen that produced about 1,400 physicians a year. Dr. Jonas said the 127 U.S. medical schools turn out about 16,000 graduates a year. The cost of medical education is high. He stated that three were tied for the costliest, noting that Georgetown University, where the group had visited, was one of the top three at US\$ 22,500 a year for tuition alone. He did state there was one free medical school in the United States, operated by the U.S. Armed Forces, in Bethesda, Maryland, that produce physicians for the military services. During their four years at the school, the students are commissioned officers with the rank of Ensign (second lieutenant) and receive the pay and allowances that is paid to other military officers of the same rank. Graduates have a specified period of mandated service in the military upon graduation.

Ms. Hutar concluded the visit by promising to send to the ISTI Washington, D.C., office additional documents which she thought would be of use to the Indonesian physicians.

Documentation:

1. Audio: Micro Tape 10, Sides A and B
2. Video: VHS Tape I, Tape Counter 2571 through 3030
3. Other:
 - AMA 1988 Annual Report
 - World Medical Association Handbook of Declaration
 - AMA Information Brochure
 - AMA News, October 13, 1989, issue

R. Cedars-Sinai Medical Center

Agency/Organization Visited:

Cedars-Sinai Medical Center
8700 Beverly Boulevard
P.O.Box 48750
Los Angeles, CA 90048

Contact Person:

Yoshi Honkawa, Vice President for Government and Industry Relations
Phone: 213-955-5701

Date and Time of Visit:

Monday, October 16, 1989, 8:00 a.m. to 6:00 p.m.

Attendees:

The six Indonesian tour members, Paul Zukin, M.D., and Al Baker

Presenters:

Yoski Honkawa, Vice President for Government and Industry Relations
Jacob H. Brand, PharmD., Senior Associate Administrator for Pharmacy, Laboratory, Nuclear
Medicine, Radiology, Material, and Purchasing
Conrad Flatley, Associate Administrator for Building Support, Housekeeping, Security, Parking,
and Clinical Engineering
Elaine Auerback, Associate Administrator for Medical Records, Nutritional Services, and Quality
Assurance
Jay Prout, Associate Administrator for Clinical Services
James S. Stewart, Associate Director for Fiscal Services
Steven Hage, Director, Admin. Services, Diagnostic Radiology Department
Rita Shane, Pharm.D., Director of Pharmacy Services
Dee Fisher, Director of Medical Records
Jerome Berkman, Director of Nutritional Services
Lester Samson, R.N., Director of Nursing Administration
Linda Bolton, R.N., Ph.D. (Nursing), Director of Nursing
Michael I. Langeberg, M.D., Director of Medical Education
John Loftus, M.D., Co-Director, Emergency Services
Jan Thompson, R.N., Administrator, Emergency Services
Gregory Strohm, Director, Quality Assurance
Nick Lewis, Director, Clinical Engineering

Summary of Presentations:

The visit to the Cedars-Sinai Medical Center was the most complete and comprehensive stop on the tour. It encompassed a full ten hours of presentations, briefings, walk-throughs, and demonstrations on the operation of a very large United States non-government, not-for-profit hospital and medical center. This section of the report will summarize only the areas covered in a general nature. The audio documentation listed below, which can be transcribed, includes the full detailed record of the visit, and may be a useful augmentation for future study, analysis, and research.

Cedars-Sinai is primarily a 1,000 bed acute care teaching hospital, affiliated with the University of

California in Los Angeles (UCLA) Medical School. It is located in the Beverly Hills/Hollywood area of Los Angeles, and therefore treats many movie and television celebrities among its varied patients. Cedars-Sinai has 255 salaried physicians (mostly teaching and research doctors) on its house staff, 200 interns/residents, and 2,300 to 2,400 attending (admitting) physicians, although the majority of patients are admitted by about 400 doctors. It employs 5,800 personnel and has another 1,300 volunteer workers. It has 2.3 million square feet of space, of which 1.3 is usable. All its rooms are private (one patient to a room), and has several intensive care units: 110 beds for general medicine, 20 for general surgery, 10 for cardiac surgery, 8 for pediatric surgery, and 30 neo-natal intensive care. The hospital also is an organ transplant center for heart, lung, liver, and kidney patients. It has three in-house magnetic resonance imagers (MRI), and two lithotripsy machines (one for gall stones and one for kidney stones). It averages between 780 to 800 in-patients a day. It also provides emergency medical services, averaging 200 cases a day. It has an annual budget of US\$ 500 million.

It is heavily automated, depending on computers for every phase of its operations: finance, pharmacy operations, medical records, purchasing, clinical engineering, food and nutrition services, admitting and discharging, quality assurance, personnel scheduling, and clinical services.

Of particular interest to tour members was the pharmacy operations which has an annual budget of US\$ 6.5 million. It employs 104 full-time equivalent staff, about half of whom are registered pharmacists. A video tape of the food and nutrition departments services followed by a walk-through of the food preparation area were also noteworthy, providing useful information for the visitors. Also of interest was the presentation by Dr. Langeberg, Director of Medical Education, who is responsible for the intern and residents training and also for the continuing education of all physicians associated with the medical center. He discussed the relationships between the medical staff and the administrative staff as well as the relationship between the UCLA medical school and the hospital.

Documentation:

1. Audio: Micro Tapes 11 A: Orientation by Medical Center officials; 11 B: Finance; 12 A: Pharmacy Services; 12 B: Pharmacy Services and Clinical Engineering; 13 A: Clinical Engineering, Food and Nutrition; and Nursing Services and Nursing Education; 13 B: Nursing and Medical Education; and 14 A: Emergency Services and Outpatient Department
2. Video: VHS Tape 1, Tape Counter 3067 to 3466
3. Other:
 - Pharmacy Policy and Procedure Memo on Detailing by Pharmaceutical Representatives
 - Organization Chart of Patient Care Services
 - Regular Menu for Patient to Select Meals
 - Special Gourmet Menu (additional charge) for Patient Meals

S. Kaiser-Permanente Regional Office

Agency/Organization Visited:

Kaiser-Permanente Regional Office
Walnut Center - 393 East Walnut Street
Pasadena, CA 91188
Phone: 818-405-5000

Contact Person:

Irwin P. Goldstein, M.D., Associate Medical Director and Physician Manager of Operations,
Southern California Permanente Medical Group, same address
Phone: 818-405-5720

Time and Date of Visit:

Tuesday, October 17, 1989, 10:00 a.m. to Noon

Attendees:

The six Indonesian tour members, Dr. and Mrs. Paul Zukin, and Al Baker

Presenters:

Dr. Goldstein (see above)
Dr. Samuel Sapin, Associate Medical Director
Kurt Van Riker, Supervisor of Drug Information Services

Summary of Presentations:

The Kaiser Foundation Health Plan is the largest health maintenance organization (HMO) in the United States with more than 6,000,000 enrollees, 4,000,000 of whom are in California, and 2,000,000 of them enrolled in the Southern California Regional Office. Kaiser/Southern California operates ten hospitals, ranging in size from a 600 bed tertiary care facility to a 180-bed hospital. They also operate several drug/alcohol treatment units as well as provide mental health in-patient care. The region covers 10,000 square miles in southern California. Dr. Goldstein explained the organization of the Southern California region, citing that enrollees pay through their employers or from Medicare a per capita membership fee which has been increasing annually due to inflation over the last several years. Enrollees receive their complete health and medical services, including preventative medicine (annual physical examinations), physician services including cost of surgical operations, and full hospitalization. Long-term care for non-acute services, however, is not part of the plan.

Quality of care is monitored by the regional office staff, under the direction of Dr. Sapin. Requirements for new medical technology equipment are reviewed by the regional office, and allocated on a priority basis, based on relative needs, projected patient/enrollee growth, and cost factors. Generic drugs are prescribed whenever possible in both their inpatient hospital facilities and through their outpatient pharmacies. Each hospital has its own formulary but it is regularly reviewed by the regional office. Pharmaceuticals are centrally purchased by the national office in Oakland, California in order to obtain the best prices from manufacturers.

Most of their hospitals are also affiliated with area medical schools and provide intern/resident training. Many of the physicians who complete their residency in a Kaiser hospital will join the Kaiser medical group on a full time basis.

Documentation:

1. Audio: Micro Tapes 14 A & B, 15 A
2. Video: VHS Tape 1, Tape Counter 3465 through 3569
3. Other: None

T. Veterans Administration West Los Angeles Hospital

Agency/Organization Visited:

Veterans Administration Medical Center - West Los Angeles
Wilshire and Sawtelle Boulevards
Los Angeles, CA 90073
Phone: 213-478-3711

Contact Person:

William K. Anderson, Director
Phone: same as above

Date and Time of Visit:

Wednesday, October 18, 1989, 9:00 a.m. to 12:30 p.m.

Attendees:

The six Indonesian tour members, Dr. and Mrs. Paul Zukin, and Al Baker

Presenters:

William K. Anderson, Director
Earl Gordon, M.D., Chief of Staff, Wadsworth Division
Joseph Flinn, M.D., Chief of Staff, Brentwood Division
Ramone Reevey, Assistant Director for Administrative Services
Paul West, Associate Director for Management and Financial Innovations
Sarah Hammond, Chief, Management Support
James Goode, Chief, Pharmacy Operations

Summary of Presentations:

The Veterans Administration Medical Center - West Los Angeles (VAMC/WLA) is the largest and most complex facility of its kind within the Veterans Administration. It has 1,645 beds in operation, organized into two divisions: the Brentwood Division with 515 beds provides a full range of psychiatric care and the Wadsworth Division has 710 beds, with 259 allocated to medicine, 215 to surgery, 41 to neurology, 165 to intermediate care and 30 to rehab medicine. Another 320 beds are for long-term care/domiciliary services. The Center has an annual budget of US\$ 200 million, 75 percent of which goes for salaries, wages, and employee benefits. It employs 4,500 full- and part-time personnel of which 2,300 are full-time.

Unlike the visit to the Veterans Administration Hospital in Chicago, where the group toured the entire facility, the VAMC/WLA presentations were confined to its largest conference room with all of the above-named presenters participating. In addition, another six or seven support staff members were present to clarify and expand on briefings and to provide assistance in answering technical questions. This format proved helpful to the group because it provided a more intimate opportunity to pose questions to the senior medical center officials and their staff, particularly when members of the group wanted clarification on or had concerns about a particular area that had been covered in our earlier visits to hospitals and agencies in the previous two weeks. In particular, problems that tour members had on generic drugs, the governmental budgeting process, medical staff/administrative staff relationships, teaching hospital/medical schools issues, and quality of medical care were clarified.

Following the presentations, Mr. Anderson, the Director, arranged for a catered luncheon for the

group so that both his staff and our tour members could informally become better acquainted with the presenters.

Documentation:

1. Audio: Micro Tapes 15 A (mid-tape) & B; 16 A and B (1st half)
2. Video: VHS Tape 1, Tape Counter 3567 to 3890
3. Other:
 - Descriptive brochure of the VAMC/WLA
 - Program schedule for the Indonesia Study Tour by the VAMC/WLA
 - Organizational Chart of the VAMC/WLA

U. Harbor General Hospital

Agency/Organization Visited:

Los Angeles County Harbor/UCLA Medical Center
1000 West Carson Street
Torrance, CA 90509
Phone: 213-533-2101

Contact Person:

Edward J. Foley, Administrator
Phone: see above

Time and Date of Visit:

Thursday, October 19, 1989, 9:00 a.m. to 1:00 p.m.

Attendees:

The six Indonesian tour members, Dr. and Mrs. Paul Zukin, and Al Baker

Presenters:

Edward J. Foley, Administrator
William H. Swanson, M.D., Medical Director
Jerrold A. Turner, M.D., Associate Medical Director for Medical Education
Peggy Nazarey, R.N., Ph.D., (Nursing Admin), Director of Nursing Services
John Hebane, Director of Mechanical Services
Cynthia Cuzman, Head Nurse, Medical/Surgery Wards
Doris Frankenstein, Staff Assistant for Public Relations (our tour guide during the walk-through of the hospital facilities)
Ardell Otten, Assistant Administrator for Radiology/Nuclear Medicine
Becky Colsen, Supervisor, Medical Technology Laboratory
Wes Kamikawa, Pharm.D., Director of Pharmacy Services

Summary of Presentations:

The Harbor/UCLA Medical Center ("Harbor General") is an acute care general and teaching hospital, owned by the County of Los Angeles in California. It has a license for 533 beds but currently only 501 are open for use. It has an average occupancy of 85 percent which is high for United States acute care hospitals. In addition, the hospital has 60 bassinets for new born babies, and had over 6,800 births in the last twelve months.

This hospital is the most similar facility to the large teaching hospitals in Indonesia that our tour members are associated with -- it is a government not-for-profit institution that services a large indigent population who use the facility not only for inpatient care but in most cases for their primary medical needs in the emergency room and outpatient clinics. More than 60 percent of the patients are poor, and qualify only for the federal Medicaid program coverage or for no coverage if they do not meet the eligibility requirements for Medicaid. Nevertheless, Harbor General serves these patients, regardless of their ability to pay. The County of Los Angeles subsidizes these patients by appropriating revenues for them. Harbor General is located in a multi-national community -- 30 percent of the population is Hispanic (Mexican or Latin America background); 10 percent Asian; 12 percent Afro-American (black); and 48 percent caucasian (white). It is affiliated with the UCLA Medical School, a state of California institution. Except for a few anesthesiologist physicians, who are contract doctors, all other physicians

are employees of the County of Los Angeles, and most additionally hold an appointment as a teacher with the UCLA Medical School with their salaries being jointly supported.

Harbor General employs 3,200 full- and part-time personnel, including physicians. Of this number 1,300 are full-time equivalent nurses of whom 780 or 63 percent are registered nurses (RN). There is a shortage, however, of nurses with 12 percent of their allotted number of nurses vacant. This problem, however, is not unique to Harbor General but occurs throughout the United States among all health care facilities, where an average of 20 percent nursing vacancy exists. Harbor General, though, has one of the strongest program in training, recruiting, and maintaining nurses of any that were observed by the tour members in their other visits. Harbor General's Director of Nursing, Dr. Peggy Nazarey, was most impressive in the presentation of her Department of Nursing's activities. She also holds an appointment as Assistant Dean of the School of Nursing and Professor of Nursing at the UCLA School of Nursing. The documentation list below pertaining to Harbor General's nursing activities is recommended for thorough review to provide ideas and direction to the problem of nurses training, retention, and recruitment in Indonesia.

A tour of the hospital included visits to and briefings at the pharmacy, medical laboratory, medical records office, radiology/nuclear medicine department, medical and surgical wards, and emergency room. The Director of Pharmacy indicated that generic drugs are used whenever possible for treatment of patients. Dr. Turner, the Associate Medical Director, and Director of Medical Education was impressive in his explanation of the relationships between Harbor General and the UCLA Medical School, and was able to answer several inquiries by the visiting tour members as to organization of the medical staff, responsibilities for intern/residents training, and similar activities.

Documentation:

1. Audio: Micro tapes 16 B (last 20 percent) 17 A and B (first 10 percent only)
2. Video: VHS Tape 1, Tape Counter 3891 to 4645
3. Other:
 - Harbor-UCLA Medical Center Profile - 1988-1989
 - Harbor General Hospital Committee List for 1989-90
 - Organization Chart - Harbor General Medical Administration
 - Status of Graduate Training Programs, Jan 1989, Harbor General
 - Pharmacy News Capsule - Harbor General - October 1989
 - Diagnostic Imaging Center Folder - Harbor General
 - Harbor General Department of Nursing Folder Containing:
 - Strategic Plan Fiscal Year 1987-1988
 - Nursing Network Newsletter - Vol. 4, No. 4, 1989
 - Brochure: Emphasis Nursing Innovation
 - Brochure: Emphasis Promoting Professional Practice
 - Brochure: Career Opportunities in Nursing

V. Straub Hospital and Burn Center

Agency/Organization Visited:

Straub Clinic and Hospital
888 South King Street
Honolulu, HI 98813
Phone: 808-522-4000

Contact Person:

Frank Cabarini, M.D., Associate Medical Director
Phone: 808-522-4000

Date and Time Visited:

Friday, October 19, 1989, 2:00 p.m. to 4:00 p.m.

Attendees:

The six Indonesian tour members, Dr. Robert T. Bonham, and Al Baker

Presenters:

Alan Hawk, M.D., Medical Director
Frank Cabarini, M.D., Associate Medical Director
James Penoff, M.D., Chief, Plastic Surgery and Burn Unit
Carl Numoto, Chief, Pharmacy Department
Robin Jordan, Head Nurse, Burn Unit

Summary of Presentations:

The Straub Clinic and Hospital is a 160-bed acute care facility that was organized 13 years ago when several physicians practicing in Honolulu decided they wanted their own hospital. In addition there are several outpatient clinics located in Oahu and one on another Hawaiian island. The hospital is entirely owned by the 140 physicians. The physicians elect their own Board of Directors who establish the hospital policies but delegate the day to day management to an administrative staff. It is a for-profit institution that pays property, sales, and income taxes to the government. Its profits are shared by the physician-owners.

The Straub Hospital has also the only acute care burn unit in the state of Hawaii. It is the smallest burn unit in the United States, but fewer burn cases per capita occur in Hawaii because there are fewer gas furnaces for heating homes and fewer open fireplaces. It was established with a relatively low capital budget of US\$ 75,000. They converted one four-bed area of the hospital into the burn unit. It provides three intensive care burn beds and the fourth bed area is used for a treatment tank with an overhead track and pulley for lowering patients into the tank. It has an average patient load of two patients a day, although as many as eight have been treated as inpatients at one time. The burn unit is under the supervision of a physician who is a plastic surgeon who also heads their plastic surgery department. It has been in operation five years. Previously serious burn patients in Hawaii had to be evacuated to mainland United States for treatment. The average length of stay for a burn patient exceeds 30 days, and mortality rates are high and infection is always a danger.

The Straub Hospital pharmacy is one of the few (less than 16 percent) in the United States that is not computerized. This proved of significant interest to our Indonesian visitors. The chief pharmacist said the biggest problem of not using a computer was the identification of drug interactions in a patient.

The nursing staff, pharmacists, and physicians had to be much more cautious. The chief pharmacist is under the direct supervision of a physician, who also heads the hospital's P&T Committee (Pharmaceutical and Therapeutic). They have a 3,000 item formulary with an annual budget that exceeds US\$ 10 million. The average prescription drug inventory turns over about 18/20 times a year. Generic drugs are prescribed whenever possible, unless the attending physician specifically requests a brand name. One economic reason for using generic drugs is that most of their third party payers (Blue Cross and commercial insurers) will only reimburse the hospital at the generic cost level, even though a brand name was supplied.

The hospital also suffers from a nursing shortage although no greater than other hospitals in the state. Some contract nurses, though, are brought in from mainland United States, but this is kept to a minimum because of higher costs.

A superior presentation on malpractice and risk management was made by Dr. Cabarini. The policy of the hospital is to avoid long, costly malpractice cases in the judicial system. Ways to do this are through arbitration, mediation, and no-fault insurance, although legislation at the state or federal level is necessary in most cases. Because malpractice insurance premiums were running in excess of US\$ 4 million a year, the Board of Directors decided several years ago to self-insure. They set aside US\$ 1 million a year in reserve, have a policy with an insurance carrier that will pay the first US\$ 500,000 only of a malpractice claim and any amount beyond US\$ 20 million. They have found this to be much more economic, although there is the possibility that several medium costly cases over a short period could be such that the physician-owners would have to be levied a share to cover the deficit. Dr. Budihartano asked about references on the subject. Dr. Cabarini said he would furnish us with such a list. Note: See Item 3 b in the Documentation List at the end of this section.

Documentation:

1. Audio: Micro Tape 18 A and B (partial)
2. Video: VHS Tape 1, Tape Counter 4646 to 5070.
3. Other:
 - Five pages of vu-graph slides on Public Perceptions of Reasons for Increases in Lawsuits Against Doctors and Hospitals; Physician Responses to Increased Professional Liability Risk; Malpractice/negligence Formula; Quality Assurance Programs; and a "Pull the Tiger's" Teeth slide
 - Malpractice and Risk Management References
 - Health Scope, a Straub Foundation publication

W. Tripler Army Medical Center

Agency/Organization Visited:

Tripler Army Medical Center
Moanalua Ridge
Honolulu, HI 96859
Phone: 808-433-6661

Contact Person:

Lieutenant Colonel Michael I. Proctor
Chief, Plans, Training, Mobilization and Security Division
Phone: 808-433-6838 Extension 6723

Date and Time Visited:

Monday, October 23, 1989, 8:00 a.m. to 11:30 a.m.

Attendees:

The six Indonesian tour members, Dr. Robert T. Bonham, and Al Baker

Presenters and Other Medical Center Officials At the Briefing:

Colonel Richard Meiers, Medical Service Corps (M.S.), Deputy Commander and Chief of Staff for Administration
Lieutenant Colonel Michael I. Proctor, M.S., Chief, PTM&S Division
Colonel Dennis Wolchek, R.N., Director of Department of Nursing
Colonel Edith Walsh, R.N., Chief of Nursing Services
Lieutenant Colonel Gordon W. Cho, M.S., Chief, Patient Admin Division
Lieutenant Colonel Alan F. King, M.S., Chief, Resource Mgmt Division
Lieutenant Colonel Harvey H. Hunter, M.S., Chief, Logistics Division
Lieutenant Colonel Richard J. Ferrell, M.S., Chief, Pharmacy Division
Chief Warrant Officer Steven Rubino, M.S., Chief, Medical Maint. Branch
Irene Tanaka, R.N., Chief, Quality Assurance

Summary of Presentations:

Colonel Meiers, the senior officer on duty at the time of our visit, explained that Major General Jerry Seitter, III, M.D., Medical Corps (MC), the Commander of Tripler Medical Center, was back in mainland United States along with his other Deputy Commander and Chief of Staff for Clinical Services and other senior physicians, attending a high level clinical services conference. General Seitter was aware of our visit and regretted his inability to be present.

The Tripler Army Medical Center (TAMC) was established at its present location in 1948 as a full service acute care hospital and medical center to provide for the health care of active duty military personnel, their dependents, retired military persons and their dependents, and veterans eligible for Federal medical care for the Hawaiian Islands, Midway, Guam, and other bases in the South Pacific where the United States has military personnel. TAMC is currently operating 479 acute care inpatient hospital beds for surgical, medical, intensive care, obstetrics/gyn, pediatric/adolescent, and psychiatric patient services with another sixty beds in various stages of modernization and renovation. It has a current occupancy rate of 85 percent down from 90 percent in 1983 and 88 percent in 1988, even though admissions have been increasing. This is accounted for by the decrease in the average length of stay, currently 5.8 days, compared to 6.3 days in 1987, 6.7 days in 1986, and 7.4 days in 1984. Its

outpatient clinic visits have been increasing from an average of 2,095 visits per day in 1981 to a current 2,517 visits per day. It has a staff of 2,809 of which 331 are physicians, 393 registered nurses, and 297 paraprofessionals. TAMC also operates a graduate medical education program, serving as one of the teaching hospitals for the University of Hawaii Medical School. It currently is training 171 Interns/residents and another 21 in other graduate programs. It also offers courses for specialized nursing training in pediatrics and ob/gyn, both 16 week courses, given three times yearly. Its current operating budget for fiscal year 1989 is US\$ 145 million, 77 percent of which is for payroll costs.

They are in the process of installing an automated medical information system that will tie in clinical and administrative services to a central computer, using 2,000 individual computer terminals throughout the hospital. The hospital is currently highly automated, using computers for pharmacy operations, medical records, financial accounting, purchasing, personnel, and other administrative functions. Although they are not using the Diagnosis Related Group (DRG) coding system for military patients as is used for Medicare for civilian hospitals, they have the ability to use such codes, and in fact do so for Veteran Administration patients that they serve in Hawaii. The Department of Defense receives reimbursement credit through the U.S. Treasury for treating VA patients with payments based on DRG codes. US\$ 5 million in such credits were received last year. The modernization program will convert open bay wards to single rooms, double rooms, and four beds to a room style.

One presentation of particular interest concerned the method of determining manpower needs, with nursing requirements as an example. The presentation on materials management with respect to maintaining and calibrating major pieces of medical equipment was informative. They maintain 4,000 items of spare parts in their inventory, 60 percent of which are obtained through a U.S. Federal government procurement depot and 40 percent procured locally. Their pharmacy operation has a staff of 21 pharmacists and 27 pharmacy technicians. Its annual budget is US\$ 6.9 million with next year's expected to be US\$ 8 million. Its formulary consists of 1,600 line items, of which 33 percent are generics. Its Pharmaceutical and Therapeutic Committee (P&T) meets monthly to review requests for new drugs from physicians and to analyze drug reaction cases that are presented to the Committee. Presentations on their budgeting process and medical school/teaching/administrative relationships also proved helpful.

Although a walk-through of the wards, laboratories, pharmacy, and other facilities was made available to the group, we determined that our time could be spent more fruitfully by availing ourselves of the experts who were presenting their information, particularly since we had been through several hospitals earlier in the tour.

Documentation:

1. Audio: Micro Tape 19 A and B
2. Video: VHS 1, Tape Counter 5071 to 5300
3. Other:
 - Set of briefing charts (copies of slides) used in presentation
 - Department of the Army, Hq U.S. Army Health Services Command, Regulation on Organization and Functions Policy, dated March 31, 1990
 - TAMC Supplementing Regulation to Item 3 b above, dated June 30, 1989
 - TAMC Organizational Chart Book, dated October 2, 1989
 - TAMC Regulation on Boards, Commissions, and Committees, dated August 22, 1989

- **Set of Manual Admission and Discharge Procedures (used prior to its automated system)**
- **Patient Control Card**
- **Ward Nursing Report**
- **Patient Clearance Record**
- **Admission and Disposition Report**
- **Admission and Disposition Recapitulation**
- **TAMC Regulation on Quality Assurance Program**
- **Briefing charts on the TAMC Resource Management Division**
- **Patient identification bracelet and embossed patient card**
- **TAMC "Caducean", an internal newspaper, special historical edition, dated September 10, 1988**

X. Kapiolani Community College

Agency/Organization Visited:

Kapiolani Community College
University of Hawaii
4303 Diamond Head Road
Honolulu, HI 96816
Phone: 808-734-9111

Contact Person:

Robert T. Bonham, M.D.,
Omega Rose Foundation
Honolulu, HI 96813
Phone: 808-574-4771 or 525-2575 or 528-5211

Date and Time Visited:

Monday, October 23, 1989, 1:30 p.m. to 2:30 p.m.
From Noon to 1:30 p.m. officials of the Kapiolani Community College and the University of Hawaii hosted a luncheon for the group at the Hotel Halekalanani in Waikiki, Honolulu

Attendees:

The six Indonesian tour members, Dr. Robert T. Bonham, and Al Baker

Presenters:

Melyn K. Sakaguchi, Vice Chancellor for Student and Community Affairs, University of Hawaii
Leon Richards, Dean of Instruction, Kapiolani Community College
Sanae N. Molkeha, Chairperson, Allied Health Department, Kapiolani Community College
Lane Kelley, Ph.D., Director, College of Business Administration, University of Hawaii
Virginia R. Crockett, Associate Director, College of Business Administration, University of Hawaii

Summary of Presentations:

The purpose of the visit was to acquaint the Indonesian physicians with the short-term (up to two years) educational opportunities available in Hawaii at the Kapiolani Community College in the area of allied health professions, such as radiology technician and emergency medical technician. The community college is a branch of the University of Hawaii and offers associate degree and certificate programs. Programs available at the Pacific Asian Management Institute, operated by the College of Business Administration, University of Hawaii, were also explained.

Documentation:

1. Audio: None
2. Video: VHS Tape 1, Tape Counter 5290 to 5480
3. Other:
 - Folder containing descriptions of the Pacific Asian Management Institute and the College of Business Administration programs

Y. Office of the Governor of Hawaii

Agency/Organization Visited:

Office of the Governor
State of Hawaii
State Capitol Building
Honolulu, HI 96813

Contact Person:

William D. Souza, Information Officer
Department of Commerce and Consumer Affairs
State of Hawaii
Phone: 808-548-8848

Date and Time Visited:

Monday, October 23, 2:30 p.m. to 3:30 p.m.

Attendees:

The six Indonesian tour members, Dr. Robert T. Bonham, and Al Baker

Presenters:

Lieutenant Governor Benjamin Cayetano
William D. Souza, Information Officer

Summary of Presentations:

Mr. Cayetano, the Lieutenant Governor, welcomed the group on behalf of the Governor, John Waihee, who was in Washington, D.C. on state business. He was pleased that the group had chosen Hawaii as one of the stops on our tour of visits to health facilities in the United States. He said that in general the people of his state were healthy because of the temperate climate, availability of fine health care institutions and practitioners, and relatively few poor and unemployed persons. He said the cost of health care in the state was high because of labor costs, the need to transport medical equipment, supplies, and pharmaceuticals from the mainland, and inflation. He said many of the hospitals in the state were in need of renovation and modernization, but because of high capital costs, improvements were being made slowly. Hawaii, with a population of 1,100,000, has 18 hospitals, half of which are located in rural areas. The nine urban hospitals have 1,817 beds, including the Tripler Army Medical Center, and the rural hospitals, 717 beds. Mr. Souza, following the visit with the Lieutenant Governor, took the group on a walk-through of the Governor's office and outer lobby, explaining much of the history Hawaii and pointing out Hawaiian cultural objects displayed in showcases in the office area.

Documentation:

1. Audio: None
2. Video: VHS Tape 1, Tape Counter 5485 to 5665
3. Other: None

Z. Tour Cultural and Recreational Events

This section of the report is to document the cultural, recreational, and entertainment aspects of the tour that provided an opportunity for both the visiting Indonesian physicians and the ISTI staff and consultants to become better acquainted and to broaden their viewpoints and experience. It will be presented in chronological order.

- Tuesday evening, October 3, 1989: Dinner at the home of Janet and Al Baker, located in Vienna, Virginia, 1701 Besley Road. Present were the six visiting Indonesian physicians, Elizabeth Connell, the Deputy Project Director in Washington, D.C., and Lyell Rushton, Ms. Connell's friend.
- Wednesday, Noon to 1:30 p.m., October 4, 1989: Review meeting and luncheon at Gary's Restaurant, 18th and M Streets, NW, Washington, D.C. This was to acquaint the visitors with a typical downtown American restaurant that is used daily by U.S. healthcare trade association representatives and other private sector and government officials in healthcare as well as by many other business and government officials to conduct informal meetings over lunch or dinner. During this meeting/luncheon, representatives from the American Medical Association, American Hospital Association, Catholic Health Association, the Federation of American Hospitals, and the National Blue Cross/Blue Shield Association stopped by our table to say hello. Present were the six Indonesian physicians, Ms. Connell, and Mr. Baker.
- Thursday, Noon to 1:30 p.m., October 5, 1989: American Foreign Service Club and Restaurant, 21st and F Streets, NW, Washington, D.C. This was a meeting in a private room of the club to review previous briefings, to discuss the remaining week's schedule in Washington, and to tour the Club used by U.S. Foreign Service officers as a meeting, dining, and cultural club. Lunch for the group was served. Present were the six Indonesian physicians, Ms. Connell, and Mr. Baker. See VHS Tape 1, Tape Counter 1395 to 1495.
- Thursday evening, October 5, 1989: Indonesian Embassy, Washington, D.C. The visiting Indonesian physicians invited Ms. Connell and her friend, Mr. Rushton, and Mr. Baker and his wife, Janet, to attend an Indonesian Armed Forces Day reception at the Embassy, where we were introduced to the Ambassador, met other Embassy officials, were entertained by native Indonesian performers, and provided a fine assortment of Indonesian food.
- Friday, 12:30 p.m. to 2:00 p.m., October 6, 1989: A tour conducted by Mr. Baker, of the Inner Harbor in Baltimore, Maryland, following our visit to the Maryland State Department of Health. The Baltimore Inner Harbor is an outstanding recent example of how a city can make an attractive tourist, cultural, and recreational area from a formerly run-down, dilapidated, and seedy part of town that has now attracted a variety of shops, eating establishments, and cultural facilities, including a fine marine aquarium operated by the U.S. Government, in a marina setting with sail and power boats on the water, and large hotels and a convention center nearby. The visiting physicians were enthusiastic about this visit. Luncheon was provided in a typical American fast food establishment. Present were the six Indonesian officials and Mr. Baker. See VHS Tape 1, Tape Counter 1564 to 1780.
- Tuesday, 8:00 a.m., October 10, 1989: A short stop at the "Parthenon", in Nashville, TN. This replica of the original in Greece proved to be an interesting site. Present were the six Indonesian visitors and Mr. Baker. VHS Tape 1, Tape Counter 1965 to 1990.
- Tuesday, 1:30 p.m. to 4:00 p.m., October 17, 1989: A visit to and tour of the exhibits at the Universal Studios, Universal City, CA., following our visit to the Kaiser Permanente Regional Office. Universal Studios is one of the outstanding tourist attractions in California, where both movie and television programs are made in both indoor and sound studios that were made available for us to visit; to ride through (on trams provided by the studio); and to hear presentations of how such shows are produced. It proved an outstanding and enjoyable

afternoon for our visitors. Present were the six Indonesian physicians, two of their wives, one sister-in-law, Dr. and Mrs. Paul Zukin, and Mr. Baker. See VHS Tape 2, Tape Counter 0050 to 0920.

Saturday, October 21, 1989, 9:00 a.m. to 4:00 p.m.: A motor tour of the island of Oahu, an outdoor picnic at a recreational area in Honolulu, and a visit to the Dillingham Gilder Airport on the north end of Oahu. This program was arranged by Dr. Robert T. Bonham and conducted jointly with his friend, William D. Souza, an Information Officer with the Governor's Office, in Honolulu. This was another highlight of the visit to Hawaii where the Indonesian visitors were provided with an intimate view and history of Oahu that included stops at several famous landmarks of the island including Diamond Head and the "blow hole". The picnic food and refreshments provided by Dr. Bonham and Mr. Souza, were consumed in Moanalua Gardens, a pleasant grassy area with many types of trees, flowers, and birds native to Hawaii. The visit to the glider airport culminated with glider rides for any of the guests that so desired, and most took advantage of this opportunity. Present were the six Indonesian physicians, two of their wives, one sister-in-law, Ms. Connell and her friend, Mr. Rushton, and Mr. Baker. See VHS Tape 2, Tape Counter 1190 to 2567.

APPENDIX A
SELECTED EXPANDED BIOGRAPHIES

U

APPENDIX A

SELECTED EXPANDED BIOGRAPHIES

DR. BOEDIHARTONO, M.H.A.
Director, General and Teaching Hospitals
Indonesian Ministry of Health

Upon completion of his medical studies at the University of Indonesia in 1960, Dr. Boedihartono was assigned as regional physician of Tidore, Irian Jaya, until 1962, when he was reassigned to the province of Manokwari as Director of the District Hospital of Manokwari. In 1963, Dr. Boedihartono was promoted to Director of Health Services in Irian Jaya, until 1967. During this time, he complemented his education with additional courses in Holland and was further promoted as Secretary to the Director General for Medical Services for the period between 1969 and 1978. In 1978, he continued his studies by attending the University of the Philippines and acquiring his Masters degree in Hospital Administration. His experience as Administrative and Fiscal Director of Cipto Mangunkusomo Teaching Hospital, the largest hospital in Indonesia, between 1980 and 1987, led to promotion to his current position as Director of General and Teaching Hospitals for the Ministry of Health.

DR. SOEDIBJO SARDADI, M.P.H.
Director, Project Implementation Office for Hospitals
Indonesian Ministry of Health

After completing his medical studies in 1960, Dr. Soedibjo served as a medical doctor in the Indonesian Navy until 1981. He then became Dean of the Medical Faculty at Trisakti University until 1982, when he was appointed Director of Sardjiko Teaching Hospital in Jogjakarta. He managed this 500 bed facility and concurrently performed as lecturer for the Medical and Dental Faculty at Gajah Mada University until 1988. Since the inception of the Health Sector Financing Project in June 1988, Dr. Soedibjo has held his current position of Director of the Project Implementation Office for Hospitals in the Ministry of Health.

DR. I.G.A. GDE OKA, M.P.H.
Director, Sanglah Teaching Hospital
Denpasar, Bali

Dr. Oka graduated from Airlangga University in 1965 with his medical degree and worked as Director of District Health Services and Director of Karangasem Bali Hospital between 1967 and 1974. A two-year sojourn in Hawaii (1976-1977) enabled him to acquire his Master of Public Health degree. During the 10-year period 1977-1987 he concurrently functioned as Director of the Gianyar Hospital and Director of Provincial Health Services. Since 1987 he has presided as Director of the Sanglah Teaching Hospital in Denpasar, Bali.

DR. ADJI MUSLIHUDDIN, M.H.A.
Director, Fatmawati Hospital
Jakarta

Upon receiving his medical doctorate degree from the University of Indonesia in 1964, Dr. Adji continued his medical education with post graduate training in ear, nose, and throat ailments in 1969. Appointed as Director of Ear, Nose, and Throat Diseases at Sriwijaya University in Palembang between 1970 and 1981, Dr. Adji simultaneously functioned as Assistant Lecturer to Sriwijaya University. Between 1975 and 1982, Dr. Adji was assigned as Assistant Director of Palembang Hospital, interrupted only by a two-year sojourn between 1978 and 1979 when he acquired his Master's degree in Hospital

Administration at the University of London. In 1982, Dr. Adji moved to Jakarta in order to assume a position as Assistant Director at the Persahabatan Hospital where he worked until 1988, when he was promoted to Director of the Fatmawati Hospital in Jakarta.

DR. SOENARSO, M.P.H.
Director, Syaiful Anwar Teaching Hospital
Malong, East Java

Born and raised in East Timur, Dr. Soenarso received his medical degree from the University of Airlangga in Surabaya and began his career as Director of Municipal Medical Services in Madiun in 1963. Courses in "Health Aspects of Human Reproduction" (1970) in India and Thailand, and "Health Planning Services" in Taiwan and the Philippines (1971) supplemented his education during his tenure as Director of Madiun's Municipal Medical Services between 1963 - 1973. Between 1972 and 1978, Dr. Soenarso also assumed intermittent responsibility for the Midwifery/Nursing School at the Madiun Hospital, while attending Pittsburgh University in Pennsylvania, USA, to acquire a Masters degree in Public Health by 1974. Upon completion of additional training in health law in 1977, he was appointed as Director of Technical Assistance to the Regional Health Director between 1977-1980. Dr. Soenarso was promoted to Director of Program Development and evaluation of the regional health office between 1980 and 1988. In 1988 he was given full responsibility for the Syaiful Anwar Teaching Hospital in Malong, East Java.

DR. NAZAROEDIN BAKAR, M.P.H.
Director, Achmad Mughtar Hospital
West Sumatra

Born in West Sumatra, Dr. Nazaroedin completed his medical studies at the University of Andalas in West Sumatra in 1968. His professional career started as a provincial physician from 1968 to 1970, after which he served as Director of Provincial Medical Services as well as the Director of the Sawahlunto Provincial Hospital until 1977. Between 1977 and 1981, he functioned as Director of General Health Affairs and thereafter as Director of Health Services for West Sumatra until 1988. He received his Master of Public Health Degree at Mahidol University in 1984 and acquired his current position as Director of Achmad Mughtar Hospital in 1988.

ELIZABETH J. CONNELL, M.B.A.
I.S.T.I. Deputy Project Director, Washington, D.C.
Indonesian Health Financing Project

Elizabeth J. Connell, Senior Associate at I.S.T.I. and Deputy Project Director in Washington, D.C., for the Indonesian Health Financing Project, has over 20 years experience in health financing. Prior to joining I.S.T.I., she held a senior policy-making position as Principal Deputy Executive Secretary in the U.S. Department of Health and Human Services. Previously she was President of the Life Insurance Association of Massachusetts where she coordinated the development of a cost effective new hospital payment system for Massachusetts hospitals and also served on several Commissions of the Governor of Massachusetts related to health care financing and service delivery. Ms. Connell has extensive consulting experience in health financing, insurance, and hospital operations. She holds a Bachelor of Arts degree from Cornell University and a Master of Business Administration degree from Harvard University with concentrations in Finance and Marketing. She has a working knowledge of French.

15

ALBERT (AL) C. BAKER, M.P.A.
Hospital Study Group Tour Guide, Tutor, and Facilitator
Washington, D.C.

Mr. Baker has just retired after 14 years with the Federation of American Hospitals as Deputy Director for Government Relations. This national healthcare trade association represents the tax-paying, investor-owned hospitals and health systems in the United States which comprises more than 1,300 hospitals and over 150,000 beds. Previously he has spent three years with the federal government (1972-1975) in health policy positions, establishing price control parameters for hospitals at the Cost of Living Council and monitoring healthcare and hospitals costs in the Office of the Secretary of Health and Human Services where he also developed options for national health insurance programs. He has also had five years with a major research and management consulting firm, Stanford Research Institute, developing programs to improve health insurance claims processing procedures; administration of emergency medical services in hospitals; and computerized management information systems. Mr. Baker also completed 20 years of active military service as a U. S. Air Force officer. He has a Bachelor of Arts degree in Business Administration and a Master of Science degree in Public Administration from the George Washington University. He resides in Vienna, Virginia.

BA