aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 18-19, 1978
Washington Hilton Hotel
Washington, D.C.

Wednesday, January 18

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, January 19

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Bancroft Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Conservatory Room
	Executive Council Business Meeting	
4:00 P.M.	Adjournment	

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

Council of Teaching Hospitals
Administrative Board

January 19, 1978
Washington Hilton Hotel
Bancroft Room
9:00 a.m. - 1:00 p.m.

A G E N D A

INFORMATION ITEMS

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
November 7, 1977

MINUTES

PRESENT:

David D. Thompson, M.D., Chairman
David L. Everhart, Chairman - Elect
Charles B. Womer, Immediate Past Chairman
John Reinertsen, Secretary
Jerome R. Dolezal
Robert M. Heyssel, M.D., Ex Officio Member
Mitchell T. Rabkin
Malcom Randall
William T. Robinson, AHA Representative

ABSENT:

John W. Colloton
James M. Ensign
Baldwin G. Lamson, M.D.
Stuart Marylander
Stanley R. Nelson
Robert E. Toomey

STAFF:

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

I. Call to Order:

Dr. Thompson called the meeting to order at 8:00 A.M. in the Bancroft Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

Prior to consideration of the minutes, Dr. Thompson asked the Board members whether they had already responded to Dr. Knapp's request for comments on the 33 recommendations made in the report of the AHA Special Committee on the Regulatory Process. Dr. Knapp indicated that only four such responses had been received thus far. Dr. Thompson then urged all the Board members to submit their comments.

Dr. Thompson asked Mr. Womer to discuss AAMC's testimony at the recent hearings held by the Senate Finance Health Subcommittee, chaired by Sen. Herman Talmadge (D-Ga.). Mr. Womer reviewed the proceedings, stating that the testimony appeared to be well accepted and that the Subcommittee did not direct any subsequent questions to him. Dr. Thompson then asked Mr. Robinson to provide an update on the AHA activities regarding hospital cost containment legislation. Mr. Robinson explained that, in response to Rep. Rostenkowski's (D-Ill.) challenge to the hospital industry and medical profession to develop a viable health care cost containment program voluntarily, the AHA, AMA, and Federation of American Hospitals have joined together to organize a national steering committee of hospital representatives, physicians, insurers, labor and business groups, consumers and others that will undertake development of a voluntary cost containment program. The steering committee will be expected to (1) establish the goals of a voluntary program to reduce the rate of increase in hospital costs, and eventually health care costs as a whole, (2) develop the mechanisms for measurement of the effectiveness of the program, and (3) develop alternative approaches for the program. There has been some discussion at the AHA that the program should achieve a 15 percent reduction in the rate of increase of hospital costs. The development of state steering committees has also been encouraged to help implement the program.

Mr. Robinson indicated that development of the program must be completed sometime between the second week in January, 1978 (after the President's state-of-the-union address) and the end of March. Some are concerned that Rostenkowski won't tolerate any delay, so the AHA would like to have implemented by the second week in January a program that would demonstrate a sufficient reduction in the rate of increase of costs to prove to both federal and state governments that rising costs can be moderated on a voluntary basis. Mr. Robinson also reported that a chairman for the national steering committee has yet to be named and invited AAMC participation on the committee, as well as the Association's suggestions for other nominees to the committee. When asked why the AHA felt it had to undertake this effort, Mr. Robinson expressed that the AHA felt Rostenkowski's challenge could not be refused or ignored.

Dr. Thompson thought that physician input into this process was good, but was not sure that the AMA could provide such appropriately. He suggested that the input of the specialty societies was necessary. Mr. Robinson agreed and suggested that these societies could provide their input through the AAMC or on their own. Dr. Rabkin related a concept attributed to Red Summers, who stated that, with the exception of support from chairmen of the various health subcommittees, the Administration's cost containment legislation failed because it had no true constituency. Mr. Summers also expressed that effective cost control must lead to increased unemployment. On this basis, r. Rabkin questioned whether the Congress has not in effect passed the blame for such an outcome to the hospital industry by having it come up with its own program.

Dr. Thompson advised that the Steering Committee will find that some of the state rate review programs have been more austere than the 15 percent reduction in the rate of increase that has been discussed as the objective for the prospective program to be developed by the Steering Committee. Mr. Robinson stated that consideration has been given to exempting such states (e.g., New York, Washington, and Maryland) from the program. Mr. Womer pointed out that inclusion of such states in the calculations for the program's base year period would make reduction needs appear more severe than they may actually be. Mr. Reinertsen asked how the base year would be calculated under the voluntary program. Mr. Robinson explained that there is still considerable disagreement on this. Mr. Everhart wondered whether the failure of the Administration's bill was due more to the existence of more pressing legislation that had to be addressed by Congress than to Red Summer's concept.

The minutes of the last COTH Administrative Board meeting were then considered.

ACTION: The minutes of the September 15, 1977 COTH Administrative Board meeting were unanimously approved.

II. Membership Applications:

The Board reviewed three applications for membership and took the following action:

Children's Hospital Medical Center, Cincinnati, Ohio	IT WAS MOVED, SECONDED, AND CARRIED TO RECOMMEND APPROVAL FOR FULL MEMBERSHIP

North Chicago VA Hospital — IT WAS MOVED, SECONDED, AND CARRIED TO RECOMMEND APPROVAL FOR CORRESPONDING MEMBERSHIP

Mr. Womer noted that N. Chicago VA Hospital fails to fulfill the full-membership requirement that it "sponsor or participate in" four approved active residencies. N. Chicago VA Hospital has only three such residencies, with one pending. Mr. Randall stressed that this deficiency would be remedied shortly and was convinced that housestaff would be on hand in four active approved residencies within three months. Mr. Womer emphasized that the Board must look at the hospital's present situation and that there was a difference between getting a residency approved and getting the residency slots filled. He suggested that the institution be given corresponding membership in the interim, until it fulfills the residency requirement and reapplies.

Orthopaedic Hospital
Los Angeles, California — IT WAS MOVED, SECONDED, AND CARRIED TO RECOMMEND APPROVAL FOR CORRESPONDING MEMBERSHIP

Dr. Bentley stated that, in the absence of Stu Marylander, he talked to Dean Mathias of the University of Southern California medical school, about the Orthopaedic Hospital and its eligibility for membership in COTH. He reviewed what Dr. Mathias said and pointed out that only two orthopaedic hospitals have gained membership in COTH to date. Dr. Thompson noted that on the basis of their application materials, the hospital does not appear to be the major orthopaedic center for the medical school. Mr. Reinertsen pointed out that the hospital's program description (on page 41 of the COTH Administrative Board Agenda) does not exhibit a commitment to teaching.

Dr. Rabkin suggested that in the future, applicants for COTH membership who could not be easily evaluated in terms of membership criteria should be asked to provide additional information, listing research bibliographies for their staff. If the hospital expresses concern over its corresponding status Mr. Womer thought that a letter should be written to explain that if they were the primary specialty affiliate of a medical school, they would have been classified as full COTH members.

IV. Nominating Committee Report:

Nominating Committee Chairman Charles Womer presented a summary review of the Committee's report, stating that

three individuals have been nominated to new 3-year terms on the COTH Administrative Board -- Lawrence Hill of New England Medical Center, Malcom Randall of the VA Hospital-Gainesville, and Elliott Roberts of Charity Hospital in New Orleans -- and that Dr. Robert Heyssel of The Johns Hopkins Hospital has been nominated as Chairman-Elect of the COTH Board. Mr. Womer also noted that John Colloton was nominated as at large representative to the AAMC Executive Council to serve the last year of the term being vacated by Dr. Heyssel.

V. Other Business:

Mr. Randall described his first meeting as a member of the Board of the American Health Planning Association

Dr. Thompson expressed his appreciation to fellow members of the Board for their efforts and support during his tenure as Board Chairman during the past year. He closed his remarks by stating that "being Chairman was not all that bad, staff works hard and does a good job."

Mr. Everhart, on behalf of all the members of the Board, expressed gratitude to Dr. Thompson for the skill and time he gave to COTH as its chairman.

VI. Adjournment:

The meeting was adjourned at 9:00 A.M.

Preliminary Report
Eligibility for Continuing 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 been undertaking a study of the eligibility of present COTH members. This report reviews current membership criteria and summarizes initial 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 the 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.

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.

Preliminary Findings

In reviewing the preliminary findings from the staff survey of membership eligibility, it should be noted that thirty-four hospitals, 8% 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 is a list of the nineteen hospitals that have responded and stated that their institution lacks the required signed affiliation agreement with an accredited medical school. The Table also lists the affiliation status of the hospital as shown in the latest LCGME Directory of Accredited Residencies, i.e., the "Green Book." Attachment A reproduces, from the LCGME Directory, the description of the procedure and criteria used by that organization to determine affiliation status.

Table 3 lists hospitals that returned the questionnaire but failed to provide a copy of their affiliation agreement. Some of these hospitals may have such an agreement; others may not. All hospitals shown on Table 3 have been sent a follow-up letter requesting a copy of their affiliation agreement.

Table 4 shows the six hospitals that indicated they sponsor or participate in three of fewer approved residency programs.

Table 5 lists the three hospitals having fewer than two residency programs in the required specialties.

Conclusion

At the March Administrative Board meeting, staff expects to present a completed report on the membership eligibility of current COTH members. It should be noted that present COTH members without the required residency program numbers (set forth in Tables 4 and 5) are eligible for corresponding membership while those without an affiliation agreement are not eligible for either type of membership.

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, pediatrics, 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

Table 1 -- COTH Members Not Responding to Directory Survey

1. L.A. County Harbor General Hospital, Torrance, California
2. The Queens Medical Center, Honolulu
3. Cook County Hospital, Illinois
4. St. Elizabeth's Hospital, Brighton, Massachusetts
5. University of Michigan Hospital, Ann Arbor
6. Wayne County Psychiatric Hospital, Michigan
7. Newark Beth Israel Hospital, New Jersey
8. Bronx-Lebanon Hospital Center, New York
9. Cumberland Hospital, Brooklyn-Cumberland Hospital Center
10. New York Medical College, Flower & Fifth Avenue Hospitals
11. Highland Hospital of Rochester
12. Charlotte Memorial Hospital, North Carolina
13. Hospital of the University of Pennsylvania
14. Eye and Ear Hospital of Pittsburgh
15. Rhode Island Hospital
16. City of Memphis Hospital
17. Texas Childrens Hospital
18. Wilford Hall, U.S.A.F. Medical Center
19. San Juan Municipal Hospital
20. University District Hospital, Puerto Rico
21. Cedars of Lebanon Hospital, Miami
22. Bronx Municipal Hospital Center
23. North Shore University Hospital, Manhasset, New York
24. Veterans Administration Hospital, Bronx, New York
25. Memorial Hospital of Rhode Island
26. Butterworth Hospital, Michigan
27. Martland Hospital Center, New Jersey
28. Methodist Hospital, Dallas
29. Veterans Administration Hospital, San Diego
30. Mount Sinai Hospital, Minneapolis
31. Memorial Hospital, Springfield
32. Mayaguez Hospital, Puerto Rico
33. Hackensack Hospital, New Jersey
34. North Central Bronx Hospital, New York

Data Prepared: 1/6/78

Table 2 -- Present COTH Members Without a Signed Affiliation Agreement

	Institution	"Green Book" Status[1]
1.	Maricopa County General Hospital, Phoenix, Arizona	Limited and Graduate Affiliate
2.	Saint Joseph Hospital & Medical Center, Phoenix	Major Affiliate
3.	Iowa Methodist Medical Center, Des Moines, Iowa[2]	Limited Affiliate
4.	Touro Infirmary, New Orleans, Louisiana	Major Affiliate
5.	NIH Clinical Center, Bethesda, Maryland	Limited Affiliate
6.	Prince George's General Hospital, Cheverly, Maryland	Unaffiliated
7.	Berkshire Medical Center, Pittsfield, Massachusetts	Limited and Graduate Affiliate
8.	Providence Hospital, Southfield, Michigan	Limited and Graduate Affiliate
9.	Monmouth Medical Center, Long Branch, New Jersey[2]	Major and Limited Affiliate
10.	Brooklyn Hospital, New York City	Major Affiliate
11.	Catholic Medical Center of Brooklyn & Queens, New York	Unaffiliated
12.	Wilson Memorial Hospital, Johnson City, New York	Limited Affiliate
13.	Cleveland Clinic, Ohio	Limited Affiliate
14.	Emanuel Hospital, Portland, Oregon	Limited Affiliate
15.	Mercy Hospital, Pittsburgh, Pennsylvania	Limited Affiliate
16.	Saint Francis General Hospital, Pittsburgh	Limited Affiliate
17.	Baptist Memorial Hospital, Memphis, Tennessee	Major Affiliate
18.	Beckley Appalachian Regional Hospital, West Virginia	Limited Affiliate
19.	Gorgas Hospital, Canal Zone, Panama	Unaffiliated

[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.
[2]Agreement developed but not signed by all parties.

Table 3 -- Present COTH Members Who Returned A Questionnaire But Who Have Not Sent A Copy of Their Affiliation Agreement

	Institution	"Green Book" Status[1]
1.	Mercy Hospital, San Diego, California	Major Affiliate
2.	Mount Zion Hospital, San Francisco, California	Limited Affiliate
3.	Veterans Administration Hospital, Washington, D.C.	Major and Limited Affiliate
4.	Little Company of Mary Hospital, Evergreen Park, Illinois	Unaffiliated
5.	Mount Sinai Hospital of Chicago, Illinois	Unaffiliated
6.	Boston Hospital for Women, Massachusetts	Major Affiliate
7.	Faulkner Hospital, Boston, Massachusetts	Major and Limited Affiliate
8.	Abbott-Northwestern Memorial Hospital, Minnesota	Limited Affiliate
9.	Saint Michael's Hospital, New Jersey	Major Affiliate
10.	Saint Barnabas Medical Center, New Jersey	Limited Affiliate
11.	Kings County Medical Center, New York	Major Affiliate
12.	Lutheran Medical Center, Brooklyn, New York	Graduate Affiliate
13.	Methodist Hospital, Brooklyn, New York	Major Affiliate
14.	Jewish Hospital of Brooklyn, New York	Major Affiliate
15.	Millard Fillmore Hospital, Buffalo, New York	Major Affiliate
16.	Akron General Hospital, Ohio	Unaffiliated
17.	Hamot Hospital, Erie, Pennsylvania	Graduate Affiliate
18.	Western Psychiatric Hospital, Pittsburgh	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.

19.	Western Pennsylvania Hospital, Pittsburgh	Limited Affiliate
20.	Women & Infants Hospital of Rhode Island	Major Affiliate
21.	Latter-day Saints Hospital, Salt Lake City, Utah	Limited Affiliate
22.	Children's Orthopedic Hospital and Medical Center, Seattle	Major Affiliate
23.	American University Hospital, Beirut, Lebanon	--

Table 4 -- 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.

Data Prepared: 12/28/77

Table 5 -- 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

COTH DISTINGUISHED SERVICE MEMBERS

Set forth on the next page is the definition of AAMC distinguished service members. The following individuals have thus far been recommended by COTH and designated AAMC distinguished service members:

Donald Casely, M.D.
Stanley Ferguson
T. Stewart Hamilton, M.D.
John Knowles, M.D.
Matthew F. McNulty, Jr.
Russell A. Nelson, M.D.
Albert Snoke, M.D.

It is recommended 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.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

I. MEMBERSHIP

Section 1. There shall be the following classes of membership, each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:

A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.

B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.

C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.

D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.

E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.

F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.

G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.

H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.

I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Section 2. There shall also be the following classes of honorary members who shall meet the criteria therefore established by the Executive Council:

A. Emeritus Members - Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.

B. Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.

C. Individual Members - Individual Members shall be persons who have demonstrated a serious interest in medical education.

D. Sustaining and Contributing Members - Sustaining and Contributing Members shall be persons or corporations who have demonstrated over a period of years a serious interest in medical education.

Section 3. Election to Membership:

A. All classes of members shall be elected by the Assembly by a majority vote on recommendation of the Executive Council.

B. All Institutional Members will be recommended by the Council of Deans to the Executive Council.

C. Academic Society Members will be recommended by the Council of Academic Societies to the Executive Council.

D. Teaching Hospital Members will be recommended by the Council of Teaching Hospitals to the Executive Council.

E. Distinguished Service Members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

DISCUSSION OF POSSIBLE SPRING COTH MEMBERSHIP MEETING

During the AAMC Officers' Retreat in December the possibility and desirability of a COTH spring membership meeting was raised as a matter for discussion. No recommendation was made, but the COTH Chairman indicated that the question would be discussed at the January COTH Board meeting.

Since 1958, when the AAMC Teaching Hospital Section was organized, a single meeting of all COTH members at the fall AAMC Annual Meeting has been the tradition. In 1966, a year following the establishment of the Council of Teaching Hospitals and the employment of full-time staff, regional meetings were held each year until 1974. Programs for the four 1974 regional meetings are on pages 20-23. Even with the efforts to bring in outside speakers, attendance at the meetings could only be considered average, and most frequently did not include member chief executives, but rather their associates and assistants. At the January, 1975 Board meeting it was decided to eliminate the regional meetings and see what reaction was forthcoming from the membership. This decision was announced by membership memorandum and in the April, 1975 COTH Report with a request for reaction from the membership. Since no reaction was received, the regional meetings have not been held, and the matter has not received further Board discussion.

In 1972 both the Council of Academic Societies (CAS) and Council of Deans (COD) initiated "spring" or "interim" meetings. Examples of programs for the meetings are on pages 24-29. A review of the programs of the two Councils demonstrates a rather different purpose and amount of time devoted to the meetings. The CAS program reflects staff discussion and interaction with academic society representatives about AAMC policy positions on current issues. While this approach is to some degree evident in the COD program, that effort is much more formal and structured with presentations by speakers from various perspectives.

It is recommended that a full discussion of the desirability of a spring meeting be undertaken. The following are matters which need to be considered.

Possible Style and Purposes of Such a Meeting

- Organizational Identification with COTH/AAMC
- Discussion of COTH/AAMC Positions on Important Issues
- "Show and Tell": Exchange of Ideas on Institutional Management Issues
- Development of Greater Comradery Among Teaching Hospital Executives

- Speakers Who Are "Recognized Experts" In Particular Fields
- Speakers From Government: Congressional and Executive Departments

Who Should Attend

- COTH Chief Executives Only
- The Chief Executive Plus One Associate
- Completely Open Meeting

When and Where Should the Meeting Be Held

- Late Spring vs. Early Summer
- Central Business vs. Resort Location

COTH SOUTHERN REGIONAL MEETING
Air Host Inn - Atlanta Airport
Friday, April 19, 1974
10:00 a.m. - 3:30 p.m.

AGENDA

10:00 a.m.	Call to Order and Welcome J. W. Pinkston, Jr. Executive Director Grady Memorial Hospital
10:15 a.m.	"The Health Resources Administration: Current Program, Organization, Financing and Priorities" Daniel W. Zwick Associate Administrator for Planning Evaluation and Legislation Health Resources Administration
11:00 a.m.	Staff Reports and Discussion James I. Hudson, M.D. Director, Department of Health Services Richard M. Knapp, Ph.D. Director, Department of Teaching Hospitals
12:00 p.m.	Informal Reception
12:30 p.m.	Lunch
1:30 p.m.	"Patient Care Studies, Utilization Review and PSRO's" Mr. W. Daniel Barker Administrator The Crawford W. Long Memorial Hospital Atlanta, Georgia Jonathan Bates, M.D. Special Assistant to the Deputy Assistant Secretary for Health Department of Health, Education and Welfare Alan Meyers, M.D. Patient Care Studies Department Yale-New Haven Hospital New Haven, Connecticut

COTH NORTHEASTERN REGIONAL MEETING
New York University Medical Center
Friday, May 3, 1974
Classroom B
Alumni Hall
560 First Avenue
New York, New York
10:00 a.m. - 3:30 p.m.

AGENDA

10:00 A.M.	Call to Order and Welcome	David D. Thompson, M.D. Director New York Hospital
10:15 A.M.	"Case Mix Adjustment by ICDA Categories at UCLA"	Baldwin G. Lamson, M.D. Director U.C.L.A. Hospital and Clinics
11:30 A.M.	Staff Reports and Discussion	James I. Hudson, M.D. Director, Department of Health Services Richard M. Knapp, Ph.D. Director, Department of Teaching Hospitals
12:15 P.M.	LUNCH	
1:15 P.M.	"Adjustment For Patient Mix Through The Use Of Appendicitis Equivalents"	Representative from Commission on Hospital and Professional Activities Ann Arbor, Michigan
2:15 P.M.	"Case Mix Adjustment: The Yale-New Haven Experience"	Alan Meyers, M.D. Director of Patient Care Services Yale-New Haven Hospital (Dr. Meyers will be accompanied by hospital staff)
3:15 P.M.	Wrap-Up and Adjournment	David D. Thompson, M.D.

COTH MIDWEST/GREAT PLAINS REGIONAL MEETING
O'Hare Inn
Salon C
6600 North Mannheim At Airport
Des Plaines, Illinois
10:00 a.m. - 3:30 p.m.
Friday, May 17, 1974

AGENDA

10:00 A.M. Call to Order

Sidney Lewine
Director
The Mount Sinai Hospital of Cleveland
Chairman-Elect, COTH

10:15 A.M. "The Role of the Organized Medical Staff in the Academic Health Center and Relationship to Teaching Hospital Management"

David Dickinson, M.D.
Chief of Staff
University of Michigan Hospitals

Donald Hastings, M.D.
Chief of Staff
University of Minnesota Hospitals

John H. Westerman
Director
University of Minnesota Hospitals

12:00 P.M. Lunch

"Congressional View On Current Health Legislation"

Honorable Donald M. Fraser, (D)
Congressman
Minnesota, Fifth District

1:30 P.M. Staff Report

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

1:45 P.M. Staff Report

James I. Hudson, M.D.
Director, Department of Health Services

2:00 P.M. "Institutional Responsibility for Graduate Medical Education"

William D. Holden, M.D.
Chairman
Department of Surgery
Case Western Reserve University
School of Medicine

T. Stewart Hamilton, M.D.
President and Executive Director
Hartford Hospital
Hartford, Connecticut

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123
(202) 466-5127

Attached is the final agenda for the COTH Western Regional Meeting to be held in Salt Lake City, Utah on Friday, March 29 at the Rodeway Inn. The meeting will be held from 9:30 a.m. to 4:00 p.m.

Stuart Altman, Ph.D., Deputy Assistant for Planning and Evaluation - Health, HEW has agreed to make a presentation encompassing the Administration's National Health Insurance Proposal as well as some discussion of COLC Phase IV depending on the status of the program at that time. Walter J. McNerney, President, Blue Cross Association, will discuss the special problems of teaching hospitals in the context of the multiple external controls which are being implemented.

An informal luncheon will be served at noon on Friday and a cash bar will be provided. We need to know the number attending in order to determine the number of lunches required. In that regard, if you have not already done so, it would be helpful if you would complete the attached postal card indicating the number of persons from your institution planning to attend the Western Regional Meeting. We would appreciate your returning the attached postal card as soon as possible.

Additionally, a block of 50 rooms has been reserved for the attendees at this meeting; reservation cards are enclosed which should be sent directly to the Rodeway Inn. Please note that reservations for an arrival later than 6:00 p.m. must be specified.

For those who wish to stay the weekend and so some skiing, a brochure of ski resorts within 45 minutes driving time, and telephone listings have already been sent to you.

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

Attachment

COUNCIL OF ACADEMIC SOCIETIES
INTERIM MEETING

AAMC
One Dupont Circle, N.W.

AGENDA

June 22, 1977

10:00 AM Convene

10:00 - 12:30 Staff Reports:

A. BIOMEDICAL RESEARCH LEGISLATION AND OVERSIGHT HEARINGS

1) Research Training
2) Disease-a-month

B. RESEARCH RESTRAINTS

1) Recombinant DNA
2) Clinical Laboratories Improvement Act '77

C. COST CONTAINMENT

D. THOMPSON BILL

E. HEALTH MANPOWER BILL AND IMPLEMENTATION

1) Capitation Requirements
2) Special Projects
3) Title VI
4) Amendment
5) Plans for 1980 Manpower Act

F. CCME AND PHYSICIAN DISTRIBUTION

G. CAS SERVICE PROGRAM

H. LCME and RRCs

12:30 PM Lunch (provided by AAMC)

1:30 PM Resume Discussion of Topics

4:00 PM Adjourn

1977 SPRING MEETING OF THE COUNCIL OF DEANS

April 17-20, 1977

Scottsdale Hilton Hotel
Scottsdale, Arizona

GRADUATE MEDICAL EDUCATION:

"Do we have to do business in the same old way?"

PROGRAM

Sunday, April 17

1:00-6:00 p.m. ARRIVAL & REGISTRATION — *Hotel Lobby*

6:30-8:00 p.m. RECEPTION — *Loggia*

Monday, April 18

8:30-10:20 a.m. **SESSION I** — *Sonora B*

WELCOME & OVERVIEW OF MEETING
John A. Gronvall
Chairman, COD

AN HISTORICAL PERSPECTIVE
Lowell T. Coggeshall

PUBLIC POLICY ISSUES IN GRADUATE MEDICAL EDUCATION
Stephan Lawton
Counsel
House Subcommittee on Health and the Environment

THE NUMBERS—1977
John S. Graettinger
Executive Vice President
NIRMP

A SUMMARY OF THE ISSUES
Chandler A. Stetson
Dean
University of Florida
College of Medicine

10:20-10:30 a.m. BREAK — *Loggia*

10:30-12 Noon **SESSION II** — *Sonora B*

GME: RATIONALE RECONSIDERED
J. Robert Buchanan
President
Michael Reese Hospital and Medical Center

ACADEMIC OBJECTIVES OF GME PROGRAMS
Albert L. Rhoton
Professor of Neurosurgery
University of Florida
College of Medicine

A SCIENCE POLICY PERSPECTIVE
DeWitt Stetten, Jr.
Deputy Director for Science
National Institutes of Health

12 Noon-5:30 p.m. UNSCHEDULED

5:30-7:30 p.m. **SESSION III** — *Sonora B*

WHAT HOUSE OFFICERS DO
Ruth S. Hanft
Visiting Professor
Dept. of Community Medicine
Dartmouth Medical School

A HOSPITAL'S OBJECTIVES IN GME PROGRAMS
Robert M. Heyssel
Executive Vice President and Director
The Johns Hopkins Hospital

FROM OUR PERSPECTIVE - A PANEL OF HOUSE OFFICERS
Christopher C. Baker
Resident in Surgery (R3)
U. of Calif.-San Francisco

James C. Chapin
Chief Resident in Anesthesiology
University of Florida

Ralph M. Stanifer
Resident in Ophthalmology (HO4)
University of Michigan

Basil Genetos
Chief Resident
Department of Internal Medicine
Indiana University

Tuesday, April 19

8:30-10:10 a.m. **SESSION IV** — *Sonora B*

IOM SOCIAL SECURITIES STUDIES REVISITED: IMPLICATIONS OF ALTERNATIVE FINANCIAL SCHEMES
John A. Gronvall
Dean
University of Michigan
Medical School

FUNDING PROSPECTS BEYOND 1977
Walter J. McNerney
President
Blue Cross Association of Chicago

10:10-10:20 a.m. BREAK — *Loggia*

10:20-12 Noon **SESSION V** *Sonora B*

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GME: THE SPECIALTY BOARDS
Charles A. Hunter
Chairman
Dept. of Obstetrics/Gynecology
Indiana University
School of Medicine

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GME: THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION
August G. Swanson
Director
AAMC Department of Academic Affairs

THE INSTITUTIONAL RESPONSE
James E. Eckenhoff
Dean
Northwestern University
Medical School

Steven C. Beering
Dean
Indiana University
School of Medicine

Sherman M. Mellinkoff
Dean
UCLA
School of Medicine

12 Noon-5:30 p.m. UNSCHEDULED

5:30-7:30 p.m. **SESSION VI** *Sonora B*

THE CANADIAN EXPERIENCE
Arnold Naimark
Dean
University of Manitoba
Medical Faculty

DIRECTIONS FOR THE FUTURE
Frederick C. Robbins
Dean
Case Western Reserve Univ.
School of Medicine

Wednesday, April 20 *Sonora B*

8:30-10:10 a.m. **SESSION VII**

COD BUSINESS MEETING

10:10-10:20 a.m. BREAK *Loggia*

10:20-12 Noon **SESSION VIII**

COD BUSINESS MEETING

12 Noon ADJOURNMENT *Sonora B*

Association of American Medical Colleges
COUNCIL OF DEANS
SPRING MEETING

PROGRAM

GRADUATE MEDICAL EDUCATION:

"Do we have to do business in the same old way?"

April 17-20, 1977
Scottsdale Hilton Hotel
Scottsdale, Arizona

Tentative Program
1/5/78

COUNCIL OF DEANS
SPRING MEETING

April 24-27, 1978
Snowbird, Utah

Monday, April 24

1:00 p.m. - 5:30 p.m.	Arrival & Registration
5:30 p.m. - 7:00 p.m.	Business Meeting Report of the President
7:00 p.m. - 8:30 p.m.	Reception

Tuesday, April 25

8:30 a.m. -10:10 a.m.	SESSION I "THE RELATIONSHIP BETWEEN FEDERAL & STATE POLICY"
8:30 a.m.	"The Context: A Review of the Forces at Play" --Lewis Butler Professor Health Policy Unit Univ. of Calif.-San Francisco
9:00 a.m.	"The Problem: A National Perspective" --Margaret Costanza Asst. to the President for Public Liaison
9:30 a.m. -10:10 a.m.	Discussion
10:10 a.m. -10:20 a.m.	Coffee
10:20 a.m. -12 Noon	SESSION II "THE RELATIONSHIP BETWEEN FEDERAL & STATE POLICY"
10:20 a.m. -10:50 a.m.	"The Problem: The Articulation of Federal & State Policies" --Peter Petkas Director, Project Management President's Reorganization Project

Tuesday, April 25 (cont.)

10:50 a.m. - 11:20 a.m.	"A Paradigm: The Implementation of the National Health Planning Act" --Eugene Rubel Special Asst. to the Administrator Health Care Financing Administration DHEW
11:20 a.m. - 12 Noon	Discussion
Noon - 6:00 p.m.	UNSCHEDULED
6:00 p.m. - 7:30 p.m.	SESSION III "REPRISE & DISCUSSION"
6:00 p.m. - 6:30 p.m.	"An Association Perspective on National and State Policy Initiatives" --J. Alexander McMahon President AHA

Wednesday, April 26

"TOWARD MORE EFFECTIVE RELATIONSHIPS WITH STATE GOVERNMENT"

8:30 a.m. - 10:10 a.m.	SESSION IV "TWO VIEWS FROM THE STATE CAPITAL"
8:30 a.m. - 9:00 a.m.	"A Governor's View of Medical Education and Health Care" --James B. Hunt, Jr. Governor of North Carolina
9:00 a.m. - 9:30 a.m.	"A Legislator's View of Medical Education and Health Care" --John Milton former State Senator from Minnesota
9:30 a.m. - 10:10 a.m.	Discussion
10:10 a.m. - 10:20 a.m.	Coffee

Wednesday, April 26 (cont.)

10:20 a.m. - 12 Noon	SESSION V "TWO APPROACHES"
10:20 a.m. - 10:50 a.m.	"The University of Washington Approach" --John N. Lein Associate Dean Continuing Education & Development
10:50 a.m. - 11:20 a.m.	"The Independent Colleges and Universities of Missouri Approach" --Charles Gallagher Executive Director Independent Colleges & Universities of Missouri Robert Blackburn Director, Governmental Relations Washington University
11:20 a.m. - 12 Noon	Discussion
12 Noon - 6:00 p.m.	UNSCHEDULED
6:00 p.m. - 7:30 p.m.	SESSION VI "REPRISE & DISCUSSION"
6:00 p.m. - 6:30 p.m.	"The Role of State Education Departments" --Theodore Hollander Commissioner of Education State of New Jersey
6:30 p.m. - 7:30 p.m.	Discussion

Thursday, April 27

8:30 a.m. - 12 Noon	Business Meeting of the Council of Deans
12 Noon	ADJOURNMENT

EXECUTIVE SALARY AND JCAH SURVEYS

At the September, 1977 Board meeting the executive salary survey and proposed JCAH survey questionnaires were reviewed. Copies of these are set forth on the following pages. A summary of the responses to the survey concerning capital expenditures resulting from JCAH recommendations will be available for review at the March Board meeting.

The Board recommended in September that questions concerning the usefulness and confidentiality of the executive salary survey be added to this year's questionnaire. Questions 25-27 have been added, and results will be made available for the March Board meeting.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

September 29, 1977

Dear Member:

A major section of President Carter's proposed cost containment program for hospitals is directed towards restricting the funds available for capital expenditures. However, neither Title I nor Title II of the Administration's proposal has taken into account the impact on hospital expenditures which results from the extensive plant and equipment requirements imposed by the Joint Commission on the Accreditation of Hospitals (JCAH). To date, this omission has received less criticism than it deserves in House and Senate hearings, due in part to the lack of adequate data on JCAH-imposed expenditures.

Additionally, there has been substantial criticism of the strict adoption of the 1973 Life Safety Code requirements by the JCAH. However, the absence of data has handicapped direct discussions with the JCAH concerning the financial impact of this decision.

Your help in remedying this lack of data for teaching hospitals is needed. Please complete and return the enclosed questionnaire by October 21, 1977. A pre-addressed envelope has been enclosed for your convenience in returning the questionnaire.

If you have any questions about the survey, please contact Armand Checker, Department of Teaching Hospitals. His telephone number is: (202) 466-5123.

Sincerely,

Dick

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

CCTH SURVEY OF
JCAH REQUIRED CAPITAL EXPENDITURES

1. Hospital NAME: _____

2. Hospital ADDRESS: _____

_____

3. When was your hospital's last J.C.A.H. accreditation survey completed?

MONTH: _____ YEAR _____

4. As a result of your hospital's last J.C.A.H. survey, was your hospital accredited for: (check one)

_____ two years?

_____ one year?

_____ other, please specify: _____

5. During your most recently completed fiscal year, what was the total dollar amount expended, by project, to bring your hospital's physical plant and capital equipment into compliance with J.C.A.H. standards?

PROJECT	DOLLARS EXPENDED
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
TOTAL	$_____

6. What would be the estimated cost, by project, if your hospital was required to immediately bring its physical plant and capital equipment into compliance with JCAH standards?

PROJECT	ANTICIPATED COST
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
TOTAL	$_____

7. Name, Title and telephone number of person completing survey:

_____

AREA CODE/TELEPHONE NUMBER: _____

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

October 27, 1977

Dear Member:

Since 1969, the Council of Teaching Hospitals has conducted an annual survey of the executive salary and fringe benefit package received by chief executive officers and key support staff of COTH member institutions. This year, we are again requesting your assistance in completing the attached questionnaire.

To facilitate your response, this year's questionnaire has been divided into two parts: Part I requests salary and fringe benefit information on your hospital's administrative and departmental executives and Part II requests information on your compensation, education, and professional experience. To enable you to confidentially submit the chief executive officer's section, the questionnaire has been printed so that you may separate the two parts -- sending Part I to the appropriate individual in your hospital who would complete it and return it to COTH and completing Part II and returning it to COTH yourself. Two pre-addressed envelopes have been enclosed for your convenience in returning the questionnaire. We would appreciate your reply to Parts I and II of the survey by November 21, 1977.

In completing Part II of the questionnaire your special attention is directed to questions 25, 26, and 27. The COTH Administrative Board has directed staff to solicit member opinion on the publication of the report and on its usefulness for structuring next year's survey. Presently, all information published in the survey is handled with institutional anonymity using group means and medians. This policy of anonymity is not being questioned or reconsidered. The Administrative Board, however, is evaluating whether the present practice of distributing the survey report to only COTH chief executive officers should be replaced by a policy of making the report a public document available to non-COTH members at a reasonable charge. Please use question 25 to provide your opinion on this issue.

We are also attempting to document the usefulness and appropriate frequency of this report, and your responses to questions 26 and 27 will provide the data we need to accomplish this. Please understand that the Board's re-evaluation of the report's distribution and usefulness will not affect this year's survey. It will be published with anonymity and distributed only to COTH chief executives.

If you have any questions about the survey, please contact Armand Checker, Department of Teaching Hospitals. His telephone number is: (202) 466-5123.

Sincerely,

RICHARD M. KNAPP, PH.D.

Part I

Please list the annual gross salary (omit fringe benefits) for each of the following questions. All respondents are asked to show the cash value (cost to the hospital) of fringe benefits separately. If a position is currently staffed by a physician, please indicate so by marking an "X" to the left of the position and state the salary offered in the appropriate space. If an individual has both an administrative and a departmental title as listed below, please use the *departmental title*.

MD	Administrative Staff	Cash Salary (Omit Fringe Benefits)	Cash Value Of Fringe Benefits
_____	1. Chief Executive's Associate	$_____	$_____
_____	2. Assistant	$_____	$_____
_____	3. Assistant	$_____	$_____
_____	4. Assistant	$_____	$_____
_____	5. DME (Only if Full-Time)	$_____	$_____
_____	6. Medical Director* (Only if Full Time)	$_____	$_____

*This position is also known as *Vice-President for Medical Affairs* or *Associate Director for Clinical Affairs.*

Departmental Executives	Cash Salary (Omit Fringe Benefits)	Cash Value Of Fringe Benefits
7. Controller (or equivalent)	$_____	$_____
8. Data Processing	$_____	$_____
9. Dietary	$_____	$_____
10. Senior Engineer	$_____	$_____
11. Housekeeping	$_____	$_____
12. Laundry	$_____	$_____
13. Nursing School (3 Yr. Only)	$_____	$_____
14. Nursing Service	$_____	$_____
15. Personnel	$_____	$_____
16. Pharmacy	$_____	$_____
17. Medical Records	$_____	$_____
18. Public Relations	$_____	$_____
19. Purchasing	$_____	$_____
20. Social Service	$_____	$_____
21. Physical Therapy—Senior non-MD Technician	$_____	$_____
22. Clinical Lab—Senior non-MD Tech.	$_____	$_____
23. Radiology—Senior non-Md Tech.	$_____	$_____
24. Inhalation Therapy—Senior non-MD Technician	$_____	$_____

25. If you have a non-MD position with sole responsibility for outpatient services, please state the salary:

$_____.

26. If you have a full-time salaried MD as director of your Emerg. Rm., please state the salary: $_____.

_____ _____

Person to contact for questions | Area Code and Telephone Number

Part II

1. **Title of your position:**
   ____ Director ____ Vice President (Admin/Oper.) ____ Superintendent
   ____ Executive Director ____ Executive Vice President ____ Other (specify)
   ____ Administrator ____ President _____

2. **Please check the highest degree you have been awarded:**
   ____ No College Degree ____ M.H.A. ____ Ph.D.
   ____ B.A. or B.S. ____ M.P.H. ____ LLD
   ____ R.N. ____ Dr. Sc. ____ LLB
   ____ M.A. or M.S. ____ Dr. P.H. ____ M.D.
   ____ M.B.A. ____ Other (specify) _____

3. **Were any of your degrees earned in hospital or health care administration?** ____ YES ____ NO

4. **Your Age:** _____

5. **Number of Years in which you have held your present position:** _____

6. **Were you promoted to your position from within the same institution rather than recruited from another?** ____ YES ____ NO

7. **If you were recruited from another institution, were you the chief executive officer in your last position?** ____ YES ____ NO

8. **Do you also hold an academic position in a college or university affiliated with your hospital?** ____ YES ____ NO

9. **Please state the annual gross salary for your position: (Do *not* include deferred compensation or fringe benefits)** $_____

10. **Please state the annual *cash* value of any deferred compensation:** $_____

11. **Please state the annual *cash* value of your fringe benefits:** $_____

12. **Does your employer maintain a Pension Plan for you?** ____ YES ____ NO

(If YES, please answer sections a-f. If you participate in two plans, respond under both headings)

	Plan 1	Plan 2
a. How many *months* must you wait before participating?	_____	_____
b. How many *years* must you wait to become *fully* vested?	_____	_____
c. What % of your base salary do *you* contribute?	_____%	_____%
d. What % of your base salary does your employer contribute?	_____%	_____%
e. How much (total of c. plus d. above) is tax sheltered (deferred)?	_____%	_____%

f. **What is the name of your Plan(s)?**

Plan 1: _____

Plan 2: _____

13. **Please check the fringe benefits which you are receiving at no personal cost.**
   ____ Health Insurance: ____ Individual Only ____ Individual and Family
   ____ Major Medical Insurance: ____ Individual Only ____ Individual and Family
   ____ Professional Liability ..... Amount of Coverage $_____
   ____ Life Insurance ..... Amount of Coverage $_____
   ____ Disability Insurance ..... Length of Coverage _____
   ____ Other Insurance (specify) _____
   ____ Bonus: (Conditions of payment) _____
   ____ Nonprofessional Club Membership: (specify) _____

14. With regard to your owning and operating an auto for business purposes, what is the hospital's policy?

_____ pays total expenses
_____ pays part of the expenses
_____ pays none of the expenses

15. With regard to your owning and maintaining a house, what is the hospital's policy?

_____ pays total expenses
_____ pays part of the expenses
_____ pays none of the expenses

16. How many weeks of vacation are you allotted in the past year: _____ weeks

	YES	NO	Don't Know	
17. Is there a *normal* retirement age for your position?	_____	_____	_____	a. If YES, please state retirement age: _____
18. Is there also a mandatory retirement age for your position?	_____	_____	_____	a. If YES, please state retirement age: _____
19. Does your institution permit you to engage in independent consultant work for extra income? (Include fees, honoraria, etc.)	_____	_____	_____	a. If YES, please state approximate *dollar* value of outside work last year: $_____
20. Did you have a salary change in your present position within the last twelve months?	_____	_____	_____	a. If YES, please indicate the *dollar* change to your base salary: $ (+) _____ $ (−) _____
21. Do you have a regularly scheduled salary review?	_____	_____	_____	a. If YES, how often? _____ Months

22. When did you receive your last salary increase? _____ (Month) _____ (Year)

23. Have you a multi-year contract? _____ _____ _____ a. If YES, what is the contract length? _____ Years

24. Please check the title of the office or board to which you report directly:

_____ Hospital Governing Board
_____ City or County Board of Supervisors or Equivalent
_____ City or County Health Commission or Equivalent
_____ Religious Order (specify) _____
_____ Dean, Medical School
_____ Vice President for Medical Affairs of University or Equivalent
_____ President or Chancellor of University
_____ Other (specify) _____

25. I prefer that future survey results remain individually unidentifiable—

_____ and that findings be distributed only to COTH members
_____ and that findings be generally distributed to interested persons

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

_____ Do Not Use It
_____ Make limited use of it
_____ Make considerable use of it (specify): _____
_____ Make extensive use of it (specify): _____

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

_____ Annually _____ Every other year _____ Other (specify): _____

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

WASHINGTON, D.C. 20201

DEC 12 1977

Terry Sanford, Ph.D.
President, Duke University
Durham, North Carolina 27706

Dear Dr. Sanford:

This is in response to your letter of August 26 to the Secretary in which you requested reconsideration and reversal of an advisory opinion from James B. Cardwell, Commissioner of Social Security, dated March 31, 1977. That opinion concerned Medicare's reimbursement of interest costs incurred or to be incurred by external borrowing for the construction of an addition to Duke University Hospital.

We are persuaded, on the basis of Mr. Thrower's memorandum of law and our own re-examination of the issue, that the Medicare regulation at 42 CFR 405.419 does not preclude the allowability of interest costs solely because of the availability of capital derived from gifts and grants, whether restricted or unrestricted.

As you may know, administration of the Medicare program -- which was vested in the Commissioner of Social Security at the time he furnished his advisory opinion -- is now vested in the Health Care Financing Administration. Accordingly, I hereby reverse the advisory opinion provided to you by Commissioner Cardwell on March 31, 1977. I regret the concern that this matter has caused you.

Sincerely yours,

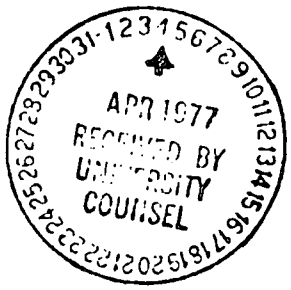
Robert A. Derzon
Administrator

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

March 31, 1977

REFER TO:
IBI-321

OFFICE OF THE COMMISSIONER



Mr. C. L. Haslam
University Counsel
Duke University
Durham, North Carolina 27706

Dear Mr. Haslam:

This is in response to your letter requesting the advisory opinion of the Social Security Administration (SSA) with respect to Medicare reimbursement of interest expense incurred, or to be incurred, by Duke University Hospital. As indicated in your letter, SSA agreed to review your detailed presentation of the issue during the meeting held in Washington, D.C., on November 12, 1976.

While the enclosures to your subject letter provide additional information with respect to the incurrence of such interest expense, this information did not alter the policy issue previously addressed by the Bureau of Health Insurance in earlier correspondence with Duke University's accounting firm. As was indicated at that time, there is no basis under existing Medicare policy for allowing interest expense on internal or external loans when funds are available within the organization to meet such requirements. The disallowance of such cost is consistent with the provisions of health insurance Regulations No. 5, section 405.419, which spell out the conditions under which interest expense is allowable under the Medicare program.

One of the conditions of the regulations is that interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Since Duke Hospital is a teaching hospital which is owned, operated, and a part of the corporate entity of Duke University, the university and hospital must be treated as related organizations under program policy. As such, the funds which the university advances to its teaching hospital, which is a part of the university complex, cannot be considered loans under Medicare since they are merely a transfer of funds between two components of the same organization. Accordingly, the interest payments on funds generated from within the organization cannot be considered allowable interest expense in determining provider reimbursement under the program.

We do not think it is unreasonable to consider funds which are unrestricted funds of the university to also be funds of the hospital. To do otherwise would result in the reimbursement of unreasonable cost if provider organizations were permitted to transfer such funds between their operating activities in order to maximize Medicare reimbursement. Such action would be inconsistent with the provisions of section 1861(v) of the Social Security Act which limit Medicare reimbursement to the reasonable cost actually incurred in the necessary and efficient delivery of patient care services. If we allowed interest expense between a university and its related hospitals, consistency would also require similar treatment whenever one corporation advances funds to another which it owns and controls. The ultimate result is, of course, that the reasonable cost principle of related organizations as it applies to interest would have no effect, thus resulting in substantially increased Government expenditures. This sum would be very large if many presently independent institutions rearranged their corporate structure so that there were two corporations involved, one holding all grants, gifts, and endowments which would then lend them to a second operating company as needed. Such action would increase Medicare costs and would undermine the cost to related organizations principle which controls self-dealing and other than arm's-length situations.

It would also be erroneous to allow interest expense on external borrowings when existing funds are currently available within the corporate entity. Where a university and a hospital are operating components of the same corporation, the revenues and unrestricted funds generated from either corporate operation represent corporate moneys which are available to meet any corporate requirement. Accordingly, revenues derived from the university's operation (student fees, tuition, etc.) are corporate revenues which may be used to satisfy expenditures incurred by the hospital component. Similarly, funds used to meet the operating costs of the university might be derived from the hospital component of the corporate entity. Therefore, since the unrestricted funds of Duke University would also be available to Duke Hospital, external borrowings would not be necessary to meet the financial needs of the hospital, and the interest expense would not be an allowable reimbursable cost under the provisions of section 405.419 of the health insurance Regulations No. 5.

We believe our existing policy with respect to necessary and proper interest expense, and the associated provisions for cost to related organizations, are both appropriate and explicit in their application.

In addition, it is our position that the existing Medicare policy in the regulations and the reimbursement manuals is in accord with the intent of the Medicare law.

Sincerely yours,

James B. Cardwell
Commissioner of Social Security

Classification of COTH Members by Non-Routine Service Points

Background

In 1976, under a grant from Blue Cross of Greater New York, Harvey Wolfe, Ph.D., and Larry J. Schuman, Ph.D., designed a hospital grouping system for metropolitan New York City hospitals using a point system for non-routine services, the number of approved residency programs, and geographic location. Because many cost containment and payment limitation proposals rely heavily on grouping similar hospitals to calculate "appropriate" and "inappropriate" costs and because several parties have suggested using measures of tertiary care services for such groupings, staff of the Department of Teaching Hospitals have classified non-Federal, general hospitals belonging to COTH using the non-routine service component of the Wolfe-Schuman approach. This paper briefly summarizes the findings.

Methodology

Using regression analysis, Wolfe and Schuman identified several non-routine services whose presence or volume of activity was systematically associated with total per diem costs in Metropolitan New York City hospitals. Table 1 reproduces the final point scheme which Wolfe and Schuman used in classifying New York hospitals. Under the point scheme a hospital could "earn" a maximum of 99.6 points.

For the COTH classification, ten non-routine services used by Wolfe and Schuman and for which comparable data could be easily collected from COTH members were selected, see Table 2. These ten items, with a maximum score of 74.4 points, were included on the annual directory questionnaire which is sent to all COTH members, see Table 3. Two hundred and sixty non-Federal, short-term, general hospitals (86% of the total) had responded when this analysis was conducted.

Findings

Non-routine service points were determined for each of the 260 responding COTH members and hospitals were rank-ordered by the number of points assigned. The rank ordering showed a reasonably continuous distribution of points with no natural clusters that could be used to establish group boundaries.

In place of empirically determined group boundaries, Tables 4-7 show quartile groups of COTH members by points assigned. Table 4 lists the quartile of hospitals with the fewest points and Table 7 lists the hospitals with the most points.

With some notable exceptions, the hospitals in the lowest quartile are primarily community general hospitals with limited residency and tertiary care programs while the hospitals in the highest quartile are primarily university-related hospitals. In general, this approach does seem to systematically group hospitals which are conventionally similar. The most significant exception to this observation appears to be the 300-450 bed hospital with major teaching and tertiary care services. Operating on a limited bed size base, such hospitals cannot obtain all of the points necessary to make a higher quartile when the average daily census in special care units is a critical element in the point scheme.

Table 1 -- Wolfe-Schuman Point System for Non-Routine Services

Service	Assignment of Points Range	Weight
Type I ICU		
2.00 ≤ ADC <	3.99	1.4
4.00 ≤ ADC <	5.99	2.7
6.00 ≤ ADC <	9.99	5.4
10.00 ≤ ADC <	11.99	8.1
12.00 ≤ ADC		10.8
Type III ICU		
2.00 ≤ ADC <	3.99	0.7
4.00 ≤ ADC <	5.99	1.4
6.00 ≤ ADC <	9.99	2.7
10.00 ≤ ADC <	11.99	4.1
12.00 ≤ ADC		5.4
Premature Nursery		
3.00 ≤ ADC <	5.99	1.0
6.00 ≤ ADC <	11.99	2.0
12.00 ≤ ADC		4.0
Neonatal ICU		
3.00 ≤ ADC <	5.99	3.9
6.00 ≤ ADC <	11.99	5.8
12.00 ≤ ADC		7.8
Newborn Unit		
6.00 ≤ ADC <	11.99	2.0
12.00 ≤ ADC <	23.99	4.1
24.00 ≤ ADC		8.2
Psychiatric Unit		
10.00 ≤ ADC <	19.99	3.4
20.00 ≤ ADC <	39.99	5.1
40.00 ≤ ADC		6.8
Drug/Alcohol Inpatient Unit		
3.00 ≤ ADC <	5.99	1.3
6.00 ≤ ADC <	11.99	2.5
12.00 ≤ ADC <	23.99	3.8
24.00 ≤ ADC		5.0

Table 1.--continued

Service	Range	Weight
Rehabilitation Inpatient Unit		
6.00 ≤ ADC ≤	11.99	1.9
12.00 ≤ ADC ≤	23.99	3.5
24.00 ≤ ADC		7.0
ER Category I		4.6
ER Category II		3.3
ER Category III		2.6
ER Category IV		1.6
Advanced Radiology		
3 or more procedure types		4.4
Advanced Neurosurgery		
2 or more procedure types		3.9
Acute Dialysis		
52 ≤ Procedures ≤	103	2.7
104 ≤ Procedures ≤	207	5.4
208 ≤ Procedures ≤	411	8.1
412 ≤ Procedures		10.8
Major Organ Transplant		3.4
Radiation Therapy		
2 or more procedure types		3.5
Advanced Laboratory		
4 ≤ Procedure types ≤ 6		4.4
7 ≤ Procedure types		8.8
Open Heart Surgery		
52 ≤ procedures ≤	207	5.3
208 ≤ procedures		10.6

Table 2 -- Non-Routine Services Used to Classify COTH Members[1]

Intensive Care Unit, Average Daily Census

Premature Nursery, Average Daily Census

Newborn Unit, Average Daily Census

Neonatal Inpatient Care Unit, Average Daily Census[2]

Psychiatric Inpatient Unit, Average Daily Census

Drug-Alcohol Abuse Inpatient Unit, Average Daily Census

Rehabilitation Inpatient Unit, Average Daily Census

Open Heart Surgery Procedures

Kidney Transplant (i.e., Major Organ) Procedures[3]

Acute Hemodialysis Procedures

[1]Several non-routine services included in the original Wolfe-Schuman analysis were deleted from the COTH survey: advanced radiology, radiation therapy, advanced neurosurgery, and advanced laboratory procedure types were deleted to simplify the questionnaire; the emergency room categories were deleted because the definitions used in New York State are not used nationwide; and the Type III ICU (nursing care, physician off premises but on call) was deleted at the suggestion of Blue Cross of Greater New York.

[2]At the suggestion of Dr. Wolfe, the neonatal ICU was replaced by the term "neonatal inpatient care unit." While this change may overstate the score of a few COTH members, it greatly simplified data collection.

[3]Kidney transplant procedures were used in place of "major organ transplant" to simplify the questionnaire and standardize data.

Table 3 -- COTH Directory Questionnaire on Non-Routine Services

VI. UNIQUE FACILITIES AND SERVICES

If your institution offers the following, please provide the information below.

1. Inpatient Care Units	Number of Beds	Average Daily Census
a. Intensive Care Unit (ICU)		
b. Coronary Care Unit (CCU)		
c. Premature Nursery		
d. Newborn Unit		
e. Neonatal		
f. Psychiatric		
g. Drug/Alcohol Abuse		
h. Rehabilitation		

2. Procedures	Number of Procedures Performed Last Fiscal Year
a. Open Heart Surgery	
b. Kidney Transplant	
c. Acute Hemodialysis	
d. Coronary Angiogram	
e. CT Scanning of the Brain	
f. CT Scanning of the Whole Body	

3. Inpatient Data

a. Percent Medicare Admissions _____%
b. Percent Medicaid Admissions _____%
c. Percent Admitted from ER _____%
d. Percent Admitted Who Received Surgical Procedure _____%

REMINDER: PLEASE PROVIDE A COPY OF YOUR MEDICAL SCHOOL AFFILIATION AGREEMENT WHEN RETURNING THIS QUESTIONNAIRE. IF THE HOSPITAL AND MEDICAL SCHOOL ARE UNDER COMMON OWNERSHIP, DISREGARD THIS REQUEST.

PERSON TO CONTACT FOR QUESTIONS: _____

AREA CODE/TELEPHONE NUMBER: _____

Table 4 -- COTH Members in the Lowest Quartile by the Wolfe-Schuman Point System

1.	Oakwood Hospital, Dearborn, Michigan	---
2.	Kaiser Foundation Hospital, San Francisco	---
3.	The Methodist Hospital, Brooklyn	---
4.	Maryland General Hospital	---
5.	Detroit General Hospital	5.4
6.	Lovelace-Bataan Medical Center, New Mexico	6.2
7.	Beckley Appalachian Regional Hospital, West Virginia	6.8
8.	Lutheran Medical Center, Brooklyn	6.8
9.	St. Mary's Hospital, Rochester, New York	7.4
10.	St. Vincent's Medical Center, Bridgeport, Connecticut	7.4
11.	The Union Memorial Hospital, Maryland	7.4
12.	Muhlenberg Hospital, New Jersey	9.5
13.	Deaconess Hospital of Buffalo	9.5
14.	Episcopal Hospital, Philadelphia	10.1
15.	George W. Hubbard Hospital of Meharry Medical College, Nashville	10.1
16.	Worcester City Hospital, Massachusetts	10.4
17.	Presbyterian-University of Pennsylvania Hospital, Philadelphia	10.7
18.	Waterbury Hospital, Connecticut	10.8
19.	Roger Williams General Hospital, Providence, Rhode Island	10.8
20.	Montefiore Hospital, Pittsburgh	10.8
21.	Truman Medical Center, Kansas City	11.5
22.	The Stamford Hospital, Connecticut	11.9
23.	Berkshire Medical Center, Pittsfield	13.7
24.	St. Thomas Hospital, Nashville	14.0
25.	Graduate Hospital, Philadelphia	14.6
26.	Touro Infirmary, New Orleans	14.6
27.	Magee-Womens Hospital, Pennsylvania	14.9
28.	St. John's Episcopal Hospital, Brooklyn	14.9
29.	The Grace Hospital, Detroit	15.6
30.	The Genesee Hospital	15.6
31.	Hospital of the Good Samaritan, Los Angeles	16.0
32.	Pennsylvania Hospital	16.0
33.	Misericordia Hospital, Bronx	16.2
34.	St. Vincent's Medical Center of Richmond, New York	16.6
35.	St. Joseph Mercy Hospital, Pontiac	18.1
36.	Presbyterian Medical Center, Denver	18.1
37.	Mount Sinai Medical Center, Hartford	18.3
38.	Allegheny General Hospital	18.4
39.	University of Connecticut-John Dempsey Hospital	18.4
40.	Long Island College Hospital	19.0
41.	Catholic Medical Center of Brooklyn & Queens	19.0
42.	Sinai Hospital of Baltimore	19.0
43.	Howard University Hospital, D.C.	19.1
44.	The Bryn Mawr Hospital, Pennsylvania	19.2
45.	University of Missouri Medical Center	19.5
46.	Mary Imogene Bassett Hospital, Cooperstown	19.6
47.	MacNeal Memorial Hospital, Berwyn	19.6
48.	Mount Sinai Hospital of Chicago	19.8
49.	Mary Hitchock Memorial Hospital	19.9
50.	Morristown Memorial Hospital, New Jersey	20.0
51.	Lankenau Hospital, Philadelphia	20.3
52.	New Britain General Hospital	21.0
53.	Harborview Medical Center, Seattle	21.1

54.	Madison General Hospital	21.2
55.	William N. Wishard Memorial Hospital, Indiana	21.3
56.	Wake County Medical Center, North Carolina	21.4
57.	Miriam Hospital, Rhode Island	21.4
58.	Norwalk Hospital	21.8
59.	Kern Medical Center, California	22.2
60.	University of Nebraska Hospital	22.2
61.	Peter Bent Brigham Hospital	22.2
62.	St. Vincent Hospital, Worcester	22.3
63.	Mount Zion Medical Center, California	22.6
64.	Conemaugh Valley Hospital, Johnston	23.0
65.	Saint Luke's Hospital, Cleveland	23.0

Table 5 -- COTH Members in the Second Quartile by the Wolfe-Schuman Point System

66.	Hospital of Saint Raphael, New Haven	23.0
67.	Overlook Hospital, Summit, New Jersey	23.7
68.	Mercy Catholic Medical Center, Philadelphia	23.7
69.	Harrisburg Hospital	24.0
70.	Blodgett Memorial Hospital, Grand Rapids	24.2
71.	Westchester County Hospital, Valhalla	24.6
72.	Presbyterian University Hospital, Pittsburgh	24.9
73.	Eugene Talmadge Memorial Hospital, Atlanta	24.9
74.	Nassau Hospital, Mineola	25.0
75.	Bridgeport Hospital	25.0
76.	Illinois Masonic Hospital	25.3
77.	Edward W. Sparrow Hospital	25.5
78.	Crawford W. Long Hospital	25.6
79.	Providence Hospital, Southfield, Michigan	25.7
80.	Roosevelt Hospital, New York	25.7
81.	Little Company of Mary Hospital, Illinois	25.8
82.	Hutzel Hospital	26.4
83.	Wayne County General Hospital	26.8
84.	West Virginia University Hospital	27.5
85.	Charles S. Wilson Memorial Hospital, Johnson City	27.5
86.	St. John's Hospital, Springfield	27.6
87.	Crozer-Chester Medical Center, Pennsylvania	27.7
88.	Harper Hospital, Detroit	28.2
89.	LSU, Confederate Memorial Hospital	28.2
90.	Edward J. Meyer Memorial Hospital, Buffalo	28.3
91.	Emanuel Hospital, Portland, Oregon	28.6
92.	Saint Michael's Hospital, New Jersey	28.9
93.	University of Arkansas Medical Center	29.0
94.	Presbyterian Hospital of Dallas	29.5
95.	Louisville General Hospital	29.7
96.	Akron General Hospital, Ohio	29.7
97.	Saint Barnabas Medical Center, New Jersey	30.1
98.	Memorial Hospital, Worcester	30.2
99.	Mercy Hospital, Pittsburgh	30.5
100.	Riverside General Hospital, California	30.5
101.	Cooper Hospital, Camden	30.5
102.	York Hospital	30.6
103.	Medical College and Hospital of Pennsylvania	30.6
104.	Mercy Hospital, San Diego	30.7
105.	Jersey Shore-Fitkin Hospital, Neptune	30.8
106.	University of Oklahoma Hospital	31.1
107.	Hurley Hospital	31.2
108.	Akron City Hospital	31.2
109.	Mercy Hospital of Chicago	31.3
110.	University of California Hospital, San Diego	31.5
111.	Brooklyn Hospital	31.8
112.	University of South Alabama Hospital	31.9
113.	Good Samaritan Hospital, Cincinnati	31.9
114.	University of Kansas Medical Center	31.9
115.	Saint John Hospital, Detroit	32.0
116.	Medical College of Ohio Hospital	32.0

117.	Rochester Methodist Hospital, Minnesota	32.2
118.	Saint Joseph Hospital, Chicago	32.5
119.	Geisinger Medical Center, Danville	32.6
120.	Abbott-Northwestern Memorial Hospital, Minnesota	32.6
121.	Cleveland Clinic	32.6
122.	Hermann Hospital	32.7
123.	Iowa Methodist Hospital	32.7
124.	Saint Francis Hospital, Hartford	32.7
125.	University of Arizona Medical Center	32.8
126.	Saint Louis University Hospitals	32.8
127.	St. Johns Mercy Hospital, St. Louis	32.8
128.	University Hospital of Jacksonville	33.0
129.	Monmouth Medical Center, Long Branch	33.2
130.	St. Elizabeth Hospital, Youngstown	33.3

Table 6 -- COTH Members in the Third Quartile by the Wolfe-Schuman Point System

131.	Mount Sinai Hospital of Cleveland, Ohio	33.3
132.	Prince George's General Hospital, Maryland	33.4
133.	Cleveland Metropolitan General Hospital	33.5
134.	Foster G. McGaw Hospital of Loyola University, Maywood	33.8
135.	Methodist Hospital, Houston	34.0
136.	St. Paul Hospital, Dallas	34.0
137.	Saint Paul-Ramsey Hospital	34.5
138.	Saint Marys Hospital of Rochester, Minnesota	35.2
139.	Presbyterian Hospital of the Pacific Medical Center, San Francisco	35.3
140.	Baystate Medical Center, Massachusetts	35.3
141.	Jewish Hospital, Louisville	35.6
142.	University of Virginia Medical Center	35.9
143.	University of Utah Hospital	36.0
144.	Thomas Jefferson University Hospital	36.1
145.	Evanston Hospital, Illinois	36.4
146.	Montefiore Hospital Medical Center, Bronx	36.6
147.	Saint Josephs Hospital, Phoenix	36.7
148.	Martin Luther King, Jr., General Hospital, Los Angeles	36.7
149.	Bernalillo County Medical Center, New Mexico	36.8
150.	Nassau County Hospital, East Meadow, New York	36.8
151.	Milwaukee County Medical Complex	37.0
152.	Emory University Hospital	37.1
153.	Lenox Hill Hospital, New York	37.5
154.	Jewish Hospital, Brooklyn	37.5
155.	University of California, Davis, Sacramento Medical Center	37.8
156.	St. Francis Hospital, Peoria	37.8
157.	Miami Valley Hospital, Dayton	37.8
158.	Latter-day Saints Hospital, Salt Lake City	37.9
159.	New England Deaconess Hospital, Boston	38.0
160.	University of Wisconsin Hospitals	38.2
161.	Harris County Hospital District Hospital	38.3
162.	St. Joseph Mercy Hospital, Ann Arbor	38.4
163.	Mount Sinai Hospital, Milwaukee	38.5
164.	Beth Israel Hospital, Boston	38.5
165.	Albert Einstein Medical Center, Philadelphia	38.7
166.	Western Pennsylvania Hospital	38.8
167.	State University Hospital, Upstate Medical Center	39.0
168.	Albany Medical Center	39.2
169.	Loma Linda University Medical Center	39.6
170.	St. Luke's Hospital of Kansas City	39.6
171.	Mount Sinai Hospital of Greater Miami	39.7
172.	Georgetown University Hospital	39.8
173.	St. Francis General Hospital, Pittsburgh	39.9
174.	City Hospital of Elmhurst	39.9
175.	Milton S. Hershey Medical Center	40.0
176.	Harlem Hospital	40.1
177.	Maricopa County General Hospital, Arizona	40.3
178.	Cincinnati General Hospital	40.5
179.	Bexar County Hospital District Hospital	40.5
180.	Duke University Hospital	40.5
181.	Montefiore Hospital, Bronx	40.7
182.	University Hospital, Boston	40.8

183.	Temple University Hospital	40.9
184.	George Washington University Hospital	41.1
185.	North Carolina Memorial Hospital	41.3
186.	State University, Downstate Medical Center, New York	41.4
187.	Creighton-Omaha Regional Health Care Center	41.4
188.	Ochsner Foundation Hospital	41.4
189.	Lutheran General Hospital, Park Ridge, Illinois	41.7
190.	Youngstown Hospital Association	41.9
191.	University of Maryland Hospitals	42.4
192.	Christ Hospital, Ohio	42.5
193.	Medical Center Hospital of Vermont	42.7
194.	Rochester General Hospital, New York	42.8
195.	Michael Reese Hospital, Chicago	43.2

Table 7 -- COTH Members in the Highest Quartile by the Wolfe-Schuman Point System

196.	University of Washington Hospital	43.5
197.	U.C.L.A. Hospital and Clinics	44.1
198.	Fairfax Hospital, Virginia	44.5
199.	William A. Shands Teaching Hospital and Clinics	44.6
200.	St. Francis Hospital, Wichita	44.8
201.	University of Minnesota Hospitals	44.8
202.	Colorado General Hospital	44.9
203.	Medical Center Hospitals, Norfolk	45.2
204.	University of California Hospitals, Irvine	45.3
205.	Hennepin County Hospital	45.3
206.	Charleston Area Medical Center, West Virginia	45.5
207.	University Hospital, Jackson	45.6
208.	Beth Israel Hospital, New York	45.7
209.	Hartford Hospital	45.9
210.	University of California Hospitals, San Francisco	46.1
211.	Wesley Medical Center	46.1
212.	Grady Memorial Hospital	46.1
213.	Baylor Medical Center	46.3
214.	North Carolina Baptist Hospitals	47.1
215.	University of Oregon Hospitals	47.3
216.	University of Chicago Hospitals	47.5
217.	New England Medical Center	47.6
218.	Hahnemann Medical College and Hospital	47.8
219.	Tucson Medical Center	48.2
220.	Riverside Methodist Hospital, Ohio	48.3
221.	St. Vincent's Hospital of New York	48.3
222.	New York University Hospital	48.4
223.	Stanford University Hospital	48.5
224.	University of Illinois Hospital	48.6
225.	Indiana University Hospitals	48.8
226.	Baptist Memorial Hospital	49.2
227.	Jewish Hospital of St. Louis	49.4
228.	Baltimore City Hospitals	50.2
229.	Johns Hopkins Hospital	50.5
230.	Henry Ford Hospital	50.6
231.	Parkland Memorial Hospital	50.8
232.	Barnes Hospital	51.2
233.	Maine Medical Center	51.4
234.	Massachusetts General Hospital	51.8
235.	Wilmington Medical Center	52.0
236.	Charity Hospital of Louisiana	52.3
237.	Greenville Hospital System	52.6
238.	Albert B. Chandler Hospital, Lexington	52.6
239.	New York Hospital	53.0
240.	Medical University Hospital of South Carolina	53.2
241.	Washington Hospital Center	53.8
242.	Good Samaritan Hospital, Phoenix	53.9
243.	Los Angeles County-USC Medical Center	54.3
244.	Strong Memorial Hospital	54.4
245.	Mount Sinai Hospital, New York	54.6
246.	Cedars-Sinai Medical Center, California	54.6
247.	University of Texas Medical Branch Hospitals	54.6

248.	University Hospital of Cleveland	55.7
249.	St. Luke's Hospital, New York	55.9
250.	Northwestern Memorial Hospital	56.4
251.	Vanderbilt University Hospital	56.5
252.	Yale-New Haven Hospital	56.7
253.	University of Alabama Hospitals	57.2
254.	Jackson Memorial Hospital	57.6
255.	Methodist Hospital of Indiana	58.4
256.	Presbyterian Hospital in the City of New York	58.5
257.	Rush-Presbyterian-St. Luke's Hospital	59.2
258.	University of Iowa Hospitals	60.9
259.	Ohio State University Hospitals	61.3
260.	Medical College of Virginia Hospitals	65.2

association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

202: 466-5175

November 17, 1977

J. Alexander McMahon
President
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Alex:

While the number and complexity of government regulations controlling hospitals and health services appears to increase daily, they are not based on a general regulatory strategy to which physicians and hospitals may respond. In this situation, the AHA's Special Committee on the Regulatory Process provides one means of focusing and examining the regulations which apply to hospitals, and the AAMC is pleased to have an opportunity to comment on that Committee's draft report, Hospital Regulation.

The Association's evaluation of the draft report was made by the Administrative Board of the Council of Teaching Hospitals. Each Board member was furnished with a copy of the report and a staff evaluation of the recommendations. Responses from Board members have been used to develop the attached comments. In general, the Board members support the substance and recommendations of the draft report. While the comments do contain some criticisms, all comments are intended to be constructive and most simply suggest a clarification in the statement of a particular recommendation. Where a recommendation does not receive comment, the AAMC either supports the recommendation or finds that it addresses a question of the internal operation of the AHA and its related organizations.

The AAMC appreciates the continuing opportunity to review and comment upon proposed AHA policy statements. We trust the attached comments are timely and hope they will assist your staff in polishing a fine report.

Sincerely,

John A. D. Cooper, M.D.

Enclosures

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

Comments of the
Association of American Medical Colleges
on the AHA Report of the
Special Committee on the Regulatory Process

RECOMMENDATION 1: The American Hospital Association should work for amendments to Public Law 93-641 that would apply planning and review processes to all health care providers, regardless of type of ownership or form of organization. All providers, including physicians, should be covered by the same review processes and submit to the same tests of appropriateness for proposed capital expenditures exceeding the dollar limit specified in the regulations.

COMMENT: The statement that "all providers, including physicians, should be covered by the same review process and submit to the same tests of appropriateness for capital expenditures. . ." could be interpreted to imply a mechanistic quantification which fails to recognize the legitimate differences between hospitals. Therefore, the AAMC strongly suggests that this recommendation be reformulated to clearly indicate that the "test of appropriateness" should recognize and account for varying local conditions, differences in service populations, differences in levels of care, and the impact of medical education and research programs.

RECOMMENDATION 2: The American Hospital Association should propose and support amendments to Public Law 93-641 to permit planning agencies to decertify health care facilities or services determined to be superfluous. Amendments should include criteria to ensure that decertification is performed in accordance with due process and other specified safeguards and that equitable financial settlements are provided to all affected providers.

COMMENT: Resource allocation and service supply decisions based solely on patient service requirements may increase total health costs by creating inefficiencies in medical education and research programs which increase their costs. It is suggested that the recommendation be revised to require that procedures give consideration to patient care, health education, and medical research programs.

RECOMMENDATION 4: The American Hospital Association should propose and support amendments to Public Law 93-641 to prohibit both private and government agencies that are major purchasers or providers of health care services from being appointed as Health Systems Agencies.

COMMENT: Implicitly, one could draw the conclusion that planning and rate review should never be in the same agency since rate review could be defined as a "public purchaser" representative. If this implication was not intended, then the AAMC suggests that the recommendation be clarified. If this implication is intended, the AAMC has not taken a position, but it is fair to say that the opinion on either side would not be unanimous.

RECOMMENDATION 5: The American Hospital Association should introduce and support an amendment to Public Law 93-641 that would repeal the existing quota system for Health Systems Agency board membership and replace it with a systematic and equitable process that incorporates specific criteria for eligibility and representation based on knowledge, record of community achievement, independence of thought, expertise in health care delivery, and familiarity with the needs and interests of a particular community. Rules regulating the size of HSA governing boards should be amended to ensure that such boards are kept to a size that instills a sense of responsibility in each individual board member.

COMMENT: An additional membership criteria should be added to include knowledge of local and regional health manpower development and educational programs.

RECOMMENDATION 7: Hospitals and allied associations should support Health Systems Agencies in their efforts to encourage development of alternate modes of health care delivery and to determine, on the basis of experience and evaluation, which services and/or facilities are most appropriate for a health service area. The American Hospital Association should seek amendments to Public Law 93-641 to require that planning decisions are based on sound information and do not constitute unwarranted interference with the day-to-day management of the institution affected.

COMMENT: The AAMC strongly suggests that the second sentence be revised to clearly indicate that areawide and community planning decisions concerned with program approval and resource allocation are to be separated from decisions concerning institutional operations. The former are legitimate HSA concerns, but mandates and directives concerning the latter should clearly be beyond the scope of the HSA's authority.

RECOMMENDATION 11: Hospital trustees and management should develop and employ appropriate internal mechanisms to help ensure the accountability of members of the medical staff. These mechanisms should include governing board representation on credentials committees and provision of information on physician activities to peer review bodies.

COMMENT: This recommendation could cause particular problems for governmentally sponsored and state owned hospitals where a legislative body or Board of Regents serves as the governing board. It is suggested that the first sentence be retained and the second deleted.

RECOMMENDATION 14: Data generated by activities of Professional Standards Review Organizations should be made available to legitimate, qualified users. PSRO data collection requirements must not interfere with any patient's right to privacy. Individual patients and physicians should not be identifiable from aggregate data released to outside data users. Each PSRO should work closely with the hospitals in its area to establish a mutually acceptable data system.

COMMENT: The phrase "legitimate, qualified users" may be narrowly or broadly interpreted. Therefore, the AAMC suggests that the recommendation be reformulated to include some criteria to determine "legitimate, qualified users."