



association of american medical colleges

MEETING SCHEDULE COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

January 23-24, 1980
Washington Hilton Hotel
Washington, D.C.

Wednesday, January 23

6:30 P.M.	COTH Administrative Board Meeting	Jackson Room
7:30 P.M.	Cocktails	Kalorama Room
8:30 P.M.	Dinner	Jackson Room

Thursday, January 24

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Jackson Room
12:30 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Map Room
1:30 P.M.	Executive Council Business Meeting	Conservatory Room

Council of Teaching Hospitals
Administrative Board

September 24, 1980
Washington Hilton Hotel

9:00 a.m. - 12:30 p.m.

A G E N D A

- I. Call to Order
- II. Consideration of Minutes Page 1
- III. Membership Applications
 - Mount Carmel Mercy Hospital Page 18
Detroit, Michigan
 - Northridge Hospital Foundation Page 31
Northridge, California
- IV. University-Owned Hospitals Cooperative Page 50
Study Project - Mr. Westerman and Dr. Dalston
- V. Report and Recommendations of the Ad Hoc Mr. Levitan
Committee on the Distinctive Characteristics
and Related Costs of Teaching Hospitals
- VI. Report of the Task Force on Graduate Medical Executive Council Agenda
Education Page 23
- VII. Medicare Reimbursement for Pathology Services Executive Council Agenda
Page 24
- VIII. Financing the Accreditation of Graduate Executive Council Agenda
Medical Education Page 28
- IX. Recommendations of the AAMC Concerning Executive Council Agenda
Medical School Acceptance Procedures Page 29
- X. Report of the Ad Hoc Committee on Clinical Executive Council Agenda
Research Training Page 31
- XI. Proposed Modifications of the Immigration Executive Council Agenda
and Nationality Act Page 45

- | | |
|---|-------------------------------------|
| XII. National Health Insurance | Executive Council Agenda
Page 50 |
| XIII. Responding to State Legislative Initiatives
Affecting Important AAMC Interests | Executive Council Agenda
Page 67 |
| XIV. Invitational Meeting on Graduate Medical
Education Task Force Report | Executive Council Agenda
Page 72 |
| XV. The Controversy over Indirect Costs | Executive Council Agenda
Page 74 |

INFORMATION ITEMS

- XVI. 1980 Committees (handout)
- XVII. COTH Spring Meeting Report - Dr. Knapp
- XVIII. New Business
- XIX. Adjournment

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
November 5, 1979

M I N U T E S

PRESENT:

Robert M. Heysse1, M.D., Chairman
John W. Colloton, Chairman-Elect
David L. Everhart, Immediate Past Chairman
Dennis R. Barry
James Bartlett, M.D.
Jerome R. Dolezal
James M. Ensign
Mark S. Levitan
Stuart J. Marylander
Mitchell T. Rabkin, M.D.
Malcom Randall
Elliott C. Roberts
William T. Robinson, AHA Representative

ABSENT:

Robert K. Match, M.D.
John Reinertsen, Secretary

STAFF:

James D. Bentley, Ph.D.
Peter Butler
Gail Gross
James Hudson, M.D.
Joseph Isaacs
Chip Kahn
Richard M. Knapp, Ph.D.

I. Call to Order

Dr. HeysseI called the meeting to order at 8:00 a.m. in the Chevy Chase Room of the Washington Hilton Hotel.

II. Consideration of Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the September 13 COTH Administrative Board Meeting.

III. Nominating Committee Report

Mr. Everhart, Chairman of the 1979 COTH Nominating Committee, presented the following slate of nominees for the Board's consideration:

19 Nominations for the AAMC Assembly for a Three-Year Term Expiring 1982

Jess E. Burrow
Veterans Administration Hospital
Sepulveda, California

Laurance V. Foye, Jr., M.D.
Veterans Administration Hospital
San Francisco, California

Louis M. Frazier, Jr.
Veterans Administration Hospital
Shreveport, Louisiana

William H. Gurtner
Mt. Zion Hospital & Medical Ctr.
San Francisco, California

Warren G. Harding
Bexar County Hospital District
San Antonio, Texas

Roger S. Hunt
Indiana University Hospitals
Indianapolis, Indiana

John E. Ives
Shands Teaching Hospital
Gainesville, Florida

Donald G. Kassebaum, M.D.
University of Oregon Hospital
Portland, Oregon

James Malloy
John Dempsey Hospital
Farmington, Connecticut

G. Bruce McFadden
University of Maryland Hospitals
Baltimore, Maryland

Joseph Moore, Veterans
Administration, Lakeside Hospital
Chicago, Illinois

Charles O'Brien
Georgetown University Hospital
Washington, D.C.

David R. Pitts
Ochsner Foundation Hospital
New Orleans, Louisiana

Ruth M. Rothstein
Mt. Sinai Hospital Medical Ctr.
Chicago, Illinois

Jerome R. Sapolsky
The Miriam Hospital
Providence, Rhode Island

Richard L. Sejnost
The Harper Hospital
Detroit, Michigan

Robert J. Taylor
Hennepin County Medical Center
Minneapolis, Minnesota

David S. Weiner
Childrens Hospital Medical Ctr.
Boston, Massachusetts

Bernard B. Weinstein
Westchester County Medical Ctr.
Valhalla, New York

One Nomination for a One-Year Term Expiring 1980:

John Reinertsen
University of Utah Hospital
Salt Lake City, Utah

Nomination for COTH Secretary for a One-Year Term Expiring 1980:

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

Nominations for Three-Year Terms on the COTH Administrative Board:

Fred J. Cowell
Jackson Memorial Hospital
Miami, Florida

Robert E. Frank
Barnes Hospital
St. Louis, Missouri

Earl J. Frederick
Childrens Memorial Hospital
Chicago, Illinois

Representative to the AAMC Executive Council for a Three-Year Term:

John Reinertsen
University of Utah Medical Center
Salt Lake City, Utah

ACTION: It was moved, seconded and carried to approve unanimously the nominees as presented in the report of the 1979 COTH Nominating Committee.

Mr. Everhart conveyed appreciation to Mr. Dolezal and Mr. Ensign whose terms as Board members would expire this year along with his own. He noted that they would receive more formal recognition of their past participation on the Administrative Board at the COTH General Session to be held later in the day.

IV. Membership Applications

Dr. Bentley reviewed two applications for COTH membership and upon staff recommendation the following actions resulted:

ACTION: It was moved, seconded and carried to approve Allentown and Sacred Heart Hospital Center, Allentown, Pennsylvania for full COTH membership.

ACTION: It was moved, seconded and carried to approve Moses H. Cone Memorial Hospital, Greensboro, North Carolina for full COTH membership.

These actions are subject to final approval by the AAMC Executive Council at its next meeting in January, 1980.

Dr. Heyssel reminded the Board that the final report of the Task Force on Graduate Medical Education would be discussed at an AAMC Assembly meeting on Tuesday, November 6 at 1:00 p.m. Since the Board had reviewed this report at prior meetings and had recommended significant changes be made in the report, Dr. Heyssel urged the Board members to attend the Assembly meeting and pay particular attention to the financing section and its potential harmful impact on teaching hospital reimbursement. Dr. Heyssel believed that this and other issues of concern regarding the report should be raised at the Assembly meeting.

V. Describing the Teaching Hospital: Alternatives for COTH Activities

Dr. Heyssel complimented the staff for its outstanding efforts in producing this report since the Board's last meeting in September and asked Dr. Bentley to describe staff's activities in this area. Dr. Bentley recalled that based on the Board's discussion of an earlier report entitled "Case Mix Measures and Their Reimbursement Applications: A Preliminary Staff Analysis," at its September meeting, staff had been directed to:

- identify data which could be used to evaluate the DRG's as an intensity measure for reimbursement;
- identify researchers/consultants with expertise and an interest in conducting such an evaluation; and
- prepare a list of projects which could be conducted or sponsored by COTH/AAMC to evaluate present DRG payment applications and the planned HCFA applications, and to develop alternative reimbursement approaches for tertiary care teaching hospitals.

He explained that the report entitled, "Describing the Teaching Hospital: Alternatives for COTH Activities" responded to these recommendations by summarizing the research activities of others and by suggesting several possibilities for COTH-sponsored projects.

Dr. Bentley then described the "On-going Case Mix Research," as set forth on pages 2-7 of the staff report, and staff's recommendations regarding this research. He suggested that COTH should avoid replication of existing efforts, but keep members informed of activity that could potentially affect them by maintaining liaison with researchers. He believed financial support by COTH for research projects should fall into three areas: (1) small amounts for project start-up; (2) special analyses for teaching hospitals; and (3) communication of research findings to those affected. Dr. Bentley noted that a project is currently being conducted by Susan Horn at The Johns Hopkins School of Public Health. Dr. Heyssel asked what mechanism would be used to review projects for funding from the \$100,000 allocated. Dr. Knapp stated that staff would develop such a mechanism for Board review. Dr. Rabkin felt the funds would be better spent on refining the two COTH documents already developed into a compendium for member use, rather than supporting extensive external activity. Mr. Roberts supported this view.

Mr. Marylander then asked Mr. Robinson about AHA activities in the area of DRGs and case-mix. Mr. Robinson reported that the COTH document on Case Mix Measures was used by the AHA for its Regional Advisory Boards' discussions of DRGs. He stated that the AHA was months behind COTH, who was the emerging center of knowledge in this area. He expressed appreciation to COTH for its cooperation and believed that as long as information continues to be shared, all hospitals will benefit from the disseminated data.

Mr. Colloton suggested modification of the wording of the second recommendation on page 7 of the report and further recommended expanding the two preliminary staff reports on case mix into a more comprehensive compendium which would make COTH the unquestionable authority in this area. The compendium would continually be updated, alerting both the COTH membership and appropriate governmental representatives of the revised information. Mr. Colloton concluded his recommendation by calling upon staff to set up a review and approval mechanism for disbursing research support funds, which would involve a minimum of bureaucratic procedures. Dr. Rabkin felt there should be a limit set on how much could be expended on an individual project and reiterated his belief that an expanded report distributed to the membership and government officials would do much to establish COTH credibility as the expert source on DRG's. Based on these suggestions and further discussion, the following Board action resulted:

ACTION: It was moved, seconded and carried to modify and approve staff's recommendations with regard to case mix research activities, as set forth on page 7 of "Describing the Teaching Hospital: Alternatives for COTH Activities," as follows:

- that AAMC staff establish and maintain liaison with each of the projects described on pages 2-7 of this report,
- that the AAMC consider supporting one or more projects in this area only if
 - relatively small amounts of money are needed for project start-up or continuation between other sources of funds,
 - special analyses of importance to teaching hospitals are identified but unfunded by other sources, or
 - funds are needed to communicate research findings to affected hospitals or public policy makers.
- that AAMC staff devise an appropriate review process and approval mechanism for disbursing funds on acceptable projects,

- that staff refine the two preliminary reports on case mix and expand them into a comprehensive compendium report which would then be distributed to AAMC constituency and government officials to establish the Council of Teaching Hospitals as the foremost authority in this area.

Dr. Bentley then outlined possible COTH projects (pages 8-15 of the report) in this area. Dr. Knapp suggested that a committee be established to work closely with staff to examine each of these projects and to determine specific courses of action with regard to each. Following a brief discussion of each of the proposed projects, Mr. Everhart recommended approval of each of these projects in principle, subject to expansion by staff. Mr. Colloton agreed, suggesting Dr. Knapp recommend the committee's composition. Further discussion led to the following action:

ACTION: It was moved, seconded and carried to approve in principle and establish an AAMC ad hoc committee to specifically address the priority of projects set forth on pages 8-15 of the staff report, "Describing the Teaching Hospital: Alternatives for COTH Activities." These projects include:

1. A Reference Book for Describing Teaching Hospitals;
2. A Tabulation of Medicare Cost Report Data;
3. A Data Base on Case Mix and Per Case Costs;
4. Examining the HCFA Methodology;
5. Workshops to Educate the Membership; and
6. A "Think Tank" Conference on Reimbursement.

With regard to number 5, Workshops to Educate the Membership, Dr. Heyssel recommended that the staff's report be distributed to the COTH membership and that the regional workshops be organized as soon as possible. The Board generally agreed. Dr. Heyssel asked Mr. Colloton COTH Chairman-Elect to work with staff in establishing the AAMC ad hoc committee to address the proposed projects.

VI. Other Business

Dr. Knapp distributed copies of a year-in-review summary of COTH activities and the letter submitted in response to the AICPA's Exposure Draft on Reporting Practices Concerning Hospital-Related Organizations. Mr. Randall then paid tribute to Dr. Heyssel for outstanding leadership during his term as COTH Chairman. The Board heartily agreed. Dr. Heyssel then praised the staff for making his job as Chairman an easy one.

Mr. Randall noted that the VA Medical Center Directors were meeting for the first time at this year's Annual Meeting of the AAMC. He hoped that this would become an annual event.

VII. Adjournment

The meeting was adjourned at 9:10 a.m.

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
September 13, 1979

MINUTES

PRESENT:

Robert M. Heyssel, M.D., Chairman
John W. Colloton, Chairman Elect
David L. Everhart, Immediate Past Chairman
John Reinertsen, Secretary
James Bartlett, M.D.
Stuart Marylander
Robert K. Match, M.D.
Mitchell T. Rabkin, M.D.
William T. Robinson, AHA Representative

ABSENT:

Dennis R. Barry
Jerome R. Dolezal
James M. Ensign
Mark S. Levitan
Malcom Randall
Elliott C. Roberts

GUESTS:

Spencer Foreman, M.D.
William D. Mayer, M.D.

STAFF:

Martha Anderson, Ph.D.
James D. Bentley, Ph.D.
Judy Braslow
Peter Butler
John A.D. Cooper, M.D.
Gail Gross
James I. Hudson, M.D.
Joseph Isaacs
Chip Kahn
Richard M. Knapp, Ph.D.
John F. Sherman, Ph.D.
Emanuel Suter, Ph.D.
August G. Swanson, M.D.

I. Call to Order

Dr. Heyssel called the meeting to order at 8:00 a.m. in the Kalorama Room of the Washington Hilton Hotel.

II. Consideration of Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the June 14 COTH Administrative Board Meeting

Dr. Knapp introduced Chip Kahn, who recently joined the Department of Teaching Hospitals' staff as an Administrative Resident. Mr. Kahn is a graduate of Johns Hopkins University and is currently pursuing a masters degree in Health Systems Management at Tulane University.

III. Membership

A. Terminations

Dr. Knapp wanted the Board to be aware that St. Elizabeth Hospital Medical Center, Youngstown, Ohio and St. Johns Episcopal Hospital, Brooklyn, New York had voluntarily withdrawn their membership in the Council of Teaching Hospitals. He also pointed out that the membership of New York Medical College - Flower and Fifth Avenue Hospital should be terminated since it has not responded to several AAMC requests for payment of overdue membership fees. Dr. Knapp also asked for Board action on termination of the membership of Mayaguez Medical Center in Puerto Rico. Its dues have not been paid for three years and Dr. Knapp has notified them that their membership would end if their account was not settled by September 30. The Board agreed with these recommendations.

B. Membership Applications

Dr. Bentley reviewed eight applications for COTH membership. Based on staff recommendation, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve Cabell Huntington Hospital, Huntington, West Virginia for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Cabrini Medical Center, New York, New York for COTH full membership.

ACTION: It was moved, seconded and carried to approve The Children's Hospital, Columbus, Ohio for COTH full membership.

ACTION: It was moved, seconded and carried to approve The Community Hospital of Springfield & Clark County, Springfield, Ohio, for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Greene Memorial Hospital, Inc., Xenia, Ohio for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve Saint Francis Hospital, Tulsa, Oklahoma for COTH full membership.

ACTION: It was moved, seconded and carried to approve Scott and White Memorial Hospital, Temple, Texas for COTH full membership.

ACTION: It was moved, seconded and carried to approve Veterans Administration Medical Center, Huntington, West Virginia for COTH corresponding membership.

AICPA "Exposure Draft"

Dr. Heyssel called attention to an "Exposure Draft on Clarification of Reporting Practices Concerning Hospital-Related Organizations," which was prepared by the AICPA Subcommittee on Health Care Matters. Dr. Bentley informed the Board that COTH submitted a statement on this a year and one-half ago and would be commenting again by October 31 of this year. Board comments and suggestions were welcomed.

Medicare Section 223 Schedule of Limits

Dr. Heyssel reviewed the contents of a September 10 letter from the AAMC to HCFA Administrator Len Schaeffer on the Section 223 limits. Dr. Knapp briefed the Board on activities relating to this issue which directly resulted from Board action at its June meeting. He reported that a COTH membership meeting was held on July 10 with HCFA officials at Georgetown University. It was attended by approximately 100 individuals from about 50 COTH-member hospitals affected by the Section 223 regulations. Presentations were made by three HCFA representatives: Leonard Schaeffer, Clif Gaus, and Bob O'Conner. Dr. Knapp felt that these officials were made aware by hospital representatives of their intense negative feelings about the regulations, particularly by California and Chicago hospitals which also visited their Congressmen. Dr. Knapp thought the fact that some hospitals' (those with large bed sizes) limits were reduced by \$12 between the proposed and final regulations was the major reason for the withdrawal of the final regulations and subsequent reissue of the regulations for a three month period with a new opportunity to submit comments. This fact had the most impact in discussions with Congressmen.

Mr. Schaeffer and Congressman Rostenkowski met on July 13th and as a result action was taken to return to the 80th percentile, at least for those institutions with a July 1 through September 30 fiscal year. However, it is uncertain whether HCFA will revert back to 115% of the mean after public comments have been received.

In his presentation at the July 10 meeting, Clif Gaus indicated that a decision would be made by December on whether HCFA will implement a per admission method of reimbursement based on the DRG model. Dr. Heyssel expressed concern about this potentiality and urged Board members to carefully review the staff report on case mix measures.

IV. JCAH Professional and Technical Advisory Committee (PTAC) Report

Mr. Everhart, AAMC representative to the JCAH Professional and Technical Advisory Committee, summarized the proceedings of the first meeting of that Committee and described its composition. George Way, AMA President-Elect, was elected Chairman of the PTAC and Mr. Everhart was appointed the PTAC's representative to the JCAH Hospital Accreditation Committee, which makes the final decision on the accreditation of all hospitals and meets monthly in Chicago. Mr. Everhart was impressed with the caliber of the individuals at the meeting and thought it would be interesting to see what impact the advisory committee would have on the process of accreditation. He promised to keep the Board informed of future PTAC activities.

V. Confidentiality of COTH Executive Salary Survey

Dr. Heyssel discussed a request made to him by John H. Gerstenmaier, Chairman of the Board of Trustee's Compensation Committee at Akron City Hospital. Mr. Gerstenmaier desired data from the COTH Executive Salary Survey which Dr. Heyssel agreed to release, thereby making an exception to current COTH policy which allows release of such data only to COTH-member CEOs. Dr. Heyssel asked the Board for guidance with regard to future requests of this nature. Dr. Knapp informed the Board that in a survey taken last year, 74% of the COTH membership reiterated the feeling that the Executive Salary Survey should be sent to Chief Executive Officers only. Mr. Colloton felt Dr. Heyssel's decision to release the information to a Trustee was appropriate, but that the chief executive officer should be notified when such information has been requested and subsequently sent to a Trustee of his institution. The Board generally agreed.

VI. COTH Spring Meeting Planning Committee Report

Dr. Knapp summarized the proceedings of the meeting of the COTH Spring Meeting Planning Committee which was held on July 26 in Chicago. The Spring Meeting will be held May 14-16, 1980 at the Brown Palace Hotel in Denver. Wednesday evening would begin with a speaker prior to cocktails and dinner; Thursday morning would be devoted to a session with a group of deans; Thursday afternoon would be a half-day to explore "case mix and hospital reimbursement;" and Friday

morning would begin with four one and one-half hour concurrent sessions and conclude with a final session of all the membership, the topic for which would be decided later.

Dr. Knapp welcomed Board comments and suggestions with regard to the style and format for the specific sessions and overall meeting. Dr. Heyssel particularly asked for suggestions for the initial speaker; Dr. Knapp suggested that a speaker well-versed in "deregulation and competition" could make a timely presentation about implications of such a policy on teaching hospitals. Several suggestions were made, with John Dunlop (former Director of the Cost of Living Council) from Harvard or someone he might suggest topping the list. It was generally decided that Mr. Colloton and Dr. Knapp would make the final decision with regard to the speaker for the opening session. Dr. Knapp stated that he would seek someone with a hospital background who could bridge the gap between theory and implementation.

VIII. Flexner and Borden Awards

ACTION: It was moved, seconded and carried that the Executive Council approve the recommendations of the Flexner and Borden Award Committees as set forth on page 24 of the Executive Council Agenda.

IX. CCME "Policy on Policy"

ACTION: It was moved, seconded and carried that the Executive Council approve the CCME "Policy on Policy" as set forth on page 25 of the Executive Council Agenda.

X. Bylaws Change for LCGME

Responding to a question from Dr. Bartlett regarding whether or not these bylaws changes had been reviewed by legal counsel, Dr. Knapp indicated that he did not know but would raise the question at the Executive Council meeting.

ACTION: It was moved, seconded and carried to approve the bylaws change for the Liaison Committee on Graduate Medical Education as set forth on page 27 of the Executive Council Agenda.

XVIII. Medical Sciences Knowledge Profile (MSKP) Program

ACTION: It was moved, seconded and carried that the Executive Council approve the substitution of the MSKP program for COTRANS and authorize moving forward with its implementation in 1980.

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VII. Case Mix Measures and Their Reimbursement Applications

Dr. Bentley reviewed "Case Mix Measures and Their Reimbursement Applications: A Preliminary Staff Report" which was a separate attachment to the COTH Agenda. He reported that, based on an initial literature review and a series of site visits which he and Peter Butler made to various individuals active in case mix research, the paper had been organized in three sections: (1) description of initial literature review and site visits, methods for measuring case mix and of ongoing and planned applications; (2) outline of proposed final report; and (3) recommendations for future AAMC policy. Dr. Bentley welcomed Board comments on the paper specifically on (1) whether any case mix applications were missed, (2) the general contents of the paper, (3) what should be done with recommendations presented in the paper, and (4) whether COTH is fulfilling the objectives set forth by the membership at the Spring Meeting. Dr. Heyssel felt that this was an outstanding initial effort on the part of the staff and noted that he had written to Clif Gaus regarding the inherent weaknesses of the DRG model.

Mr. Colloton maintained that HCFA clearly intends to implement the DRG model by the end of 1980. He suggested that a collaborative effort should be considered wherein COTH and HCFA conduct pilot studies of case mix. Mr. Reinertsen agreed that there was urgency in dealing with this issue, but did not favor sharing any information with HCFA until the data can be better verified. Mr. Marylander also felt that it would not be feasible to work with HCFA productively in the formative stages of the study, but resources should continue to be devoted to learning more about the whole issue in order to prepare for future implementation of the DRG model. In addition, he recommended that the staff paper be widely distributed among the membership.

Dr. Bentley noted that everyone he and Peter talked to -- large and small hospitals, state regulators and hospital associations -- believed they would win with case mix and this give him some concern. Mr. Everhart asked if there were alternatives to the DRG model that had been explored by anyone. Aside from some conference and workshop level involvement of some "Big Eight" accounting/consulting firms, staff could not offer evidence of any investigations of other alternatives. Mr. Colloton suggested employing a consulting firm to grapple with the problem and evaluate other methods. Dr. Cooper suggested that RAND Corporation might be a good choice for such consulting services.

Following further discussion the board generally agreed that (1) the "Preliminary Staff Report on Case Mix" should be sent to the COTH membership with a cover letter discussing the future plans for the case mix study and (2) prior to the COTH annual meeting in November staff should:

- identify data which can be used to evaluate the DRG's as an intensity measure for reimbursement;
- identify researchers/consultants with expertise and an interest in conducting such an evaluation; and

- prepare a list of projects which could be conducted or sponsored by COTH/AAMC (1) to evaluate present DRG payment applications and the planned HCFA application and (2) to develop alternative reimbursement approaches for tertiary care teaching hospitals.

XVIII. Liaison Committee on Continuing Medical Education

Dr. Cooper reviewed this item for the Board. Mr. Colloton asked Mr. Robinson where the AHA stood on this issue. Mr. Robinson reported that the AHA supported continuation of the LCCME. Following discussion the Board decided on the following action:

ACTION: It was moved, seconded and carried that the Executive Council adopt the policy regarding LCCME as set forth in numbers 1-3 on page 134 of the Executive Council Agenda.

XIII. A Position Paper: The Expansion and Improvement of Health Insurance in the United States

Mr. Colloton, a member of the AAMC ad hoc Committee on National Health Insurance, described the position paper which resulted from that Committee's review of the AAMC's 1975 policy statement on national health insurance. The Committee decided to move away from a comprehensive national health insurance program toward a policy statement that promotes the expansion of health insurance in the United States. The statement addresses three major deficiencies: (1) the coverage gap which exists relative to basic health insurance for low income Americans; (2) the inadequacy of health insurance protection for catastrophic illness; and (3) the need for an accepted minimum standard for basic health insurance plans. Addressing these deficiencies, the statement calls for expansion and improvement of Medicaid on a national scale to bring about broader eligibility of low income people and minimum standardization of the benefit package. With regard to catastrophic illness, it is recommended that employers be mandated to provide full-time employees with catastrophic health insurance meeting certain minimum HEW standards for adequacy of coverage and eligibility. Commercial insurance firms would form pools to underwrite catastrophic coverage for self-employed part-time workers and the non-employed. Finally, it is recommended that an independent certifying body or commission composed of representatives of insurance carriers, providers and consumers be established for purposes of placing its "seal of approval" on minimally acceptable basic health insurance packages. It is hoped that this would promote the upgrading of inadequate basic plans and provide a valuable source of additional information.

Mr. Colloton concluded that the statement also addressed the matter of reasonable reimbursement of physicians and institutional providers, graduate medical education reimbursement, and lastly the appropriate use of cost sharing mechanisms in the financing of the nation's health insurance program. Mr. Colloton believed the paper's one shortcoming is in this area where he believed there is a lack of emphasis on controlling the unnecessary demand for medical services through use of deductibles and co-insurance. He then presented evidence from the research literature indicating the influence of co-insurance and deductibles on demand.

Dr. Heyssel indicated concern about mandating that employers provide catastrophic coverage for full-time employees. Mr. Everhart disagreed and felt the employer requirement was necessary. Dr. Bartlett believed that employers should not be subject to such a mandate and felt that the language on page 72 of the Executive Council Agenda, discussing the nation's health insurance system as an appropriate mechanism for "replenishing the health manpower pool," did not represent conventional wisdom on this issue. Following further discussion, the Board generally agreed that the position paper represented a good start but that some parts need more attention and modification.

Dr. Cooper indicated that approval of the new position statement was necessary to replace a former AAMC position on national health insurance in the event that the Association must testify on national health insurance before January (1980). He suggested Board approval of the statement with recommendations for improvement and/or changes. The Board discussed and generally agreed with the three major disparities identified as persistent in the nation's health insurance system, as set forth on page 62 of the Executive Council Agenda. Mr. Marylander emphasized that any expansion of the health insurance system must be contingent on the existence of a sound financial structure for it and reimbursement under it. Mr. Reinertsen recommended that the Board agree to abandon the former AAMC position, agree in principle with the new policy statement, and further pursue the draft and alter it as necessary for use as official AAMC policy. There was a division of opinion among the Board members with regard to the proposed solutions set forth in the paper to deal with the three identified disparities. Further discussion resulted in the following action:

ACTION: It was moved, seconded and carried to accept the following measures with regard to the Position Paper on the Expansion and Improvement of Health Insurance in the United States:

- Abandon the 1975 AAMC policy statement on national health insurance;
- Express agreement with the three major disparities that persist in the nation's health insurance system as set forth in the Position Paper on page 62 of the Executive Council Agenda;
- Express concern with the "mandating" concept, the section on co-insurance and deductibles, and other issues discussed which were noted by the staff and suggest redrafting of these positions of the position which would be more acceptable to the Board; and
- Use this Position Paper as preferable to the 1975 position should it become necessary to have a formulated AAMC policy prior to the recommended redrafting.

XIV. Final Report - Specialty Distribution Working Group

Spencer Foreman, M.D., a member of the Working Group on Specialty Distribution of the Task Force on Graduate Medical Education, reviewed the final report of the working group which is set forth on pages 76-104 of the Executive Council Agenda. Dr. Foreman indicated that there was considerable compromise involved in developing the report recommendations. He felt that the paper had more deficiencies than strengths since there are conclusions presented without supporting data. He continued that the paper is an attempt to address specialty distribution through reimbursement mechanisms which seem most rational. Dr. Cooper warned that HEW's alternative could be control by the Secretary of the number of residencies or some other undesirable arrangement. He said that the Board's approval of the report in principle was being sought and that a group of residents will be reviewing this prior to the annual meeting, at which time the report will be presented to the full AAMC Assembly for approval. Following discussion, the Board generally agreed to approve the report in principle but raised a number of concerns.

ACTION: It was moved, seconded and carried to approve, in principle only, the Final Report of the Specialty Distribution Working Group, with the understanding that there would be further discussion and modification of the report prior to the AAMC Assembly meeting in November. In addition, it is requested that the recommendation on page 95 of the Executive Council Agenda be reworded to more clearly suggest the provision of incentives to academic medical centers by third-party payors and governmental agencies for adjustment of the mix and size of their graduate programs.

XVI. Final Report - Working Group on Financing

Dr. Swanson reviewed this report for the Board, noting that the posture taken was that graduate medical education should be financed by third-party payors of all categories in order to ensure necessary physician manpower in the future.

Mr. Colloton felt that item #2 on page 18 of the document failed to address the longitudinal involvement of the physician in the care of a patient throughout his or her stay. He suggested language to read under Special Issues, (1) Compensating Teaching Physicians, No. 2 on page 18 (Lines 14-17) as follows:

2. "Payment of professional fees for service rendered by graduate medical education faculty should be provided by third-party payers when the faculty member has intimately participated with the resident team in the provision of care to a beneficiary throughout the course of the beneficiary's hospitalization or clinic stay."

Dr. Swanson suggested I.L. 372 language here. Mr. Colloton was amenable.

Mr. Colloton contended that the section under Special Issues, (3) Financing Ambulatory Care Educational Settings, Allocation of Costs on Page 25 (Lines 9 on) failed to adequately address the allocation of graduate medical education costs. He called for the addition of such discussion, without specifying particular language (i.e., he spoke generally of GME as a general burden, based on inpatient revenue to the clinics, etc.). Dr. Swanson agreed with the need for such discussion.

Dr. Heyssel was generally concerned that the paper was argued on the basis of educational concerns rather than those relating to the service component. He suggested that the service performed by residents could be discussed as part of the educational experience. He was also concerned with statement No. 2 under Capital Costs on Page 8 (Lines 11-13) because he did not believe that decisions on technological needs should be based on graduate medical education needs.

Under Sources for Financing Graduate Medical Education, Page 11 (Lines 4-7) Dr. Swanson recommended the following language with which most Board members concurred: "This view neglects two facts: patients benefit from the services they receive from residents who care for them during their educational experiences in teaching hospitals, and 94% of all hospital revenues are now derived from third-party insurers."

On Page 3 (Lines 5-8) Dr. Knapp called for the deletion of the last two sentences of the paragraph which ends on lines 5-8 and discusses the size of resident stipends as noncontroversial.

After further discussion, the Board took the following action:

ACTION: It was moved, seconded and carried to approve, with modification suggested by the Board, the final report of the Working Group on Financing, subject to further action by the Assembly at the annual meeting in November.

XI. General Requirements Section of the Essentials of Accredited Residencies

Dr. Swanson reviewed the "Essentials," noting that the LCGME has not as yet had a chance to approve or disapprove the document. He anticipated that comments would be forthcoming from the LCGME following its meeting in November.

Mr. Colloton pointed out that at the March 29 COTH Board meeting, action had been taken to delete the word "detailed" from line 15 of section 1.1.2 on page 36, as well as the first two sentences of that section. However, the current document showed no evidence of such changes. Dr. Swanson indicated that he would try to have the changes incorporated into the document this time.

ACTION: It was moved, seconded and carried to approve "The Essentials of Accredited Residencies in Graduate Medical Education" as set forth on pages 29-49 of the Executive Council Agenda, modifying section 1.1.2 on page 36 by deleting the word "detailed" from line 15 and the first two sentences of that section.

XV. Final Report - Working Group on Quality

Dr. Anderson reviewed this report and the following action resulted from Board discussion:

ACTION: It was moved, seconded and carried to approve the Final Report of the Working Group on Quality subject to the following changes:

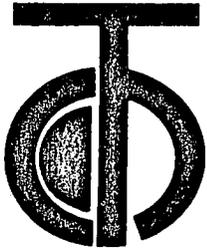
- Principle 2 on page 122 of the Executive Council Agenda should read: "The institution(s) should have an appropriate mechanism for an effective allocation of educational resources and the evaluation of the quality of each program."
- Line 9 on page 122 should read: "institution(s) should be of concern to the entire institution. How institutions. . ."
- The first word on line 10 on page 122 -- "faculties" -- should be deleted.

XII. Final Report - Ad Hoc Committee on Continuing Medical Education

William Mayer, M.D., Committee Chairman, reviewed the report explaining that changes recommended by the COH Board at its previous meeting had been incorporated into the report.

ACTION: It was moved, seconded and carried to approve the Final Report of the Ad Hoc Committee on Continuing Medical Education as set forth on pages 49-60 of the Executive Council Agenda.

The meeting was adjourned at 1:00 p.m.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
Council of Teaching Hospitals
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: MOUNT CARMEL MERCY HOSPITAL

Hospital Address: (Street) 6071 W. Outer Drive

(City) Detroit (State) MI (Zip) 48235

(Area Code)/Telephone Number: (313) gen.number 927-7000

Name of Hospital's Chief Executive Officer: Michael J. Madden

Title of Hospital's Chief Executive Officer: President & Chief Executive Officer

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>557</u>	Admissions:	<u>16,571</u>
Average Daily Census:	<u>502.5</u>	Visits: Emergency Room:	<u>47,794</u>
Total Live Births:	<u>na</u>	Visits: Outpatient or Clinic:	<u>59,420</u>

B. Financial Data

Total Operating Expenses: \$ 56,035,900

Total Payroll Expenses: \$ 35,305,900

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 2,025,000
 Supervising Faculty: \$ 401,200

C. Staffing Data

Number of Personnel: Full-Time: 1826
 Part-Time: 402

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 322
 With Medical School Faculty Appointments: 112

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Medicine Pediatrics Radiology Psychiatry
Surgery Phys. Med. & Rehab Pathology Family Practice

Does the hospital have a full-time salaried Director of Medical Education?: yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>23</u>	<u>23</u>	<u>Elective</u>
Surgery	<u>14</u>	<u>14</u>	<u>Elective</u>
Ob-Gyn	<u>0</u>		
Pediatrics	<u>10</u>	<u>9</u>	<u>Elective</u>
Family Practice			
Psychiatry			
Other: <u>Physical Med. 1</u>		<u>1</u>	<u>Elective</u>
<u>Physical Diagnosis</u>	<u>16</u>	<u>16</u>	<u>Required</u>
<u>Pathology</u>	<u>2</u>	<u>2</u>	
<u>Emergency Medicine</u>	<u>18</u>	<u>7</u>	

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B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	<u>2</u>	<u>2</u>	<u> </u>	<u> </u>
Medicine	<u>30</u>	<u>5</u>	<u>25</u>	<u>October 2, 1944</u>
Surgery	<u>20</u>	<u>13</u>	<u>7</u>	<u> 1945</u>
Ob-Gyn	<u>--</u>	<u> </u>	<u> </u>	<u> </u>
Pediatrics	<u>24</u>	<u>4</u>	<u>20</u>	<u>March 25, 1959</u>
Family Practice	<u>4</u>	<u>3</u>	<u>1</u>	<u>November 16, 1976</u>
Psychiatry	<u>--</u>	<u> </u>	<u> </u>	<u> </u>
Other: Orthopedics	<u>15</u>	<u>15</u>	<u> </u>	<u>May 7, 1975</u>
Pathology	<u>5</u>	<u>-</u>	<u>5</u>	<u>March 14, 1950</u>
Radiology	<u>8</u>	<u>-</u>	<u>8</u>	<u>July 1, 1947</u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

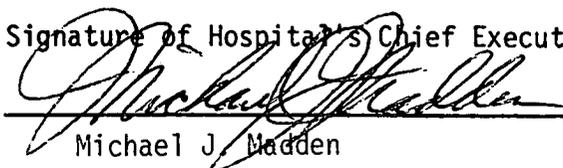
Name of Affiliated Medical School: Wayne State University School of Medicine

Dean of Affiliated Medical School: Robert D. Coye, M.D., Dean

Information Submitted by: (Name) Kathleen K. DeVine

(Title) Administrative Assistant

Signature of Hospital's Chief Executive Officer:

 (Date) December 7, 1979

Michael J. Madden

MOUNT CARMEL MERCY HOSPITAL - DETROIT

Mount Carmel Mercy Hospital, located in Detroit's northwest section, is a 597 bed voluntary, non-profit hospital owned and operated by the Sisters of Mercy Health Corporation. The Medical Staff numbers over 400 with 120 house staff officers.

Mount Carmel is a teaching hospital with over 500 students in allied health programs.

Mount Carmel, with the designation, Northwest Detroit Trauma Care Center, sees an average of 160 patients per day in its Emergency Room. Mount Carmel is a leader in Emergency Medicine in the greater Detroit area and boasts a superb Pediatric Emergency Department and an Emergency Center Facility which has its own Stat lab, X-ray, Maxillofacial Surgery Room and Operating Room within the Emergency Room.

Mount Carmel also has a large Ambulatory Health Care Center which accommodates over 17,000 patients annually. An Ambulatory Surgery Center opened in 1975 which currently performs an average of 10 ambulatory procedures daily.

Supportive services at Mount Carmel include a new 33 bed Intensive Care Unit for surgical, coronary and medical patients, a 14 bassinets neonatal Intensive Care Unit and a 5 bed Pediatric Intensive Care Unit.

Mount Carmel also has an active Hemodialysis and Renal Transplant program. A large Physical Medicine Department services both inpatients and outpatients with all modalities of physical, occupational and speech therapy.

Affiliations include the Wayne State University School of Medicine, the University of Michigan School of Medicine, the Metropolitan Northwest Detroit Hospitals Corporation.

RESIDENCY PROGRAMS AND SENIOR ELECTIVES

Residency Programs at Mount Carmel include a fully approved three-year training program in Internal Medicine. The objective of the Internal Medicine Department is to develop Internists with broad backgrounds in clinical medicine and high competence as clinicians and consultants. It is based on the premise of increasing responsibility with growing experience. The program is implemented by intensive bedside instruction, primary patient care responsibility on inpatient and outpatient services, teaching conferences and rounds and participation in research projects. A critical attitude and spirit of inquiry are fostered; pedantry, didacticism and dogmatism are discouraged. Fellowships in Cardiology, Gastroenterology and Nephrology are offered under the Department of Medicine as are first year Flexible positions.

Senior Electives offered by the Department of Medicine are General Medicine, Cardiology, Electrocardiography, Gastroenterology, Infectious Disease, Nephrology. There are also senior electives in Emergency Medicine and Critical Care Medicine.

The Family Practice Residency program places particular emphasis on the individual and provides a well rounded schedule for development in all areas of the Family Practice specialty. Flexibility of schedule is maintained throughout the entire three-year program in order to provide continued contact within the Family Practice Center with each resident's patients.

The Pediatric Department consists of 80 inpatient beds and a five-bed Pediatric Intensive Care Unit. The Emergency Room has a separate Pediatric section which sees 25,000 children per year.

The Pediatric Residency is a Quadrangle program based at Mount Carmel. There is also a new 40-bed Child Psychiatry Unit with a full-time staff adjacent to the Pediatric Department ensuring complete evaluation of medical and psychosocial needs of the children. Fellowships in Neonatology are also offered.

Four and eight week rotations in the Department of Pediatrics are available to senior medical students.

The Department of Surgery offers a comprehensive five-year training program in General Surgery. This includes a first postgraduate year which may be Categorical or Transitional. Residents acquire maximum experience in General Surgery and surgical subspecialties under the supervision of staff members of the Department of Surgery.

In addition to the five-year programs, a one, two or three-year program of graduate training in General Surgery is offered to those physicians planning to enter subspecialty programs which require prior training in General Surgery.

There is also a renal transplantation fellowship offered in the Department of Surgery.

Senior electives are offered in General Surgery and Clinical Nutrition.

A fully approved Quadrangle Orthopaedic Residency was started in July of 1974. Participating hospitals are Mount Carmel, Sinai, Grace Northwest and Providence. The Orthopaedic senior elective is devoted to the study of patients on the reconstructive and traumatic service.

Diagnostic Radiology Residency has a four-year program, which is organized into four divisions. The Radiology senior elective is a one-month rotation, offered to give the student an evaluation of Radiology and Nuclear Medicine as practiced at one community hospital. It is expected the student will elect to spend most of the rotation time in Diagnostic Radiology.

The Pathology Department offers a fully approved four-year training program in combined Anatomic and Clinical Pathology. Senior electives are offered in both Anatomic and Hematologic Pathology.



WAYNE STATE UNIVERSITY

SCHOOL OF MEDICINE

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

OFFICE OF THE DEAN

November 1, 1979

Association of American Medical Colleges
Council of Teaching Hospitals
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Gentlemen:

I am pleased to support the application of Mount Carmel Mercy Hospital for Council of Teaching Hospitals membership. This hospital is a very valuable component of our overall medical education program and is highly oriented to academic activities.

Sincerely,

Robert D. Coye, M.D.
Dean

RDC/dmm

cc: Mount Carmel Hospital



UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE
SCHOOLS OF BASIC MEDICAL SCIENCES AND CLINICAL MEDICINE
MEDICAL SCIENCES BUILDING
URBANA, ILLINOIS 61801

(217) 333-9284

October 26, 1979

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

Dear Dr. Knapp:

This letter is in support of the application of Carle Foundation Hospital to become a corresponding member of the Council of Teaching Hospitals. Carle's involvement has been essential to our teaching program since the founding of the School of Basic Medical Sciences in 1971. When the School of Clinical Medicine at Urbana-Champaign was inaugurated in July, 1978, Carle became one of the three teaching hospitals with a major affiliation. Each of these hospitals maintains a clinical education center in which full-time faculty members of the College of Medicine work jointly with voluntary faculty from the community. A majority of Carle physicians have joint appointments with the College of Medicine. Carle physicians have teaching responsibilities throughout the four years of undergraduate medical education and are involved in two accredited residency programs, as well as in the curriculum planning process for new residencies. They are also actively involved in the governance of both Schools. I am pleased to recommend Carle Foundation Hospital for membership in the Council of Teaching Hospitals.

Yours truly,

Daniel K. Bloomfield, M.D.
Dean

kb4/g

AFFILIATION AGREEMENT

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

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

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

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

NOW THEREFORE, the parties agree as follows:

1. That a standing committee be established which shall have as its function the continued overall study of the various relationships, and coordinate joint programs between the University and the Hospital.
2. That said committee shall consist of three members on a policy-making level from each institution, appointed by the President of the University, and the Director of the Hospital. If, in the judgment of either party, it is deemed necessary in order to assure adequate representation of its concerns on the committee, it may appoint additional members. However, it is understood between the parties that each shall have an equal voice in committee actions.
3. The committee shall make recommendations to the Board of Trustees of the Hospital and to the President of the University regarding joint staff and faculty appointments, and appropriate rank, but such recommendations are to be within the framework of the By-Laws of the Hospital, and

the policies of the University. A report of all committee activities shall be presented periodically, and at least once a year, to the governing boards of the respective institutions.

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

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

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

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

7. That wherever possible in the pursuit of their mutual objectives of teaching, research, and service, the University and the Hospital will

accord, each to the other, access to and every reasonable use of their respective physical facilities; and that this shall be done without allocation of costs or fees for the use of these facilities, including administrative costs, provided that amounts and costs may be apportioned by the respective institutions to specific joint projects of departments, research projects supported by the outside sources carrying provision for institutional overhead expense, and to projects in which separate and individual agreements are made between the University and the Hospital, according to the terms of those agreements.

8. Both parties covenant and agree that they will not discriminate on the basis of race, creed, color, age, sex or national origin and that they will comply with the relevant State and Federal laws governing same.

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

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

BOARD OF TRUSTEES
MOUNT CARMEL MERCY HOSPITAL
OF DETROIT, MICHIGAN

BOARD OF GOVERNORS
WAYNE STATE UNIVERSITY

By [Signature]

[Signature]
Executive Vice President

WITNESSED BY:
[Signature]

WITNESSED BY:
[Signature]

12/15/74
Date

12/16/74
Date

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CERTIFICATION

I, the undersigned, NORMAN J. SCHLAFMANN, DO HEREBY CERTIFY as follows:

1. That I am the duly chosen, qualified and acting Secretary of the Board of Governors of Wayne State University, and keeper of the official records thereof;

2. That the foregoing is a full, true and compared copy, and the whole thereof, of a resolution of the Board of Governors of Wayne State University, duly presented and adopted at a regular meeting duly called and held by said Board of Governors, at Detroit, Michigan, on the 13th day of December, 1974, at which a quorum was present and voting;

3. That the following members were present: Atchison, Calloway, Edwards, Keydel, Pincus, Sokolowski and Stockmeyer and the following were absent: Brucker

4. That said resolution was adopted unanimously, is duly recorded in the minute books of the Board of Governors of Wayne State University and is still in force and effect.

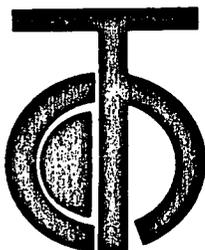
IN WITNESS WHEREOF, I have set my hand and the official seal of Wayne State University this 17th day of December, 1974.


Norman J. Schlafmann, Secretary
Board of Governors of Wayne State
University

(SEAL)

WSU/MT. CARMEL MERCY HOSPITAL AFFILIATION AGREEMENT

Action: Upon motion by Governor Keydel and seconded by Governor Calloway, the Master Affiliation Agreement with Mt. Carmel Mercy Hospital, Detroit, Michigan was approved. Motion carried with a vote of 7-0.



APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges
Council of Teaching Hospitals
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Northridge Hospital Foundation
Hospital Address: (Street) 18300 Roscoe Boulevard
(City) Northridge (State) California (Zip) 91328
(Area Code)/Telephone Number: (213) 885-8500
Name of Hospital's Chief Executive Officer: Paul A. Teslow
Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>319</u>	Admissions:	<u>10,006</u>
Average Daily Census:	<u>240</u>	Visits: Emergency Room:	<u>36,450</u>
Total Live Births:	<u>1229</u>	Visits: Outpatient or Clinic:	<u>169,970</u>
Reporting Period <u>7/1/78 to 6/30/79</u>			

B. Financial Data FYE 6/30/79

Total Operating Expenses: \$ 35,204,300

Total Payroll Expenses: \$ 18,586,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 376,944
 Supervising Faculty: \$ 0

C. Staffing Data

Number of Personnel: Full-Time: 1010
 Part-Time: 433

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 156
 With Medical School Faculty Appointments: 78

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Family Practice Cardiology Radiology Respiratory Serv. P/T
Rehabilitation Emergency Room Laboratory Cardiac Surgery P/T

Does the hospital have a full-time salaried Director of Medical Education?: No - P/T

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	<u>4</u>	<u>4</u>	<u>Elective</u>
Psychiatry	_____	_____	_____
Other: <u>SCOPE*</u>	<u>2</u>	<u>2</u>	<u>Elective</u>
<u>Phys. Diagnosis**</u>	<u>12</u>	<u>12</u>	<u>Required</u>

*Student Community Organization Preceptor Externship

**Organized by the Calif. Medical Association

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B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	<u>18</u>	<u>18</u>	<u>0</u>	<u>December 3, 1976</u>
Psychiatry	<u>1</u>	<u>1</u>	<u>0</u>	<u>June 8, 1977</u>
Other: Physiatry	<u>2</u>	<u>2</u>	<u>0</u>	<u>July 1, 1979</u>
Emergency Room	<u>1</u>	<u>1</u>	<u>0</u>	<u>July 5, 1979</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University California Los Angeles

Dean of Affiliated Medical School: Sherman M. Mellinkoff, M.D.

Information Submitted by: (Name) Doran D. Newhart

(Title) Administrative Staff Assistant

Signature of Hospital's Chief Executive Officer:
Paul A. Farrow (Date) 11-5-79

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UNIVERSITY OF CALIFORNIA, LOS ANGELES

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SANTA BARBARA · SANTA CRUZ

OFFICE OF THE DEAN
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

October 2, 1979

Mr. Paul A. Teslow
Hospital Administrator
Northridge Hospital Foundation
Medical Center
18300 Roscoe Blvd.
Northridge, California 91328
Attn: Doran Newhart

Dear Mr. Teslow:

It is my understanding that the Northridge Hospital Foundation is in the process of applying for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. I am happy to endorse this application.

One of the four residencies at the Northridge Hospital, i.e. the family practice residency, is affiliated with the UCLA School of Medicine. That residency is an excellent one and is responsive to an important regional need. The UCLA School of Medicine is pleased to be associated with the Northridge Hospital Foundation in a medical educational enterprise of great value to the San Fernando Valley and to the medical profession. The School-Hospital relationship is growing, constructive and synergistic.

With best regards,

Sincerely,

SHERMAN M. MELLINKOFF, M.D.

SMM:pg

ASSOCIATION AGREEMENT

THIS ASSOCIATION AGREEMENT is entered into this third day of December, 1976, in the State of California by and between Northridge Hospital Foundation, 18300 Roscoe Boulevard, Northridge, California 91324, a California non-profit corporation (hereinafter called "Hospital"), and The Regents of the University of California, a California corporation (hereinafter called "University").

WITNESSETH:

WHEREAS, the Hospital, under the administrative direction of its Administrator (hereinafter referred to as "Administrator"), operates a patient care facility at 18300 Roscoe Boulevard, Northridge, California; and

WHEREAS, the Hospital desires to assure its continued operation as a teaching hospital, so that the quality of care may be maintained and improved; and

WHEREAS, the University operates a qualified school known as the School of Medicine of the University of California, Los Angeles (hereinafter referred to as "School of Medicine"); and

WHEREAS, the Hospital can improve as a teaching hospital if it is associated with a qualified medical school;

NOW, THEREFORE, IT IS AGREED THAT: ;

1. The School of Medicine shall be associated with the Hospital as provided in this Agreement.

2. This Agreement covers an association of the below listed staff of the following administrative units of the Hospital and University, as of the effective date of this Agreement:

- a. Hospital - attending staff
Department of Family Practice; and
- b. University - full-time staff
School of Medicine, Division of Family
Practice of the Department of Medicine

3. At the time of appointment to the attending staff of the Hospital in an associated administrative unit, candidates may be nominated for appointment to the faculty of the School of Medicine of the University. All such appointments shall be made in accordance with regular University academic review and appointment procedures and shall be without University salary, unless there is a written agreement between the Administrator and the appropriate University dean to pay a salary.

4. The University shall select such students or postgraduate trainees as are to be assigned to clinical instruction and experience within the associated administrative unit of the Hospital or University hereunder. (The term "students" specifies undergraduate medical students of the University. The term "postgraduate trainee" includes "intern" or "resident" of the University.) The content of the clinical teaching of students and postgraduate trainees of the University under this Agreement within the associated administrative unit of the Hospital shall be prescribed by the Curriculum Committee of the associated administrative unit of the School of Medicine. Students and postgraduate trainees of the University assigned for clinical instruction and experience in an associated administrative unit of the Hospital shall be subject to the supervision, direction and control of the staff physicians of the Hospital who have academic appointments in the School of Medicine of the University.

5. As between Hospital and University, the Hospital shall be solely responsible for the acts or omissions of (a) Hospital its agents or employees, and (b) students or physicians, whether employees or independent contractors, including postgraduate trainees, engaged in patient care or related activities within premises of Hospital; and Hospital agrees to indemnify and save harmless University, its agents, employees, or students, from and against all claims, expenses, losses, or damages, including attorneys fees, resulting from bodily injury or death of any person or persons, or damage, destruction or loss of use of property caused by such acts or omissions. Hospital shall maintain in force a policy or policies of insurance with limits per occurrence as specified below insuring against liability which may be imposed arising out of the above described acts or omissions:

1. Professional negligence in the amount of five million dollars; and
2. All other liability in the amount of three million dollars.

Any such policy or policies of insurance shall be in a form issued by a carrier satisfactory to the University, shall require at least thirty days advance written notice of cancellation to the University and shall name The Regents of the University of California as an additional insured.

6. As between University and Hospital, the University shall be solely responsible for the acts or omissions of (a) University; its agents or employees, and (b) students or physicians, whether employees or independent contractors, including post-graduate trainees, engaged in patient care or related activities within premises of University; and University agrees to indemnify and save harmless Hospital, its agents, employees, or students, from and against all claims, expenses, losses, or damages, including attorneys fees, resulting from bodily injury or death of any person or persons, or damage, destruction or loss of use of property caused by such acts or omissions. University shall maintain in force a policy or policies of insurance with limits per occurrence as specified below insuring against liability which may be imposed arising out of the above described acts or omissions:

1. Professional negligence in the amount of five million dollars; and
2. All other liability in the amount of three million dollars.

Any such policy or policies of insurance shall be in a form issued by a carrier satisfactory to the Hospital, shall require at least thirty days advance written notice of cancellation to the Hospital and shall name the Hospital as an additional insured.

7. A schedule of the University's teaching activities and a statement of the number and kinds of students and post-graduate trainees under this Agreement will be presented for the approval of the Hospital Administrator or his designee before the beginning of each major academic interval. It is understood that such teaching programs will not interfere with the Hospital's primary mission in the care of its patients.

8. Assignment or rotation of students or postgraduate trainees to the Hospital or to the University under this Agreement will be with the mutual approval of the heads of the appropriate associated administrative units at the University and the Hospital. Such assignment or rotation will not affect the source or amount of payment for services rendered by postgraduate trainees, unless there is a prior written agreement between the heads of appropriate associated administrative units to do otherwise.

9. It is mutually agreed that by the terms of this Agreement, the Hospital has not granted or delegated any of its powers, statutory, implied, administrative, medical or otherwise, to the University or School, and that the treatment of the Hospital patients and the use of the clinical equipment, the hiring, acceptance and assignments of personnel, will be and remain within the jurisdiction of the Hospital. Also, this Agreement in no way constitutes a delegation of the Hospital's power to determine the admissibility and eligibility of patients for care, either as outpatients or inpatients in the Hospital, and this

Agreement in no way confers upon the University or the School the right to possess, to use, or to control any Hospital property.

10. Both parties agree to abide by all applicable Federal and State laws prohibiting discrimination against any employee, applicant for employment, student, or prospective student because of race, color, religion, sex, age or national origin.

11. The term of this Agreement is for one year, commencing December 3, 1976. Such Agreement shall be renewed annually if neither Hospital nor University take action hereunder; provided, however, that either the Hospital or the University may terminate this agreement as of July 1 of any year by furnishing to the other written notice of intention to terminate no later than July 1 of the preceding year.

12. Any notices required or permitted to be given pursuant to this Agreement shall be in writing addressed, as follows:

If to the Hospital:

Administrator
Northridge Hospital
18300 Roscoe Boulevard
Northridge, California 91324

If to the University:

Dean
School of Medicine
University of California
405 Hilgard Avenue
Los Angeles, California 90024

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the date first written above.

NORTHRIDGE HOSPITAL FOUNDATION

THE REGENTS OF THE UNIVERSITY
OF CALIFORNIA

BY

Paul A. Teslow

NAME: Paul A. Teslow

TITLE: Administrator

BY

Charles E. Young

NAME: Charles E. Young

TITLE: Chancellor

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

JUN 8 1977

IN REPLY
REFER TO: 141B



Director (00)
VA Hospital
Sepulveda, California 91343

SUBJ: Memorandum of Understanding between Northridge Hospital
Foundation, Northridge, CA and VAH, Sepulveda, CA
(Psychiatric Residents)

1. Thank you for the copy of the subject Memorandum of Understanding.
2. We have reviewed the document and are pleased to advise you that it meets the requirements of Interim Issue 10-73-9 and is, therefore, approved.

By direction of the ADCMD for Operations.

William J. Maloney, M.D.
WILLIAM F. MALONEY, M.D.
Director, Education Service

REC'D DIRECTORS
OFFICE

JUN 10 9 05 AM '77

V.A.H. SEPULVEDA

ACTION OFFICE	
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MEMORANDUM OF UNDERSTANDING

BETWEEN

NORTHRIDGE HOSPITAL FOUNDATION, NORTHRIDGE, CALIFORNIA

AND

VETERANS ADMINISTRATION HOSPITAL, SEPULVEDA, CALIFORNIA

This cooperative relationship between the Veterans Administration Hospital, Sepulveda, California and the Northridge Hospital Foundation, Northridge, California, is agreed to for purposes of education and training. The Veterans Administration retains full responsibility for the care of patients, including all administrative and professional functions relating thereto. The Northridge Hospital Foundation accepts advisory responsibility for the clinical portion of the program(s) conducted at the Veterans Administration Hospital.

The Northridge Hospital Foundation agrees:

1. To be responsible for the educational program of students assigned to the hospital; and for selection and assignment of students in accord with agreed-to schedules and work assignments.
2. To provide necessary assurance or evidence of acceptable health levels of and liability insurance coverage for assigned students and instructors.
3. To be responsible for the proper conduct of students and instructors during their tours of duty at the VA Hospital, as governed by the rules and regulations of the VA.
4. To the provision that it does not and will not discriminate against any employee or applicant for employee or applicant for employment or registration in the course of study because of race, color, creed, sex, or national origin.

The Veterans Administration Hospital agrees:

1. To provide, insofar as possible, laboratory and practicum instruction and facilities to the students during the agreed-to tours of rotation.
2. To provide necessary orientation, administrative guides and procedures, and other media deemed essential to the conduct of the work experience.
3. To maintain administrative and professional supervision of students insofar as their presence affects the operation of the hospital and/or the direct or indirect care of patients.

Mutual Terms:

1. Acceptable schedules and work assignments developed will not interfere with the primary mission of the hospital.
2. Instructors and hospital staff supervisors will evaluate performance in accordance with published curricula guidelines.
3. An annual review of programs and policies will be made.
4. The criteria contained in M-3, part II, will apply in carrying out the provisions of this agreement.
5. Either party may terminate this Memorandum of Understanding upon notice to the other six months in advance of the next training experience.

Date Signed: 5-11-77

Paul A. Teslow

Paul A. Teslow, Administrator

Date Signed: 5-11-77

J. E. Burrow

J. E. BURROW
Hospital Director
Veterans Administration Hospital
Sepulveda, California

GENERAL AGREEMENT OF AFFILIATION
BETWEEN
UNIVERSITY OF SOUTHERN CALIFORNIA AND
NORTHRIDGE HOSPITAL FOUNDATION MEDICAL CENTER

This agreement, made and entered into as of the 1st day of July 1979, by and between the UNIVERSITY OF SOUTHERN CALIFORNIA, (hereinafter called the "University"), and the NORTHRIDGE HOSPITAL FOUNDATION MEDICAL CENTER, located at Northridge, California, (hereinafter called the "Hospital"), is based on the following premises:

- A. The Hospital operates as a California nonprofit Corporation maintaining a medical center located at 18300 Roscoe Boulevard, Northridge, California 91328, and
- B. The University operates a medical school, known as its School of Medicine; and
- C. The University and the Hospital recognize that mutual benefit can be derived from a cooperative association whereby the Hospital shall provide facilities for teaching and patient care for a Physical Medicine and Rehabilitation Residency Program ("teaching program" herein), in return for which the University shall assist with acquiring and retaining highly qualified professional staff members and also shall provide educational expertise, and faculty support.

THEREFORE, in order to achieve the mutual benefits to be derived from this cooperative association, and in consideration of the premises and the covenants of the respective parties contained herein, the parties do hereby agree as follows:

1. The parties recognize that in order for the Affiliation Agreement (hereinafter called the "Agreement") to be effective and to achieve the desired goals, each of the parties must surrender some of its unilateral decision-making power which it has previously exercised. The parties therefore agree that:

(a) Direction for the teaching program shall be provided jointly by the Dean, USC School of Medicine on behalf of the University and its Department of Rehabilitative Medicine and by the Hospital's President and Chief Executive Officer and President of the Medical Staff on behalf of the Hospital.

(b) The administration of the University's School of Medicine shall take appropriate steps to provide that no member of the University's teaching and research staff shall be appointed to serve as a faculty member or permitted to perform ongoing teaching functions in the Hospital unless such member is proposed for appointment to the Medical Staff of the Hospital and follows the procedures established at the Hospital for appointment to such Medical Staff, all in accordance with the Bylaws and rules and regulations of the Hospital's Medical Staff as are from time to time in effect, and has his appointment to the Hospital's Medical Staff duly approved by the Board of Directors of the Hospital.

(c) From and after the effective date of this Agreement, it shall be the policy of the Hospital with respect to appointments to the Hospital's Medical Staff that each candidate proposed for membership shall be eligible to hold a clinical or academic appointment to the faculty of the University's School of Medicine, if he desires to participate in the teaching program and be regarded as a regular member of the Hospital faculty. Consequently, any application for appointment to the clinical teaching staff at said Hospital by one desiring an academic appointment shall be subject to the University's review and approval. It is understood, however, and agreed by the University and the Hospital that the foregoing procedures with respect to Medical Staff appointments and qualifications will not apply to any physician holding on the effective date of this Agreement an appointment on the Medical Staff of the Hospital.

2. In order to promote the most appropriate use of residents in the teaching program, consistent with the goals to be achieved by this agreement, the following principles and procedures shall be followed:

- a. Hospital shall take the necessary action to appoint the USC Chairman of the Department of Rehabilitative Medicine as Director of the Residency Program at Hospital.
- b. The University in cooperation with the Hospital will recruit individuals to serve as residents in the teaching program.
- c. Scheduling of residents' rotations at Hospital will be determined by the Director of Residency Training.
- d. Residents will be compensated by the Hospital in which they are serving and that Hospital will be responsible for professional liability insurance, health insurance and appropriate vacation time.
- e. University medical students shall rotate through the Hospital services under the supervision of the residents, full-time faculty, and volunteer faculty. The exact number of students and the rotational schedule shall be determined by the University subject to concurrence of the Hospital.
- f. The University shall accept major responsibility for curriculum design for the teaching program in concert with the Hospital.

3. Both parties certify and agree that all persons employed by their organization, its affiliates and subsidiaries, will be treated equally, without regard to or because of race, religion, ancestry, national origin, sex, age, or physical or mental handicap, in compliance with all antidiscrimination laws and regulations of the United States of America and the State of California as they now exist or may hereafter be adopted.

4. In the event of default by either party in the performance of any part of this agreement, terms and conditions contained in this agreement, the other party may terminate this agreement on thirty (30) days' written notice specifying such default; thereupon, the party to whom such notice is addressed shall have the right and opportunity to cure such default within the period of thirty (30) days following receipt of such notice, and unless an extension of time is granted by the party giving such notice of default, if such default is not cured within the applicable period of this agreement, shall automatically terminate at the expiration of said period.

5. Either party to this agreement shall have the right to terminate the same as of June 30 of any calendar year by giving the other party written notice of intention so to do on or before July 1 of the preceding calendar year.

6. All notices required or permitted to be given hereunder shall be in writing and shall be effective when delivered personally to the person designated below as the one authorized to receive notices hereunder on behalf of the party to whom the notice is given, or when deposited, postage and post office charges prepared, in the United States mail, registered or certified, with return receipt requested, addressed as follows:

If to the University: Dean, School of Medicine
University of Southern California
2025 Zonal Avenue
Los Angeles, California 90033

If to the Hospital: Administrative Director
Center for Rehabilitation Medicine
Northridge Hospital Foundation Medical Center
18300 Roscoe Boulevard
Northridge, California 91328

7. This agreement shall become effective, following its authorization and approval by the respective Boards of Directors of the University and of the Hospital, on such date as recorded at the beginning of this agreement.

THE UNIVERSITY OF SOUTHERN CALIFORNIA

By Allen W. Mathies, Jr.
Allen W. Mathies, Jr. M.D.
Dean, School of Medicine

By Joseph P. Van Der Meulen, M.D.
Joseph P. Van Der Meulen, M.D.
Vice President Health Affairs

NORTHRIDGE HOSPITAL FOUNDATION MEDICAL CENTER

By Paul A. Focoloro

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Department of Health Services
Los Angeles County - University of Southern California
Medical Center

BERNARD M. AREVALO
Medical Center Administrator

SOL BERNSTEIN, M.D.
Medical Director

FOTINE D. O'CONNOR, R.N.
Director, Nursing Services
and Education

GENERAL HOSPITAL
PEDIATRIC PAVILION
PSYCHIATRIC HOSPITAL
WOMEN'S HOSPITAL
CANCER HOSPITAL & RESEARCH INST
E.L.A. CHILD AND YOUTH CLINIC
MEDICAL CENTER SERVICES
SCHOOL OF NURSING



Affiliated with
UNIVERSITY OF
SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
SCHOOL OF DENTISTRY
SCHOOL OF PHARMACY

June 4, 1979

J.D. Arterberry, M.D.
Director, Emergency Department
Northridge Hospital Foundation
18300 Roscoe Blvd.
Northridge, California 91328

Dear Dr. Arterberry,

After careful consideration of your request to have LAC/USC Department of Emergency Medicine Residents rotate through Northridge Hospital, I am pleased to notify you that we would very much like to enter into an agreement with your facility.

Our Director of Medical Education advised me that a letter, indicating that Northridge Hospital Foundation will reimburse the County of Los Angeles for the resident's salary plus 12% for fringe benefits (including health and dental insurance) must be signed jointly by the Director of your emergency group and your administrator, as well as by me and our administrator, Mr. Drozd. In addition, the agreement must include payment of each resident's malpractice insurance by your facility. Such a document is enclosed for your consideration.

The Medical Center's Office of Financial Management will bill you monthly for each resident (by name) rotating through your emergency department. The residents, however will continue to pick up their County pay checks from our department as they usually do.

We would like to send one junior resident to your facility every four weeks beginning July 8, 1979 for a total of 12 four week rotations.

Specific working schedules of the Residents while in your department would be at the discretion of the person you designate to coordinate the resident rotation. It has been our experience that community hospital emergency departments, as well as our own, are least busy in the mornings, and we would hope that the resident assignments would be focused on those times when your census is more active. We would like a written timetable

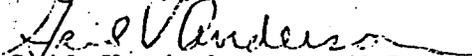
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of the resident's clinical responsibilities as well as participation in educational conferences and administrative meetings. No resident will be permitted any vacation time while on rotation at your facility. Further details, such as uniforms, meals, and parking should be defined in writing by you Emergency Resident Coordinator. Finally, you will be expected to provide us with a written evaluation of each resident's performance at the conclusion of his/her four week rotation.

Should all of this material be acceptable to you, and your proposed rotation requirements be acceptable to us, we will send you a list of names, addresses and home telephone numbers of the residents who will be assigned to rotate at Northridge Hospital Foundation, and the dates of their assignments. We understand that this will be a new experience for both of our programs and some problems are naturally anticipated. Should unresolvable differences develop, it must be understood that either institution may terminate the residency rotation.

Thank you for your interest in affiliating with our program. We look forward to hearing from you soon.

Sincerely,



Gail V. Anderson, M.D.
Professor and Chairman
Department of Emergency Medicine

enclosure

Department of Health Services
Los Angeles County-University of Southern California
Medical Center

BERNARD M. AREVALO
Medical Center Administrator

SOL BERNSTEIN, M.D.
Medical Director

FOTINE D. O'CONNOR, R.N.
Director, Nursing Services
and Education

GENERAL HOSPITAL
PEDIATRIC PAVILION
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CANCER HOSPITAL & RESEARCH INST
E.L.A. CHILD AND YOUTH CLINIC
MEDICAL CENTER SERVICES
SCHOOL OF NURSING



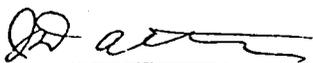
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SCHOOL OF DENTISTRY
SCHOOL OF PHARMACY

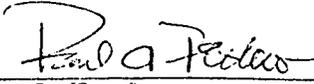
June 4, 1979

The undersigned members of the Northridge Hospital Foundation and the LAC/USC Medical Center agree to participate in a rotation of Department of Emergency Medicine Residents through the Northridge Hospital Emergency Department. We understand that residents will be scheduled for four week rotations, and that Northridge Hospital will reimburse the County of Los Angeles for each resident's salary plus 12% fringe benefits, and will provide for the resident's malpractice insurance coverage while on rotation. The Medical Center's Office of Financial Management will bill Northridge Hospital Foundation on a monthly basis for each resident (by name) rotating through the Emergency Department. Both institutions agree to this affiliation based on details outlined in the accompanying letter. It is understood that, should unresolvable differences develop during the course of this affiliation, either institution may terminate the residency rotation.


Gail V. Anderson, M.D.
Professor and Chairman
Department of Emergency Medicine


Paul Drozd
Acting Executive Director
LAC/USC Medical Center


J.D. Arterberry, M.D.
Director, Emergency Department
Northridge Hospital Foundation


Paul Teslow
Executive Administrator
Northridge Hospital Foundation

UNIVERSITY-OWNED HOSPITALS
COOPERATIVE STUDY PROJECT:
ORGANIZATIONAL CONSIDERATIONS FOR
THE CREATION OF AN IMPERFECT UNION

I. History of University Hospital Cooperative Efforts

University Hospitals have had a history of cooperative actions within the communities they operate and among other university hospitals for education and research programs. The mission, size and political characteristics of these institutions have provided a fertile base for multiple relations with the local/regional health care delivery system.

The type of cooperative efforts have evolved through the years. The 1930s and 1940s might be described as the "island of excellence" era. In this era the science of medicine was largely restricted to academic hospitals. The conceptual framework for the growth of specialization came out of the findings and conclusions of the research laboratories. The 1950s and 1960s were characterized by rapid expansion of students, facilities and investigative funds. Reimbursement to hospitals became more comprehensive and academic hospitals saw their system greatly expanded through the addition of new medical schools. Educational affiliations increased to accommodate the increased number of health sciences students. With the increase of affiliations, operating revenues and capital funds, community hospitals became more like teaching hospitals. Academic hospitals began to participate in voluntary planning agencies. Careers in clinical investigation were plentiful and much sought after. By the '70s there was a push to sort out what the '50s and '60s had wrought. The total expense and % of G.N.P. that health had captured drew much attention. While still active in cooperative efforts, academic hospitals tended toward interactions with community groups in terms of ambulatory care, mental health, rural outreach -- usually with a strong educational rationale. Meanwhile affiliated community hospitals began to think of cooperative efforts in terms of multiple hospital arrangements, including vertical and horizontal arrangements.

Thus by the 1980s, there is a growing sense that academic hospitals are nearing the end of their options with cooperative arrangements. There is no strong sense that university hospitals cannot survive as they exist in 1979; it is just that if they want to change toward other arrangements, the marketplace and external regulatory hospitals are closing out the options.

Cooperation can take many forms. What will be the most desirable form for university hospitals in the 1980s?

II. Rationale for Considering a Cooperative Venture at This Time

The enclosed papers reflect some rationale advanced by university hospitals for looking at the future on a cooperative basis. The difficulties and issues facing the system are reasonably well understood by all parties involved. There is a sense that if university hospitals don't undertake a posture of aggressive resolution of these difficulties and issues, no-one is going to do it for them. It is possible that a number of institutions working together can accomplish more than institutions working separately.

It is less clear what it is the hospitals can do together. Part IV suggests some areas for consideration. But first a summary of the discussions among the various university councils to date.

III. Assumptions and Observations About the Proposal: What the Cooperative Proposal Is and What the Cooperative Proposal Is Not

Assumptions and Observations

A proposal for a cooperative endeavor among university hospitals is neither new nor of any intrinsic value in itself. A proposal must be evaluated in terms of what it will do for an individual participant and for the university hospital

system as a whole -- if such a system exists. As the importance of the study objectives escalate, participants will be more careful about the nature and degree of cooperation. Mission preservation or enhancement is likely to be a more difficult study objective than comparing cost information. The reasons for the existing difficulties facing university hospitals are complex.

It is recognized that each of the 64 institutions have their own set of strengths, weaknesses and environmental characteristics. It is assumed the research/development-tertiary care portion of university hospitals' function is worth preserving, if not enhancing. The educational mission is particularly significant in the areas of integrating health sciences clinical experiences and offering highly specialized graduate training programs. The university hospitals are not thought of as a particularly strong system of health delivery in a competitive marketplace, if thought of as a system at all. Further, there do not appear to be any particular set of advocates for the university hospital group. Trade organizations are concerned with a broader constituent base, and the ownership (parent university) is concerned with many more items at a higher level of priority than their university hospital. There are some problems associated with an educational corporation operating a service enterprise, especially when that enterprise is subject to so many external regulatory forces. The key group is the clinical chiefs. The clinical chiefs must also be concerned about a number of affiliated hospitals. The interest of the chiefs is a key determinant in defining what the hospital will do. In terms of patient care, the clinical chiefs tend not to have an interest in building a diverse delivery system for education/research through university ownership.

The state university hospitals rely on legislative support to varying degrees. The rationale for and the way the legislative support is managed is a key variable

among institutions. Legislative-university difficulties are also university hospital strengths. There is a high degree of survival stability amidst a most unstable managerial hospital. Universities and legislators will not let their university hospital die, although they may not provide much in the quality of life.

Therein lie certain contradictions. Universities are managing on the downside, while most university hospitals need an expansion model to support a critical mass of clinical faculty and high technology. The hospital system is gearing up for a competitive marketplace type of health delivery system, while university hospitals are less and less able to compete. University hospitals pride themselves on unique tertiary offerings while to some it appears the offerings are less unique than extraordinarily expensive. University hospitals put much weight on integrated health sciences clinical training at the academic site while the academic units put less weight on the aberrations of the university hospital site and eagerly seek community affiliations better filling the academic unit's educational needs. There is a gap between university hospitals and the other 25 academic centers in terms of a forum to work together. University hospital operators see a fact situation calling for immediate attention while university ownership has little time for even cursory stewardship.

These contradictions are not impossible to reconcile but it will require some commonality of purpose, process and execution to achieve.

IV. Definition of Cooperative Options

- A. Development of a liaison with AAHC
- B. Development of regional cooperative efforts
- C. Creation of an organization for a cooperative study group

Development of a Liaison with AAHC

Roy Rambeck has worked hard to find a means whereby university hospitals may be represented within AAHC. This option is mentioned in context that the AAMC-COTH, AHA liaisons are well developed and AAHC represents another logical relationship. AAHC has indicated an interest in exploring a method for interacting with the university hospital group.

Development of Regional Cooperative Efforts

There are examples of regional and/or various university hospital cooperative efforts. It has been suggested that further efforts at strengthening regional cooperative efforts among university hospitals may lead to the recognition of a working network of university hospitals. It is not unlike the existence of some 70 Blue Cross plans without a central coordinating mechanism. To achieve recognition under some form of NHI, Blue Cross (Blue Shield) worked very hard to develop a national network. The university hospitals may need similar cooperative efforts if they want favorable consideration under NHI.

Creation of Organization for a Cooperative Study Group

These considerations are covered in the Kralewski paper enclosure. The idea would be to form an association to bring together the key participants. An organization is also required to attract funds for research. The organization can take any number of forms and will be covered in the next section.

V. Organizational Considerations for University Hospitals Participation

This section is what the participants want it to be. It is difficult to project the considerations for each individual institution. Some of the primary concerns may be:

What is the purpose of the organization?

What will be the form of the organization?

How many and what type of representation will our institution have?

How much will it cost us?

What kind of agenda items will be discussed and who will control the agenda?

What will be the role of the resource faculty and consultants?