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aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

March 22-23, 1978
Washington Hilton Hotel
Washington, D.C.

Wednesday, March 22

6:30 P.M.	COTH Administrative Board Meeting	Edison Room
7:30 P.M.	Cocktails	Farragut Room
8:30 P.M.	Dinner	Edison Room

Thursday, March 23

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Dupont Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Conservatory Room
3:00 P.M.	Executive Council Business Meeting	Map Room

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 466-5100

Council of Teaching Hospitals
Administrative Board

March 23, 1978
Washington Hilton Hotel
Dupont Room
9:00 a.m. - 1:00 p.m.

AGENDA

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III.	Membership	
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	C. Eligibility for Continuing COTH Membership	Dr. Bentley (Separate Attachment)
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XIX.	Discharge in Bankruptcy of Student Loans	Executive Council Agenda Page 109
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XXI.	New Business	
XXII.	Adjournment	

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Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
January 19, 1978

MINUTES

PRESENT:

David L. Everhart, Chairman
Robert M. Heyssel, M.D., Chairman-Elect
David D. Thompson, M.D., Immediate Past Chairman
John Reinertsen, Secretary
Jerome R. Dolezal
James M. Ensign
Lawrence A. Hill
Stuart Marylander
Stanley R. Nelson
Malcom Randall
Elliott C. Roberts
Robert E. Toomey
William T. Robinson, AHA Representative

ABSENT:

John W. Colloton
Mitchell T. Rabkin, M.D.

GUEST:

Martin Egelston
Robert G. Petersdorf, M.D.

STAFF:

James D. Bentley, Ph.D.
Armand Checker
John A. D. Cooper, M.D.
Gail Gross
James I. Hudson, M.D.
Joseph C. Isaacs
Richard M. Knapp, Ph.D.

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I. Call to Order:

Mr. Everhart called the meeting to order at 9:00 A.M. in the Bancroft Room of the Washington Hilton Hotel. He then welcomed new members and introduced the staff. He also welcomed Martin Egelston, Manager, the Division of Medical Services at the AHA.

For the benefit of the new members, Mr. Everhart then briefly summarized the format for the COTH Board meetings, including meeting times and schedules. He explained that there were four administrative boards of the AAMC including COTH and that all the Board meetings were held simultaneously followed by a Joint Luncheon of the boards and then a meeting of the Executive Council which is the governing board of the AAMC. He pointed out that COTH has four representatives on the Executive Council; 9 representatives are from the Council of Deans; 4 representatives are from the Council of Academic Societies; and 2 representatives are from the Organization of Student Representatives. Mr. Everhart told the Board members that their commitment was to stay through the Administrative Board meeting of COTH, however, he encouraged them to stay through the joint luncheon. He also named some of the AAMC's key personnel not normally seen at the meetings--Trevor Thomas, Charles Fentress, and John Sherman--and briefly described their functions within the Association.

II. Consideration of Minutes:

The minutes of the November 7, 1977 COTH Administrative Board meeting were unanimously approved.

III. Cost Containment Program of the National Steering Committee on Voluntary Cost Containment

Mr. Everhart asked that Dr. Knapp comment on and summarize the events of the meeting of the AHA Advisory Panel on Voluntary Cost Containment. Following a brief summary, Dr. Knapp reported that he had told the Advisory Panel that he would see that the issue was put on the agendas of both the COTH Board and the AAMC Executive Council for purposes of debate and staff recommendation. He suggested the Administrative Board make some recommendations (the four appearing on Executive Council Agenda pages 63 & 64) which would then be incorporated into a letter from Dr. Cooper to Alex McMahon, who would convey the AAMC position to representatives of the three organizations sponsoring the voluntary program (AHA, AMA, and the FAH). These observations would then be passed along to the state level committees as they screened the extent to which hospitals were or were not meeting program goals. Dr. Knapp felt that another observation should be included regarding the screening process as described on page 67 of the Executive Council Agenda--that the growth in the emergency or outpatient setting should not be taken into account when the percentage increases in the total revenue and expenditures of the institution are calculated. Dr. Knapp summarized that for purposes of debate he would like to see the Administrative Board contribute to the momentum of the voluntary program by endorsing it and presenting the aforementioned concerns in the form of a letter that would ultimately reach the state level committees.

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Mr. Everhart then invited general discussion. Mr. Randall felt that Dr. Knapp's point about inpatient vs. outpatient revenues and expenditures was well taken. Mr. Marylander thought that the overall subject could be philosophically discussed but no more than that. He expressed skepticism regarding national organization efforts. Mr. Hill thought that it could be potentially harmful to teaching hospitals if Congressmen became aware that AAMC supported this program, but made it appear that they wanted more than special consideration. He felt that teaching hospitals should not look self-serving and take a stand to forthrightly support the voluntary cost control proposal of the National Steering Committee. In other words, suggested Mr. Everhart, teaching hospitals should grant an unconditional approval. Dr. Thompson felt that the Board had to say that they were supporting the program, but should also express the concerns. There seemed to be general agreement for strong support of the program, pointing out those issues with which there was particular concern. Mr. Everhart expressed personal reservations about the potential effectiveness of the program and Congressional reaction to it but believed it was a step in the right direction and significant, for it represented the genuine efforts of three disparate organizations working together.

At this point a question was raised by Dr. Heyssel as to how it was planned for this program to be implemented at the lcoal level? Dr. Knapp responded that it was his understanding that it had been proposed that if a board of trustees at a given institution signed a commitment to a first screen, that would be sufficient. Each institution would then be asked to submit small bits of information and the committee at the state level would review the numbers provided and compare them against the established screens. It was not clear how hospitals that fell outside the screen would be affected. This is the part that bothered the state hospital associations the most because there are some obvious public relations problems. As an example, Dr. Knapp noted that there are over 500 hospitals in the State of Texas and if 10% of them fell outside the screen it would mean that each of their budgets would have to be reviewed which would not be an easy task. Mr. Marylander expressed that it was his understanding that a list would be published which would announce the hospitals that did not comply with the screens. Thus, coercion would take the form of publicity.

Mr. Everhart did not understand how the state committees would be created and their members appointed. Dr. Bentley pointed out that the first action of the 15 point program adopted by the National Steering Committee states that the state committees would be established through the leadership of the state hospital association, the state medical society and investor-owned representatives. Dr. Bentley explained that a Justice Department sign-off for the program is being requested, but even if the Justice Department exempts a program in an anti-trust sense, any provider or other party may still bring suit on its own that the program is anti-competitive.

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Mr. Everhart suggested that this agenda item be tabled until Mr. Robinson arrived since he could provide specifics about the program and respond to questions. Shortly thereafter, Mr. Robinson arrived and was requested to discuss the progress of the program and respond to some of the questions that had been raised. Mr. Robinson reported that progress on the cost containment program couldn't go much further at this point until some sort of anti-trust clearance was obtained because of the anti-trust implications that exist at all levels. Each of the three organizations have selected counsel to assist with this matter. These legal representatives have tried to obtain a "business letter" from the Justice Department which in essence recognizes that even though anti-trust implications exist, the program is being conducted satisfactorily. Even if such a clearance should be obtained, Mr. Robinson explained that other organizations could still bring suit.

He reported that the Steering Committee has generally agreed upon the 15-point program and that efforts are being made at the state level to create committees that will carry out the program. There is some confusion and reluctance at the state level concerning this process. Significantly, however, no state hospital association has refused -- either undertaking the effort or seriously considering doing so. Other national organizations representing hospitals have given a generalized assent. Mr. Robinson described the AHA Advisory Panel on Voluntary Cost Containment which had had substantial input to the 15-point document of the Steering Committee. He emphasized that states could not be expected to act as the national associations have and therefore the program must be tailored to acommodate such variables.

Summarily, Mr. Robinson explained, the whole focus of the program is to restrain costs in total health care, beginning initially with the emphasis on hospitals. There are risks involved with this program for the industry and the three sponsoring associations, such as the potential loss of viability and embarrassment, as well as a possible acceleration in the legislative process and diminished congressional consideration in the future. The obvious reward would be successful demonstration that this activity can be conducted at the state level on a voluntary basis. He hoped the COTH Board would pass a resolution giving its whole-hearted support to the program.

Mr. Robinson indicated that there seemed to be an increased concentration by hospitals on cost containment over the past several months and momentum has built. Based on general national guidelines each state would assess its own needs. He emphasized that the program seeks to reduce the nationwide average rate of increase by at least two percent below the previous fiscal year. Dr. Heyssel asked what would happen to hospitals that declined to participate in the program? Mr. Robinson suggested that they might possibly publicize the non-participants or only the participants in a manner that would make those not involved conspicuous. He pointed out, however, that the AHA's anti-trust lawyers have concerns about both so they have yet to address the topic of penalties. Dr. Heyssel noted that traditionally where voluntary programs have failed, the states have established state rate review commissions, as with

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public utilities. He questioned whether the cost containment effort was leading to this and whether support should be given for federal legislation which would mandate state rate review programs. Mr. Robinson reported that the AHA has drafted three legislative models for state budget review, but is uncertain as to which one should be introduced and when. He stated that the "mandatory-voluntary" program was the most popular model. Mr. Marylander pointed out that California hospitals are in a very reactionary position on the issue of state budget review. Mr. Roberts questioned the enthusiasm for the voluntary program, yet stated the realization that no one wants to be mandated. Therefore, he believes the voluntary program should be supported, but recognizes that cost containment will have to come about one way or the other. Mr. Randall asked whether a mandated program would be much more punitive in the event that the voluntary program fails. Mr. Robinson stated that the New York hospital association people have warned of this possibility, yet support from the states has been very promising. He did not believe that Congress would jump on the hospital industry if the program has some success and showed potential.

When asked about the time frame for the state rate review legislation, Mr. Robinson stated that it was expected that the AHA House of Delegates would approve the guidelines in late January which would then be translated into legislation. The question then would be when to introduce it into Congress. Some board members again expressed concern that if the voluntary effect failed legislatively, there would be punitive consequences. Mr. Robinson felt that this would not be the case as they were responding to a direct challenge from Rep. Rostenkowski.

Mr. Everhart wondered if Mr. Robinson could make any suggestions with regard to strategy for the Administrative Board in terms of action on the voluntary program, either for full strong support unconditionally or support with expressed concerns (as previously discussed) and with regard to whom it should be sent. Mr. Robinson felt that it would be perfectly acceptable to send a letter voicing any concerns, and that it should be sent to Alex McMahon for consideration at the national level and the state level.

Dr. Thompson concluded that the 15-point program should be strongly supported by the Administrative Board and that the concerns as discussed should be transmitted to the AHA in a letter from Dr. Cooper to Alex McMahon and he so moved.

Dr. Knapp reported that the Congressional staffs were skeptical about the voluntary program and were taking a wait-and-see attitude and would be looking closely at Consumer Price Index changes. He pointed out that Jay Constantine, chief staffer on the Senate Finance Health Subcommittee, has never liked the state rate-setting concept and feels it would make the federal government a check-writing machine and the states would become the spenders. Dr. Heyssel believed that a major effort should now be made in support of legislation for state rate-setting. Mr. Robinson said that Dr. Heyssel's views were similar to those of Dave Hitt's and believed that since one-third of the states now have rate-setting programs under way they would make for a strong faction.

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Mr. Roberts reminded the Board that its support of the voluntary program will not be what makes it work, but rather the concerted effort of all individual hospitals. Mr. Toomey stressed that the program will not be dealing with the over 7,000 individual hospitals because hospitals are organized differently nowadays with voluntary hospital chains. He stated that he would support amending the proposed resolution to place particular emphasis on the particular needs of networks of academic health center/teaching hospitals and their affiliates.

With regard to the question of state vs. federal rate review the Administrative Board seemed to be divided. Mr. Everhart suggested that this issue be put on the agenda for the next meeting in March. In the meantime the staff could concentrate on developing materials on this for the Board members to be guided by and perhaps an amendment could be made to the current motion and the Board could decide on a firm position at the next meeting. Mr. Marylander asked whether March would be late to arrive at a position. Mr. Robinson felt that there would be enough time since it wasn't certain how soon the House of Delegates would act and since Alex McMahon was still supporting debate on the program and legislative specifics.

It was decided that a letter should be sent from John Cooper to Alex McMahon expressing AAMC approval of the program and also the concerns previously discussed. It was also felt that a letter should be sent to the COTH membership, requesting their input and making them aware of the Association's position prior to their negotiation with the State Committees. Dr. Heyssel felt that this was such an important issue that it should be a major agenda item for a Spring meeting of the Council.

Mr. Robinson added the final point that it was the overall objective of the voluntary program to make the spread of percentage points in the rate of increase in hospital expenditures to compare to the rate of increase in the Gross National Product. Several board members felt this was an unreasonable measurement and objective.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve the recommendations appearing on pages 62-64 of the Executive Council Agenda and that once approved the AAMC's positions and concerns be conveyed to all AAMC constitutents and by letter from Dr. Cooper to Alex McMahon, President of the AHA, who would be asked to forward the letter to other organizational sponsors of the voluntary program, as well as to the state-level voluntary cost containment committees.

IV. Eligibility for Continuing COTH Membership: Preliminary Report

As required by COTH Board and AAMC Executive Council action in 1975, Mr. Everhart explained that the staff had conducted a survey of continuing membership eligibility; the preliminary findings as presented in the agenda identifies those teaching hospitals that do not meet current COTH membership criteria. Mr. Everhart suggested that this

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preliminary report be treated as an information item and that any action be deferred until the March Administrative Board meeting when a final report will be available.

Dr. Knapp reported that the VA Hospital in Fayetteville, N.C. had applied for corresponding membership in COTH. Since it met all the established criteria, he proposed that that institution be accepted.

ACTION: It was moved, seconded, and carried to recommend approval of the VA Hospital-Fayetteville for corresponding membership.

V. COTH Distinguished Service Members

ACTION: It was moved, seconded, and carried to recommend that the names of Gerhard Hartman, Ph.D. and Sidney Lewine be sent forward to the Executive Council as COTH nominations for AAMC Distinguished Service Membership.

VI. Discussion of Possible Spring COTH Membership Meeting

Mr. Everhart provided an overview of the history of past COTH Spring Regional meetings, indicating that those meetings had been held for a period of eight years. In 1975 the Administrative Board decided to eliminate the regional meetings on the basis of insufficient interest of the membership. Mr. Everhart felt that now would be a good time to consider an annual spring meeting of the entire membership and opened this matter for discussion. He explained that he visualized this as a national meeting which would be aimed only at the Chief Executive Officer at COTH member hospitals rather than to a larger audience. He felt that there are a substantial number of issues that would warrant coverage at this kind of meeting. He thought the agenda could be meaningful and topical given the current issues relating to teaching hospitals. The obvious question, should it be decided to have such a meeting, would be when and where it should be held and what format it should take. General discussion followed.

Mr. Marylander stated that he would be in favor of the meeting if it had a meaningful agenda, addressed important issues, and was held in a central location. Mr. Ensign believed the meeting should be attended only by the CEO and possibly one other person or the CEO's appointed representative. Several members felt that this would be a good opportunity for CEOs to get together and share concerns. There was general agreement that a spring meeting should be held. Dr. Thompson was in favor of the meeting and recommended that it be held in a less formal locale, rather than a central business environment, in order to foster personal interaction among the attendees. Mr. Toomey felt the agenda was the most important issue, regardless of where the meeting is held. Dr. Heyssel moved that a spring meeting be planned and carried out this year and then judge the future of such meetings as an annual event on the success of this one.

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Dr. Knapp cautioned that there would be a lot of work involved, a short time period in which to accomplish this effort, and that much enthusiasm would be needed from the Board to make the meeting successful. Board members generally voiced their enthusiasm for the meeting. Mr. Everhart suggested that a committee be appointed to determine the location, time, program, etc., prior to the March meeting. There was agreement that May would be a good month to hold the meeting.

ACTION: It was moved, seconded, and carried that COTH would hold a Spring meeting this May, the specific arrangements for which would be determined by a committee appointed by the COTH Chairman.

VII. Student Representation on the LCME

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to accept the invitation of the LCME to appoint a student as a non-voting observer participant in accordance with the conditions set out on page 29 of the Executive Council Agenda.

VIII. OSR Resolution on Graduate Medical Education Directory

Dr. Cooper informed the Board that this resolution had been tabled by the COD at the request of the OSR which had reconsidered this issue.

ACTION: It was moved, seconded, and carried that this issue be tabled at the present time.

IX. Committee on Future Staffing

Dr. Heyssel informed the Board briefly of the background for this agenda item. He explained that CCME is the parent organization for the LCGME, LCME, and LCCME. The problem relates to the LCGME which was put together as the accrediting body for residency training programs to approve and oversee the actions of the residency review committees which have the initial responsibility to set the standards for graduate medical education in their respective specialties. The LCGME has been marginally successful. The major problem is the AMA financial support and staffing of the LCGME, making it difficult to separate costs and identify staffing responsibilities. It is felt that there should be a move for independent staffing for the LCGME (independent of the AMA). Dr. Cooper made a change in the recommendation on page 32 of the Executive Council Agenda to read "...for the LCGME only under Option #4..."

With regard to one aspect of financial requirements, Dr. Cooper indicated that the LCME had lengthened the accreditation period from seven to ten years when the medical schools appeared to be in good shape, and there isn't any reason why first rate residency programs need to be reviewed every three years. Dr. Heyssel agreed that the process of accreditation has to be revised. There would appear to be two possibilities: either totally revolutionize the process or try to do it incrementally with the first step being to gain an independent staff for the LCGME and then proceed with other issues.

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Dr. Thompson felt that a staffing problem existed for all of the component bodies of the CCME, with the exception of the LCME, and that the LCGME would be a good place to start and press for the change in staffing.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to recommend independent staffing for the LCGME under Option #4 of the report of the Committee on Future Staff (as it appeared on page 32 of the Executive Council Agenda).

X. American College of Surgeons' Letter

Dr. Heyssel summarized the background of this issue. The thrust of the ACS Letter is to remove the power of the LCGME in overseeing the Residency Review Committees. He understood that the thrust of Dr. Cooper's letter was in support of bringing the matter up through the CMSS. Dr. Cooper elaborated on this point.

ACTION: It was moved, seconded and carried that the Executive Council be recommended to ask the Association to respond to the American College of Surgeons recommending that the December 5, 1977 letter be presented by the CMSS representative to the LCGME for its consideration and response (as presented on page 73 of the Executive Council Agenda).

XI. Report of the Committee on Physician Distribution

Dr. Thompson provided the background information for this item. The CCME formed a committee on specialty and geographic distribution which has been long developing a report. After many drafts a final version was submitted to the CCME on December 12. Dr. Thompson felt that the document was weak, with inadequate data and interpretation of that data. However, he believed further delay would not improve the report, and that it was time to put this report behind us. Limited discussion ensued followed by a motion to approve the proposed recommendation.

ACTION: It was moved, seconded and carried that the Executive Council be recommended to approve the Report of the Committee on Physician Distribution, "The Specialty and Geographic Distribution of Physicians" (as recommended on page 35 of the Executive Council Agenda).

XII. Ethical Practices Governing Privately Sponsored Research in Academic Settings

Mr. Everhart explained that this item dealt with a letter sent to Dr. Cooper by Congressman Rogers raising four questions about the role of sponsored and directed research in public or publicly-funded university medical centers, where the outcome of that research may be deleterious to the public health. Dr. Knapp indicated that a memorandum had been sent to each dean asking if they had data or policies on this subject

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and encouraging them to raise Congressman Rogers' 4 questions in the appropriate setting at their own institutions and then relay the results to the AAMC. A draft position paper on this issue should be available by the March meeting.

Dr. Heyssel felt the Administrative Board should come out very strongly on this as a moral issue and moved to support the proposed recommendation.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to ask the AAMC staff to draft a position on the issues raised by Mr. Rogers' letter, taking into consideration the discussions at this meeting and the replies received from the medical school deans, and to present the draft position paper to the Administrative Board and to the Executive Council at their March meetings (as set forth on page 57 of the Executive Council Agenda).

XIII. Recommendations of the AMA Commission on the Cost of Medical Care

Mr. Everhart reviewed the item and proposed that the Board not take any action on this document. There was general agreement that the board was comfortable with not taking a position at this point.

XIV. Report of the AAMC Officer's Retreat

Mr. Everhart explained that the Retreat is attended by the Chairmen and Chairmen-Elect of the AAMC Councils and the Executive Staff of the AAMC. He suggested that the board read the report since it expressed the priorities of the Association and might enable the board to be more responsive to the issues.

He indicated that a fair amount of time at the Retreat was spent on ethical issues in medicine - pages 6 & 7 of Report. There were also discussions about the roles of the Association, teaching institutions and medical schools in educating the public about health -- should the roles be expanded? Mr. Ensign wondered if it would be appropriate for the AAMC to recognize outstanding efforts in this area by outside organizations. Mr. Everhart said that the Association's emphasis was on determining where those programs are and on the promotion of those efforts by its constituent members. Mr. Ensign thought that it might be possible to formally commend NBC for its TV special on health care, but Dr. Knapp indicated that there might be some unwillingness on the part of the AAMC to do so because of the varying ways certain medical school programs were portrayed. Mr. Hill suggested that perhaps some sort of inventory could be done on what is being done to educate the public about health care and noted that much public health information is disregarded by the public anyway. Mr. Toomey agreed with Mr. Hill and believed that the medical school should not have to teach the public about health except in those areas where public health is an important part of the medical school. He pointed out that there are other organizations for doing this. Mr. Everhart suggested that medical centers and educators in this country need to be more involved in the

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education of the public than they have been and that staff should be alerted that this is an issue that will require attention. The board agreed that it should be expressed to the Executive Council as being important, but not necessarily a responsibility of the AAMC particularly. Mr. Toomey believed Schools of Public Health have this responsibility and that medical schools should not be saddled with it. He expressed that if consumer education is to be advocated by the Association, it should be from an institutional setting -- a COTH, not AAMC-wide, responsibility. Mr. Marylander thought this responsibility was more appropriately a function of the AHA. Dr. Heyssel moved that the staff should spend time on more important issues at this time.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to advise staff to spend time on issues other than public health education at this time, although educating the public about health is recognized as an important objective.

INFORMATION ITEMS

XV. Executive Salary and JCAH Surveys

Dr. Knapp reported to the board on the progress to date on these surveys and said that final results should be available for the March Board meeting.

XVI. Reversal of Cardwell Decision at Duke University Hospital

Dr. Knapp thought that it was significant that HCFA Administrator Bob Derzon, in his letter reversing the advisory opinion provided Duke in March, did not address the central issue directly. Dr. Knapp said according to his discussions with Mr. Derzon this was done purposefully because there were several issues in which HCFA did not want to get entangled.

XVII. Classification of COTH Members by Non-routine Service Points

Dr. Bentley presented an explanation and description of this item to the Board. Some members of the board felt that this listing should get some visibility. Mr. Marylander felt that it needed to be refined somewhat, but was good. Dr. Heyssel thought a letter should be sent to those included in the listing, requesting their reaction to the rating. Mr. Everhart suggested possibly sending the listing to all COTH members and inviting their response. Dr. Thompson advised that it might be wiser if the Board did not try to push this too hard as "the" method for peer-grouping. It was generally agreed by the board that the staff would refine the listing, distribute it and request response to it.

XVIII. AAMC Comments on the Report of the AHA Special Committee on the Regulatory Process

Mr. Everhart stated that he thought the board was well-informed about and familiar with this report and said that he felt it was well done. No action was deemed necessary -- this was merely an informational item.

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XIX. Additional Information Items

COTH Nominating Committee--Mr. Everhart explained that the composition of the Nominating Committee of COTH is made up of the Immediate Past Chairman as Chairman, the Chairman and one other representative at large. Dan Capps had agreed to serve as the at large representative.

Other Committee Nominations--Irv Wilmot has been appointed to the Flexner Award Committee and Dr. Spencer Foreman appointed to the Task Force on Graduate Medical Education (replacing Dr. Heyssel who resigned from the Task Force).

MAP Program--Mr. Everhart informed the board that COTH is sponsoring a third Management Advancement Seminar to be held June 9-14, 1978 in Florida. The invitations to that session have been sent and Mr. Everhart urged anyone who has not participated to do so.

Cost Containment Attitudes of Other AAMC Councils--Dr. Bentley reported on the meetings of the CAS and COD Boards where he had reported on cost containment. He said that the CAS supported all of the recommendations. They weren't enthusiastic about a voluntary program, but don't have any alternative to suggest. The COD would not take a position and are waiting for the COTH Board to provide some guidance to them on how to vote on the recommendations. COD feels that the voluntary program accepts two concepts with which they don't agree. The first being that the gap between GNP and any hospital cost index needs to be closed. Secondly they object to reducing capital expenditures on a formula approach.

NEW BUSINESS

Martin Egelston reported that the AHA Committee on Medical Education had addressed some issues which may be of interest:

1. Reacted to the Essentials of Graduate Medical Education
2. Women in Medicine
3. Foreign Medical Graduates
4. Request for Critical Care as a new specialty
5. Second Opinion Surgery
6. Guidelines for affiliation of community hospitals and medical schools.

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Mr. Toomey announced that he has accepted a new position as AHA Coordinator for Development of Multi-Hospital Systems and is now setting up staffs both in Chicago and Greensboro. He will be working on developing cooperative arrangements between hospitals throughout the country. Mr. Everhart commended the AHA for the creation of this service and for its selection of Mr. Toomey to direct the effort.

XX. Adjournment

The meeting was adjourned at 12:45 P.M.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

(a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

(b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

SINAI HOSPITAL OF DETROIT
HOSPITAL NAME

6767 W. Outer Drive — Detroit
STREET — CITY

Michigan — 48235 — 493-5010
STATE — ZIP CODE — TELEPHONE NUMBER

Chief Executive Officer: Julien Priver, M.D.
NAME

Executive Vice President
TITLE

Date hospital was established: January 15, 1953

APPROVED FIRST POST-GRADUATE YEAR

TYPE[2]	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Flexible	(rotating) 6/19/54*	0	0	0
Categorical		24	15	6
Categorical*		6	2	1

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.

2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program directpr; Categorical*-graduate program under supervision of single program director but content is flexible.)

***At the time of initial approval by CME of AMA we had 11 rotating internships.**

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APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E.[1]* Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Medicine	2/28/55	45	31	14
Surgery	6/6/55	16	5	8
Ob-Gyn	7/26/54	13	11	2
Anesthesia	4/19/56	9	8	1
Psychiatry	4/25/62	18	7	8
Ophthalmol.	6/8/60	6	5	0
Pathology	3/22/55	2	0	1
Radiol. DX	6/17/55	6	0	6
Radiation Thr.	6/17/55	2	0	1

***Includes PG/1 positions**

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specifici reference to the following questions.

A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).

D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristids and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: **Wayne State University - School of Medicine**

540 East Canfield Avenue, Detroit, MI 48201

Name of Dean: **Robert D. Coye, M.D.**

Information Submitted by:

Mrs. Norma G. Silver
NAME

Associate Administrator
TITLE OF PERSON SUBMITTING DATA

2/10/78.
DATE

Sydney C Peimer
SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

Sydney C. Peimer
Senior Vice President/Medical Affairs

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WAYNE STATE UNIVERSITY

SCHOOL OF MEDICINE

GORDON H. SCOTT HALL
OF BASIC MEDICAL SCIENCES
540 EAST CANFIELD AVENUE
DETROIT, MICHIGAN 48201

OFFICE OF THE DEAN

February 3, 1978

Mr. David L. Everhart
President
Council of Teaching Hospitals
American Association of Medical Colleges
Northwestern Memorial Hospital
Chicago, Illinois 60611

Dear Mr. Everhart:

This is in support of the application of Sinai Hospital of Detroit for membership in the Council of Teaching Hospitals of the AAMC.

Sinai Hospital is a major affiliate of this medical school with undergraduates in three of the four years of our program having educational experiences at Sinai. These include physical diagnosis, required third year clerkships in gynecology/obstetrics and psychiatry and numerous electives in the fourth year. A number of Sinai Hospital based physicians are members of our full-time affiliate faculty with all rights and responsibilities of the full-time faculty with many additional Sinai faculty members of our voluntary faculty.

In addition we have enjoyed a very effective relationship with respect to developing further and closer linkages with the Medical School. We have regular meetings of the hospital and medical school administration and review both present joint programs and possibilities for future ventures. Out of one such review an appointment was recently made which designated the Sinai Chief of Anesthesiology as Chairman of the Department at the School of Medicine.

There is no question in my mind that Sinai Hospital of Detroit is completely dedicated to the educational and research goals of the Medical School and fully merits favorable consideration for membership in COTH.

Sincerely,

Robert D. Coye

Robert D. Coye, M.D.
Dean

RDC:lel

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COUNCIL OF TEACHING HOSPITALS - APPLICATION FOR MEMBERSHIP

ATTACHMENT A.

Wayne State University's second, third, and fourth-year students rotate at Sinai Hospital of Detroit as follows:

2nd year - 32 (physical diagnosis)

3rd year - 48 OB/Gyn

76 Psychiatry

4th year (includes electives)

120 Medicine

26 Gynecology

12 Psychiatry

3 Radiology

In addition, Sinai offers a Summer Fellowship in all programs to first and second-year students. Approximately 60 students will receive a combined 330 weeks of training.

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COUNCIL OF TEACHING HOSPITALS - APPLICATION FOR MEMBERSHIP

ATTACHMENT B - DEPARTMENT CHAIRMEN/WAYNE STATE UNIVERSITY APPOINTMENTS

Arnold R. Axelrod, M.D., Professor
Chairman Department of Medicine - Sinai

Hugh Beckman, M.D., Clinical Associate Professor
Chairman Department of Ophthalmology - Sinai

Eli Brown, M.D., Professor and Chairman, Department of Anesthesiology
Chairman Department of Anesthesiology - Sinai

Milton H. Goldrath, M.D., Assistant Professor
Chairman, Department of Obstetrics/Gynecology - Sinai

Sidney D. Kobernick, M.D., Ph.D., Clinical Associate Professor
Chairman, Department of Pathology - Sinai

Harold Perry, M.D., Clinical Associate Professor
Section Chief, Department of Radiation Therapy - Sinai

Norman Rosenzweig, M.D., Professor
Chairman, Department of Psychiatry - Sinai

Saul Sakwa, M.D., Clinical Assistant Professor
Chairman, Department of Surgery - Sinai

Maurice Tatelman, M.D., Professor
Chairman, Department of Radiology - Sinai

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COUNCIL OF TEACHING HOSPITALS - APPLICATION FOR MEMBERSHIP

ATTACHMENT C - DIMENSION OF HOSPITAL'S FINANCIAL SUPPORT OF MEDICAL EDUCATION COSTS*

1. Dollars devoted to House Staff salaries and fringe benefits - $2,393,363.00.

2. Percentage of hospital budget - 6.7%

3. Hospital's contribution to cost of supervising faculty - $838,359.00

*Based on approved 1977/1978 budget

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COUNCIL OF TEACHING HOSPITALS - APPLICATION FOR MEMBERSHIP

ATTACHMENT D - FACULTY APPOINTMENTS OF SINAI MEDICAL STAFF

Professors	33
Associate Professors	15
Clinical Professors	15
Clinical Associate Professors	37
Assistant Professors	16
Clinical Assistant Professors	95
Adjunct Professor	1
Adjunct Assistant Professors	2
Instructor	6
Clinical Instructors	82
Adjunct Instructor	1
	303

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AFFILIATION AGREEMENT

WHEREAS, the Board of Trustees of Sinai Hospital of Detroit is a duly established hospital in accordance with the laws of the State of Michigan, hereinafter referred to as "Hospital; and

WHEREAS, the Board of Governors of Wayne State University is a public body corporate, organized pursuant to Article VIII, Section 5, of the Constitution of the State of Michigan, hereinafter referred to as "University"; and

WHEREAS, the University and the Hospital are dedicated to furthering the goals of health care education, research, and service to patients; and

WHEREAS, it is desirable that various colleges, units or division cooperate in their endeavors toward these mutual objectives;

NOW THEREFORE, the parties agree as follows:

1. That a standing committee be established which shall have as its function the continued over-all study of the various relationships, and coordinate joint programs between the Hospital and the University.

2. That said Committee shall consist of three members on a policy-making level from each institution, appointed by the President and the Director of the Hospital. If, in the judgment of either party, it is deemed necessary in order to assure adequate representation of its concerns on the committee, it may appoint additional members. However, it is understood between the parties that each shall have an equal voice in committee actions.

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3. The committe shall make recommendations to the Board of Trustees of the Hospital and to the President of the University regarding joint staff and faculty appointments, and appropriate rank, but such recommendations are to be within the framework of the bylaws of the Hospital and the policies of the University. A report of all committee activities shall be presented periodically, and at least once a year, to the governing boards of the respective institutions.

No action shall be taken which would deprive the Hospital of its rights as a corporation, commit it to action contrary to its charter or bylaws; impose an unreasonable demand upon said hospital due to University rules concerning tenure and retirement, or which would jeopardize the rights and privileges of those members of the Hospital staff who do not take part in teaching and research and who are not concerned with this agreement.

4. That when salaries are the joint obligation of the two institutions, the amount of recompense shall be determined by concerted action of the two institutions and that neither will alter its agreed-upon share without the knowledge and written consent of the other; and that changes in salary will be implemented only upon agreement between the two institutions.

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5. That this agreement shall not limit the right of the Hospital to recompense any person rendering service to the Hospital, provided, however, that the Hospital shall not pay additional compensation to a University full-time appointee without the knowledge and consent of the University, and that the University shall not pay additional remuneration to a full-time appointee of the Hospital without the knowledge and consent of the Hospital.

6. That all faculty appointees of professorial rank, regardless of source of income, (Hospital, University, or combined), will be accorded professorial standing and will be eligible for appointment to administrative and other committees of the College.

7. That, wherever possible, in the pursuit of their mutual objectives of teaching, research and service, the University and the Hospital will accord, each to the other, access to and every reasonable use of their respective physical facilities; and that this shall be done without allocation of costs or fees for the use of these facilities, including administrative costs; provided that amounts and costs may be apportioned by the respective institutions to specific joint projects or departments; research projects supported by outside sources carrying provision

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for institutional overhead expense; and to projects in which separate and individual agreements are made between the University and the Hospital, according to the terms of those agreements.

This agreement is subject to revision from time to time, as agreed upon by the two institutions, and may be extended by mutual agreement to include specific departments of the University and the Hospital. Either party may terminate this agreement by giving the other party written notice of its desire to terminate at a date not less than six months after the date of such notice. Unless this agreement is terminated in the manner set forth above, this agreement shall be deemed to be renewed from year to year.

IN WITNESS WHEREOF the parties hereto have on the day and year first above written set their hands and seals.

BOARD OF TRUSTEES
SINAI HOSPITAL OF DETROIT

By _____

Witnessed By:

_____

BOARD OF GOVERNORS
WAYNE STATE UNIVERSITY

By _____

Witnessed By:

_____

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COTH Members Who Have Not Paid Their Annual Dues

For the Year 1976-77:

1. Los Angeles County - USC (Paid for FY 77-78)
2. Harlem Hospital, New York
3. Mayaguez Medical Center, Puerto Rico (Also owe for FY 75-76)

For the Year 1977-78:

1. Veterans Administration Wadsworth Hospital, Los Angeles
2. Cedars of Lebanon Hospital, Miami
3. Schwab Rehabilitation Hospital, Chicago
4. Veterans Administration Lakeside Hospital, Chicago
5. Veterans Administration Hospital, Biloxi
6. Veterans Administration Hospital, Albany
7. Bronx Municipal Hospital
8. Harlem Hospital, New York
9. Jewish Hospital and Medical Center, New York
10. North Central Bronx Hospital
11. Veterans Administration Hospital, Northport, New York
12. New York Medical College - Flower and Fifth Avenue Hospitals
13. Hubbard Hospital of the Meharry Medical College, Nashville
14. University Hospital, Seattle
15. Mayaguez Medical Center, Puerto Rico
16. San Juan City Hospital

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HOSPITALS WHICH HAVE DROPPED FROM COTH MEMBERSHIP

6/67 - Milwaukee Psychiatric Hospital
Milwaukee, Wisconsin

12/67 - National Institute of Mental Health
Lexington, Kentucky

7/68 - Baptist, Nashville

10/68 - Detroit Memorial

6/69 - Children's Hospital of Birmingham

6/69 - David Grant USHFH
Travis Air Force Base, Cal.

6/69 - Highland General Hospital
Oakland, Cal.

6/69 - Lafayette Charity Hospital
Lafayette, La.

6/69 - The Reading Hospital
Reading, Pennsylvania

6/69 - St. Luke's Hospital
Bethlehem, Pennsylvania

6/69 - San Joaquin General Hospital
Stockton, California

6/69 - Scott & White Memorial Hospital
Temple, Texas

6/69 - U.T. Memorial Research Center & Hospital
Knoxville, Tennessee

6/69 - William Beaumont General Hospital
El Paso, Texas

8/69 - St. Joseph Hospital
Baltimore, Maryland

6/30/70 - Brooke General Hospital
Fort Sam Houston, Texas

6/70 - Buffalo General Hospital
Buffalo, New York

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6/70 - Carney Hospital
Boston, Mass.

6/70 - The Charles T. Miller Hospital
St. Paul, Minne.

6/70 - Crouse Irving Memorial Hospital
Syracuse, New York

6/70 - Fitzsimons General Hospital
Denver, Colorado

6/70 - Harrisburg Polyclinic Hospital
Harrisburg, Pennsylvania

6/70 - Lincoln Hospital
Bronx, New York

6/70 - Maimonides Medical Center
Brooklyn, New York

6/70 - Mount Carmel Medical Center
Columbus, Ohio

6/70 - Providence Hospital
Washington, D.C.

6/70 - Queens Hospital Center
Jamaica, New York

6/70 - St. Agnes Hospital
Baltimore, Maryland

6/70 - St. Clare's Hospital & Hlth. Center
New York, New York

6/70 - St. Mary's Hospital
Minneapolis, Minne.

6/70 - St. Vincent's Hospital
Jacksonville, Fla.

6/70 - Univ. of Miami School of Medicine
National Children's Cardiac Hospital
Miami, Florida

6/71 - The Jamaica Hospital
Jamaica, New York

6/30/71 - Jersey City Medical Center
Jersey City, New Jersey

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6/30/71 - Pontiac General Hospital
Pontiac, Michigan

6/71 - Sisters of Charity Hospital
Buffalo, New York

6/71 - U.S. Public Health Service Hospital
New Orleans, Louisiana

6/71 - U.S. Public Health Service Hospital
San Francisco, California

5/16/72 - Fairview General Hospital
Cleveland, Ohio

6/73 - Milwaukee Children's Hospital
Milwaukee, Wisconsin

6/73 - St. Joseph Infirmary
Louisville, Kentucky

6/74 - Bayfront Medical Center, Inc.
St. Petersburg, Florida

6/74 - Good Samaritan Hospital, Inc.
Baltimore, Maryland

3/75 - University of Texas M.D. Anderson
Hospital and Tumor Institute
Houston, Texas

4/75 - University Hospital, State University of
New York at Stony Brook
Stony Brook, New York

6/30/75 - Allentown Hospital Association
Allentown, Pennsylvania

6/30/75 - Fairview Hospital
Minneapolis, Minnesota

6/75 - Massachusetts Mental Health Hospital
Boston, Massachusetts

5/76 - St. Francis Hospital
Evanston, Illinois

6/30/76 - Baptist Medical Center of Oklahoma
Oklahoma City, Oklahoma

6/30/76 - Church Home and Hospital
Baltimore, Maryland

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3/77 - Greater Baltimore Medical Center
Baltimore, Maryland

4/77 - Fordham, New York (CLOSED)

4/77 - Morrisania, New York

5/27/77 - The Children's Hospital of Buffalo
Buffalo, New York

6/1/77 - Mount Carmel Mercy Hospital
Detroit, Michigan

6/30/77 - Philadelphia General Hospital (CLOSED)
Philadelphia, Pennsylvania

6/77 - Presbyterian Hospital Center
Albuquerque, New Mexico

2/78 - Methodist Hospital
Houston, Texas

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RESPONSES TO COTH SPRING MEETING INITIAL INVITATION

153 Total Number of Institutional Responses

68 Total Number of Individuals Planning to Attend As Their Hospital's Only Representative

32 Total Number of Individuals Planning to Attend and Bring One Additional Staff Member

132 Total Number of Individuals Planning to Attend

16 Total Number of Responses from Individuals at Veterans Administration Hospitals Who Plan to Attend

53 Total Number of Individuals Not Planning to Attend

These tabulations reflect data received at COTH Offices as of March 13, 1978.

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INDIVIDUALS PLANNING TO ATTEND COTH SPRING MEETING

William E. Hassan, Jr., Ph.D.
Peter Bent Brigham Hospital, Boston

*David Weiner
Childrens Hospital Medical Center, Boston

*Mitchell T. Rabkin, M.D.
Beth Israel Hospital, Boston

Doyle R. Liles
VA Hospital, Newington, CT.

C. Thomas Smith
Yale-New Haven Hospital

*Clarence W. Bushnell
Bridgeport Hospital, CT

M. Michael, Jr.
VA Hospital, East Orange, NJ

*John D. Phillips
St. Barnabas Medical Center
Livingston, NJ

*Robert L. Evans, M.D.
Cooper Medical Center, Camden, NJ

Donald S. Broas
Hospital for Special Surgery, NY

David A. Reed
Lenox Hill Hospital, NY

*David D. Thompson, M.D.
New York Hospital

Seymour Cohen
Bronx-Lebanon Hospital Center

Lloyd V. Sturm
VA Hospital, Bronx

Robert K. Match, M.D.
Long Island Jewish - Hillside Medical Center

Harold Light
Kings County Hospital Center, NY

Charles H. Meyer
Brookdale Hospital Medical Center, NY

*Charles Ashley, M.D.
Mary Imogene Bassett Hospital
Cooperstown, NY

*Paul W. Hanson
The Genessee Hospital, Rochester, NY

John B. Stevens
Highland Hospital, Rochester, NY

Allan C. Anderson
Strong Memorial Hospital, Rochester, NY

*Lad F. Grapski
Allegheny General Hospital, Pittsburgh

Irwin Goldberg
Montefiore Hospital Association of Western Pennsylvania, Pittsburgh

C.R. Youngquist
Magee - Womens Hospital, Pittsburgh

Henry Hood
Geisinger Medical Center, Danville, PA

*Francis J. Sweeney, Jr., M.D.
Thomas Jefferson University Hospital

Gerald Katz
St. Christopher Hospital for Children, Philadelphia

*Raymond S. Alexander
Albert Einstein Medical Center, Phila.

Philip S. Birnbaum
George Washington Univ. Hospital

A.A. Gavazzi
VA Hospital, D.C.

Robert M. Heyssel, M.D.
The Johns Hopkins Hospital

Spencer Foreman, M.D.
Sinai Hospital of Baltimore

Charles D. Jenkins
The Union Memorial Hospital, Baltimore

Dennis Barry
North Carolina Memorial Hospital

*Planning to bring one additional individual to the meeting.

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Richard H. Peck
Duke University Hospital

P.K. Whiteside
VA Hospital, Decatur, GA

Malcom Randall
VA Hospital, Gainesville

John E. Ives
Shands Teaching Hospital

Fred J. Cowell
Jackson Memorial Hospital

Alvin Goldberg
Mt. Sinai Med. Center
of Greater Miami

Robert P. Blair
VA Hospital, Birmingham

J.E. Stibbards
The Children's Hospital,
Birmingham

Russell B. Wimmer
VA Hospital, Louisville

John R. Rowan
VA Hospital, Lexington

*Charles B. Womer (Tentatively)
Univ. Hospitals of Cleveland

*Allen E. Howland
Akron General Medical Center

*Thomas A. Saladin
Good Samaritan Hospital
Cincinnati

*Lonnie M. Wright, Ph.D.
Children's Hospital Medical
Center, Cincinnati

Jack A.L. Hahn
Methodist Hospital of Indiana

Michael R. Swhwartz
St. Joseph Mercy Hospital
Pontiac, MI

*George Cartmill
Harper Grace Hospitals, Detroit

*William J. Downer, Jr.
Blodgett Memorial Medical Center
Grand Rapids

*Marvin F. Neely, Jr.
Milwaukee Cty Medical Center

*Gordon M. Derzon
University of Wisconsin Hospitals

John H. Westerman
Univ. of Minnesota Hospitals & Clinics

John F. Imirie, Jr.
Foster G. McGaw Hospital of Loyola

William Jeffries
VA - Lakeside Hospital, Chicago

William Hejna, M.D.
Rush Medical Center

Earl Frederick
Childrens Memorial Hospital, Chicago

Gerald Mungerson
Illinois Masonic Medical Center, Chicago

*Robert E. Frank
Barnes Hospital, St. Louis

*Linn B. Perkins
St. Louis Childrens Hospital

*David A. Gee
Jewish Hospital of St. Louis

Robert Haith, Jr.
VA Hospital, Kansas City

J.L. Kurzejeski
H.S. Truman Memorial VA Hospital
Columbia, MO

Sheldon Krizelman
University of Kansas Medical Center

T.P. Mullon
VA Hospital, Omaha

*Planning to bring one additional individual to the meeting.

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*Robert J. Baker
Univ. of Nebraska Hospital & Clinic

*James M. Ensign
Creighton Omaha Regional
Health Care Corp

*L.R. Jordon
Ochsner Foundation Hospital

James E. Crank
Univ. Hospital, Little Rock

Bruce M. Perry
University Hospital & Clinics
Oklahoma City

*C. Wayne Hawkins
VA Hospital, Dallas

*William F. Smith
Hermann Hospital, Houston

Jose R. Coronado
Audie L. Murphy Memorial
VA Hospital, San Antonio

James H. Henderson
Presbyterian Medical Center, Denver

James A. Cunningham
VA Hospital, Denver

John Reinertsen
University of Utah Hospital

Daniel W. Capps
University Hospital, Tucson

Stuart Marylander
Cedars-Sinai Medical Center

*John D. Ruffcorn
Loma Linda Univ. Medical Center

Robert W. White
Univ. of California, Irvine Med. Ctr.

William B. Kerr
Univ. of California Hospitals
and Clinics, San Francisco

Gary Mecklenburg (Undecided)
Stanford Univ. Hospital

James Heidenreich
Orthopaedic Hospital, Los Angeles

Roy S. Rambeck
Univ. of Washington Hospitals, Seattle

W.G. Hitchings
VA Center, Dayton

Ira Clark
Kings County Hospital Center

*Barry Bowers
Maryland General Hospital, Baltimore

*G. Bruce McFadden
Univ. of Maryland Hospitals, Baltimore

Thomas Beckett
Hahnemann Medical College and
Hospital of Pennsylvania

Barry M. Spero
Mount Sinai Hospital of Cleveland

Wayne E. Sarius (Tentative)
VA Hospital, Syracuse

Plato A. Marinakos
Mercy Catholic Medical Center, Philadelphia

William I. Jenkins
William N. Wishard Memorial Hospital
Indianapolis

Thomas A. Gigliotti
VA Hospital, Pittsburgh

Robert E. Mack
Hutzel Hospital, Detroit

Donald F. Brayton
Kern Medical Center, Bakersfield

*J. Robert Buchanan, M.D.
Michael Reese Hospital and Medical Center

*David L. Steffy
Ohio State University Hospitals

*Planning to bring one additional individual to the meeting.

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INDIVIDUALS NOT PLANNING TO ATTEND THE COTH SPRING MEETING

David Barrett
The Memorial Hospital, Worcester

Lawrence Hill
New England Medical Center
Hospital, Boston

Charles A. Sanders, M.D.
Massachusetts General Hospital

Laurens Maclure
New England Deaconess Hospital
Boston

James M. Malloy
Univ. of Connecticut Health Center

John K. Springer
Hartford Hospital

Felix M. Pilla
Monmouth Medical Center
Long Branch, NJ

Alvin Conday
Catholic Medical Center,
Jamaica, NY

Donald Eisenberg
Nassau County Medical Center
East Meadow, NY

Paul Philipps
VA Hospital, Albany, NY

Lyle W. Byers
Eye and Ear Hospital of Pittsburgh

Harold W. Luebs
Childrens Hospital of Pittsburgh

William E. Corley
Milton S. Hershey Medical Center

Milton H. Appleyard
Harrisburg Hospital, PA

Carl I. Bergkvist
Bryn Mawr Hospital, PA

Joseph J. Mason
VA Hospital, Philadelphia

H. Robert Cathcart
Pennsylvania Hospital, Philadelphia

Stanley W. Elwell
Episcopal Hospital, Philadelphia

Carl L. Mosher
Presbyterian Univ. PA Medical Center

David C. Schmauss
Albert Einstein Medical Center, Northern
Philadelphia

Paul A. Scholfield
Graduate Hospital, Philadelphia

Richard M. Loughery
Washington Hospital Center, D.C.

Mortimer B. Lipsett, M.D.
NIH, Bethesda

R.J. Lipin, M.D.
VA Hospital, Baltimore

Don L. Arnwine
Charleston Area Medical Center

J.W. Pinkston, Jr.
Grady Memorial Hospital, Atlanta

Dr. Wadley R. Glenn
Crawford W. Long Memorial Hospital
Atlanta

Paul Hofmann
Emory Univeristy Hospital

John B. Byrd
VA Hospital, Memphis

Sheeler B. Lipes
City of Memphis Hospital

Harold Margulis
Louisville General Hospital

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Gerald W. Wagner
Jewish Hospital, Louisville

Judge T. Calton
Albert B. Chandler Medical Center
Lexington

E.J. Conklin, M.D.
Wayne County General Hospital
Eloise, MI

Robert H. Gregg, M.D.
Childrens Hospital of Michigan,
Detroit

William R. Merchant, M.D.
Memorial Veterans Hospital
Madison, WI

Bernard J. Lachner
Evanston Hospital

Marvin C. Miles
MacNeal Memorial Hospital Assoc.
Berwyn, IL

J.L. Buckingham
Touro Infirmary, New Orleans

Elliott C. Roberts
Charity Hospital of LA at New Orleans

Louis M. Frazier, Jr.
VA Hospital, Shreveport

David H. Hitt
Baylor University Medical Center
Dallas

Newell E. France
Texas Childrens Hospital, Houston

Donald G. Shropshire
Tucson Medical Center

Baldwin G. Lamson, M.D.
UCLA Hospital and Clinics

Donald C. Carner
Memorial Hospital Medical Center
Long Beach

William K. Anderson
VA Wadsworth Hospital Center
Los Angeles

Neal D. Asay
Riverside General Hospital, CA

J. Rock Tonkel
Childrens Hospital of San Francisco

John R. Simmons, M.D.
Gorgas Hospital, Ancon, Canal Zone

Edward M. Stein
University Hospital, Seattle

Daniel L. Stickler
Presbyterian University Hospital

Edward C. Andrews Jr., M.D.
Maine Medical Center, Portland

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SUGGESTED TOPICS FOR COTH SPRING MEETING

Mitchell Rabkin Beth Israel Hospital	Medicare Section 223 Decision - Where Are We Going With This and Who Else is Getting Clobbered? Propietary Hospitals: What's Happening at Roosevelt Hospital and What are the Larger Implications of This Fast-growing Sector of the Business
Charles Allen Ashley Mary Imogene Bassett Hospital	Update on Federal Cost Control Legislation Possible Exemption of Hospitals from Pending Legislation re: "forced retirement"
David Thompson New York Hospital	Federal vs. State Control of Reimbursement Health Planning Act - Impact on Teaching Hospitals
Robert L. Evans Cooper Medical Center	Relationships of Medical Colleges and Their Non-Owned Hospitals Which Form Core Units of Clinical Campuses The Role of the Hospital Chief Executive Officer in Assuring Quality of Care Evaluation is Productive and Cost Effective
William J. Downer, Jr. Blodgett Memorial Medical Center	Potential for Utilization of Rural Hospitals as Teaching Program Components in Affiliation With Major Teaching Hospitals The Impact of the National Health Planning Guidelines on the Teaching Hospital
Doyle R. Liles Veterans Administration Hospital	Ambulatory Care - Uniform Coding of Episodes of Care to Establish and Update Data Base. Considered Essential to Program Management and Justification of Resource Allocations. Utilization of CAT Units - Innovative Approaches to Share on a Cost-effective Basis Among Institutions
Earl Frederick Childrens Memorial Hospital	Possibility of Operating a "One Class" Service to Outpatients in a Teaching Setting Possibility of Incentive Compensation for the Full-time Clinician in a Teaching Setting, If so, How

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Sheldon Krizelman University of Kansas	Voluntary Cost Containment Shared Services
Henry Hood Geisinger Med. Ctr.	Marketing Multi-Institutional Systems
Philip Birnbaum GW University Hospital	"Cost Containment" and the Teaching Hospital Health Planning, HSA Focus, and Medical Education and Research
Allen Anderson Strong Memorial Hospital	Rationalizing the Adaptation of the Teaching Hospital to Restricted Reimbursement The Teaching Hospital and the Local HSA.
C.R. Youngquist Magee-Womens Hospital	How to Convince Medical School Faculty That They Have an Obligation to Take Cost Containment Seriously How are Medical Schools and Teaching Hospitals Getting Research Funded for Their Faculty as Federal Funds Dry Up.
Ira Clark Kings County Hospital Ctr	Long Range Planning and Operational Adjustments Indicated in Anticipation of the Future Non-availability of FMGs Methods by Which Collaboration Between Dean's and Hospital Directors Can Be Enhanced and Conflict Reduced., e.g. Particularly Where Chairmen Are Shared.
David A. Gee Jewish Hospital of St. Louis	Strategies for Coping With Cost Containment Activities on Teaching Hospitals Organization of Ambulatory Primary Care That Will Meet the Medical Education Requirements But Which will be Financially Reasible.
Clarence Bushnell Bridgeport Hospital	Special Relationships of Teaching Hospitals to Planning and Cost Control Agenices --HSAs etc. Will There be Further Development of a National Policy (and program) Controlling Choice of Specialty by Way of Further Controlling or Regulating Residency Programs

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G. Bruce McFadden University of Maryland Hospitals	Governance Structure and/or Issues of the University, Academic Health Centers
	The Financing of Graduate Medical Education -- Source and Control. The Numbers Game in Graduate Medical Education
	Section 227 Operation in October 1978
Lad F. Grapski Allegheny General Hospital	Voluntary Cost Containment's Effects on Teaching Programs and Hospital Care
Lonnie M. Wright Children's Hospital Cincinnati	Implications of Cost Containment for Teaching Hospitals
Irwin Goldberg Montefiore Hospital	Governance of Academic Science Centers Including the Relationship of Non-University owned Teaching Hospitals to Medical Schools
	The Joint Commission on Accreditation of Hospitals Requirements and Their Impact on Teaching Hospitals
Garald Katz St. Christophers Hospital	Regionalization and the Academic Medical Center
	Organizing the Academic Medical Center in an Era of Cost Constraint
Malcom Randall VA Gainesville	Improving Effectiveness in Hospital Operation
	Development of Hospital Employees and Physicians as a Cohesive Team
Gerald Mungerson Illinois Masonic Med. Ctr.	A Session on the Effects of Changing Mix in Students, i.e., more females, more minorities less F.M.G.s -- What are the soothsayers saying re: Future Composition of Medical Staffs and how That Will Effect Medical Programming
John Westerman U of Minne Hospitals & Clinics	An Analysis of Teaching Hospital Mission Patterns and Acceptance by Various HSA's - Including Description of Outreach Efforts
	Accountability Systems -- of Teaching Hospital Board -- of Teaching Hospital Management for Research Grants With Patient Care Funds

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C. Wayne Hawkins VA - Dallas	Cost Containment Impact of Health Planning Guidelines & P.L. 93-641 on Teaching Hospitals
Marvin Neely Milwaukee Cty.	JCAH and Ther "So Called" Teaching Hospital Survey Teams - How and Where are They Trained Discussion of the Voluntary Cost Containment Program and the Effects upon GME Programs
Russell B. Wimmer VA - Louisville	COTH Involvement in Health Systems Agency Activities.
John F. Imirie Foster G. McGaw Hosp.	Cost Effectiveness as it Relates to Teaching Hospitals The Separation of Education from HEW will have What Effect?
John Ives Shands Teaching Hosp.	Governance Regulations
Dennis Barry N.C. Memorial Hosp.	Impact of Hospital Cost Controls on the Educational Programs of Teaching Hospitals Realistic Financing of Outpatient Services
Harold Light Long Island Coll. Hosp.	Who Should Control Graduate Medical Education -- The Teaching Hospital or the Medical School
William F. Smith Hermann Hospital	Teaching Costs in Hospitals - Who Will Pay in the Future? Relationships with Medical Schools - Where Primary Hospital is not Owned by Medical School
John Byrd VA - Memphis (CAN'T ATTEND DUE TO PRIOR COMMITMENTS)	Greater Support of HSA's Role in Cost Containment of Expensive Equipment and Control of Available Beds of Different Category in Assigned Area. VA Deans Committee Responsibilities and Limitations in Univeristy/VA Hospital Affiliations

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A.A. Gavazzi VA - D.C.	Role in Schools of Health Care Administration by COTH. Program Approval, etc.
J.L. Kurzejeski Truman Memorial VA	HSAs Role National Health Insurance
Fred J. Cowell Jackson Memorial Hosp.	Accountability of Chiefs of Services Effective Organizational Structures
Barry Bowers Maryland General Hosp.	Effect of P.L. 94-484 on Residency Programs in U.S. What is the Posture of the Federal Government on Funding Residency Programs in the Future as Regards Rate Setting Through Medicare and Medicaid.
James C. Heidenreich Orthopaedic Hospital	Roles of Universities and Hospitals in Coordination of Joint Programs (How is it Done With Pros and Cons) Private Practices for University Faculty Within the Teaching Hospital and the Ramifications for the Hospital
William Hassan, Jr., Ph.D. Peter Bent Brigham Hosp.	Group Practice Arrangements Within the Hospital
Raymond Alexander Albert Einstein	Effect of Cost Control Programs on Houst Staff Trianing - Current and Future Outlook. The "real" facts on Salary and Practice Arrangements with Full-time and Part-time Physicians
John D. Ruffcorn Loma Linda Univ.	How Can we Get Government to Recognize on a Timely Basis that Teaching Hospitals Have Heavier Operating Costs than Comparably Sized Community Hospitals
Robert White UC, Irvine	Integrated Planning in the Teaching Hospital -- How to Achieve Implications of Federal HMO push on Teaching Hospitals
Dan Capps U of Arizona	The Relationship of COTH to the AAMC in light of the emergence of the Association of Academic Health Centers COTH Comparative data gathering and reporting

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Richard Peck Duke University Hosp	The impact of State Rate Review/Setting on University Teaching Hospitals
Charles Jenkins The Union Memorial Hosp.	Future of Free Standing Residency Programs Major Town/Gown Conflicts and How Best to Resolve Role of CEO vis a vis Organized Medical Staff in Relation to Residency Programs
Linn Perkins St. Louis Childrens	National Health Policy Directions Retaining University Hospitals Ability to Pioneer New Technology, Determine Efficacy and Cost/Benefits New Technology in an Anti-Technology and Cost-Constraint Environment
Robert Frank Barnes Hospital	Teaching Hospitals' role in National Health Teaching Hospitals in the CAP approach to Cost Control
Paul Hanson The Genessee Hospital	Status of Medical Education in the COTH Group of Hospitals Relationship of COTH Hospitals as Affiliates of Medical Schools -- Have They Changed With Present Fiscal and Regulatory Circumstances
Lloyd V. Sturm Hospital Director	Report on HMOs Effectiveness as Health Care Delivery Modes Progress Report on HSAs Across the Nation
M. Michael, Jr. VA Hospital East Orange, N.J.	Is there anyway to show or predict a dropoff or restriction of number of residents entering specialities the next five years? We all have to do some considerable replanning to take care of our patients ratio physician staff wise if this is going to occur to any degree.
Alvin Goldberg Mt. Sinai Med. Center of Greater Miami Beach	The Future of Self Standing Programs (Not Controlled By A University) Political Understanding of Continuation of Educational Costs as Part of Reimbursement

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Jack A. Hahn Methodist Hospital of Indiana	Status of Reimbursement in Affiliated Hospitals for Teaching Faculty Teaching ambulatory care - move from traditional OPD Approach
Roy S. Rambeck Univ. of Washington	Case Mix Determination in Teaching Hospitals; Need, Technology, Data Source, et al. Cost Containment Ideas
Bruce Perry Univ. Hospital & Clinics Oklahoma City	Organization and Reimbursement for Ambulatory Services Strategy for Improving Ambulatory Reimbursement Since COTH Hospitals Operate Majority of Ambulatory Care Programs HSA Encounters - Problem Progresses; Problem Impact
James Crank Univ. Hospital Little Rock	Placement of Medical School Graduate for House Staff Training Financing of Intensive Care - Perinatal, etc.
T.P. Mullon VA Hospital, Omaha	The Relationships of Teaching Hospitals and P.L. 93-641
John Reinertsen Univ. of Utah Hospital	It is my understanding that the Commission on Public General Hospitals will publish their report by mid-April. It would seem timely therefore to have as a topic the review of this report by Dr. Russell Neilsen or Arthur E. Hess.
Gordon Derzon U of Wisconsin Hosp.	Role of the Medical Staff of State University Hospitals in Approaches to Cost Containment. What Has Been Done; What Approaches Have Been Utilized?
David Weiner Childrens Hosp., Boston	Marketing Opportunities And Strategies for the Teaching Hospital Physician Practice Plans - Alternative Organizational Arrangements and Their Implications for Future Reimbursement of Teaching Hospital Based Physicians
Robert J. Baker U of Nebraska Hospital and Clinics	Long Range Teaching Hospital Financial Stability Under Federally Mandated Revenue Ceilings. Impact of Revenue Ceilings on University Hospital Financial Control (Governance by U Regents and Legislature)

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L.R. Jordan Ochsner Foundation Hosp.	Financing of Graduate Medical Education in a Hostile Environment
Thomas A. Saladin Good Samaritan Hospital	In the Halls of Congress How Strong is the Push to Control Medical Education Dollars? Will the Number of Medical School Graduates Decline in the Near Future or Will It Continue to Increase
Gary Mecklenburg Stanford U Hospital	The Increasing Difficulties and Costs Associated With JCAH Compliance - The Need to Continue Evaluation of the Accreditation Process The Relationship of the Teaching Hospital to HMOs
Robert M. Heyssel, M.D. The Johns Hopkins Hospital	Cost Containment in Hospitals Multiple Hospital Consortions & Teaching Hospitals
William Hitchings VA Hospital, Dayton	Sharing of CAT Scanners and other Sophisticated Tertiary Care Equipment Strengthening Affiliations
Wayne E. Sarius VA Hospital, Syracuse	A discussion concerning the apparent disagreement between Residency Review Boards of specialties and sub-specialties and the LCGME Board and what strategy should teaching hospitals use to help alleviate these differences so we can avoid their consequences. I would like to hear a discussion on strategies that teaching hospitals should use with their affiliated medical schools to come to some reasonable agreement of lead time schools need to adjust their residency assignments in the teaching hospital and, if necessary, reduce the number of residents needed in the teaching hospital.
Thomas Beckett Hahnemann Medical College and Hospital of PA	Legislative Developments: a. National Health Insurance b. Cost Containment c. Health Planning
William I. Jenkins William N. Wishard Memorial Hospital	Cost Containment via Prospective Rate Setting in Teaching Hospitals Practice Plans-Salaries for Full-Time Physicians

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Thomas A. Gigliotti VA Hospital, Pittsburgh	Planning of the expanding clinical requirements of educational programs in line with cost containment and restricted resources. The inter-institutional planning between medical school and hospital to assure the need to meet the objective of both institutions in the areas of patient care, education and research.
Donald F. Brayton Kern Medical Center Bakersfield, CA	Statement from the Commission on Public-General Hospitals Status of the Long-Ribicoff-Talmadge Catastrophic Health Insurance and Medical Assistance Reform Proposal
Edward M. Stein University Hospital, Seattle (WILL NOT ATTEND)	Rate regulation and teaching hospitals - how have the agencies affected these organizations. What does the future hold? Evergency medical services - What is the academic relationship in a teaching hospital?

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WILL NOT ATTEND - COMMENTS

Don Arnwine Charleston Area Medical Center	Will Plan to in Future years. "Booked" this year.
Donald Shropshire Tucson Medical Center	Already Committeed. However, idea is good.
J.W. Pinkston Grady Memorial Hospital	I like the idea but already have commitments for these dates.
William Corley Milton S. Hershey Medical Center	I believe the most effective meetings are those conducted by the Applachian Teaching Hospital group. Membership is restricted to about 20 institutions and we discuss "burning issues" of the day with no outside speakers.
Richard Loughery Washington Hospital Center	Regrets, but am already committed to another meeting. I think your idea is good and will be beneficial.
Milton Appleyard Harrisburg Hospital	Sorry. Major Conflict in Dates.
Donald C. Carner Memorial Hospital Long Beach, CA	Unless Subsequent meeting information suggests more compelling reasons to participate.
Wheeler Lipes City of Memphis Hosp.	Conflicting Meetings
John Springer Hartford Hospital	Thanks! I regret having a conflict.
Carl Mosher Presbyterian U	Sorry, but this year I have conflicting dates.
David Hitt Baylor Univ.	Unfortunately, I am committed for May 3 and 4
Barry M. Spero Mt. Sinai Hosp. of Cleveland	I may have a conflict that will prevent me from attending, but will not know until mid-April
Daniel L. Stickler Presbyterian U Hosp.	My regrets - I have a major conflict!

EXECUTIVE SALARY SURVEY

At the September, 1977 Board meeting, the executive salary survey was reviewed. The Board recommended that questions concerning the usefulness and confidentiality of the executive salary survey be added to this year's questionnaire.

RECOMMENDATION: Based upon the survey results it is recommended that the Executive Salary Survey be continued on an annual basis and that the results continue to be distributed to COTH members only.

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Question 25: "I prefer that future survey results remain individually unidentifiable and that findings be

- distributed only to COTH members
- generally distributed to interested persons."

Nearly three-fourths of the members preferred that the current practice of distributing the report only to COTH members be continued. The major dissent from this view was among municipal hospitals. Nearly two-thirds of the municipal hospital directors preferred that the report be made available to interested parties.

Desired Distribution of COTH Executive Salary Survey Report
1977-78

Hospital Affiliation	Restricted To COTH Members	General Distribution To Interested Persons	Total
University-Owned	77% (34)	23% (11)	100%
Major	76% (91)	24% (28)	100
Limited	68% (21)	32% (10)	100
None	43% (3)	57% (4)	100
AGGREGATE	74% (149)	26% (53)	100%

Desired Distribution of COTH Executive Salary Survey Report
1977-78

Hospital Ownership	Restricted To COTH Members	General Distribution To Interested Persons	Total
State	67% (20)	33% (10)	100%
Municipal	36% (8)	64% (14)	100
Church	84% (21)	16% (4)	100
Other, Nonprofit	80% (100)	20% (25)	100
AGGREGATE	74% (149)	26% (53)	100%

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Q. 26 - Please indicate the use, if any, your hospital makes of the COTH Executive Salary Survey report.

Overall, 38 percent of the members reported that they made considerable use of the report, 60 percent made limited use, and 2 percent made no use of the report. Grouped by various types of hospital ownership, more state hospitals reported a higher rate of usage than did other hospitals.

Usage of Executive Salary Report By Membership, 1977-78

Hospital Ownership	Considerable	Limited	None	Total
State	49% (14)	51% (5)	0%	100%
Municipal	44% (10)	56% (13)	0%	100%
Church	40% (10)	60% (15)	0%	100%
Other, Nonprofit	34% (40)	63% (76)	3% (4)	100%
AGGREGATE	38% (74)	60% (119)	2% (4)	100%

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Q. 27 - From your hospital's present use of the COTH Executive Salary Survey report, how often should the survey be conducted?

More than three-fourths of the membership believed that once per year was the preferred frequency for the survey. Nearly all of the reminader reported that they preferred alternate years for conducting the survey. On the basis of their common ownership, relatively more state hospital members wanted the survey to remain on an annual basis.

Frequency of Executive Salary Survey Desired By Membership, 1977-78

Hospital Ownership	Annually	Biennially	Other	Total
State	83% (25)	17% (5)	0% (0)	100%
Municipal	72% (18)	24% (6)	4% (1)	100%
Church	73% (19)	26% (7)	0% (0)	100%
Other, Nonprofit	77% (55)	21% (26)	2% (3)	100%
AGGREGATE	77% (157)	22% (44)	1% (4)	100%

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AHA Multi-Institutional Systems Program: Request to Sponsor a Seminar

The attached agenda represents a brief committee discussion of a plan to hold a seminar on the role of the academic health science center and teaching hospitals in multiple-unit management systems. The impetus for the seminar originally came from Dr. James Campbell, President of Rush-Presbyterian-St. Luke's Medical Center. The program will definitely be held and will be sponsored by the American Hospital Association and Rush-Presbyterian-St. Luke's Medical Center. A request was made at the meeting that the Council of Teaching Hospitals formally serve as a third sponsor for the program. It is recommended that the COTH Board jointly sponsor this seminar.

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AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-645-9400

A G E N D A

TASK FORCE TO PLAN TEACHING HOSPITAL SEMINAR

Room 2042, O'Hare-Hilton, Chicago
March 9, 1978
Beginning 8:00 a.m., CDT

1 WELCOME AND INTRODUCTIONS

2 ROLE OF THE TEACHING HOSPITAL

A. Is there a need and a desire to establish a role for the academic health science center and teaching hospitals in the Multi-Institutional Systems program.

B. If it is the opinion of the group that there is an appropriate role, how can it be defined and what items should be covered.

3 INDIVIDUALS TO BE INVITED

4 DATES, TIME AND LOCATION FOR SEMINAR

5 ADJOURNMENT

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AICPA Exposure Draft

On the following pages appears the Exposure Draft issued by the Subcommittee on Health Care Matters of the American Institute of Certified Public Accountants entitled "Proposed Statement of Position on Modification of Reporting Practices Relating to Hospital Related Organizations and Funds Held in Trust By Others." The staff of the Department of Teaching Hospitals will be drafting a response and a full discussion of this document would be most helpful to the staff. In addition, it is recommended that each Board member submit comments to the AICPA.

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EXPOSURE DRAFT

PROPOSED STATEMENT OF POSITION ON MODIFICATION OF REPORTING PRACTICES RELATING TO HOSPITAL RELATED ORGANIZATIONS AND FUNDS HELD IN TRUST BY OTHERS

FEBRUARY 10, 1978

Issued by the Subcommittee on Health Care Matters of the
American Institute of Certified Public Accountants
For Comment From Persons Interested in Accounting and Reporting

Comments should be received by June 15, 1978, and addressed to
Robert C. Mullins, Manager, Federal Government Relations Division, File No. G-1-402
AICPA, 1620 Eye Street, N.W., Washington, D.C. 20006

AICPA

American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, New York 10036 (212) 575-6200

February 10, 1978

To Practice Offices of CPA Firms; Members of Council; Technical Committee Chairmen; State Society and Chapter Presidents, Directors and Committee Chairmen; Organizations Concerned With Regulatory, Supervisory, or Other Public Disclosure of Financial Activities; Persons Who Have Requested Copies:

An exposure draft of a proposed statement of position entitled Modification of Reporting Practices Relating to Hospital Related Organizations and Funds Held in Trust by Others accompanies this letter.

This exposure draft has been prepared by the Subcommittee on Health Care Matters of the American Institute of Certified Public Accountants to help focus attention on the issues considered and foster the interchange of ideas among those interested in improving accounting and reporting standards.

The subcommittee recommends that those reviewing and commenting on this draft also refer to a discussion of this subject contained in an AICPA discussion draft entitled A Tentative Set of Accounting Principles and Reporting Practices for Nonprofit Organizations Not Covered by Existing AICPA Industry Audit Guides. Although that document states specifically that it does not apply to hospitals, it deals with problems and concepts similar to those in this exposure draft.

The subcommittee believes that this exposure draft presents a workable approach in dealing with the problems described. Accordingly, it is being distributed to representatives of the health care industry, certified public accountants, and other interested parties for their comment. Positive recommendations regarding this subject will be welcomed, and written comments should be submitted to arrive at the AICPA not later than June 15, 1978. Written comments on the exposure draft (other than statistical data and related explanatory material submitted on a confidential basis) will become part of the public record of the American Institute of Certified Public Accountants and will be available for public inspection at the AICPA Library in New York City after June 22, 1978.

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In addition to accepting written comments for consideration, the subcommittee will hold a public hearing on the exposure draft in Washington, D.C., on June 14, 1978. Persons or organizations wishing to make presentations should notify Robert C. Mullins as early as possible, but not later than June 1, 1978, and should submit written outlines by June 8, 1978. Selection of the time and exact location of the hearings will be made at a later date, and persons expecting to attend should contact Mr. Mullins at (202) 872-8190 for this information.

Sincerely,

Albert A. Cardone

Albert A. Cardone, Chairman
Subcommittee on Health Care Matters

Joseph F. Moraglio

Joseph F. Moraglio, Director
Federal Government Relations Division

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PROPOSED STATEMENT OF POSITION ON MODIFICATION OF REPORTING PRACTICES RELATING TO HOSPITAL RELATED ORGANIZATIONS AND FUNDS HELD IN TRUST BY OTHERS

INTRODUCTION

1. There is increasing interest in, and an apparent trend toward the creation of, separate organizations, frequently referred to as foundations, to raise and hold certain funds for hospitals.

2. One of the basic reasons usually cited for establishing those separate organizations is to broaden the base of philanthropic support in the community while at the same time distributing the burden of board or trustee responsibility and effort among more individuals. More recently, the reasons appear to center around the desire to insulate contributed funds against the effects of actual and potential regulation by government and, in particular, against use by third-party payors to underwrite their programs. Many hospitals fear the return of constraints similar to the Economic Stabilization Program requirement to prove "severe financial hardship" in order to be permitted to raise prices, which caused some facilities to use contributed funds to support operations. Malpractice claims are also seen as threats to funds contributed to hospitals. Organizers of separate fund-raising entities hope that exposure of those funds to such threats may be avoided or lessened by the use of such organizations.

3. Some believe that the financial statements of such separate organizations should not be combined with those of hospitals because they believe that combining them would limit the effectiveness of the organizations and thereby subject contributed funds to the feared expropriation by third-party payors and others. Others share the concerns about the potential effects on reimbursements but believe that those concerns should be dealt with independently of accounting considerations and that accounting and reporting should be determined without reference to those potential effects.

THE PROBLEM

4. The AICPA's *Hospital Audit Guide* presently calls for combined financial reporting for related organizations if "significant resources or operations of a hospital . . . are handled by such organizations and they . . . are under the control of (or common control with) hospitals. . . ." However, the guide does not give any guidance about or explanation of what constitutes "control" or "hospital resources." As a consequence, a variety of reporting practices are being followed in identical or similar circumstances. The financial statements of some related organizations are combined with those of hospitals, while the financial statements of others in similar circumstances are not. The related facts and circumstances are sometimes disclosed and sometimes not.

5. Concerns are expressed that new organizations are being created and existing organizations are being modified in a manner designed to overshadow the substance of the relationship and to avoid the requirements for combined financial statements.

6. In these circumstances, the subcommittee believes that the *Hospital Audit Guide* should be modified to give more guidance in this increasingly important and complex area. Furthermore, since funds held in trust for the benefit of hospitals by independent organizations are similar in many respects to resources held by hospital related organizations and to endowment and other restricted funds held by hospitals, the subcommittee believes it is necessary to reconsider financial reporting for funds held in trust by others for the benefit of hospitals.

APPROACHES TO THE PROBLEM

7. One approach to the problem would be to continue that which is presently set forth in the guide with the primary focus on control, and merely to expand it by defining or giving guidance about what constitutes "control" and "hospital resources."

8. A second approach is based on the rationale that the encouragement and development of philanthropy is a function separate and distinct from the operation of a hospital as a self-sustaining enterprise in the current environment of health insurance and third-party payors. Under this approach, it might be argued that there is such a distinct difference in functions that it is not necessary or appropriate to combine financial statements of the two entities or to disclose the related facts and circumstances. Alternatively, it might be argued that while combination is not necessary, disclosure of the circumstances of the relationship is appropriate. Under this alternative, reference to Statement on Auditing Standards no. 6, *Related Party Transactions* (SAS 6), might provide adequate guidance.

9. A third approach, which is presented in this draft, is based on a comprehensive concept of hospital resources, as defined in paragraph 12. Under this approach, if hospital resources (as defined) exist, they should be reflected in the hospital's financial statements by combination or otherwise (see paragraph 13), regardless of the forms of organization that hold legal title to them and regardless of whether the hospital controls the other organizations. This approach places control in a secondary role, as a determinant of the method and extent of combination and not as a determinant of whether the financial statements should be combined.

10. This third approach affects reporting of hospital resources handled by organizations that are not controlled. Under this approach, those hospital resources would be treated as a restricted fund in the combined financial statements. All contributions to the hospital resources handled by such a separate organization would be reported as additions to the restricted fund balance in the combined financial statements pending distribution to the hospital. The timing of distributions and any other restrictions on distributions imposed by the separate organization would be recognized in addition to any donor-imposed restrictions. This treatment recognizes that a separate organization that is not controlled by the hospital has discretion over the use of hospital resources and provides for full disclosure of those resources in the hospital's financial statements.

11. A significant consequence of this approach is that funds held in trust by others for the benefit of a hospital would also be included in the hospital's financial statements. However, these funds are held under wills and trust agreements set up by donors, and the terms of distribution of income and principal vary widely. Some may believe that unless the hospital is entitled to distribution of principal within a reasonable length of time, the funds do not meet the definition of "hospital resources." However, many endowment funds also are long-term or permanent in nature concerning the distribution of principal. Under the subcommittee's approach, "funds held in trust by others" would be accorded the same treatment—inclusion in the hospital's financial statements—as endowment funds held by the hospital.

THE SUBCOMMITTEE'S CONCLUSIONS

12. Based on the subcommittee's tentative conclusions, the sections of the *Hospital Audit Guide* that currently deal with "Other Related Organizations" (pages 11 and 12) and with "Funds Held in Trust by Others" (page 11), should be deleted and replaced with the following text:

RELATED ORGANIZATIONS AND FUNDS HELD IN TRUST BY OTHERS

Resources handled by an organization separate from the hospital are considered to be resources of the hospital if, in substance, their use or eventual distribution is limited to the hospital by the organization's charter or by other means, or is limited to support activities managed by, or otherwise closely related to, the hospital. The resources, if significant, should be reported on the accrual basis in the hospital's financial statements. The manner of reporting should be determined in the light of all relevant attendant circumstances. The overriding consideration should be to reflect the substance and not merely the form of the relationship between the hospital and the separate organization.

A. *Organizations Functioning for a Single Hospital*

If the primary purpose or function of a separate organization is to handle significant resources of a single hospital, its financial statements should be combined with those of the hospital. An example is a separate organization that solicits contributions in the hospital's name or in such a way that the contributors have a reasonable basis for believing that the funds are to be used by or for the benefit of the hospital.

If such a separate organization is under the control of or under common control with the hospital, the two entities should be combined as a single entity, recognizing only external donor restrictions. Restrictions imposed by the separate organization should be treated as the equivalent of board designations. As defined in Statement on Auditing Standards no. 6, *Related Party Transactions*, "Control means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a specified party whether through ownership, by contract, or otherwise." Among the factors considered to be evidence of control of an organization by a hospital are any of the following:

1. The hospital's board members or other hospital representatives, or both, constitute a majority of the other organization's board.
2. The hospital has the power to appoint, reappoint, or remove a majority of the board members of the other organization.
3. Board members representing the hospital have unequal or special voting rights, such as veto power.

If such a separate organization is not under the control of or under common control with the hospital, the combination should be made by treating all of the separate organization's assets, liabilities, and fund balances as resources of the hospital in a separate restricted fund in the combined financial statements. Activity during the period should be reflected as changes in the restricted fund balance. As funds are distributed or become distributable to the hospital, they should be recorded by the hospital, recognizing any external donor or separate organization restrictions.*

*Distributions should be recorded by the hospital as receivables if, at the end of the period, they have been allotted or approved by the separate organization's board for disbursement to the hospital on a specific subsequent date.

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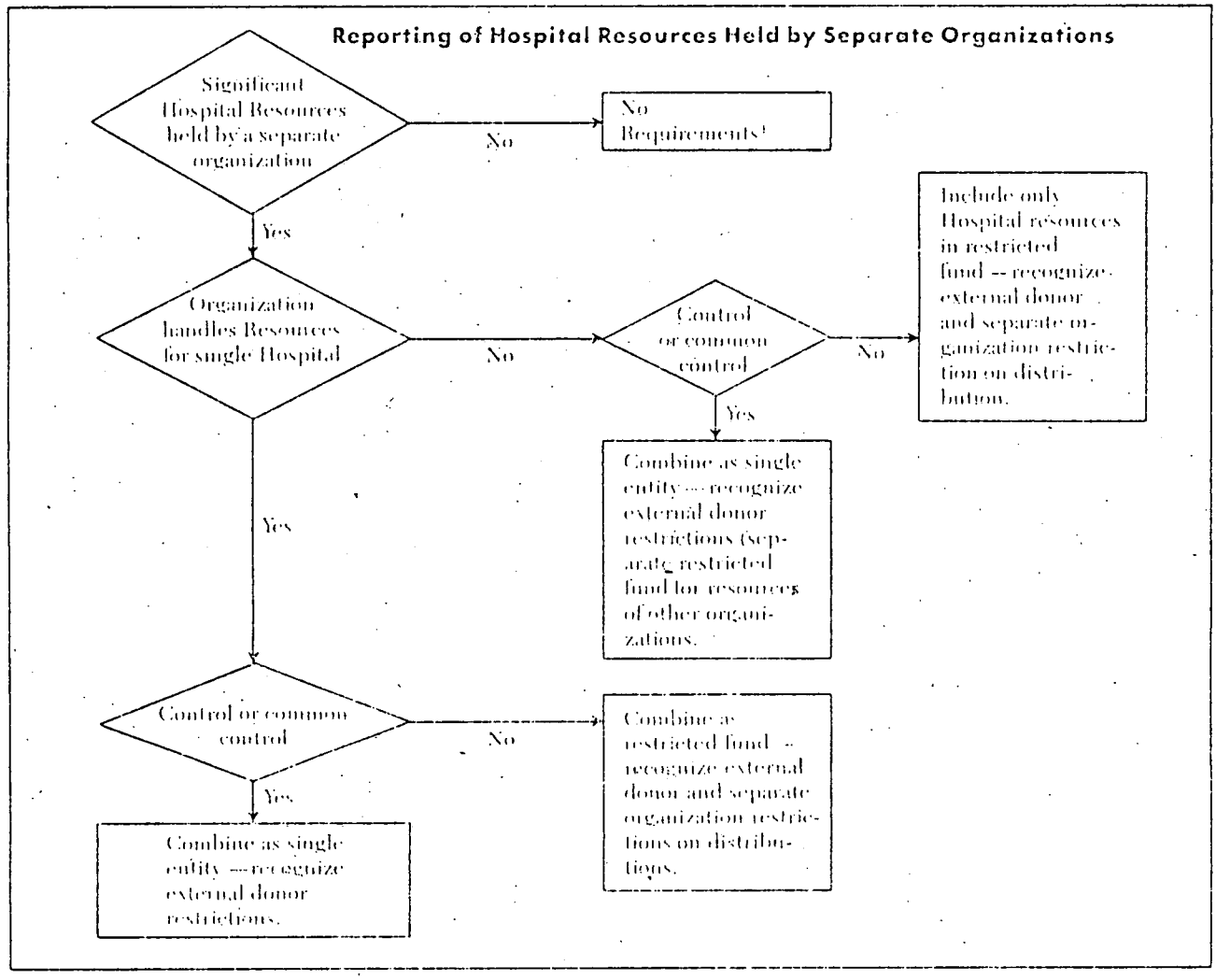
B. *Organizations Functioning for More Than One Other Organization*

If a separate organization handles significant resources of a hospital as well as significant resources for entities other than the hospital and is under the control of or under common control with the hospital, its financial statements should be combined with those of the hospital as if they were a single entity. Recognition should be given in the combination only to external donor restrictions. Those resources handled by the separate organization the use or eventual distribution of which is restricted by external donors or is limited by other means to use by entities other than the hospital, or to support activities managed by or otherwise closely related to such entities, should be included as a separate restricted fund in the combined financial statements of the hospital, reflecting a liability or trust relationship, such as "funds held in trust for others."

If such a separate organization is not under the control of or under common control with the hospital, only those assets, liabilities, and fund balances or the applicable portion or interest in them comprising resources of the hospital should be included in the hospital's financial statements. The amounts should be reported in a separate restricted fund. Activity during the period should be reflected as changes in the restricted fund balance. As funds are distributed or become distributable to the hospital, they should be recorded by the hospital, recognizing any external donor or separate organization restrictions. Examples of such separate organizations are a bank as a trustee, a university if the hospital is either part of the same corporation or is related, and a foundation (fund-raising organization) that solicits contributions for the hospital and other entities.

13. The following flow chart depicts the reporting of hospital resources held by separate organizations as described in this draft.



*Significant funds that do not meet the definition of hospital resources may be received by a hospital on a recurring basis from another organization. For example, a hospital may regularly or periodically receive significant amounts from an independent foundation or other separate organization which also makes such distributions to other recipients. If the separate organization is not obligated to make distributions to the hospital, the distributions do not meet the test of being hospital resources. Disclosure of the related facts and circumstances may be appropriate in the financial statements of the hospital.

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State Rate Review

At the January Board meeting it was suggested that the issue of state rate review be placed on the agenda for full discussion at the next meeting in March. For purposes of providing a framework for discussion, the attached "Guidelines for State-Level Review and Approval of Budgets for Health Care Institutions" should be helpful. This document was approved by the American Hospital Association Board of Trustees on January 29, 1978.

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GUIDELINES FOR STATE-LEVEL REVIEW AND APPROVAL OF BUDGETS FOR HEALTH CARE INSTITUTIONS

Approved by Board of Trustees
January 29, 1978

I. Introduction

For many years, society in general and the government in particular have accorded high priority to making high-quality health care accessible to all. As a result, insurance coverage and governmental financing of care have increased to the extent that consumers of health services are largely insulated from the impact of their purchase decisions. In addition to these increased expenditures for services, there has been a massive infusion of government funds for facilities, manpower, and research programs to improve the distribution and availability of services. Both have contributed to extensive "demand-pull" inflationary increases in the cost of health care and growing financial problems for many health care institutions as well as for government. These pressures are further exacerbated by the inefficient method of retrospective payment determination that is currently employed.

The trend of spending an increasing percentage of the gross national product for health services presents a major problem for the nation's economy and for the federal budget. It is now evident that the effects of the public and private sectors responses to the priority of health care will require compatible and comprehensive remedies in order to effect a moderation of the increases in expenditures for health care services.

The hospital industry recognizes the many reasons for the escalation of expenditures and, in a collective effort, is attempting to develop a rational system for regulating expenditures while maintaining quality and access. The industry has done this already by supporting planning and other regulatory mechanisms, such as utilization review and accreditation. The American Hospital Association advocates a system of payment regulation as described in sections II and III of these guidelines as a further effort in this direction.

This proposed system of payment regulation is supported by the American Hospital Association for the following reasons:

1. The proposed system is deemed the best method of moving to a prospective payment mechanism that apportions the payments equitably among all purchasers of services. The inadequacies of retrospective cost reimbursement have rapidly become more unsatisfactory to providers and payers alike.

2. Appropriate financing is essential to maintaining health care institutions' ability to continue to deliver high quality services to their communities. The public support necessary to obtain financing for institutions at an appropriate level on a sustained basis depends upon public understanding of the reasons for cost increases related to new technology, improvements in quality, inflation, and volume fluctuations. Because of this need, effective methods must be developed to inform the public of the nature of hospital costs and to assure the public about the efficiency and effectivenesss of these institutions' expenditures and management.

3. The making of decisions on health service priorities and financing must be by a system that is publicly accountable and that balances the interests of consumers as well as third-party payers and providers.

4. The distribution of finite funds requires a highly flexible regulatory system. The processes of the system must consider the following:

   - the broad spectrum of local needs and circumstances
   - the full variety of organizational and service configurations properly found in institutions
   - the needs of all types of institutions from the small rural hospital to the large regional medical center

From year to year, the payment regulatory system must allow for payments as required not only for institutions that are adding expensive, complex services in response to planning decisions or incurring continual shifts in patient mix, volume, or scope of services, but also for institutions that are relatively stable in their operation or that are reducing their level of services.

5. The payment regulatory system must be capable of integrating its decisions precisely with the decisions of other regulatory systems operating at the state and local level, such as planning, utilization review, or quality assurance controls, so that each regulatory system performs its intended purposes well and facilitates or complements the activities of each of the other regulatory systems.

6. The payment regulatory system must be capable of identifying and impacting upon expenses in health care institutions that are considered excessive. This should be accomplished by

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prospectively denying recognition and payment of such expenses by promoting cost avoidance, and by stimulating sound management through appropriate incentives.

7. It is important to recognize that a health care delivery system must be consonant with the needs and desires of the community that is served. So, too, must all forms of regulation be consonant with the needs and desires of the community. In developing and implementing mechanisms that regulate the accessibility and utilization of health care institutions, the federal government has enacted P.L. 93-641 and P.L. 92-603 on the principle that administration and regulation at the state level is the most appropriate method to ensure community involvement. This principle has equal application to the mechanism for regulating health care expenditures, since the community's needs and desires relate directly to the level of health care institution expenditures. Therefore, the states, through appropriate public policy mechanisms, should have the responsibility to make decisions concerning the level of expenditures necessary to ensure that the ends and desires it has determined for its institutions are met. A state-level regulatory mechanism provides greater access to the community and its institutions, and thus an awaremess of local issues that may impact upon them. These factors can then be considered in any determinations made.

Sections II and III of these guidelines are founded on the conviction that a federally mandated, state-administered or state-sanctioned prospective payment regulatory system, based on certain principles and characteristics described herein, has advantages over all other systems for accomplishing the above purposes. These guidelines would be implemented through federal legislation requiring government-regulated health care payment programs to recognize the payment decisions made by entities established at the state level. The federal legislation would also have to provide for the degree of national consistency among the state entities that would allow their role to be continued under any universal health insurance program. Thus, the federal legislation would be establishing another basic element in preparation for universal health insurance, compatible with the already established planning and Professional Standards Review Organization networks.

Several states now utilize some type of regulation of hospital payments. Most of these programs have not applied to all payers, and many use regulatory techniques that do not comply with the principles described herein. It is important, therefore, to distinguish between their very limited effectiveness and the greater potential for the system proposed in these guidelines.

As early as 1970, the probability of expanded payment regulation for health care was recognized by the American Hospital Association, and it initiated studies of other regulated industries in an effort to benefit from their experience. It established the Advisory Panel on Public Utility Regulation whose recommendations became the basis for the Guidelines for Review and Approval of Rates for Health Care Institutions and Services by a State Authority that were approved in 1972.

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In 1976, the Association established its Advisory Panel on the Regulation of Hospital Payment; its report is an addendum to the report of the Special Committee on Regulatory Process. The advisory panel's findings were generally consonant with the earlier reports but emphasized the importance of integrating the payment regulation with planning and other regulations and avoiding the establishment of incentives for excessive utilization of patient services.

A succession of events has contributed to the growing support among health care institutions for federal legislation that places the responsibility and authority for administering payment regulation at the state level. One such event was the Economic Stabilization Program and the distortions in hospital economics it created. The latest impetus has been the introduction of federal legislative cost containment proposals. These proposals seek to regulate hospital expenditures with no recognition of the potential impact on the quality and availability of health care services or of the economic viability of institutions whose purpose is to serve patients.

II. The Guidelines: Purpose and Concept

The basic objective of the guidelines delineated below is to promote the development of state-level regulation of hospital payments under which each institution would be paid its full financial requirements through a prospective payment mechanism that apportions the payments equitably among all the purchasers of its services. The realization of this objective will require that government and other payers accept nationally determined standards for the regulatory process. Flexibility must be built in to allow the state entity to use discretion in making decisions that will accommodate local considerations and provide management incentives.

In response to this need, the American Hospital Association proposes the following guidelines:

A. Each institution will establish its budget in accordance with the principle set forth in the American Hospital Association's Statement on the Financial Requirements of Health Care Institutions and Services and related interpretations.

B. The budgets will be submitted to an entity established as described in section III-C of these guidelines for reviewing and approving the budgets, using procedures and standards that are equitable to providers, payers, and consumers.

C. The review will be focused upon the institution's demonstrated financial requirements and projected volume at the departmental level. The approval will be of the budgeted gross and net revenue related to those financial requirements and volume. The charge schedule will then be required to be related to its approved aggregate gross and net revenue requirements. Individual charges will be subjected to challenge only on the basis of their being discriminatory among classes of payers.

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D. Charges will apply to all purchasers of services.

E. The approved revenue budget will apply for the following fiscal year, although the process will include an acceptable method for considering emergency adjustments of the budgets during the fiscal year.

F. The entity will receive fiscal year-end reports of the operating results of each institution. Its procedures will provide for retrospective evaluation of those results and prospective handling of substantial gains or losses due to major volume changes for the amounts projected.

G. Appropriate appeal mechanisms, including the right to direct judicial review, will be established to protect the rights of all parties.

III. Guidelines for Federal Delegation

A. The purpose of the state regulatory process to be included in federal legislation is to approve budgets that promote quality and availability of service based on the health care institution's full financial requirements.* The regulatory process must take into account the institution's community and regional role and its responsibilities as defined by the planning and other regulatory programs.

The process will cause those financial requirements to be allocated among all purchasers through equitable charge schedules. In any federal program of payment regulation that delegates a significant role to the states, the size of federal expenditures for health care services and the achievement of the national goals of such a regulatory program will require that provisions be made for federal oversight of the program. Therefore, to allow for effective delegation, certain criteria must be used to ensure the achievement of the desired goals and outcomes as well as equity among the programs conducted in the various states.

B. Under its authority, each state will be required to submit a plan and provide reports to the Secretary of Health, Education, and Welfare, showing that it meets the established criteria. Federal approval of those plans and reports will constitute federal delegation of the budget review and approval entity.

1. Budget review and approval will extend to all health care institutions that customarily charge for their services. For health care institutions participating in a comprehensive prepaid health insurance program on a capitation basis of payment, the entity will review and approve the rate of payment for contracted institutional services under the capitation program and ensure that the institution's charge schedules are equitable for all purchasers, including those not participating in the capitation program.

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*As defined in the American Hospital Association's Statement on the Financial Requirements of Health Care Institutions and Services.

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2. After a public hearing process it will promulgate and adopt standards for uniform reporting.

3. After a public hearing process, it will develop equitable criteria and methods for the review and approval of budgets including cost performance measurements and comparative evaluations that are equitably defined and uniformly applied.

4. The individual needs and peculiarities of health care institutions require it to recognize the individuality of the institutions it regulates, therefore, precluding the use of standardized payment formulae uniformly applied to all institutions. It will review and approve institutions' budgets individually, based on their respective demonstrated financial requirements. The review will be on the institution's revenue total as opposed to line items. The approval decisions will be such that institutions rendering needed health care services and operating efficiently and effectively will have their financial requirements met and their financial solvency preserved on a current basis.

5. Its decisions should provide for financial incentives to institutions to encourage them to manage efficiently, and its decisions will encourage experimentation and innovation in institutional and financial management.

6. Its decisions will support the purposes of planning and other regulatory controls. It will facilitate the voluntary discontinuance of unneeded services and facilities by recognizing the costs associated with phasing them out as a financial requirement for the institution, and it will approve the budgets accordingly.

7. Its decisions will not encourage excessive volume of services and facilities by rewarding the increased use of services. It will use "per patient day" and "per case" costs only as a screen for selecting institutions for closer review, not as a unit for direct regulation.

8. It will monitor the decisions of other state regulatory agencies and legislative bodies and will inform them of the economic impact of their decisions on the operation of health care institutions.

9. It must be accountable to the public, the health care industry, and the state and federal governments. Public accountability requires it to operate in full public view. Further, public accountability requires it to certify to the public as to the reasonableness of the budgets established by the health care institutions, therefore requiring it to explain to the public the nature of institutional costs, the reasons for those costs, and the reasons for differences in costs among comparable institutions. In order to perform this function it must require the public disclosure of health care institutions' financial condition, including balance sheets detailing

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assets, liabilities, and net worth as well as detailed statements of income and expense.

10. It is accountable to the public for assuring the solvency of institutions that operate efficiently and effectively and are deemed necessary by the appropriate planning agency.

11. It is accountable to the state and federal government to periodically document its activities by presenting financial data concerning the regulated industry.

12. Its budget approval decisions must be made on the weight of the evidence in the record. In any budget review and approval proceeding, it is the health care institution's responsibility to justify its budget. Potentially aggrieved parties may appeal alleged arbitrary and capticious decisions to the courts. The courts must adjudicate based upon the weight of the evidence in the record.

C. Organization and Financing

In each state the budget approval entity may be organized in one of the following ways, but in order to avoid conflict of interest and promote objectivity, the entity must not engage in administering health service programs or purchase institutional health services for either itself, its subscribers, or the state or federal government.

1. It may be organized as a full-time independent commission, composed of three to five highly qualified, well-compensated commissioners appointed by the governor to serve for relatively long, staggered terms. Recommendations for commissioners shall be solicited from providers as well as other interested parties. The commissioners should be chosen with a view toward their ability to bring to the commission broad-gauged, effective, and impartial policy direction. During their terms of appointment, commission members should not be permitted to engage in any other business, profession, vocation, public elective office or employment, or in any activity that would result in a conflict of interest with their duties as commissioner.

2. It may be organized as an independent commission, composed of five to nine highly qualified compensated or uncompensated commissioners, appointed on a part-time basis by the governor to serve for relatively long, staggered terms. Recommendations for commissioners shall be solicited from providers as well as other interested parties. They should bring to the commission broad-gauged, effective, and impartial policy direction, which may include a balanced representation from various interests.

3. It may be organized as a nongovernmental entity operating under a contract with the state and under sanction of state laws. Such an entity would have to be nominated or approved by two-thirds

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of the providers and the majority of major third-party payers subject to its decisions. The entity's actions would have to be generally authorized by state legislation so that its actions will be at least quasi-governmental or its decisions would have to be specifically approved by a government entity so that its decisions will be governmental in their effect. States should have wide latitude in the format for such entities, but they should follow procedures and principles that fulfill all of the requirements listed in these guidelines.

Regardless of the manner in which it is organized, the entity must have a professional, well-qualified staff of adequate size. The staff will conduct ongoing activities, including gathering and analyzing financial data and providing recommendations on budget approval requests.

The entity's financing will be through assessments levied by the state legislature on an equitable basis against health care institutions. Assessments so levied must be used only for financing the direct and related expenses of the budget review and approval process. The financing, especially during the start-up period, may be augmented by grants from other sources. The cost of any assessment against the health care institution will be includable in its financial requirements.

D. Relationship with the Planning Process

The plan submitted by each state applying for federal delegation of the budget approval responsibility will include a protocol for the integration of payment regulation with other regulatory mechanisms within the state.

Decisions of the budget approval entity must be reached with the assurance that the health care institution's facilities are adequate and acceptable and do not unnecessarily duplicate other facilities and services within the community. Decisions related to the approved level of payments will be made in accordance with the established planning process and will finance the necessary provisions for changes in services and facilities in the region to achieve more effectiveness.

The entity's decisions should promote long-term efficiency and effective use of resources by facilitating voluntary discontinuation of unneeded services and facilities as approved by the planning process.

In addition, the protocol for the integration of planning regulation with budget review and approval will provide that:

1. The criteria used by the Health Systems Agency and the certificate-of-need agency in the review of the financial feasibility of applications will be jointly developed by the budget approval entity and the certificate-of-need agency.

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2. On all applications for certificate-of-need agency approval, that agency will receive and consider financial analyses and economic impact studies provided by the budget approval entity.

3. The certificate-of-need agency's approval of a certificate-of-need application will be binding upon the budget approval entity to recognize the financial requirements associated with the service or facility.

E. The Budget Review and Approval Process

1. Grandfathering

At the time of the establishment of the entity and promulgation of its administrative regulations, the charges of all health care institutions then currently offered would be deemed reasonable, adequate, and proper; they will thus be constructively approved by the entity.

2. Budget Approval Process

Proposed budgets and charges, together with data for their justification, will be submitted by the health care institution within a specified period of notice prior to the beginning of the budget year. The institution could make a request more than 90 days in advance of the proposed effective date, but the notice should not be required to be longer than 90 days. During this notice period, the entity will perform the necessary approval process and reach a decision on the propriety of the application. In the event that a decision is not announced by the 90th day following such application, the application will be deemed approved and may then be implemented by the institution.

Where emergency situations arise under which changes might be needed to maintain the institution's ability to serve the community, the entity may reduce the specified notice period. This will be done under circumstances clearly defined in its regulations and after a prompt review of the institution's reasons for requesting emergency consideration.

In order to simplify the budget review and approval process, the entity will be authorized to permit changes in charges by the health care institution to be filed and implemented without the necessity for the formal hearing process in certain predefined situations, which are likely to be repetitive (such as allowances for routine inflation adjustments). The waiving of the advance notice requirements and the hearing process should apply to routine requests for changes in institutional health care charges when such changes are consistent with the approved budgeted gross and net revenue.

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All institutional costs associated with the budget review and approval process will be considered appropriate elements of financial requirements.

3. Public Hearing Process

When budget applications are filed, the budget approval entity will cause public notices of the application to be given as specified in the entities regulations. The notice will specify a deadline for filing written comment. In the event of protest, a formal public hearing on the merits of any substantial application may be ordered by the entity. In any case where the application is being contested, the affected parties will have the right to present related evidence and arguments. The entity will prepare an official record, including testimony and exhibits, in each contested case and will follow appropriate rules of procedure for notice and hearing.

All evidence, including records and documents in the possession of the agency of which it desires to avail itself, will be offered and made a part of the record in case, and no other factual information or evidence will be considered in the determination of the case. Documentary evidence could be received in the form of copies or excerpts or could be incorporated by reference.

Whenever in a contested case the majority of the members of the entity who are to render a final decision have not heard the evidence, the decision will not be made until a proposal for a decision, including findings of fact and conclusions of law, has been served upon the parties. In addition, an opportunity must be afforded to each party adversely affected to file exceptions and present arguments to a majority of the members who are to render the decision.

Every decision and order rendered by the entity that is adverse to a party in a contested case will have to be in writing or stated in the record and be accompanied by findings of fact and conclusion of the law. The findings of fact will consist of a concise statement of the conclusions upon each contested issue of fact. A copy of the decision or order and the accompanying findings and conclusions will be delivered or mailed promptly to each party of record.

Any party aggrieved by a final decision in a contested case will be entitled to judicial review. In order to expedite its early determination, a matter under judicial review shall be given priority on the court dockets as a case of public interest. Any legal fees incurred by the institution in the budget review and approval process, as well as the appeals process, are justified elements of an institution's financial requirements. The entity, by regulation, shall provide for interim budgets and charge schedules to be used by the institution while the decision on its application is under judicial review.

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IV. Implementation

A. In the legislation establishing the budget approval entity, there must be provisions for the implementation of the proposal with ample opportunity for the development of sound standards for reporting, criteria and methods for establishing the budget approval procedures, and implementation of the budget approval process. It is vital that deadlines be set as to how long the states have to initiate the entity and have the program become operational. Rather than setting different time spans for each stage of implementation, it is recommended that it be required that the program be enacted by law at the first legislative session subsequent to enactment and be implemented by submission of the plan for federal approval within one year after enactment. This allows flexibility for states in which the timing of the legislature's meetings does not coincide with a specified time period for setting up the entity.

The full implementation of the budget approval process should be approached with due consideration of the importance of developing a sound process as well as meeting the urgency of the timing. In order to achieve this, the need to educate health care institutions about budgets and the budgeting process must be met. While provisions for education are not the duty of the budget approval entity, it is imperative that all involved be aware of the need. This would then allow for the state hospital associations or some other body to fulfill the educational role.

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DEFINITIONS

Full Financial Requirements

Full financial requirements, as differentiated from accounting costs, are defined as those resources that are not only necessary to meet current operating needs, but also sufficient to permit replacement of the physical plant when appropriate and to allow for changing community health and patient needs, education and research needs, and all other needs necessary to the institutional provision of health care services that must be recognized and supported by all purchasers of care.

Health Care Institution

The definition of "health care institution" as contained in the American Hospital Association's Classification of Health Care Institutions is: Establishment with permanent facilities and with medical services for patients, including inpatient care institutions, outpatient care institutions with organized medical staffs, and home care institutions.

Independent Commission

An independent commission is defined as a entity, established by law, whose sole purpose is the review and approval of budgets for health care institutions. It shall not be a subsidiary of any other agency or entity.

Major Third-Party Payers

Major third-party payers are organized groups or governmental programs that usually pay hospitals directly for the hospital services provided to group members or program beneficiaries.

Oversight

The review of the implementation of a program, on a periodic basis, with specific attention to the regulations being promulgated and their consistancy with the enabling legislation.

Parties

Parties are payers, providers, and consumers who have a direct or indirect interest in the activities and pronouncements of the budget approval entity.

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Public Hearing

A public hearing is an open forum for any member of the public as well as all other parties involved or interested in the budget review and approval process. Such hearings should be governed by the state's Administrative Procedures Act.

Volume Changes

Volume changes, for the purpose of this document, are defined as changes in the number of patients treated as well as changes in case mix, intensity, and utilization patterns.

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STATEMENT

ATTACHMENT B

AMERICAN HOSPITAL ASSOCIATION

FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES

Financial requirements, as differentiated from accounting costs, are defined as those resources that are not only necessary to meet current operating needs, but also sufficient to permit replacement of the physical plant when appropriate and to allow for changing community health and patient needs, education and research needs, and all other needs necessary to the institutional provision of health care services that must be recognized and supported by all purchasers of care.

If an institution ensures that its role and mission is consonant with community needs, there is a corollary that the institution be assured that its financial requirements are met. In essence, the community must provide the proper financing of its health care delivery system, and the components within the health care system must accept the responsibility for proper planning and management of that system. Philanthropy should be encouraged as an important source of funding. To provide this encouragement, it should not be used as reimbursement for services that could otherwise be paid by the patient or a third party.

This revision of the 1969 Statement on the Financial Requirements of Health Care Institutions and Services *reaffirms and updates the position taken in that document by emphasizing that all purchasers of health care must recognize and share fully in the total financial requirements of institutions providing care. It further recognizes the established concept of the need for adequate reserves as a capital requirement. This statement was approved by the House of Delegates of the American Hospital Association in August 1977.*

Introduction

The delivery of health services requires a vast array of professional services, institutions, allied health organizations and educational programs, research activities, and community health projects. A high-quality health care delivery system is dependent upon the commitment of sufficient resources and their effective management. The system must ensure that necessary services are provided to the public in an effective, efficient, and economic manner. Coordination of the components of the health care delivery system and self-discipline of all participants within the system are necessary to meet this end. Three interrelated functions whereby such coordination and self-discipline can be achieved are effective planning, effective utilization, and effective management. These functions share the ultimate purpose of maintaining the highest standards of quality in the delivery of health care.

The health care delivery system has and should continue to have multiple sources of financing that must meet total financial requirements. These sources of financing should recognize that health care institutions must be financed at a level that supports the health objectives of the community, including uncompensated care costs as defined herein. The health care delivery system and its financing should be sufficiently flexible to change as the needs of the community change and as new and effective technologies are developed so that the total financial requirements can continue to be met.

Elements of financial requirements

Institutional financial stability requires that there be a realistic appraisal of the two major financial components: (1) current operating requirements and (2) operating margin.

Meeting these financial requirements will enable the institutions to maintain and improve current programs and facilities and to initiate new programs and facilities consistent with community needs and advances in medical science.

Health care institutions differ in size, scope, and types of ownership and services, and therefore their operating and capital requirements differ. However, all elements of financial requirements must be reflected in the payments to health care institutions to provide adequately for demonstrated financial needs. The elements of financial requirements are described below.

Current operating requirements

Current operating requirements include the following costs:

1. Patient care

   These costs include, but are not limited to, salaries and wages, employee benefits, purchased services, interest expense, supplies, insurance, maintenance, minor building modification, leases, applicable taxes, depreciation, and the monetary value assigned to services provided by members of religious orders and other organized religious groups.

2. Patients who do not pay

   It must be recognized that a portion of the total financial requirements will not be met by certain patients who:

   a. Fail to fully meet their incurred obligation for services rendered,

   b. Are relieved wholly or in part of their responsibilities because of their inability to pay for services rendered.

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Therefore, these unrecovered financial requirements must be included as a current operating requirement for those who pay.

3. Education

Where financial needs for educational programs having appropriate approval have not been met through tuition, scholarships, grants, or other sources, all purchasers of care must assume their appropriate share of the financial requirements to meet these needs.

4. Research

Appropriate health care services and patient-related clinical research programs are an element of the total financial requirements of an institution. The cost of these programs should be met primarily from endowment income, gifts, grants, or other sources.

Operating margin

In order to meet the total financial requirements of an institution, a margin of net patient care revenues in excess of current operating requirements must be maintained. This difference will provide necessary funds for working capital requirements, capital requirements, and return on equity.

1. Working capital requirements

Financial stability is dependent on having sufficient cash to meet current fiscal obligations as they come due.

2. Capital requirements

Health care institutions are expected to meet demands resulting from such factors as population shifts, discontinuance of other existing services, and changes in the public's demand for types of services delivered. In order to be in a position to respond to such changing community needs, health care institutions must anticipate and include such capital needs in their financial requirements. There must be assurances that adequate resources will be available to finance recognized necessary changes.

The capital requirements of a health care institution must be evaluated and approved by its governing authority in the context of the institution's role and mission in the community's health care delivery system. Coordination among the health care institution's governing authority, administration, and medical staff and the cooperation among health organizations and the appropriate areawide health planning agency are essential to this evaluation.

a. Major renovations and repairs

Funds must be provided for necessary major repairs of plant and equipment to ensure compliance with changing regulatory standards and codes and to finance planned and approved renovation projects.

b. Replacement of plant and equipment

Because of deterioration and obsolescence, assets must be replaced and modernized based on community needs for health care services. Funds that reflect the changes in general price levels must be available for the replacement and modernization of plant and equipment.

c. Expansion

Sufficient funds must be available for the acquisition of additional property, plant, and equipment when consonant with community needs.

d. New technology

Advances in medical science and advances in the technology of delivering health services often require additional expenditures. Sufficient financial resources must be available for continued additional investment in the improvement of plant and equipment, consonant with community needs, so that health care institutions can keep pace with changes in the health care delivery system.

3. Return on equity

Investor-owned institutions should receive a reasonable return on their owners' equity.

Responsibilities of purchasers for meeting financial requirements

Each institution's total financial requirements should be apportioned among all purchasers of care in accordance with each purchaser's use of the institution and measurable impact on the operations of the institution. Any apportionment that permits a purchaser to assume a lesser responsibility is not appropriate and does not alter the total financial requirements of the health care institution. Rather, it requires other purchasers to make up the deficiency.

Responsibilities of providers

Health care institutions have an obligation to disclose to the public evidence that their funds are being effectively utilized in accordance with their stated purpose of operation. Institutions also have a responsibility not only to purchasers of care but also to their community to provide effective management. An institution's goals and the methods that it uses to acheive those goals should be consonant with community planning and the resources in that community.

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MANAGEMENT ADVANCEMENT PROGRAM SEMINAR

Phase I

La Coquille Club
Palm Beach, Florida
June 9-14, 1978

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Ann Arbor, MI 48104

11. Felix E. Demartini, M.D.
Executive Director
The Presbyterian Hospital in
the City of New York
622 West 168th Street
New York, NY 10032

12. Jerome R. Dolezal
Hospital Director
Veterans Administration Hospital
4435 Beacon Avenue South
Seattle, WA 98108

13. Donald H. Eisenberg
Superintendent
Nassau County Medical Center
2201 Hempstead Turnpike
East Meadow, NY 11554

14. James M. Ensign
President
Creighton Omaha Regional
Health Care Corporation
2305 South Tenth Street
Omaha, NE 68108

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15. Robert L. Evans, M.D.
President
Cooper Medical Center
Sixth and Stevens Streets
Camden, NJ 08103

16. Irwin Goldberg
Executive Director
The Montefiore Hospital Association
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3459 Fifth Avenue
Pittsburgh, PA 15213

17. William H. Gurtner
Executive Director
Mt. Zion Hospital and Medical Center
1600 Divisadero Street
San Francisco, CA 94120

18. John F. Harlan, Jr.
Hospital Director
University of Virginia Medical Center
Jefferson Park Avenue
Charlottesville, VA 22901

19. Thomas L. Hawkins, Jr., M.D.
President & Director
Albany Medical Center Hospital
New Scotland Avenue
Albany, NY 12208

20. William F. Hejna, M.D.
Senior Vice-President
Rush-Presbyterian-St. Luke's
Medical Center
1753 West Congress Parkway
Chicago, IL 60612

21. Paul Hofman
Administrator and Chief
Executive Officer
Emory University Hospital
1364 Clifton Road, N.E.
Atlanta, GA 30322

22. John F. Imirie
Hospital Director
Foster C. McGaw Hospital of
Loyola University of Chicago
1360 South First Avenue
Maywood, IL 60153

23. John E. Ives
Executive Director
Shands Teaching Hospital & Clinics
Box 767, J. Hillis Miller Health
Center
University of Florida
Gainesville, FL 32610

24. William I. Jenkins
Administrator
William N. Wishard Memorial Hospital
1001 West Tenth Street
Indianapolis, IN 46202

25. L. R. Jordan
President, Ochsner Foundation Hospital
of the Alton Ochsner Medical Foundation
1516 Jefferson Highway
New Orleans, LA 70121

26. William B. Kerr
Director of Hospitals & Clinics
University of California Hospitals
and Clinics
Third Avenue & Parnassus
San Francisco, CA 94143

27. Sheldon S. King
Director of Hospital & Clinics
University of California, San Diego
Medical Center
225 West Dickinson Street
San Diego, CA 92103

28. William Kreykes
Executive Director
Vanderbilt University Hospital
1161 - 21st Avenue, South
Nashville, TN 37221

29. Mark S. Levitan
Executive Director
Hospital of the University
of Pennsylvania
3400 Spruce Street
Philadelphia, PA 19104

30. Edgar O. Mansfield
Administrator
Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, OH 43214

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Executive Vice-President
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8700 Beverly Boulevard
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33. Charles M. O'Brien, Jr.
Administrator
Georgetown University Hospital
3800 Reservoir Road, N.W.
Washington, DC 20007

34. C. J. Price
Administrator
Dallas County Hospital District
5201 Harry Hines Boulevard
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35. Ruth M. Rothstein
Vice President-Executive Director
Mt. Sinai Hospital Medical Center
of Chicago
California at 15th Street
Chicago, IL 60608

36. Peter Sammond
Executive Director
Mt. Sinai Hospital
2215 Park Avenue
Minneapolis, MN 55404

37. Richard C. Schripsema
Director
Hurley Medical Center
Sixth Avenue & Begole Streets
Flint, MI 48502

38. John K. Springer
Executive Director
Hartford Hospital
80 Seymour Street
Hartford, CT 06115

39. David L. Steffy
Director
Ohio State University Hospitals
410 West Tenth Avenue
Columbus, OH 43210

40. Lavand M. Syverson
Executive Director
St. Paul-Ramsey Hospital and
Medical Center
640 Jackson Street
St. Paul, MN 55101

41. William Towle
Executive Vice-President
The Roosevelt Hospital
428 West 59th Street
New York, NY 10019

42. Dennis F. Buckley
Executive Vice-President
North Shore University Hospital
300 Community Drive
Manhasset, NY 11030

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With Mar 22-23, 1978 agenda COTH Adm Bd

ELIGIBILITY FOR CONTINUING COTH MEMBERSHIP

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Eligibility for Continuing COTH Membership

Background

In 1975 the COTH Administrative Board recommended and the AAMC Executive Council and Assembly approved the establishment of a new membership category, Corresponding Membership, for the Council of Teaching Hospitals. In making its recommendation, the COTH Administrative Board adopted the position that "membership criteria . . . be communicated to all present hospitals and that they be advised that their eligibility for continued membership after November 1977 will be determined on the basis of these criteria." Department staff have undertaken a study of the eligibility of present COTH members. This report reviews current membership criteria and summarizes staff findings on members who may not fulfill required criteria.

Membership Criteria

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

Teaching Hospital membership is limited to not-for-profit -- IRS 501(C)(3) -- and publicly-owned hospitals which sponsor, or significantly participate in, at least four approved, active residency programs. At least two of the approved residency programs must be in the following specialty areas: internal medicine, surgery, obstetrics-gynecology, pediatrics, family practice, or psychiatry. Other considerations evaluated in determining a hospital's participation in medical education activities are:

- -- the availability and activity of undergraduate clerkships;
- -- the presence of full-time chiefs of service or a director of medical education;
- -- the number of internship and residency positions in relation to bed size, the proportion (in full-time equivalents) which are filled, and the proportion which are filled by foreign medical graduates;
- -- the significance of the hospital's educational programs to the affiliated medical school and the degree of the medical school's involvement in them; and
- -- the significance of the hospital's financing support for medical education.

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In the case of specialty hospitals -- such as children's, rehabilitation, and psychiatric institutions -- the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Non-profit and governmental hospital and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership but having affiliation agreements are eligible for corresponding membership.

Findings

In reviewing the preliminary findings from the staff survey of membership eligibility, it should be noted that, in spite of several follow-up letters, twenty-two hospitals, 5% of the total membership, have not yet returned the questionnaire used to obtain the necessary criteria information. Some of these hospitals, all of which are listed in Table 1, may increase the number of present members who do not fulfill membership criteria.

Table 2 lists eighteen hospitals that returned the questionnaire but failed to provide a copy of their affiliation agreement. The table also lists the affiliation status of the hospital as shown in the latest LCGME Directory of Approved Residencies, i.e., the "Green Book." Attachment A reproduces, from the LCGME Directory, the description of the procedure and criteria used by the LCGME to determine affiliation status. All of the hospitals shown in Table 2 have been sent a follow-up letter requesting a copy of their affiliation agreement; however, none of these hospitals has responded to that follow-up letter.

Table 3 is a list of twelve present COTH members submitting, with their membership questionnaires, a letter indicating the hospital is unaffiliated. Copies of the letters are included in Appendices B-N.

Table 4 lists six current COTH members submitting a letter from the Dean of the related school describing the hospital's relationship with the medical school. Copies of the letters are included as enclosures O-T.

Five current COTH members have unsigned affiliation agreements with their related medical schools. The five members are shown in Table 5.

Table 6 lists two members who lack institutional affiliation agreements but have department level agreements between hospital services and school departments.

Table 7 shows six hospitals that sponsor or participate in three or fewer approved residency programs and Table 8 lists three hospitals having fewer than two residencies in the required specialties. Members listed in Tables 7 and 8 are eligible for corresponding membership.

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Conclusion

Based on the actions of a previous COTH Administrative Board and AAMC Executive Council, it is recommended that the present COTH Administrative Board recommend to the AAMC Executive Council what actions, if any, should be taken with respect to current COTH members not fulfilling present Teaching Hospital membership requirements.

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Table 1 -- COTH Members Not Responding to 1978 Directory/Membership Questionnaire

1. Cedars of Lebanon, Florida
2. The Queens Hospital, Hawaii
3. Cook County Hospital, Illinois
4. Wayne County Psychiatric Hospital, Michigan
5. Mt. Sinai Hospital, Minnesota
6. Martland Hospital, New Jersey
7. Newark Beth Israel Hospital, New Jersey
8. Bronx Lebanon Hospital Center, New York
10. Cumberland Hospital, New York
11. New York Medical College, Flower & Fifth Avenue Hospital
12. North Central Bronx Hospital, New York
13. Highland Hospital of Rochester, New York
14. Charlotte Memorial Hospital, North Carolina
15. Hospital of the University of Pennsylvania
16. Eye and Ear Hospital of Pittsburg, Pennsylvania
17. City of Memphis Hospital, Tennessee
18. Wilford Hall, U.S.A.F. Medical Center, Texas
19. Mayaguez Hospital, Puerto Rico
20. San Juan Municipal Hospital, Puerto Rico
21. University District Hospital, Puerto Rico
22. Memorial Hospital of Rhode Island

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Table 2 -- Present COTH Members Who Returned a Questionnaire But Who Have Not sent a Copy of Their Affiliation Agreement

	Institution	"Green Book" Status[1]
1.	Mount Zion Hospital, San Francisco, California	Limited Affiliate
2.	Veterans Administration Hospital, Washington, D.C.	Major and Limited Affiliate
3.	Little Company of Mary Hospital, Evergreen Park, Illinois	Unaffiliated
4.	Mount Sinai Hospital of Chicago, Illinois	Unaffiliated
5.	Boston Hospital for Women, Massachusetts	Major Affiliate
6.	Butterworth Hospital, Grand Rapids, Michigan	Major Affiliate
7.	Abbott-Northwestern Memorial Hospital, Minnesota	Limited Affiliate
8.	Saint Michael's Hospital, New Jersey	Major Affiliate
9.	Saint Barnabas Medical Center, Livingston, New Jersey	Limited Affiliate
10.	Kings County Hospital Center, New York	Major Affiliate
11.	Methodist Hospital, Brooklyn, New York	Major Affiliate
12.	Harlem Hospital, New York City	Major Affiliate
13.	Jewish Hospital of Brooklyn, New York	Major Affiliate
14.	Akron General Hospital, Akron, Ohio	Unaffiliated
15.	Western Psychiatric Hospital, Pittsburgh	Major Affiliate
16.	Western Pennsylvania Hospital, Pittsburgh	Limited Affiliate
17.	Women & Infants Hospital of Rhode Island	Major Affiliate
18.	Latter-day Saints Hospital, Salt Lake City, Utah	Limited Affiliate

[1]Hospitals have been identified as a major affiliate when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals have been identified as a limited affiliate when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. A graduate affiliation indicates a hospital used by the school for graduate training programs only.

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Table 3 -- Present COTH Members Submitting a Letter Indicating Hospital Is Unaffiliated

Institution	"Green Book" Status[1]	See Attachment
1. St. Joseph's Hospital and Medical Center, Arizona	Major Affiliate	B
2. Mercy Hospital and Medical Center, California	Major Affiliate	C
3. Gorgas Hospital, Canal Zone	Unaffiliated	D
4. Touro Infirmary, Louisiana	Major Affiliate	E
5. National Institute of Health, Maryland	Limited Affiliate	F
6. Prince George's General Hospital and Medical Center, Maryland	Unaffiliated	G
7. The Catholic Medical Center of Brooklyn and Queens, Inc., New York	Unaffiliated	H
8. St. Vincent's Medical Center of Richmond, New York	Unaffiliated	I
9. Wilson Memorial Hospital, New York	Limited Affiliate	J
10. Cleveland Clinic, Ohio	Limited Affiliate	K
11. Mercy Hospital, Pennsylvania	Limited Affiliate	L
12. St. Francis General Hospital, Pennsylvania	Limited Affiliate	M
13. Baptist Memorial Hospital, Tennessee	Major Affiliate	N

[1]Hospitals have been identified as a major affiliate when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals have been identified as a limited affiliate when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. A graduate affiliation indicates a hospital used by the school for graduate training programs only.

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Table 4 -- Present COTH Members Submitting a Letter From Dean of "Affiliated" Medical School In Lieu of Signed Affiliation Agreement

Institution	"Green Book" Status[1]	See Attachment
1. Maricopa County General Hospital, Arizona	Limited and Graduate Affiliate	O
2. Berkshire Medical Center, Massachusetts	Limited and Graduate Affiliate	P
3. Brooklyn Hospital, New York	Major Affiliate	Q
4. Lutheran Medical Center, New York	Graduate Affiliate Graduate Affiliate	R
5. Emanuel Hospital, Oregon	Limited Affiliate	S
6. Beckley Appalachian Regional Hospital, West Virginia	Limited Affiliate	T

[1] Hospitals have been identified as a major affiliate when a medical school has indicated that the hospital is a major unit in the schools' teaching program. Hospitals have been identified as a limited affiliate when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. A graduate affiliation indicates a hospital used by the school for graduate training programs only.

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Table 5 -- Present COTH Members With Unsigned Affiliation Agreements

Institution	"Green Book" Status[1]
1. Memorial Hospital Medical Center of Long Beach, California	Major Affiliate
2. Iowa Methodist Medical Center, Iowa	Limited Affiliate
3. St. Elizabeth's Hospital of Boston, Massachusetts	Limited and Graduate Affiliate
4. Monmouth Medical Center, New Jersey	Major and Limited Affiliate
5. Texas Children's Hospital, Texas	Major Affiliate

[1]Hospitals have been identified as a major affiliate when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals have been identified as a limited affiliate when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. A graduate affiliation indicates a hospital used by the school for graduate training programs only.

Date Prepared: 3/13/78

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Table 6 -- Present COTH Members With Affiliations Only At Departmental Level

Institution	"Green Book" Status[1]
1. Providence Hospital, Southfield, Michigan	Limited and Graduate Affiliation
2. Hamot Medical Center, Erie, Pennsylvania	Graduate Affiliate

[1] Hospitals have been identified as a major affiliate when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals have been identified as a limited affiliate when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. A graduate affiliation indicates a hospital used by the school for graduate training programs only.

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Table 7 -- Present COTH Members With Three or Fewer Approved Residency Programs

Institution

1. Norwalk Hospital, Connecticut - Internal Medicine, Pathology
2. Little Company of Mary Hospital, Illinois[1] - Pathology, Radiology, Surgery
3. Abbott-Northwestern Memorial Hospital, Minnesota - Internal Medicine, Pathology, Surgery
4. Veterans Administration Hospital, Dayton, Ohio - Internal Medicine, Surgery, Urology
5. Saint Thomas Hospital, Nashville, Tennessee - Internal Medicine, Surgery, Thoracic Surgery
6. Beckley Appalachian Regional Health Care, West Virginia - Internal Medicine, Pathology, Surgery

[1]Would have four approved programs if Flexible First Year accepted as a residency program.

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Table 8 -- Present COTH Members With Less Than Two of the Required Residency Programs

Institution
1. Norwalk Hospital, Connecticut - Internal Medicine
2. Little Company of Mary Hospital, Illinois - Surgery
3. NIH Clinical Center, Bethesda, Maryland - Psychiatry

Date Prepared: 3/13/78

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Residencies by Medical School Affiliation and Bed Capacity

Table 13 classifies programs by bed capacity and medical school affiliation. It must be emphasized that affiliation with a medical school is *not* a requirement for approval of graduate training programs; programs are evaluated on the basis of their quality and their conformance with the requirements stated in the "Essentials of Approved Residencies."

Information concerning the affiliation of medical schools with hospitals offering residency programs is obtained from the office of the dean of the medical school; it is not solicited nor usually accepted on the basis of a statement from the institution, because of the variety of affiliation arrangements possible, and because of the necessity of using the information provided from an official source. The indication of affiliation with a medical school for an individual hospital as shown in the "Consolidated List of Hospitals" which follows these reports in each issue of the Directory. Hospitals may be listed as having a major affiliation with a medical school, be affiliated to a limited extent, or be affiliated only for graduate medical education. The classification designated by the dean of a medical school is accepted, but each school, is provided with a definition of the expected use of these terms. When a hospital has been designated as having a major affiliation, it is expected that it plays a major role in the clinical clerkship program of the medical school, with students serving regularly on inpatient services under the direct supervision of members of the medical school faculty. It is expected that hospitals listed as being major teaching hospitals would provide clerkships in two or more of the major services of internal medicine, general surgery, pediatries, and obstetrics, but the list might also include hospitals responsible for most of the teaching in a single specialty, such as psychiatry, chest diseases, or pediatrics.

A hospital used for teaching to a limited extent might provide clerkship experience irregularly, on an elective basis, in limited specialties, or only in the outpatient service, but such experience should still be related to curricular assignments and should be under the supervision of faculty members. Hospitals may be indicated as having an affiliation for graduate training even though they do not participate in the clerkship program of a medical school. The designation of graduate affiliation may be used for hospitals not already designated as having a major or limited affiliation and in cases in which one or more of the following arrangements is in effect:

1. House staff selected by officials of a specific medical school department or by a joint committee of the hospital teaching staff and the medical school faculty;

2. Some degree of actual exchange of residents between the hospital designated with a graduate type of affiliation, and the principal medical school teaching hospital;

3. Regularly scheduled participation of medical school faculty (other than the hospital's own attending staff) and teaching programs at the "G" Hospital;

4. A contractual arrangement (with or without financial commitment) for assistance in the organization and supervision of the graduate program in the hospital designated for graduate training.

The designation of graduate affiliation should not be used if the hospital is used for undergraduate clerkship teaching, if the faculty participation is as tenuous as an occasional lecture or consultation visit, or if the hospital's residents attend medical school teaching conferences only as visitors.

Of the hospitals designated as having an affiliation, the "combined hospital" category represented 11% of the total number of hospitals offering residencies, and this group had 29% of the approved programs, offered 40% of the residency positions, and recruited 41% of the total candidates appointed. They obtained 45% of the U. S. and Canadian graduates and 29% of the foreign graduates. The previous year this category represented 14% of the total number of hospitals, offered 40% of the residencies; obtained 44% of the U. S. and Canadian graduates, and 25% of the available foreign graduates. Therefore, although the number of hospitals involved has decreased, their success in recruiting candidates has increased. The next largest group among the affiliated hospitals was the group with 500 or more beds, which comprised 21% of the hospitals offering residencies. This group offered 32% of the total positions, recruited 32% of the available residents, including 31% of the available U. S. and Canadian graduates and 35% of the available foreign graduates. Their record for 1973 was similar. The group of affiliated hospitals with 300 to 499 beds comprised 19% of the total number of hospitals participating in residencies, offered 19% of the programs and 14% of the total positions. They recruited 14% of the available candidates, obtaining 13% of the available U. S. and Canadian graduates and 16% of the available foreign graduates. Their record also was similar to that of 1973.

In the group of non-affiliated hospitals, the largest group was that of less than 200 beds. This group, which comprised 11% of the hospitals offering programs, offered 3% of the programs, with 2% of the total positions offered. They recruited 1% of the available candidates, filling their positions with less than 1% of the available U. S. and Canadian graduates and with 2% of the foreign graduates. This group had the lowest percentage of positions filled, 79%, but also had the lowest percentage, among the non-affiliated hospitals of foreign graduates recruited. The non-affiliated hospitals, however, recruited only 7% of the total candidates available, appointing only 4% of the available U. S. and Canadian graduates and 14% of the foreign graduates. In 1973 they had recruited 9% of the available candidates, and had appointed 5% of the available U. S. and Canadian graduates, and 16% of the available graduates of foreign medical schools. The total number of residents appointed in the non-affiliated hospitals was 451 less than in 1973, or a decrease of about 11%.

SOURCE: LCGME Directory of Accredited Residencies, 1975-76

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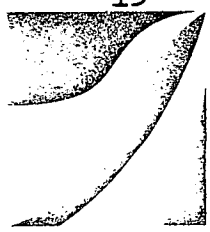

ST. JOSEPH'S
HOSPITAL AND MEDICAL CENTER

Post Office Box 2071
Phoenix, Arizona 85001
277-6611 (Area 602)

December 15, 1977

James D. Bentley, Ph.D.
Assistant Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, NW
Washington, D.C. 20036

Dear Dr. Bentley:

This is in reply to your letter of November 30, 1977, regarding our affiliation with the University of Arizona.

St. Joseph's Hospital and Medical Center [redacted] agreement with the University of Arizona. However, individual departments - Internal Medicine, Pediatrics, Neurology, Neurological Surgery and Family Practice - have departmental agreements for undergraduate medical education.

The undergraduate training offered in these departments is listed in the University of Arizona's catalogue of available senior rotations.

If you wish copies of the individual departmental agreements, please let us know, and we will be happy to forward them.

Sincerely yours,

Joseph C. White, Jr., M.D.
Director of Medical Education

JCW/fmg

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MERCY HOSPITAL AND MEDICAL CENTER

SERVING THE COMMUNITY SINCE 1890

4077 FIFTH AVENUE / SAN DIEGO, CALIFORNIA 92103 / PHONE (714) 294-3111

January 3, 1978

James D. Bentley, Ph.D.
Assistant Director
Council of Teaching Hospitals
Assoc. of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Bentley:

This letter is in response to your request for a copy of our agreement with the University of California, San Diego Medical School. [redacted] The only documentation that I can think of at this time is a listing of residencies in the green book which includes Pediatrics, Orthopedics and Surgery.

If there is some other way we can meet your request, please let me know.

Sincerely,

Edward G. Hertfelder
Administrator

EGH/mg

Almighty God, we humbly ask the help of Thy mercy on behalf of Thy servants who are sick, that being restored to health they may give thanks to Thee.

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CANAL ZONE GOVERNMENT
CANAL ZONE

IN REPLY REFER TO:

Gorgas Hospital
Box "O"
Balboa Heights, Canal Zone
December 5, 1977

James D. Bentley, PH.D.
Assistant Director
Department of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Bentley:

We have received your letter requesting copy of the hospital's present medical school affiliation agreement.

Gorgas Hospital is operated by the U.S. Government in the Canal Zone and [redacted]. We, therefore, cannot provide this document for your Directory.

Sincerely yours,

Richard T. Travis, M.D.
Assistant Director/Medical Activities

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ESTABLISHED 1854

TOURO INFIRMARY

1401 FOUCHER STREET • (504) 897-8244 • NEW ORLEANS, LOUISIANA 70115

office of the EXECUTIVE DIRECTOR

December 12, 1977

Richard M. Knapp, Ph.D.
Director, Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, NW
Suite 200
Washington, D.C. 20036

Dear Dr. Knapp:

This letter will serve to document the relationship between Touro Infirmary and Tulane University School of Medicine as regards post-graduate teaching programs conducted by Tulane at Touro.

For many years, Touro has been one of the principal institutions utilized by Tulane for residency training. There has never been, however, a written affiliation agreement. Both institutions recognize that such agreements should be committed to writing. The Dean of the School of Medicine and the Executive Director of Touro have pledged themselves to preparation of a written affiliation agreement which will be presented to the Boards of the two institutions for approval. In the meantime, this letter is intended to outline the scope of our affiliation for presentation to the Council of Teaching Hospitals.

Touro and Tulane are affiliated in the following departments:

Department/Division	Number of Residents Assigned to Touro
Medicine	18
Surgery	3
Orthopedics	3
Urology	2
Ophthalmology	2
Plastic Surgery	1

In addition, ten fourth-year medical students are assigned to Touro at any one time by Tulane.

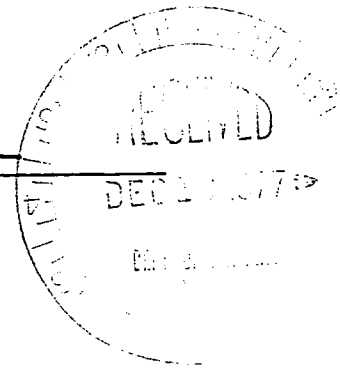
I hope that this letter will be sufficient evidence that Touro and Tulane are indeed closely affiliated for purposes of medical education. It is anticipated that a formal written affiliation agreement will be developed within the first quarter of 1978.

Sincerely,

James T. Hamlin III, M.D.
Dean, School of Medicine
Tulane University

J. L. Buckingham
Executive Director

JLB:cl



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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND 20014

August 25, 1977

Our Reference: CC-ASD-PVC

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

Dear Dr. Knapp:

A completed 1977 questionnaire for the Directory of Educational Programs and Services, giving data for the Clinical Center of the National Institutes of Health is enclosed. As I'm sure you know, the Clinical Center is an unusual "teaching hospital". It is not possible to give a fair description of the educational activities which go on here, in a format designed with most teaching hospitals in mind.

To begin, we don't have a formal affiliation agreement with a medical school. The affiliated Foundation for Advanced Education in the Sciences offers many evening courses for physicians, and the NIH-FAES is accredited by the AMA Council on Medical Education.

We offer nine clinical elective courses for medical students, open to 3rd and 4th year students in all U.S. medical schools, which are accepted as creditable towards the M.D. degree. About 120 students take these electives each year. Thus in a sense we are affiliated with all the Nation's schools.

The Associate program of the NIH offers advanced post-graduate training in virtually all fields of clinical and pre-clinical bio-medical research. These two-or three-year appointments (both clinical and non -clinical) are accepted by about 200 physicians every year. Only a few Associateships qualify as approved "free-standing" residency programs--namely Blood Banking and Clinical and Anatomical Pathology. More limited residency credit may accrue to the Clinical Associateships in Neurology, Psychiatry, Dermatology, and Nuclear Medicine. (I have listed these under Section IV as "PA", although these programs are not affiliated with any particular school or other hospital.

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By and large the Clinical Associateships are much more analogous to sub-specialty Fellowship programs in most teaching hospitals, creditable toward sub-specialty certification. As of July 15, 1977 there were 190 Clinical Associates on duty here.

Three catalogs, which give information on the FAES, electives for students, and the Associate program are enclosed. If it were somehow possible to include the information about the Associate in your directory, as I have summarized it above, we would appreciate it.

Sincerely,

P. V. Cardon, M.D.
Associate Director
The Clinical Center

Enclosures

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PRINCE GEORGE'S GENERAL HOSPITAL and MEDICAL CENTER

CHEVERLY • MARYLAND • 20785
301-341-3300

RALEIGH CLINE
Executive Vice President

November 16, 1977

Richard M. Knapp, Ph.D.
Council of Teaching Hospitals
One DuPont Circle, Suite 200
Washington, D. C. 20036

Dear Mr. Knapp:

The Board of Directors of Prince George's General Hospital and Medical Center has moved to negotiate a Medical School Affiliation Agreement with The University of Maryland. The hospital has not yet completed negotiations with the University of Maryland. When the negotiations are completed, a copy of our Medical School Affiliation Agreement will be sent to your office.

Sincerely,

Raleigh Cline
Chief Executive Officer

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THE CATHOLIC MEDICAL CENTER OF BROOKLYN AND QUEENS, INC.

88-25 153 ST. JAMAICA, N.Y. 11432
(212) 657-6800

December 7, 1977

James D. Bentley, Ph.D.
Assistant Director
Department of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Bentley:

In response to your correspondence of November 30, 1977, please be advised that [redacted]. However, as reported, it does maintain Departmental Free Standing Residency Programs.

Sincerely,

Irwin Shapiro
Director of Hospital
Administration

IS/th

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JOHN J. De PIERRO
Executive Vice President

January 12, 1978

James D. Bentley, Ph.D.
Assistant Director
Department of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Bentley:

In response to your letter of December 28, 1977 requesting a copy of our institution's affiliation agreement, please be advised that at the present time St. Vincent's does not have a formal agreement with a medical school.

For your information, at the present time we have departmental affiliations in Medicine, Surgery and Ob/Gyn with Downstate Medical Center.

We are expecting a letter shortly from the Medical School regarding our application and as soon as we receive word we will transmit this information to you.

Sincerely,

John J. DePierro
Executive Vice President

JJDeP/lsa

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WILSON MEMORIAL HOSPITAL

DEPARTMENT
OF
MEDICAL EDUCATION

33-57 HARRISON STREET
JOHNSON CITY, N.Y. 13790
TELEPHONE 607-773-6391

December 13, 1977

James D. Bentley, PH.D.
Assistant Director
Department of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Doctor Bentley:

In response to your letter of November 30th regarding our affiliation agreement with the Upstate Medical Center of Syracuse, New York, please be advised that the Upstate Medical Center to our knowledge has not formalized any affiliation agreement with its major teaching hospitals.

We are currently setting up representative committees to formally discuss these matters in view of Wilson Memorial Hospital's extended involvement with the Binghamton Clinical Campus of the Upstate Medical Center.

I will be pleased to provide you any other additional information if you so wish.

Sincerely,

Eugene M. Wyso, M.D.
Director of Medical Education

cc:Mr. Stith
Mr. Rozzi

EMW:bcd

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CLEVELAND CLINIC

THE CLINIC CENTER • 9500 EUCLID AVENUE, CLEVELAND, OHIO 44106, U.S.A. • 216/444-5694 • CABLE: CLEVCLINIC CLV.

EDUCATION DIVISION
William M. Michener, M.D.
Director

December 19, 1977

James D. Bentley, Ph.D.
Assistant Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Bentley:

In answer to your letter of November 30, 1977, indicating "a copy of the hospital-medical school affiliation agreement has not yet been received" I am writing to inform you that the Cleveland Clinic Education Foundation does not have any formal written teaching agreements whether they be affiliation or association agreements. No such written agreements have ever existed in the history of the Cleveland Clinic Foundation and its Educational Foundation. Graduate and other education programs in this Institution have always fallen under the "free-standing" designation.

I believe you are probably aware of the Cleveland Clinic Foundation's efforts in education but so that these may be documented for the purposes of the Council of Teaching Hospitals I would like to elaborate a few of these. The Cleveland Clinic Foundation at the present time has a full-time staff of 270 physicians practicing in the Cleveland Clinic and in the Cleveland Clinic Hospital, a hospital of 1000 beds. At the present time there are 437 medical doctors taking graduate education in all 27 training programs. All programs at the present time are approved as well. During the past year, 374 fourth year students from 70 different medical schools took electives in many different programs within the Institution. The Department of Pediatrics participates in the required clerkship for third years students at Case Western Reserve University Medical School. This Department is affiliated for the purposes of teaching pediatrics. Approximately 20 percent of the Case Western Reserve School of Medicine class takes their required pediatric experience in this Institution. Clinical faculty appointments are held by 35 to 40 Cleveland Clinic staff and there are many cooperative conferences between the various teaching programs.

I hope this information satisfies the criteria for memebership in the Council of Teaching Hospitals. If any any further information is needed,

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please contact me, and I will be happy to provide information or answer any questions you might have.

Sincerely yours,

William M. Michener, M.D.
Director of Education

WMM:ec

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Mercy
Hospital
Founded in 1847

Pride & Locust Streets
Pittsburgh, Pennsylvania 15219
Telephone (412) 232- 7500

December 8, 1977

James D. Bentley, PH.D.
Assistant Director
Dept. of Teaching Hospitals
Association of American
Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Mr. Bentley:

Per your phone conversation with my secretary regarding your correspondence of November 30th, please be advised that [redacted] t with the University of Pittsburgh Medical School.

If we can be of further assistance, please do not hesitate to call upon us.

Sincerely,

Sr. M. Ferdinand Clark

Sister M. Ferdinand Clark
Executive Director

SMF/js

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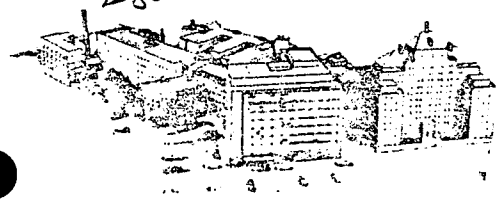

ST. FRANCIS GENERAL HOSPITAL

45th STREET (off PENN AVENUE) PITTSBURGH, PENNSYLVANIA 15201 (412) 622-4343

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December 22, 1977

James D. Bentley, Ph.D.
Assistant Director
Department of Teaching Hospitals
Council of Teaching Hospitals
One DuPont Circle, N. W.
Washington, D. C. 10036

Dear Doctor Bentley:

This is in reply to your letter of November 30, 1977 in which you request a copy of our hospital's medical school affiliation agreement.

Although we provide clinical facility for several areas of the teaching program at the University of Pittsburgh School of Medicine, including a prominent portion of its orthopaedic residency, we do not have a specific affiliation agreement which can be documented.

Sincerely,

Sister M. Sylvia Schuler

Sister M. Sylvia Schuler
Executive Director

SMS:cmp

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BAPTIST MEMORIAL HOSPITAL
899 MADISON AVENUE
MEMPHIS, TENNESSEE 38146

FRANK S. GRONER, PRESIDENT

December 19, 1977

ROBERT F. SCATES
SENIOR VICE PRESIDENT

Mr. James D. Bentley, Ph. D.
Assistant Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dr. Bentley:

We acknowledge your letter of November 30, 1977 on the subject of the hospital-medical school affiliation agreement. At this time, we do not have an over-all agreement that is current though we do have a number of medical school relationships.

We trust that this letter will explain the fact that we have not previously sent you the material which you requested.

Sincerely,

Robert F Scates

Robert F. Scates
Senior Vice President

RFS/mlo

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Attachment O

-28-

THE UNIVERSITY OF ARIZONA

ARIZONA MEDICAL CENTER
TUCSON, ARIZONA 85724

VICE PRESIDENT
HEALTH SCIENCES

RECEIVED
AUG 31 1977
DIRECTOR
HEALTH SERVICES

August 29, 1977

Mr. William A. Markey, Director
Maricopa County General Hospital
2601 East Roosevelt
Phoenix, Arizona 85008

Dear Mr. Markey:

I have received your letter of August 24 which addresses the subject of affiliation agreements between our respective institutions. We do not have a single, master agreement between our institutions because the master agreement used by the University for its many clinical teaching affiliations was apparently unacceptable to you when an effort was made a few years ago to execute such an agreement. If your group now wishes to reapproach the question of a master agreement we would be glad to reexamine it with you.

In the meantime, our respective institutions are operating through an agreement with the Phoenix Hospitals Associate Pediatric Program and, in addition, the Departments of Internal Medicine, Obstetrics and Gynecology, and Surgery at our College of Medicine are rotating students through the respective teaching services at your hospital in the absence of a written agreement.

Those of us at the University of Arizona Health Sciences Center have appreciated the opportunity to have students in your hospital. We hope that your medical staff will continue to be interested in perpetuating that arrangement.

Very sincerely yours,

Merlin K. DuVal, M.D.

MKD/lw

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UNIVERSITY OF MASSACHUSETTS
AMHERST • BOSTON • WORCESTER

CHANCELLOR, UNIVERSITY
OF MASSACHUSETTS AT WORCESTER
DEAN OF THE MEDICAL SCHOOL
55 LAKE AVENUE NORTH
WORCESTER, MASSACHUSETTS 01605

November 2, 1976

Gerald L. Haidak, M.D.
~~Berkshire Medical Center~~
Pittsfield General Unit
725 North Street
Pittsfield, MA 01201

Dear Dr. Haidak:

This letter is to verify the major affiliation between the Berkshire Medical Center and the University of Massachusetts Medical School.

Sincerely,

Roger J. Bulger, M.D.
Chancellor/Dean

MS/mg

Enclosures

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Attachment Q

-30-

STATE UNIVERSITY
OF NEW YORK

DOWNSTATE MEDICAL CENTER

Office of the Vice President
for Hospital Affairs

May 23, 1977

Vincent Tricomi, M.D., F.A.C.S.
Director of Medical Affairs
The Brooklyn Hospital
121 DeKalb Avenue
Brooklyn, New York 11201

Re: Major Affiliation with the
State University of New York,
Downstate Medical Center.

Dear Dr. Tricomi:

This is to certify that The Brooklyn Hospital enjoys a Major (M) affiliation with the State University of New York, Downstate Medical Center and is so listed with the Council on Medical Education of the American Medical Association.

Very truly yours,

Julius E. Stolfi, M.D.

Julius E. Stolfi, M.D.
Vice President for Hospital Affairs
Associate Dean of Clinical Affairs

RECEIVED
MAY 23 1977
OFFICE OF EXECUTIVE DIRECTOR

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STATE UNIVERSITY
OF NEW YORK

DOWNSTATE MEDICAL CENTER

Office of the Vice President
for Hospital Affairs

June 25, 1975

Mr. George Adams
President
Lutheran Medical Center
4520 Fourth Avenue
Brooklyn, N. Y. 11220

Re: Change in Affiliation Status
to "G" Directly

Dear George:

I am pleased to notify you that your request for a change in affiliation status and the data submitted have been reviewed and approved.

Lutheran Medical Center will henceforth be listed as a "G" affiliation directly with our school and no longer by way of Maimonides Hospital. The latter has been duely notified through Dr. George Degenshein, Associate Dean. He voiced no objection.

The Council on Medical Education of the AMA will be instructed to list your hospital as indicated above.

Congratulations and best wishes for continued success in your efforts to upgrade all phases of patient care and educational programs in your fine hospital.

Cordially yours,

Julius E. Stolfi, M.D.
Vice President for Hospital Affairs
Associate Dean of Clinical Affairs

JES:pl
cc: Calvin H. Plimpton, M.D.
Dean Leonard Laster, M.D.
George Degenshein, M.D.
Gabriel Cucolo, M.D.

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EMANUEL Hospital

Attachment S

OFFICE OF THE DEAN
SCHOOL OF MEDICINE

Area Code 503 225-8220

Portland, Oregon 97201

UNIVERSITY OF OREGON

HEALTH SCIENCES CENTER

August 12, 1977

Hugo Uhland, M.D.
Director of Medical Education
Emanuel Hospital
2801 N. Gantenbein Street
Portland, Oregon

Dear Doctor Uhland:

The purpose of this letter is to respond to your telephonic request for some written statement regarding the affiliation for educational programs between Emanuel Hospital and the School of Medicine. I do not know what written documents there might be scattered through the files of the two Institutions but I do not have at hand any at all. However, in connection with preparing an application for the Health Manpower Capitation Award, we have had to review, according to the definitions in the application form, what actual or implied affiliations we have with community hospitals.

With respect to Emanuel Hospital, my current understanding is that in Pediatrics, Obstetrics/Gynecology, Orthopedics and in Urology residents are appointed by Program Directors at the School of Medicine with or without concurrence of counter parts at Emanuel and that house officers rotate to Emanuel being paid while there by your Institution.

According to the newly introduced definition in the Capitation Questionnaire, the programs in Family Practice, Medicine, Flexible and Surgery at Emanuel Hospital also qualify as affiliated because of the existence of volunteer faculty appointments to individuals having instructional responsibility in those programs.

I regard the whole matter of the appointment basis for volunteer faculty, titles, privileges and obligations as a piece of rather disorderly housekeeping. In addition, our affiliation agreements

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AUG 1 0 1977

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need to be formalized with all of the hospitals with whom we cooperate. During the next six months or so, members of the faculty and I will be working on these matters to try to put them into a more systematic framework. Undoubtedly there will be consultation with individuals in the various hospitals in order to exchange view points. I hope that you will be involved and help us to sort things out.

If this letter does not serve your purpose, please do let me know and I will try to do something more appropriate.

Sincerely,

Robert S. Stone, M.D.
Dean, School of Medicine

RSS:mk

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MARSHALL UNIVERSITY

OFFICE OF THE VICE PRESIDENT FOR HEALTH SCIENCES
AND DEAN OF THE SCHOOL OF MEDICINE

HUNTINGTON, WEST VIRGINIA 25701

September 16, 1977

Guy Hollifield, M.D.
Appalachian Regional Hospital
304 Stanaford Road
Beckley, WEst Virginia 25801

Dear Guy:

Although the formal Affiliation Agreement between the Beckley Appalachian Regional Hospital and the School of Medicine has not been signed by all parties, the BARH is an affiliate of the Marshall University School of Medicine.

Many of the attending staff of BARH have faculty appointments in the School of Medicine. The residency programs are Marshall affiliated and the Program Directors are School of Medicine faculty. Beckley area faculty members have been active participants in several of our School Committees.

It is my intention to formalize our affiliation with a signed agreement in the near future.

Sincerely,

Robert W. Coon, M.D.
Vice President and Dean

RWC/db

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