aamc association of american medical colleges

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 29, 1981
Washington Hilton Hotel
Hamilton Room
9:00am-12:30pm

A G E N D A

I.	Call to Order	
II.	Consideration of Minutes	
	o September 24, 25, 1980	Page 1, 6
	o October 27, 1980	Page 23
III.	Membership Applications	
	o Carney Hospital Boston, Massachusetts	Page 28
	o Danbury Hospital Danbury, Connecticut	Page 33
	o Saint Mary's Hospital Grand Rapids, Michigan	Page 54
IV.	Commission on Professional and Hospital Activities	Dr. Bentley Page 82
V.	Resident Moonlighting	Executive Council Agenda- Page 24
VI.	GMENAC Response	Executive Council Agenda- Page 28
VII.	Draft Report of Ad Hoc Committee on Competition Please read this agenda item carefully. We need a thorough discussion of all aspects of this issue, and would welcome suggestions for additional activity in this area.	Executive Council Agenda- Page 33

Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

VIII.	National Health Planning Program	Executive Council Agenda- Page 105
IX.	General Requirements Section of the Essentials of Accredited Residencies in Graduate Medical Education	Executive Council Agenda- Page 107
X.	Due Process for House Officers	Executive Council Agenda- Page 108
XI.	Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal , GAO Report	Executive Council Agenda- Page 111
XII.	New Business	

INFORMATION ATTACHMENTS

- Summary of AAMC Project to Support Long Term Care Gerentology Centers
- "State vs. Academe" , Harper's, December, 1980
- "Now I Know Why People Complain About Teaching Hospitals" , Medical Economics, December, 1980

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
September 24, 1980

M I N U T E S

PRESENT:

John W. Colloton, Chairman
Robert M. Heyssel, MD, Immediate Past Chairman
Mitchell T. Rabkin, MD, Secretary
Dennis R. Barry
James W. Bartlett, MD
Fred J. Cowell
Earl J. Frederick
Robert K. Match, MD
John A. Reinertsen

ABSENT:

Robert E. Frank
Mark S. Levitan
Stuart J. Marylander
Malcom Randall
Elliott C. Roberts, Sr.
William T. Robinson, AHA Representative

STAFF:

James D. Bentley, PhD
Peter Butler
Mary Eng
Charles Fentress
Joseph C. Isaacs
Richard M. Knapp, PhD
Mary McGrane
Melissa H. Wubbold

DISCUSSION OF AAHC STUDY ON GOVERNANCE AND ORGANIZATION

Mr. Colloton opened the meeting at 2:25pm in the MAP Room of the Washington Hilton Hotel. Dr. Knapp prefaced the meeting by introducing Mary Eng, a graduate of the Duke University Program in Health Administration who will serve as an Administrative Resident in the Department of Teaching Hospitals through June, 1981. He also introduced Mary McGrane, Legislative Analyst in the AAMC's Department of Planning and Policy Development.

Mr. Colloton then explained that the purpose of this meeting was to discuss the AAHC Study on Governance and Organization of Academic Health Centers (AAHC) in order to be able to provide an AAMC response to it to Dr. John Hogness, President of the AAHC at a 3:30pm meeting that afternoon. The primary goal of this meeting, he emphasized, was to assist the Executive Council in deciding on the posture to be taken by the AAMC on the AAHC report. Mr. Colloton then introduced a departmental staff paper which analyzed the underlying issues perceived to exist in the report in relation to the following subject areas: the role of the Vice President for Health Affairs, the financing of academic health centers, the location of support services, the organization of basic sciences, the relationship of academic health center policies to university policies, the use of the teaching hospital for growing clinical education demands, the relative influence of academic health center components in decision making, and their relationship to external groups and agencies.

Mr. Colloton then called on Dr. Heyssel to open the discussion as a participating author in Volume 3 of the AAHC study which addressed "The Role of the Clinical Department Chairman in Hospital Management". This volume of the report was not focused on in the staff analysis. Mr. Reinertsen then asked Dr. Knapp whether staff believed the AAHC report primarily intended to "legitimate" the role of the Vice President (VP) for Health Affairs as the chief administrative officer of the academic health center (AHC). Dr. Knapp responded by stating that he felt that this was definitely one of the purposes of the study.

Mr. Barry wondered how many COTH Board members actually operated under a VP for Health Affairs or CAO, and felt that a large number of people who have direct responsibility for the smooth operation of major center functions were ignored by the study.

Mr. Reinertsen felt that the University of Utah Health Sciences Center is a successful example of a system working under a VP for Health Affairs, but noted that the Utah operation did not fit the criteria presented in the AAHC study model because it leans more heavily on delegation of responsibility and a coordinating function for the VP. Dr. Bartlett held the position that it is difficult

to have a non-conflicting role within the academic health center administrative function and felt strongly that this issue could not be resolved effectively by placing overall responsibility with one individual -- a VP for Health Affairs. Such a model, he believed, would serve to further discontinuity in the AHC administrative role. Mr. Reinertsen pointed out that at Utah, though the VP for Health Affairs made great use of delegation of responsibilities to various council structures, he remained involved in all facets of the Health Sciences Center operation through his coordinating function and is talked with on issues ranging from clinical training concerns to budget needs and maximizing appropriations.

After some general discussion, Mr. Colloton summarized by stating that he felt that the situation at Utah and possibly a handful of other AHC's may be notable exceptions of where the VP for Health Affairs concept is meeting with some success. Moreover, he agreed with Dr. Match who noted that VP's for Health Affairs have more generally faced extensive difficulty in asserting themselves in the role of Chief Executive and exerting influence on line-level policy. Mr. Colloton viewed the term "academic health center" as a euphemistic one rather than descriptive of an actual entity because the true strengths of the AHC are determined by the strengths of the individual sub-units within it. He felt that responsibilities should be delegated at these individual collegiate and teaching hospital levels, allowing the subunits to move with individual authority within the missions of the overall center. Additionally, he thought that the centralization of responsibilities called for in the AAHC proposal would require a "superstar", a generally impossible requirement. He saw the role of the VP for Health Affairs as one of coordinator or statesman-type spokesperson who largely delegated responsibility and coordinated the effects as both an "initiator" and "stimulator". From this perspective, Mr. Colloton posed the questions of whether the AAHC report is at odds with the interests of teaching hospitals and colleges of medicine, and whether the AAMC by not taking a stance on the report in a formal fashion would risk its distribution as some sort of legitimized guideline to university presidents and others.

Mr. Barry was of the opinion that the report, by its very nature, would be inhibitive to teaching hospitals in dealing with external and future factors and in relation to their potential in the health delivery system. On the basis of his experiences at the University of Utah, Mr. Reinertsen warned that the AAHC proposal should not be condemned as a non-viable model, as it was working, though in a decentralized fashion, in Utah. Dr. Heyssel expressed dissatisfaction with the tone of the report and its implication that there is only one valid methodology for the operation and management of an AHC. Dr. Rabkin did not believe

the AAHC system should be condemned but that other more viable models should be noted. He also questioned the role of VP for Health Affairs as delegator and coordinator, believing that this duality would create conflict between the manager-subordinate relationship and the coordinative relationship. He emphasized that explicit limits on distinctions between the roles of manager or coordinator would have to be clearly expressed.

Mr. Colloton then described an option which would be to optimally divide the AHC into two spheres, one for service (teaching hospitals) and one for academics under separate governance, regulation and payment structures. Dr. Heyssel thought that it might be good to form two spheres, but their missions and goals would have to be coordinated and not independent of one another. He noted that this can be achieved between two chief executives and without a VP for Health Affairs. Mr. Cowell felt that it was inconceivable that the system proposed in the report could be superimposed on an established operation such as Jackson Memorial Hospital in Miami (a large public hospital owned by county government and affiliated as the primary teaching hospital with a private medical school).

Dr. Match then cited the example of James Mulvihill, recently appointed VP for Health Affairs at the University of Connecticut-Farmington, as a site where the AAHC model might well work. Mr. Frederick noted that the off-campus location of the Connecticut AHC could prove ideal for the chances of the VP for Health Affairs model to succeed. Though the AAHC report predicts that fewer universities would own hospitals in the future, Dr. Heyssel noted that a key issue which the report fails to address is whether universities should own and operate their own hospitals in the first place. He further believed that the report did not deal with the role of clinical chairmen realistically and that its suggestion for an Administrative Council for resolving school/hospital issues is a clear effort to subvert the role of the hospital director and would lead to health services concerns playing "second fiddle" to academic interests

Dr. Match raised the question as to whether the AAHC study was camouflage aimed at containing the teaching hospital as a captive resource for academia, a role that teaching hospitals have finally begun to escape. Mr. Frederick described the report as a "solution looking for a problem". Mr. Colloton concluded that the AAHC report was essentially an attempt to elevate the role of the VP for Health Affairs to some higher level of significance.

In response to questioning, Dr. Knapp indicated that the political

implications regarding the establishment of a competing association with the AAMC should be discussed at the afternoon joint Board meeting with Dr. Hogness. Dr. Match felt that the AAMC should not be concerned about being straightforward on this issue. In further discussion of whether and how the AAMC should respond to the AAHC proposals, a number of the Board members questioned the need to dignify the AAHC report with a lengthy response.

Mr. Colloton adjourned the meeting at 3:30pm.

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
September 25, 1980

M I N U T E S

PRESENT:

John W. Colloton, Chairman
Robert M. Heyssel, M.D., Immediate Past Chairman
Mitchell T. Rabkin, M.D., Secretary
Dennis R. Barry
James W. Bartlett, M.D.
Fred J. Cowell
Robert E. Frank
Earl J. Frederick
Mark S. Levitan
Robert K. Match, M.D.
John A. Reinertsen
William T. Robinson, AHA Representative

ABSENT:

Stuart J. Marylander, Chairman-Elect
Malcom Randall
Elliott C. Roberts

GUESTS:

John Bassett
Charles B. Womer

STAFF:

Martha Anderson, Ph.D.
James D. Bentley, Ph.D.
Peter W. Butler
John A. D. Cooper, M.D.
Mary Eng
James I. Hudson, M.D.
Joseph C. Isaacs
Richard M. Knapp, Ph.D.
Mary McGrane
August G. Swanson, M.D.
Katherine S. Turner
Melissa H. Wubbold

I. Call to Order

Mr. Colloton called the meeting to order at 9:00 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 26, 1980 COTH Administrative Board Meeting without amendment.

III. Membership and Applications

Two applications for COTH membership were reviewed. Based on staff recommendations, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve the National Jewish Hospital and Research Center-National Asthma Center, Denver, Colorado for COTH corresponding membership.

ACTION: It was moved, seconded and carried to approve the Valley Medical Center, Fresno, California, for COTH full membership.

IV. 1981 Spring Meeting Planning Committee Report (see attached memorandum)

Dr. Knapp reported that the staff was unable to secure Boston as the location for the 1981 COTH Spring Meeting and that it would be held at the Peachtree Plaza Hotel in Atlanta, Georgia, on May 6-8. He reported that the 1982 COTH Spring Meeting was booked at the Colonnade in Boston.

Minutes of the September 18 meeting of the 1981 Spring Meeting Planning Committee in Chicago were distributed in a memo to the Board. Dr. Bartlett, Chairman of the Committee, reviewed the memo and raised the issue of the need for a keynote speaker before the cocktail hour on the first evening. John Naisbitt, Senior Vice President of Yankelovich, Skelly and White -- publishers of the Trend Report, was suggested by Committee member, Dr. J. Robert Buchanan. Other Committee suggestions included Victor Fuchs, John Gardner, Robert Merton, Rene Fox, Walter Wristen and Congressman Gephardt. Dr. Knapp expressed a preference for Mr. Naisbitt,

and recommended reading his paper entitled, "The New Economic and Political Order of the 1980's". He asked the Board members to give some thought to other possible speakers in case Mr. Naisbitt was unattainable. Dr. Bentley related his knowledge of the Trend Report, describing it as informational and projecting presentations published a number of times during the year for a select group of approximately 30 subscribing firms (e.g., GM, Exxon, ATT) to advise of the results of particular trends studied.

A discussion then began on alternative speakers to Mr. Naisbitt. Mr. Levitan stated that he would learn more about Rene Fox if the Board desired. Dr. Rabkin suggested David Mahoney of Norton-Simon, who is Chairman of the Charles Dana Foundation, and Steve Stammons who heads the Exxon Foundation. Dr. Bartlett stated that corporate types were being sought more for the Friday morning session. Mr. Levitan suggested Ralph Saul, a major insurance industry figure with health interests such as INA. After further discussion, it was agreed Mr. Saul should be the first choice.

Dr. Bartlett reported that individuals with involvement in the nursing field were being looked at as speakers for the Thursday morning session. Names that have been discussed include Henry Simmons, M.D., Walsh McDermott M.D. and Lee Ford of the University of Rochester. Mr. Colloton concluded discussion on this item by asking that the Board continue to give thought to selection of speakers and appropriate topics.

V. Progress Report on Case Mix Projects

Mr. Levitan reviewed this item for the Board. He reported that Peter Butler and Jim Bentley have been active on this study since the last Board meeting. Out of 34 invited institutions, 21 hospitals have agreed to participate in the study; most of those that declined explained they no longer had access to the required information -- medical abstract and financial data for 1978. An additional 14 institutions will be invited to participate in the project to hopefully round out the final sample to 30-35 hospitals, well distributed by geographic location, bedsize, and medical school affiliation relationship. SysteMetrics, Inc. of Santa Barbara, California has been chosen as the data processor for the study based on their experience and capacity to handle large amounts of data and make it comparable. Additionally, they are developing second stage output measures based on a severity index.

Mr. Levitan then described the activity which occurred at the September 5 COTH meeting held in Chicago with representatives of 34 potential study participants. He noted that Jim McCord, President of SysteMetrics, Inc., was also in attendance. The meeting was conducted as a two part program, discussing: (1) how gathered data should be formatted for processing, and (2) what items should be included in the questionnaire on programmatic description of hospitals. As a result of the latter discussion, the questionnaire will be revised and reduced to more specific special characteristics of the teaching hospital. Much was also learned about the availability of cost data at the various hospitals and it was decided that the Medicare Cost Reports would provide such data most uniformly.

Dr. Bentley felt the meeting was beneficial and very insightful because the participants were well informed and fully cooperative. He indicated that the second draft of the taped format is now out for review to the participants with comments due next week. Additionally, he noted that the programmatic description questionnaire is in the process of being revised at this time and that project coordinators have been assigned at the 21 participants approved thus far. He was very pleased with the quality and caliber of these coordinators and their interest in the study. Mr. Levitan expressed some concern over the northeast bias in the geographic distribution of participating institutions and the implications of regulated versus unregulated states with regard to stored and available data.

Dr. Bentley indicated that they would like to distribute the first set of reports at the 1981 Spring Meeting but did not know if all the participating institutions would be able to compile the necessary information by that time, so a partial report may be distributed at the meeting instead. Mr. Levitan then described some of the difficulties encountered in attempting the compile this information, citing as one example the discrepancies between final medical diagnoses and billing diagnoses. Dr. Bentley elaborated on this theme, detailing the complications involved in determining a seemingly simple measure like duration of patient stay. He noted that admissions data is collected in so many varying ways, with some hospitals known to count a patient's stay as a new admission on the first of each month. Mr. Levitan suggested that staff could develop a paper on the difficulties collecting, and distinctions between this kind of data. Dr. Heyssel thought that such an undertaking would produce a generally useful document.

Mr. Reinertsen then asked whether the cost of data collecting procedures would be examined. Mr. Fredericks believed that one of the outcomes of the study should be direction for hospitals on the kinds of data they should be collecting and at what cost. Discussion on this agenda item concluded with Dr. Knapp noting that much progress on the study had been made in a very short period of time, and that he believed that staff's activity was ahead of HCFA's activity on the subject.

VI. Coordinating Council on Medical Education/Council for Medical Affairs

Mr. Colloton introduced this agenda item by reviewing the material presented on page 28 of the Executive Council Agenda and the Executive Council's support of a recommendation (which resulted from a meeting between Bruce Spivey, CCME Chairman, and the sponsoring parent organizations of the Council) that the CCME be abolished because it is no longer effective as a "coordinator" of the accreditation activities of the Liaison Committees. In its place, a new COUNCIL FOR MEDICAL AFFAIRS (CFMA) would be formed. The CMFA would continue to serve as a national forum for the major medical professional societies, but would not supervise the accreditation activities of the Liaison Committees.

ACTION: It was moved, seconded and carried to approve the recommendation of the Executive Council to abolish the CCME in favor of establishing the CFMA.

VII. LCCME 1981 Budget

After a brief discussion of this issue (summarized on page 42 of the Executive Council Agenda), the Board took the following action.

ACTION: It was moved, seconded and carried to recommend that the Executive Council approve the 1981 LCCME budget and authorize a per seat payment of $5,000.

VIII. Review and Comment: Draft Report of the Ad Hoc Committee on Competition

Dr. Knapp opened discussion by noting that the draft report was on page 28 of the COTH Agenda and that he expects a second meeting of the Committee will be held in November for a redrafting of the paper (which will then go to the AAMC Officers' Retreat in December).

Dr. Bartlett felt the concept of "price competition" was too narrow and that the issue of economic competition for teaching hospitals was much broader and encompasses charge competition as well. He recommended that the report address the whole gamut of various kinds of dollar arrangements that can be made, such as contractual bidding alternatives. Dr. Rabkin agreed, stating that he would like to see the alternatives for teaching hospitals expanded beyond the five cited in the draft report. He also felt that the subject of "the delivery of services to meet consumer needs" should be addressed since there is much public ignorance in the area of purchasing of health care. Mr. Barry emphasized the need to also recognize that the teaching hospital's market is not merely comprised of patients, but includes physicians in the key role of purchasing agent. Dr. Rabkin then noted that "big buyers," such as large corporations and insurers, should be considered as well. Mr. Levitan felt the report should also examine the issue of "competition vs. access."

Mr. Colloton believed the report should be directed to the legislative proponents of competition, challenging them to develop the preventative measures which must be incorporated into any competition scheme. He suggested a manpower replenishment tax on health care charges as one possible option worthy of consideration. He also felt that "quality of care" is an issue that has gone unaddressed in the draft report and should not remain so. Dr. Heyssel reemphasized that the impact on quality is of major concern and must not be disregarded in the paper.

Mr. Colloton then asked Mr. Frank about his recent conversations with Representative Gephardt on health care issues, particularly his pro-competition legislation. Mr. Frank felt that Rep. Gephardt was "wide open" to suggestions on how teaching hospitals should be dealt with in a competitive system. He explained that he also talked with John Crosby and Dr. Burnside (formerly of the Institute of Medicine), both members of Rep. Gephardt's staff. They emphasized that the Congressman truly wants to correct the inequities inherent in the present cost reimbursement system and that they had discussed the role of teaching hospitals as a national resource and concluded that the impact of

competition could be very damaging to these hospitals and the recovery time very great. Mr. Frank felt Rep. Gephardt was soliciting help and was very receptive to the teaching hospital's plight. The Congressman felt that passage of a pro-competition bill, such as his and Rep. SCockman's, was several years away but that much discussion would be given to the issue in the future. Mr. Colloton also asked Mr. Frank if he knew where Rep. Gephardt got the rationale for supporting only 70% of graduate medical educational costs in his bill. Mr. Frank replied that he believed that the provision was written by Dr. Burnside and based on the feeling that house staff and medical students do provide the hospital with some level of productive work, which was estimated at the resulting percentages.

Dr. Bartlett expressed concern about how the listing of high cost factors in teaching hospitals was prioritized on page 29 of the paper. He felt that perhaps case mix should be listed first instead of "the presence of educational programs," which unnecessarily highlights a component at which the government would like to target reimbursement reduction activity. Some discussion followed Dr. Match's question of whether the object of competition was to put the competitor actually out of business. The point was then made that if competition is going to reduce the system, how will it be determined who gets put out of business and and whether they are the appropriate institutions to be closed? The Board felt that careful consideration of these questions by competition proponents might well dampen their enthusiasm for this approach.

IX. Proposed AAMC Bylaw Change

Dr. Cooper joined the meeting for this particular agenda item to briefly explain that the Executive Committee had approved the bylaw change recommendation to prevent ambiguity by limiting Institutional and Provisional Institutional membership in the AAMC to medical schools located in the United States and its territories (as described on page 27 of the Executive Council Agenda). He explained that it was felt that foreign medical schools, which under the current bylaws would be eligible for AAMC membership if they were incorporated in the U.S., were often substandard to American schools and heavily influenced by the local foreign political environment and not directly subject to American laws. He cited examples of a number of foreign schools that are faced with tremendous difficulty to meet standards for LCME accreditation.

He also discussed the current membership of the American University of Beirut (AUB). He noted that AUB was now essentially a local Lebanese medical school and has not been accredited by the LCME in over a decade. He thought it would be unfortunate to provide similar AAMC memberships. After some discussion, the Board took the following action.

ACTION: It was moved, seconded and carried to approve the bylaw change appearing on page 27 of the Executive Council Agenda which limits AAMC membership to medical schools and colleges located within the United States and its territories.

X. Medicare's Moonlighting Policy

Dr. Knapp reviewed this agenda item for the Board, explaining that HCFA received a directive from the federal district court in Kansas ordering it to change Medicare's policy of disallowing charges for services provided by residents moonlighting at the same institutions in which they were training. He indicated that he was opposed to such a policy change, but recognized that HCFA must do something. He then asked the Board what it believes AAMC policy should be on the issue at this time. Dr. Rabkin rasked whether conveyance of an AAMC policy position could bring about alteration in the Medicare policy approach to be taken. Dr. Knapp believed it might and suggested that one policy option could be to permit moonlighting only with prior approval of the Chief of Staff. Mr. Barry wondered whether the problem could be addressed in such an institution by institution manner. Dr. Bartlett believed it could probably be managed, but would potentially create "a breaking of the ranks." Dr. Match did not believe that the change in policy could be implemented in a manageable way and that the term "moonlighting" would become obsolete becaus the policy change would ultimately mean a prescribed work week for house staff beyond the current normal hospital week.

Dr. Knapp asked whether any of the Board members felt the new policy would be a good thing. Their responses were generally negative. Dr. Bentley then noted that particularly the new policy on moonlighting would impact on large affiliated networks of hospitals where it becomes a question of where, in fact, is the resident not performing as part of his training program.

Dr. Heyssel questioned why the AAMC should fight HCFA on this subject, since COTH hospitals normally have their own moonlighting prohibitions (though their enforcement varies). Dr. Heyssel was also concerned about the malpractice coverage for moonlighting house staff and how the costs for such coverage would be reimbursed.

Mr. Colloton then suggested that the AAMC, while not "fighting with anyone", adopt a firm position in opposition to Medicare reimbursement of residents moonlighting within their own training institutions. Dr. Heyssel pointed out that Medicare would not be directly reimbursing the moonlighting resident anyway, but rather a physician group or emergency room who has employed the resident.

Another potential problem Dr. Rabkin foresees with the new policy is that the combination of resident stipends and moonlighting fees could produce very high financial gains for residents under the guise of moonlighting and attract suspicion of malpractice. Dr. Match noted, additionally, that this could easily lead to house staff income (through this combination of stipends and moonlighting fees) surpassing the salaries of fulltime junior faculty members, potentially causing tremendous faculty conflict and faculty-student strain. Dr. Rabkin felt that the AAMC should develop a policy statement, clearly presenting strong opposition on this issue and why. In addition, he suggested that the Association could survey COTH hospitals on the number of house staff known to be moonlighting in and outside the institution, and their current policies and practices regarding such activity. He thought that the data collected could be used to develop useful guidelines for the hospitals.

Dr. Bentley explained that while HCFA is presently under a court order to establish policy that does not discriminate in resident mooonlighting reimbursement by setting, it can maintain its current policy if (1) it undertakes regulatory action and receives substantial public support for maintaining present policy or (2) there was strong Congressional commitment to opposing the recent court ruling on substantial grounds. After further discussion, the following action was taken.

ACTION: It was moved, seconded and carried to approve Recommendation 1 on page 37 of the Executive Council Agenda, stating that the AAMC opposes the Medicare policy which would permit a resident to moonlight in a hospital where the resident participates in a graduate medical educational program by urging HCFA to develop regulations altering administrative directives. It

was further recommended that current Association policy on this issue be strongly reiterated in a detailed position statement to be submitted to HCFA.

XI. National Resident Matching Program (NRMP) Institution Agreement

Dr. Match reviewed this item for the Board, referring to Dr. Mulvihill's letter on page 23 of the COTH Board Agenda. The correspondence takes issue with the recent inclusion of a required signatory statement by the medical school deans on the NRMP's Institution Agreement. He questions whether it is really appropriate for the dean to be part of the application review process between the NRMP and institutions where residencies are separately accredited from programs operated by the medical schools.

Dr. Swanson, who had joined the meeting to participate in the discussion on this item, explained that the NRMP is attempting to increase the amount of information made available to students through its directory. Consequently, information on hospitals' medical school affiliation was one of the primary interests to these students. Inclusion of the Dean's signature requirement is an attempt to ensure that the Deans realized who was claiming affiliation with their medical schools, simply for verification purposes.

Dr. Swanson agreed to convey the concerns about the required signatory dean's statement to John S. Graettinger, MD, Executive Vice President of the NRMP. No Board Action was taken on this agenda item.

XII. General Requirements of Accredited Residency Programs

Dr. Swanson provided the background information on this agenda item (as described on page 33 of the Executive Council Agenda). He noted that the current version of the Requirements before the Board is very similar to the last draft, incorporating minor changes suggested by the various parent bodies of the LCGME. He reported that the American Board of Medical Specialties (ABMS) had already ratified this version of the Requirements, but that the LCGME as a whole had not yet approved them. Dr. Knapp stated that he had reviewed the changes recommended by the COTH Administrative Board and was pleased that they had, for the most part, been incorporated into the document. Without further discussion, Dr. Heyssel moved approval of the Requirements.

ACTION: It was moved, seconded and carried that the Executive Council ratify the General Requirements.

XIII. LCGME Subspecialty Accreditation Report

Dr. Swanson explained that the major issue is the question of which subspecialty programs in which disciplines should be subject to the accreditation process, respecting the limited resources available for accreditation review. He noted that internal medicine alone would add 1,500 different types of programs to the accreditation schedule, while hand surgery was provided as an example of a specialty not wanting subspecialty certification. He then reviewed staff's recommendation on this issue.

ACTION: It was moved, seconded and carried that the Executive Council approve the accreditation of subspecialty programs for which certification is provided by a specialty board recognized by the ABMS in graduate medical education under the policies and approaches presented by the LCGME.

XIV. Universal Application Form for Graduate Medical Education

A sample of the proposed universal application form had been distributed to the Board. Dr. Swanson noted that the sample form had been mailed through the NRMP to over 671 program directors representing 2,996 programs in order to assess the acceptability level of the form. A total of 1,405, or 40%, of the program directors responded from 51% of the hospital's surveyed. The acceptability rate of the form was 87% among responding program directors and 85% among the 308 hospital respondents. Dr. Swanson indicated that present plans are to distribute the form to students through their deans offices at the same time that the NRMP materials are distributed (late April 1981). He also noted that the possibility of defraying the printing costs ($12,000 to $15,000) by a $1.00 increase in the NRMP student fee is being explored with the NRMP.

ACTION: It was moved, seconded and carried that the Executive Council approve the implementation of the Universal Application Form in 1981 and endorse defraying its costs through a $1.00 increase in the student NRMP fee.

XV. Discussion Item: Report of the Graduate Medical Education National Advisory Committee (GMENAC)

Dr. Swanson advised the Board that the long-awaited GMENAC report would be submitted to the Secretary of HHS on September 30, bringing an end to the GMENAC charter (though one of the report's recommendations is the continuance of GMENAC under a new charter and different membership). The major underlying premise of the report is a predicted oversupply in 1990 of 69,750 physicians. To address this projected physician surplus and projected shortages/surpluses in medical specialties, the GMENAC report recommends: that medical schools reduce entering class size in the aggregate by a minimum of 10% by 1984 relative to 1978 enrollment; that no new medical schools be established beyond those with first year students in place in 1980-81; that the number of FMGs entering the United States yearly be severely restricted; and that no specialty or subspecialty should be expected to increase or decrease the number of first year trainees in residency or fellowship training programs more than 20% by 1986, compared to 1979.

Dr. Swanson noted that much attention has been given to the report by the press, explaining that its conclusions have been discussed in New York Times articles, on the MacNeil-Lehrer television report, and by numerous other major media sources. In addition, he indicated that the AAMC has been receiving a great deal of inquiry about the report. He concluded from this reaction that the Secretary's activities in relation to the report will be carefully monitored by many. Without having had much time to analyze the report in depth, Dr. Swanson's first impressions were that the data produced in the GMENAC study are soft and therefore, he feared across the Board cuts to medical schools by states on the basis of the projections. He believed that it would be extremely damaging to medical schools to have to reduce their student population so significantly within the time frame suggested by GMENAC.

Dr. Bartlett took issue with recommendation 24 of the draft GMENAC report. The recommendation calls for a portion of graduate medical training to occur in other than tertiary care medical centers in order that a broad-based clinical experience is provided with emphasis on the generalist clinical fields. He felt it was frivolous to ignore the fact that tertiary care centers are broadly based and provide extensive training in both primary and more specialized care.

Dr. Knapp particularly wished to bring to the attention of the Board recommendation 32 of the GMENAC report and the AAMC response to it, which appears on page 4 of the handout preliminary AAMC comments. Recommendation 32 addresses the true costs of graduate medical education and states, among other things, that the cost of education and the cost of patient care should be distinguished between by a uniform recognized reporting system. AAMC staff contends that the concept that some system of uniform reporting will permit the separation of these two facets of resident activity is not supported by any known prior study. Staff comments note that the cost of graduate medical education should be included in reimbursements to teaching hospitals to support their accredited educational programs, but expecting that a uniform reporting system will distinguish the cost of education from the cost of patient care is not reasonable.

Dr. Swanson concluded discussion on this agenda item by reporting that staff is awaiting the actual final report and hopes to have formal AAMC comments on it in time for the next quarterly Council Board Meetings in January, 1981.

XVI. AAMC Response to the General Accounting Office (GAO) Report: Policies Regarding U.S. Citizens Studying Medicine Abroad Are in Need of Careful Review and Reappraisal

Dr. Swanson described the GAO document as a good report at describing the inadequacies of six foreign medical schools, but he felt that the recommendations made were weak. While the AAMC could support certain modifications in licensure requirements, it strongly opposed GAO recommendations for the establishment of a world-wide accreditation system for medical schools and the creation of a complex rehabilitation program for U.S. citizens studying medicine abroad. The latter two recommendations were seen as potentially massive undertakings and very unrealistic. The AAMC also took issue with GAO's contention that a major reason for many U.S. citizens turning to foreign medical schools is the intense competition for a limited number of positions in U.S. medical schools. The AAMC points out that the greatest number of applicants per position was experienced between 1947 and 1949 when entry to medical schools was easier. Dr. Swanson then reviewed other AAMC comments and noted that the report was very critical of the Office of Education and therefore would be turned over to the Office of the HHS Inspector General.

Dr. Bartlett expressed concern about the AAMC recommendation suggesting elimination of Medicare reimbursement for the services of foreign medical graduates. He believed that such a prospect would be very damaging particularly to teaching hospitals. Mr. Womer referred to the denial of such reimbursement as a "shadow" weapon, especially since the teaching costs involved are often very small. Mr. Colloton was concerned about the potentiality of such a policy being applied to students in U.S. medical schools as well someday. He called for the modification of this AAMC recommendation to reflect the concerns expressed by himself, Dr. Bartlett and Mr. Womer Dr. Heyssel suggested that opposition on the reimbursement issue should be coupled with support for the elimination of federal subsidies for U.S. students studying medicine abroad. After further discussion, the Board took the following action.

ACTION: It was moved, seconded and carried that the AAMC comments be approved for submission to the GAO, emphasizing the Association's support for the elimination of federal subsidies for U.S. citizens studying medicine abroad and its strong opposition to disallowance of reimbursement for any educational cost to U.S. hospitals entering into agreements with foreign medical schools to provide clinical experiences for their students.

XVII. Report on the Commission on Professional and Hospital Activities (CPHA)

Mr. Colloton opened the discussion by introducing Mr. John Bassett, appointed as the President of CPHA last July. He noted that the American Hospital Association (AHA) is now overseeing and revitalizing the CPHA through a managerial contract arrangement being led by Mr. Bassett.

Mr. Bassett provided background on himself and the CPHA, explaining that he had come to CPHA from the Hospital Association in New York, where he spent a great deal of time constructing state-wide hospital data bases and examining the application of case mix to reimbursement. He described the CPHA as having a very large national hospital data base that has been developed over 25 years and contains over 200 million discharges in it. He reported that over the years a tremendous amount of research has been done using this data. He expressed concern about the significant decrease in the number of teaching hospitals participating in CPHA during recent years. With only 50 teaching hospitals now subscribing to PAS, he felt that teaching hospitals were no longer adequately represented in the data base

and therefore study results using the data, such as in the areas of length of stay and DRGs, are biased. He then described his purpose for attending the COTH Board Meeting as an effort to sell the Board on the idea of developing a separate data base for teaching hospitals in the United States as a joint project between the Council and CPHA. The data base would be created at the computer facilities of the University of Michigan in Ann Arbor, with CPHA on-line to the university system. He felt that the advantages to teaching hospitals participating in the development of such a data base would be the provision of extensive data for use in special studies, improved ability to do medical research, and improved representation in a data base which has been used by Medicare for comparing hospitals under various reimbursement and other types of methodologies. He indicated that the advantages of this project to CPHA would include expansion and improvement of its data base, expansion and improvement of its research capabilities and an improved financial situation.

Mr. Bassett invited COTH Board members and staff to visit Ann Arbor and examine CPHA and the University of Michigan data processing facilities. After such a visit, he felt, the Board could then decide whether there was sufficient interest in pursuing the concept of a national data base for teaching hospitals. If there was sufficient interest, CPHA would work with AAMC staff to develop "input" document for the data base and explore pricing options. Mr. Colloton indicated an awareness of the difficulty of collecting data internally and then applying it to the appropriate agencies. He wondered whether there has been wider support expressed in the field for CPHA becoming the national voluntary repository of all hospital data. He noted that if such support existed, hospitals in Iowa would be very interested in participating. However, he believed that the development of such a national data base would have to be undertaken cautiously, recognizing the sensitivity of state hospital associations who entered the data processing business due to the questionable use and reliability of CPHA data. He felt that in his state, the Iowa Hospital Association would need to be interacted with and serve as the marketing arm for such a national data base. He further emphasized his belief that the AHA made a tactical error in not involving the state associations in the revitalization program for CPHA but felt that such associations would buy into the concept of decentralized marketing and centralized processing because of the benefit of a national repository and the economies of scale involved.

Dr. Rabkin asked Mr. Bassett why there has been such a decline in teaching hospital participation in CPHA. Mr. Bassett felt that the primary reason such hospitals no longer subscribe was because they had instituted their own internal

data processing. However, he also felt that many of these institutions were processing poor quality data and noted an example of such at four hospitals reviewed by the Hospital Association of New York State. Mr. Colloton again raised the question of whether the Council would desire to support a national voluntary repository for hospital data or depend upon government monitoring of this data on a national basis. Dr. Match felt that the latter alternative only accentuated the problem because government-accumulated data was rarely available in output form for individual studies and was heavily manipulated for government application. Aside from the difficulties of obtaining such data from the government, Dr. Match made it clear that he would not like to see government as the only source for such information. Dr. Heyssel felt that the problems in the past were due to lack of useful data from CPHA and difficulty knowing with which hospitals we should compare ourselves. He noted that at Hopkins, it was considered easier to work through a state hospital association who would compile such data for their own purposes anyway. Mr. Bassett was then questioned as to whether CPHA was at a stage now where it could deliver at a reasonable cost what a group of COTH member hospitals might want from its system. Mr. Bassett replied that he felt the system was extremely flexible and could accommodate almost anything the group would want.

Mr. Frederick moved that a group of COTH members be selected to accept CPHA's invitation to go to Ann Arbor, indicating that he believed that nothing should be decided as to the future of a national data base before the CPHA operations could be viewed. He believed that COTH should put off any basic policy questions at this time until more could be learned about CPHA's capabilities at fulfilling the proposal. Mr. Colloton agreed that policy questions could best be decided after reviewing what CPHA had to offer. He then asked Mr. Bassett what the long-term AHA plans were for CPHA. Mr. Bassett explained that the AHA is one of the sponsoring organizations of CPHA. He noted that CPHA still has 600 hospitals submitting clinical data, however it began to lose hospital subscribers in 1977 and that this loss accelerated considerably by 1979 to the point where the organization found itself in deep financial difficulty. The AHA, he stated, was extremely concerned about the possibility that CPHA, the only national voluntary data base around, might go out of business and it stepped in as one of the sponsoring organizations, offering management support through 1981. Without CPHA, AHA was concerned that the massive hospital data base would be fragmented among at least 40 different data collectors. Both AHA and CPHA felt that should this occur, government would have an ideal opportunity to step in and declare that there was no national data base voluntarily so such information would simply be collected through its intermediaries. He noted that this is already

happening in a number of states, such as New Jersey. He emphasized that CPHA is currrently attempting to turn this movement around by developing new packages and products (e.g., a national data base for teaching hospitals). He stated that 200 hospitals have already asked for demonstrations of CPHA capabilities and a number of these have already expressed a desire to become new subscribers.

ACTION: It was moved, seconded and carried to send a COTH working group to Ann Arbor, Michigan, to examine CPHA operations. Subsequent to this visit the working group would submit a proposal to the COTH Adminstrative Board on policy related to participating in the creation of a national voluntary data base for COTH-member hospitals through CPHA.

Mr. Robinson concluded discussion on this item by stating that, on behalf of the AHA, he was delighted with the Board's action. He explained that though he had hesitated to state the AHA position until the Board had made its decision, he could now emphasize that AHA is very committed to support of the CPHA as well as the proposal for a teaching hospital data base.

XVIII. Adjournment

The meeting was adjourned at 12:35p.m.

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
October 27, 1980

M I N U T E S

PRESENT:

John W. Colloton, Chairman
Robert M. Heyssel, MD, Immediate Past Chairman
Stuart J. Marylander, Chairman-Elect
Mitchell T. Rabkin, MD, Secretary
Dennis R. Barry
James W. Bartlett, MD
Mark S. Levitan
Robert K. Match, MD
Malcom Randall
John A. Reinertsen
William T. Robinson, AHA Representative

ABSENT:

Fred J. Cowell
Robert E. Frank
Earl J. Frederick
Elliott C. Roberts, Sr.

GUEST:

David L. Everhart

STAFF:

James D. Bentley, PhD
Peter Butler
Mary Eng
James I. Hudson, MD
Joseph C. Isaacs
Richard M. Knapp, PhD
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING MINUTES
October 27, 1980

I. Call to Order

Mr. Colloton called the meeting to order at 7:30am in the Chevy Chase room of the Washington Hilton Hotel. Copies of the minutes from the September COTH Board Meeting were distributed.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the September 25, 1980 COTH Administrative Board Meeting without amendment.

III. Membership and Applications

Three applications for COTH membership were reviewed. Based on staff recommendations, the Board took the following actions:

ACTION: It was moved, seconded and carried to approve the Fresno Veterans Administration Medical Center of Fresno, California for corresponding membership.

ACTION: It was moved, seconded and carried to approve St. Joseph's Hospital of Milwaukee, Wisconsin for full membership.

ACTION: It was moved, seconded and carried to approve Tampa General Hospital of Tampa, Florida for full membership.

IV. Nominating Committee Report

Dr. Heyssel presented the Nominating Committee's (consisting of Mr. Colloton, Mr. Gee and Dr. Heyssel, Chairman) for 1980-81 COTH Board Officers and new three-year appointments as follows:

Chairman - Stuart J. Marylander
Chairman Elect - Mitchell T. Rabkin, MD
Immediate Past Chairman - John W. Colloton
Secretary (three-year appointment) - James W. Bartlett, MD

Three-year Board positions:

Spencer Foreman, MD - Sinai Hospital of Baltimore, Baltimore, Maryland
Haynes Rice - Howard University Hospital, Washington, DC
John V. Sheehan - Veterans Administration Medical Center, Houston, Texas

The nominations to the AAMC Assembly would be presented for action by Dr. Heyssel at the COTH Business Meeting.

V. Management Advancement Program (MAP) Report

Mr. Colloton called on Mr. Everhart to present a report on the general outcome of the most recent MAP Steering Committee Meeting.

Mr. Everhart reported that funding for MAP from the Johnson Foundation was "drying up" and that new sources of funding needed to be found, and the Program would have to become somewhat more self-supporting. He indicated that the pertinent question from COTH's standpoint would be how often to offer such a program to the COTH membership in the future. He reported that last year's attendance was low (with a high number of cancellations) and the dynamics were poor.

Mr. Everhart listed four possible alternatives to stimulate COTH member interest and attendance of MAP:

1. Open up the meetings to the entire COTH membership rather than having attendance on an invitational basis;

2. Redirect the Program only to Chief Executive Officers of primary hospitals with the emphasis on new members and those who have yet to attend a session;

3. Open the Program for the first time to the Executive Vice Presidents(VP's) or Chief Operating Officers(COO's)

4. Direct the Program soley at VA Directors for at least one year.

There was varied enthusiasm expressed by the Steering Committee for the last three alternatives but the prospect of "open invitation" type of program was regarded as inviting traditional polyglot difficulties. It was felt that the disparity in backgrounds of the attendees in this type of program would not be sound dynamically. Mr. Everhart then asked the COTH Board members to share their views.

Dr. Knapp gave a brief run down on recent registration figures, indicating that approximately 210 invitations had been issued this past year, resulting in the largest registration ever (40). However, the attendance (18) was the smallest ever. He stated that approximately 85-90 COTH representatives had attended one of the MAP Programs.

Dr. Rabkin suggested that it might be useful to open the Program to both CEO's that have yet to attend and chief operating officers. He did not feel that alternatives two and three were mutually exclusive. Instead, he believed the interaction of the groups could be productive. He noted that

while Mr. Everhart had indicated that mixing the Deans and Associate and Assistant Deans had caused status and organizational level problems, he did not feel that the mixed Program he had attended had this problem. Mr. Randall agreed with Dr. Rabkin and noted that he did not recall such a problem existing at the first MAP meeting. Additionally, Dr. Rabkin believed MAP could become self-supporting.

Dr. Bentley pointed out that an additional problem affecting attendance might be the time of the actual meeting dates and pointed out that June is a bad month for many individuals. Dr. Knapp, on the other hand, felt the dates themselves had really made little difference in the past. Mr. Everhart concurred with Dr. Knapp, adding that June had always been the COTH time slot. Mr. Everhart indicated that he did not feel it would complicate his position if the Board recommended addressing both the CEO's and the VP's or COO's. However, he noted that Phase II will be abandoned, having failed with the Dean's group.

Mr. Colloton summarized the Board's suggestions as follows:

- o Consider a date change
- o Combine CEO's and VP's or COO's
- o Wait on the VA until further word from Mr. Randall

Dr. Heyssel pointed out that there may be a limited market and suggested that if attendance was poor, it may be symptomatic of a prevailing lack of interest and possibly "the product" should be dropped altogether. Mr. Everhart felt this was a valid consideration, but noted that attendee feedback had been very positive.

Mr. Randall explained that the VA had tried to conduct a MAP-type program less expensively on its own through its Executive Development Program, but it is failing. While he felt strongly about VA Hospital Directors attending MAP, he felt there would be funding problems in achieving this attendance. The fourth alternative was thereby obviated.

Mr. Everhart indicated he would relay the Board's sentiments on MAP as noted above.

VI. <u>New York State Proposal to Allow FMG's to Serve in New York Hospitals for Clinical Education/Residency (Board of Regents' Document)</u>

Dr. Match explained that the New York State Board of Regents has directed the State Education Department to draft specific regulations for accrediting foreign medical schools and for allowing foreign medical school students to complete their "clinical clerkships", or up to two years of training, in New York teaching hospitals. He offered his assistance if the Association desired a direct dialogue with the Board of Regents.

Mr. Colloton reminded the Board that at this time this was an informational item only.

VII. General Discussion

Mr. Marylander took this opportunity to commend Mr. Colloton on his superb leadership as Chairman of the Council for 1979-80, and to express appreciation on behalf of the Council for his insightful policy decision-making over the past year.

Mr. Randall then gave a brief update on the status of the VA Chiefs of Staff. He stressed the growing divisiveness and the attempt at unionizing by some Medical Center Directors. He indicated that a number of VA Directors are in opposition to the concept of medical education, the AAMC and medical schools. This movement, he feels, is gaining some support.

He reported that Don Custis, MD, the current Chief Medical Director of the VA had appointed an Advisory Committee, of which Mr. Randall is the Chairman, with an eye to setting policy on the basis of the Committee's recommendations. Mr. Randall indicated that great efforts were being made to reduce the divisiveness between the VA Chiefs of Staff and the Hospital Directors, which is a strong indication of their desire to lessen some of the dissension now existent within the VA.

Mr. Randall emphasized the great commitment and involvement of the VA in medical education, and stressed the degree to which medical schools would be affected by the loss of VA support. He then reiterated the very real need to expose VA Hospital Directors to medical education and the "real world", for which he feels for the most part they are not now academically prepared.

Mr. Colloton indicated that he felt the attendance of a large majority of the VA Hospital Directors at the 1980 AAMC Annual Meeting showed great progress. Thanks was then expressed to Dr. Hudson for his cooperation with and contributions to the Council over the past years. He will be leaving the AAMC forthwith to begin an undertaking in Holland. Mr. Colloton thanked the Board for their support and fine participation over the past year.

VIII. Adjournment

The meeting was adjourned at 8:45am.

DAUGHTERS
OF CHARITY OF
ST. VINCENT
DE PAUL

carney HOSPITAL
2100 DORCHESTER AVENUE
BOSTON, MASSACHUSETTS 02124
TELEPHONE 296-4000

November 24, 1980

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Doctor Bentley:

We are enclosing Application for Membership, which you sent to us, recently, and call your attention to Section 111.B which we have completed. I do hope that this information will warrant a change in our hospital's designation from Corresponding Membership to that of COTH Teaching Hospital Membership.

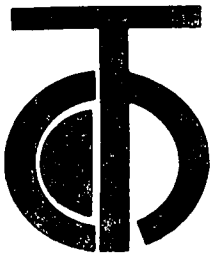
I do appreciate your assistance in this regard and look forward to hearing from you following the January 29 meeting of the Administrative Board.

Sincerely,

Sr Margaret Tuley

Sister Margaret Tuley
President

fmc/



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: The Carney Hospital

Hospital Address: (Street) 2100 Dorchester Avenue

(City) Boston (State) MA (Zip) 02124

(Area Code)/Telephone Number: (617) 296-4000

Name of Hospital's Chief Executive Officer: Sister Margaret Tuley

Title of Hospital's Chief Executive Officer: President & Chairman of the Board

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): _____

Average Daily Census: _____

Total Live Births: _____

Admissions: _____

Visits: Emergency Room: _____

Visits: Outpatient or Clinic: _____

B. Financial Data

Total Operating Expenses: $_____

Total Payroll Expenses: $_____

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $_____
Supervising Faculty: $_____

C. Staffing Data

Number of Personnel: Full-Time: _____
Part-Time: _____

Number of Physicians:

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

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

_____ _____ _____ _____

_____ _____ _____ _____

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

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:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice			
Psychiatry			
Other: _____			

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	7	6	1	July 1976
Medicine	31	15	9	October 1947
Surgery	4	4		October 1947
Ob-Gyn	1	1		February 1970
Pediatrics				
Family Practice				
Psychiatry				
Other:				
Pathology	4		4	October 1958
Orthopedics	6	2	4	October 1966
Urology	1	1		December 1974
Dental	1	1		October 1977

[1]As 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.

[2]As 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: _____

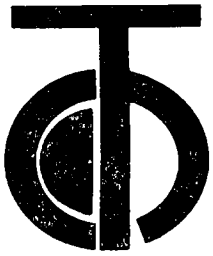
Dean of Affiliated Medical School: _____

Information Submitted by: (Name) Sister Margaret Tuley

(Title) President & Chairman of the Board

Signature of Hospital's Chief Executive Officer:

Sr. Margaret Tuley (Date) November 24, 1980



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: Danbury Hospital

Hospital Address: (Street) 24 Hospital Drive

(City) Danbury (State) Connecticut (Zip) 06810

(Area Code)/Telephone Number: (203) 797-7000

Name of Hospital's Chief Executive Officer: John C. Creasy

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):	405	Admissions:	17,939
Average Daily Census:	329.7	Visits: Emergency Room:	59,799
Total Live Births:	1705	Visits: Outpatient or Clinic:	54,007

B. Financial Data

Total Operating Expenses: $ 38,987,000.

Total Payroll Expenses: $ 20,271,000.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 555,853.00
Supervising Faculty: $ 1387,804.00

C. Staffing Data

Number of Personnel: Full-Time: 1253
Part-Time: 482

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 220
With Medical School Faculty Appointments: 46

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

Medicine	Pediatrics	Obstetrics	Psychiatry
Anesthesia	Radiology	Out-Patient	Infectious Disease
Surgery(part time)	Pathology	Emergency Room	Pulmonary Medicine
Cardiology	Nephrology	Endocrinology	

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:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	5/month	50/year	12 - Req.
Surgery	-	1 PA Clerk	Elective
Ob-Gyn	2/month	12	Elective
Pediatrics	-	-	-
Family Practice	-	-	-
Psychiatry	2/2 months	12	Elective
Other: ER/MED	-	6	Elective
E.R. 1 PA's	-	12 PA	Req.
Neuro	2/month	16	

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	-	-	-	
Medicine	29	21	8	1974
Surgery	-	-	-	
Ob-Gyn	9	1	8	1976
Pediatrics	-	-	-	
Family Practice	-	-	-	
Psychiatry	18	1	14	Affiliated with Fairfield Hills Hosp. 1977
Other:				
Pathology	7	0	5	1962
Nuclear Medicine	8	2	6	Affiliated with Univ. of Conn. 1977

[1]As 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.

[2]As 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: Yale University

Dean of Affiliated Medical School: Robert W. Berliner, M.D.
James D. Kenney, M.D.
Associate Dean for Graduate
and Continuing Education

V.

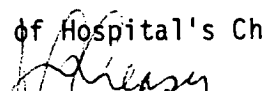
* A. We are enclosing the current copy of the Danbury Hospital Yale School of Medicine affiliation agreement which you can see is for five years. Danbury Hospital has requested that the Yale Corporation extend this agreement for an additional five years as called for in the terms of the original agreement signed in 1975. A copy of the extension of the agreement will be forwarded to you when it is available.

** B. In addition, we have submitted a copy of the letter of support from the Dean for Regional Activities at Yale University School of Medicine, Dr. Kenney, who is responding for Dean Robert Berliner, M.D.

Information Submitted by: (Name) Gerard D. Robilotti

(Title) Director of Medical Services

Signature of Hospital's Chief Executive Officer:



(Date) November 26, 1980

John C. Creasy, President

Danbury Hospital
Application for membership - Council of Teaching Hospitals
Association of American Medical Colleges

IV. SUPPLEMENTARY INFORMATION

The Danbury Hospital serves one of the most rapidly expanding areas in the Northeast of the United States. It is a 405 bed community medical center serving a primary service population of 150,000 and secondary service population of 200,000. As the only hospital in the area, Danbury Hospital has become a regional referral center for Northwestern Connecticut and Putnam County in Eastern New York State.

In addition to its major affiliation with the Yale University School of Medicine, the hospital maintains written affiliation agreements with New York Medical College and University of Connecticut School of Medicine. Specialized in-patient units include Psychiatry, Medical Oncology, Rehabilitation, Alcohol Detoxification and Renal Dialysis. The hospital has also developed comprehensive Ambulatory and Emergency services. The Emergency Department which is the fifth busiest in the State of Connecticut sees over 60,000 visits per year and the out-patient department includes a comprehensive list of over thirty clinics sees another 60,000 patients per year. The hospital has an active nuclear cardiology, cardiac catherization and rehabilitative cardiology service. The hospital also maintains a whole body C.T. scanner.

The Medical Education programs of the hospital are approved for Category 1 credit and the hospital has maintained this approval since 1976. Joint Commission accreditation is maintained on a full two year basis and the hospital has an outstanding staff of full time physicians, backed up by qualified practioners in the community it serves.

Yale University *New Haven, Connecticut 06510*

SCHOOL OF MEDICINE
333 Cedar Street
Office of Graduate and Continuing Education
Phone (203) 432-4582

September 29, 1980

Mr. Gerard Robilotti
Director of Medical Services
Danbury Hospital
Hospital Avenue
Danbury, CT 06810

Dear Mr. Robilotti:

It is a pleasure to write in support of the application of Danbury Hospital for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges.

Yale School of Medicine values its formal affiliation with Danbury Hospital since 1971. An inventory of factors which contribute to this value would include shared faculty (35 located at Danbury Hospital), the programs of regular faculty teaching at Danbury, a special relationship between the groups in nuclear medicine at the two institutions, and the provision of student opportunities, both in rotations and electives. Inasmuch as Danbury Hospital contracts with Yale departments for the provision of many services, it is quite fair to point out that Yale School of Medicine has benefited by its participation in the improvement and advances in medical education and services which have occurred at Danbury Hospital during the past ten years.

There is no question but that Danbury Hospital's present development and state of sophistication make it deserving of membership in the Council of Teaching Hospitals.

Yours very truly,

James D. Kenney, M.D.
Associate Dean for Graduate
and Continuing Education

JDK/hk

Part I

AFFILIATION AGREEMENT

between

Danbury Hospital

and

Yale University School of Medicine

This AFFILIATION AGREEMENT (hereinafter called "this agreement") made on the 18 day of APRIL, 1975, by and between the Danbury Hospital ("The Hospital") and Yale University ("Yale"), both being Connecticut Corporations with the Hospital being located in the City of Danbury and Yale University being located in the City of New Haven.

WITNESSETH THAT:

1. Objectives. The common objectives of the parties to this Affiliation are the promotion of:

Care of patients,

Effective medical education,

Productive clinical and health care research.

2. Cooperative Spirit. The Hospital and Yale recognize that although an agreement like this is necessary for a successful affiliation, it is also necessary that understanding and sincerity control the many actions large and small taken from day to day if the parties are to achieve not only the common objectives of this affiliation but also the institutional goals of each party. These goals are consistent with the common objectives.

3. Hospital's Goals. As may be mutually agreed upon and so as to foster interchange, the Hospital will utilize the educational, consultative, and clinical resources of the School:

> To maintain high quality educational programs for medical students, medical staff, house staff and allied health personnel.
>
> To utilize certain specialties of patient care not available in the Hospital; to utilize effectively the regional facilities and maintain high standards of patient care.
>
> To aid in the search and selection of Hospital-based, full-time chiefs of departments.
>
> To participate in clinical research programs of the School or to utilize the resources of the School in community health services research or Hospital clinical research.
>
> To improve communication and cooperation between the Hospital and the School to provide better service to the region by the Hospital and the School.
>
> To foster the creation of a regional network of cooperative arrangements among health care providers, both officially and voluntarily, to improve patient care, community health services, education, and research.

The above elements of affiliation are all directed towards the primary goal of the Hospital to provide high standards of patient care.

4. School's Goals. This Agreement will be performed for Yale by its School of Medicine ("the School"). The School has the following institutional goals which might be achieved through this affiliation:

> The increase of good quality clinical facilities available for training and
>
> Exposure to a wider variety of patients and a broader spectrum of patient care;
>
> Increase in the numbers of the clinical faculty of the School in certain specialties, and provisions for effective participation by them in the teaching program of the School;

Creation of opportunity to render service to a larger number of patients in connection with the educational and clinical research work of the School;

Support of complex, integrated professional services, such as organ transplantation and dialysis, with a broader base of patients and faculty members;

Improvement of the graduate training programs of the School in certain specialties by means of rotation of residents and fellows;

Improvement of communication and cooperation between the School and medical staff of the Hospital; and

Advancement in the creation of a regional network of cooperative arrangements among health care institutions, both official and voluntary, looking toward improved education, research, patient care, and community service.

5. Minimum Requirements for Affiliation. The minimum requirements of the School are that the Hospital shall:

Have at least one full-time staff member who will be either chief of staff, chief of medicine, or chief of surgery. These appointments should be made in accordance with the procedure outlined in this Agreement (see Item #9, Part I).

Express a commitment to work toward full-time chiefs of services in its major departments.

Maintain strong supporting clinical and laboratory services for both inpatients and ambulatory patients.

Maintain a continuing education program for physicians and other health professionals. This includes a satisfactory system of peer review in each of the admitting clinical services.

Cooperate with other community health care institutions for improved education, research, patient care and community service.

Develop and maintain open communication with the Medical School administration and departmental leadership.

Part I - 4

6. Joint Affiliation Committee.

(a) There shall be a Joint Affiliation Committee (hereinafter called the "JAC"). The JAC shall consist of eight (8) members. The President of the Hospital and the School's Associate Dean for Regional Activities (hereinafter referred to as "Associate Dean") shall be members ex officio. In addition, three (3) members shall be appointed by the Hospital and three (3) members shall be appointed by Yale. Unless otherwise determined by the Hospital, the Hospital members, and their successors, shall be appointed by the President of the Hospital, after consultation with the President of the Medical Staff; the School's members, and their successors, shall be appointed by the Chairman of CORA. The representatives to the Committee from both the Hospital and the School should be designated in writing at the commencement of each academic year followed by exchange of this information between the institutions. Changes in appointments throughout the academic year should be handled in a similar fashion.

The first Chairman of JAC shall be the President of the Hospital, ex officio, and he shall serve for one year. The next Chairman shall be the Associate Dean, ex officio, and he shall serve for one year, after which the President and Associate Dean shall alternate as Chairman, ex officio, each for a term of one year. When the President is Chairman, the Associate Dean shall designate a Secretary from among the Hospital members.

(b) Neither the Hospital nor the School by virtue of this Agreement confers upon the JAC any authority to make decisions binding

Part I - 5

upon the Hospital or the School. However, the JAC will in effect have such authority from time to time as is held and personally exercised by the Hospital members of the JAC in their capacities as officials of the Hospital, or as is specially conferred upon them by the Hospital, and as is held and personally exercised by School members in their capacities as members of the faculty or administration of the School, or as is specially conferred upon them by the School. The JAC may take final action within the scope of such authority, and such action shall be taken in the same manner hereafter required for the making of recommendations. The JAC, however, is hereby authorized from time to time to make recommendations to the Hospital and to the School in respect of matters of common concern to the Hospital and the School. In making such recommendations there shall be two votes only, one by the Hospital members and one by School members, and each recommendation shall therefore be unanimous. In case of disagreement among the Hospital members the disagreement shall be resolved in such manner as the Hospital shall determine. In case of disagreement among the Yale members the disagreement shall be resolved in such manner as the School shall determine. Such recommendations on matters of common concern shall be considered to have been duly adopted when approved by the Hospital and the School and incorporated in a writing executed and delivered by each. Each party shall determine for itself the procedure for the approval or disapproval of such recommendations and the designation of the authority who shall execute and deliver the writing in case of approval.

(c) For the purposes of the Agreement a matter of common concern is one which any member of the JAC designates as such by requesting the Secretary to include it on the agenda of the JAC. The Secretary shall honor all such requests and the JAC shall consider them at its next meeting.

(d) Meetings of the JAC shall be held in a building of the Hospital at such time and place as shall be specified by the Chairman. The Chairman shall call a meeting of the JAC to be held whenever in his judgment it is desirable that there be a meeting, or whenever any member of the JAC requests that a meeting be held, or according to any schedule of regular meetings which the JAC may adopt. A minimum of one annual meeting of the JAC shall be held for purposes of review of the terms of this Affiliation Agreement, progress of existing programs and either the adoption of new joint programs or modifications of old ones.

(e) The Hospital shall determine the terms of membership of each of the three members of the JAC appointed by the Hospital. The Chairman of CORA shall determine the terms of membership of each of the three members of the JAC whom he has appointed.

(f) This Agreement does not establish a partnership or joint venture between the Hospital and the School, and neither has any authority to act for the other by virtue of this Agreement.

7. Basic Principles and Understandings. In the administration of the work of the Hospital and the School in this affiliation, and in the consideration of matters of common concern by the JAC, the following principles and understandings shall control:

Part I - 7

(a) Participation by medical students in the provision of medical care is an integral part of medical education and therefore of this Affiliation. Programs for the participation of Yale Medical students in teaching programs at the Hospital, however, will not be undertaken except in accordance with a written agreement as described in Part II of this Affiliation Agreement. The activities of medical students should include: taking patients' histories, conducting complete physical examinations, stating tentative diagnoses, proposing diagnostic and therapeutic procedures and measures, and making recommendations for patient disposition upon discharge.

The work of medical students should be critically reviewed with the student by the house staff and/or faculty members. Diagnostic and therapeutic procedures should be approved and ordered by the responsible physician. When possible, students should participate in performing the approved procedures. The patients' records should include, at least for the duration of the patients' current admissions, the students' histories, records of physical examination, proposals for diagnostic and therapeutic procedures, and disposition. Medical students should be encouraged to follow their patients through their in-patient stay, out patient visits, and at nursing homes, as well as at extended care or long-stay care facilities, and in the homes of the patients.

Interns and residents, whenever possible, should participate to some extent in the education of medical students.

Adequate space and facilities for students participating in the educational program should be provided as mutually agreed upon by the

Hospital and School. This will include lockers for clothes and equipment, access to the library or other study space, access to the cafeteria, etc.

(b) Interns, residents and fellows who rotate in their assignments have both moral and legal responsibilities to the hospital to which they are assigned. Their education and supervision are the responsibility of the Staff of the Hospital when they are in the Hospital and of the Faculty of the School when they are in the School. Programs for interchange of interns and residents between Yale-New Haven Hospital, Inc. and the Hospital will not be undertaken except in accordance with a written agreement between those hospitals. Primary responsibility for the initiation of such programs rests with the Chairmen of the Departments at the Hospital and Chairman of the appropriate clinical department at the School. The details of house officer exchange or rotation programs between the Hospital and Yale are described in Part II of this Agreement.

(c) Appropriate participation in work under this Affiliation by para-professional, public health and other graduate students is appropriate as an integral part of their education. Such participation shall be the joint responsibility of the Hospital and the School. The details of any programs of this type are described in Part II of this Agreement.

(d) The Hospital has established and will continue to develop and maintain inpatient and ambulatory teaching services. Patients admitted to the teaching services will be admitted with the understanding that they will participate in the teaching program.

(e) Research should be an essential element of this Affiliation, and may include laboratory studies in the organization, administration and delivery of medical and hospital services and other related investigations. The Hospital has the responsibility to make sure that due regard is given to personal rights, safety, and understanding of the patients involved in clinical research, and the School shall assist the Hospital in fulfilling this obligation. All joint clinical research projects will be approved by the Clinical Research Committees at both the Hospital and the School before the research program is initiated. Except for those projects that have originated at Yale, it is understood that the School assumes no legal responsibility for clinical research being conducted at the Hospital. All research programs involving School and Hospital joint participation, in effect at the time this Agreement is signed, are referred to in Part II of this Agreement. It is understood that nothing in this Affiliation Agreement shall be deemed an assumption by the School of legal responsibility for clinical research being conducted at the Hospital, whether or not in affiliation with the School, or by the Hospital for clinical research being conducted other than at the Hospital.

8. Work to be Directed by Chairmen and President and Dean

(a) The Hospital and the School are organized respectively in services and departments and for each Hospital service there is a corresponding School department. The work of the Hospital and the School in respect of each department or service in carrying out the common objectives of this Affiliation shall be directed, within their respective spheres of authority as conferred by each institution outside the provisions of this Agreement,

by the Chairman of the Department at the Hospital and the Chairmen of the Department at the School.

(b) Whenever a decision concerning the affiliated work is beyond the authority of the Chairmen of the Department at the Hospital and the Chairman of the Department at the School, these officers shall consult, respectively, the President of the Hospital and the Dean of the School, and the matter shall be determined by the President and the Dean, each acting within the scope of the authority granted to him by his own institution outside the provisions of this Agreement.

(c) Whenever the decision concerning the affiliated work is outside the authority of the President and the Dean, or whenever they elect to refer the decision to the JAC, the decision shall be referred to the JAC as a question of common concern for recommendation, in appropriate cases, by the JAC to the Hospital and the School.

9. Appointment of Chairmen of Departments and Hospital Chiefs of Service

(a) The Hospital agrees that it will not appoint any full-time Chairman of a Department at the Hospital except after receiving the recommendation of a search committee appointed by either the Board of Trustees or the President of the Hospital, as the Hospital may determine. Also, in any participating service of the Hospital or in a service which anticipates participation, the Hospital agrees that it will not appoint any Chief of that Hospital service, except after receiving the recommendations of a search committee appointed by either the Board of Trustees or the President of the Hospital, as the Hospital may determine. Two members of the search committee shall be persons nominated by the Associate Dean and appointed by the President and one of these two shall be the Chairman

of the corresponding Department of the School. The search committee shall search for and evaluate candidates and shall make recommendations to the President of the Hospital in regard to the appointment. The compensation and terms of employment of such Chairman of Departments or Chief of Hospital services shall be provided by and determined by the Hospital. By mutual written consent deviations from policy 9(a) may be permitted.

(b) Each chief of a hospital service or full-time Chairman of a Department selected in accordance with the provisions outlined above [9(a)] will receive a clinical faculty appointment with rank commensurate with his experience and accomplishments. Continuation of the appointment shall be determined by the School in accordance with its standard procedures in such cases in effect from time to time. The Chairman of the corresponding Department of the School shall consult with the prospective Chairman of the Department of the Hospital concerning faculty responsibilities, privileges, and rank. The Yale faculty appointment of the full-time Chairman of the Department at the Hospital shall be co-terminus with his Hospital appointment. Simultaneous clinical appointment at one or more medical schools is acceptable providing responsibilities of the the other appointment do not interfere with the responsibilities of the School's appointment.

10. Appointment of Staff to Faculty. From time to time a Chairman of the Department of the Hospital may recommend to the Chairman of the corresponding Department of the School the appointment of a member of the Hospital Staff to the clinical faculty of the School. In the

consideration of such recommendations credit will be given by the School, among other things, for participation in the education at the Hospital of students in the School. Such appointments shall be made according to the policies and procedures of the School in effect from time to time in respect of appointments to the clinical faculty.

11. Appointment of Faculty to Staff. From time to time the Chairman of a Department at the School may recommend to the Hospital the appointment of a member of the faculty of the School to the medical Staff of the Hospital. The decision upon such recommendations shall be made by the Hospital according to policies and procedures in effect from time to time in respect of the making of such appointments generally except as the Hospital may decide to modify them in order to adapt them to the appointment of full-time members of the faculty of the School. Nothing in this paragraph shall limit the authority of the Hospital in regard to the appointment of members of its Staff who do not participate in the affiliated work of the hospital and the School under this Agreement.

12. Postgraduate education programs. All regularly scheduled postgraduate teaching exercises involving faculty members of the School will be arranged through the Office of Continuing Medical Education at Yale. Copies of letters requesting the participation of School faculty in postgraduate teaching at the Hospital which are not regularly scheduled will be sent to the School's Office of Continuing Medical Education. Specific requests for School faculty participation in postgraduate education are described in Part II of this Agreement.

Part I - 13

13. Cooperative fellowship programs. School-affiliated Hospital fellowship programs must be approved by both the Hospital administration and appropriate departmental chairman at the Hospital and the School. Responsibility for the establishment and conduct of such fellowships is the responsibility of the appropriate full time faculty members at the School and Hospital based preceptors. Arrangements for these fellowships and their level of recognition by the School are to be in accord with established School policy. The expense of these programs will be borne by the Hospital involved in the fellowship program. Ongoing cooperative fellowship programs at the Hospital at the time of the signing of this Agreement are described in more detail in Part II of this Agreement.

14. Expenses. All expenses arising out of or related to the patient care, educational and research programs conducted at the Hospital under this Agreement shall be paid by the Hospital unless such expenses shall be paid for by the School with the written approval of the Dean or his authorized delegate and such approval shall be in advance of any expenditures. Written approval by the Hospital Administrator or the duly authorized delegate of the Hospital Administrator shall be obtained in advance of any expenditures.

15. Malpractice Liability Insurance. Each of the School and the Hospital shall procure, and each at its own expense shall maintain in full force and effect while this Agreement remains in effect, a policy or policies of malpractice insurance in such coverages and amounts as the Hospital and the School may from time to time mutually agree upon in writing, provided, however, that in the absence of any further written

agreement the total coverage afforded by each policy shall be substantially in the same form now carried by each and shall have limits of not less than $500,000 for each person and $1,000,000 for each occurrence.

16. Other Affiliations of the School. The School is affiliated with Yale-New Haven Hospital, Inc. as its primary teaching hospital. This Agreement is subject to the agreement as amended which provides for that affiliation. The School is also affiliated with other hospitals and nothing in this Agreement shall preclude the School from time to time from taking up new affiliations or discontinuing old ones with other hospitals. However, no new affiliations shall be undertaken which in the School's judgment would interfere substantially with this Affiliation while this Affiliation remains in effect. The Hospital may also be affiliated with other schools and institutions.

17. License for Access. The Hospital hereby grants to the faculty, administration, and students of the School a license for entry upon and egress from the land and buildings of the Hospital and for use of the facilities and equipment of the Hospital all for the purpose of carrying on the affiliated work under this Agreement and all subject to such rules and regulations as are now in effect or may hereafter be promulgated by the Hospital.

18. Level of this Affiliation. The extent of this affiliation in terms of AMA classification, letterheads, advertising, etc. shall be as specifically stated in Part II of this Agreement.

19. Term of this Agreement; Termination. This Agreement shall remain in effect for a term expiring 5 years following its signing. Thereafter it shall be extended from time to time for such extended terms

as shall be mutually agreed by the School and the Hospital in a writing, one for each extension, executed and delivered before the expiration of the original or any extended term. The usual period of extension is 5 years. This Agreement may be terminated during the original or any extended term by either party acting in its sole discretion, by delivering to the other party a notice that it does thereby terminate this Agreement and stating the effective date of such termination, which effective date shall not be earlier than one year after the date of the giving of the notice of termination. Without imposing a legal obligation so to do it is understood that if either party at any time desires not to extend this Agreement, it should inform the other of such desire, preferably not less than one year before the end of the current term.

In Witness Whereof the Hospital and the University have caused this Agreement to be executed and delivered in duplicate at New Haven, Connecticut the day and year first above stated.

Attest:

THE HOSPITAL DANBURY HOSPITAL

Hospital President

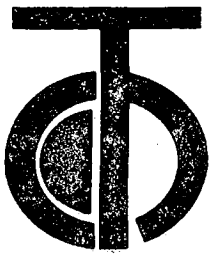
By
Its Chairman of the Board
hereunto duly authorized

Attest:

YALE UNIVERSITY

Dean of the School of Medicine

Its
hereunto duly authorized
Treasurer



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: Saint Mary's Hospital

Hospital Address: (Street) 200 Jefferson, S.E.

(City) Grand Rapids (State) Michigan (Zip) 49503

(Area Code)/Telephone Number: (616) 774-6402

Name of Hospital's Chief Executive Officer: Sister Margaret J. Straney

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):	370	Admissions:	16,163
Average Daily Census:	292	Visits: Emergency Room:	39,104
Total Live Births:	2,060	Visits: Outpatient or Clinic:	45,970

B. Financial Data

Total Operating Expenses: $ 39,900,000

Total Payroll Expenses: $ 17,850,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 989,865.00
Supervising Faculty: $ 135,200.00*

*Indicates only the portion of salaries charged to Medical Education

C. Staffing Data

Number of Personnel: Full-Time: 1150
Part-Time: 388

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 230
With Medical School Faculty Appointments: 114

Clinical Services with Full-Time PROGRAM DIRECTORS: (list services):

Orthopaedic Surgery (part-time) | Family Practice (Full-time) | OB/Gyn (part-time) | Radiology (full-time)
Medicine (part-time) | Pathology (full-time) | Surgery (part-time)

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: (Sept., 1979-Sept., 1980)

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	3	5	R
Surgery	2	4	R
Ob-Gyn	2	3	R
Fundamentals of Pat. Care	3	30	R
Radiology	N/A	13	E
Family Practice	N/A	9	E
Pulmonary	N/A	10	E
Other: Pathology	N/A	5	E
Anesthesiology	N/A	5	E
Gastroenterology	N/A	1	E
Nephrology	N/A	12	E
Hematology	N/A	4	E
Emergency	N/A	6	E
Orthopaedics	N/A	5	E
Endocrine	N/A	2	E

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	5	5	0	1975 (1923**)
* Medicine	14	13	0	1975
* Surgery	7	7	0	1979 (1937)
*Ob-Gyn	6	6	0	1968 (1948)
Pediatrics	-	-	-	-
Family Practice	12	12	0	1972
* Psychiatry	1	1	0	1974
Other: Orthopedic Surgery	8	8	0	1953
* Radiology	3	2	0	1976
* Pathology	2	1	0	1977 (1956)
* Plastic Surgery	1.5	1.5	0	1974

[1]As 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.

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

* Indicates combined programs

** First accredited as a rotating internship in 1923. Designation changed to Flexible in 1975.

*** Year in parenthesis indicates year in which the residency at Saint Mary's Hospital was first accredited.

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: Michigan State University College of Human Medicine

Dean of Affiliated Medical School: W. Donald Weston, M.D.

Information Submitted by: (Name) John C. Peirce, M.D.

(Title) Coordinator of Medical Education

Signature of Hospital's Chief Executive Officer:

Sister Margaret J. Straney RSM (Date) 10/30/80

SAINT MARY'S HOSPITAL
Grand Rapids,Michigan

IV. SUPPLEMENTARY INFORMATION - Graduate Medical Education

Saint Mary's Hospital had its first rotating interns in 1923 and has had these or flexible interns every year since then. In the mid thirties, a "general residency" was begun and this was subsequently accredited as a General Surgery Residency in 1937. Following World War II, Saint Mary's Hospital became part of the University of Michigan Medical School's statewide Affiliated Hospital Program funded by the Kellogg Foundation. The purpose of this program was to develop community hospital residencies through an affiliation which allowed the residents to rotate through University Hospital services and to take medical school courses, e.g., surgical anatomy, and to provide a visiting professor program for the community hospitals. During the late 40's and 50's, Ob/Gyn, Orthopedic Surgery and Pathology were accredited as was a one year program in Internal Medicine. The major thrust of the Saint Mary's Hospital's medical education program in those years was training physicians for general practice in Western Michigan. Physicians would frequently take an additional year in Medicine, Surgery and/or Obstetrics prior to starting practice.

By 1965 general practice faded, the free-standing, rotating internship had become an anachronism and one year programs in Internal Medicine were discontinued. With a Director of Medical Education, who was hired in 1963, the hospital developed an explicit strategy of promoting combined medical education programs rather than duplicating those in existence at Butterworth and Blodgett, and developed a mission of having its medical education programs address the needs of the underserved areas of Western Michigan. This was fostered by the receptivity of these institutions and the stated philosophy of Michigan State University College of Human Medicine. In 1968, the first of many city-wide combined residencies was approved with the Blodgett/Saint Mary's Obstetrics and Gynecology Residency. Saint Mary's provided needed complementary subspecialties such as Nephrology to strengthen existing residencies in the other hospitals, and subsequently became combined with them, e.g., Internal Medicine in 1975. With the long tradition in general practice, Saint Mary's Hospital took the leadership in obtaining funding from the Kellogg Foundation for a city-wide Family Practice Residency. The major model Family Practice unit is based at Saint Mary's Hospital.

Since its first graduate in 1975, the program has graduated 34 residents, 60% of whom have located in towns of 25,000 or less and 91% have stayed in Michigan, 13% are on Michigan Family Practice Residency faculties.

Throughout the 1970's with the stimulus of having medical students take their clinical years in Grand Rapids under the control of GRAMEC (vide infra), many more combined residencies evolved. Presently, Saint Mary's has sole control of two graduate medical education programs: a Flexible Internship and an Orthopaedic Surgery Residency, and is part of eight combined residencies:

- Internal Medicine (Blodgett/Saint Mary's)
- General Surgery (Blodgett/Saint Mary's)
- Obstetrics and Gynecology (Blodgett/Saint Mary's)
- Family Practice (Saint Mary's/Blodgett/Butterworth)
- Radiology (MSU/GRAMEC)

- Psychiatry (MSU/GRAMEC)
- Pathology (GRAMEC)
- Plastic Surgery (GRAMEC).

Residents from the Butterworth General Surgery, Internal Medicine and Urology Programs also rotate through services at Saint Mary's Hospital. During 1980-1981, the hospital will have 52 - 60 house staff physicians on location at any given time, averaging 56 (see Appendix A which is an example of the assignments). A total of 122 house officers will rotate through Saint Mary's Hospital during the academic year (see Appendix B for a picture of the Grand Rapids House Staff, noting that virtually all are United States Medical Graduates).

Undergraduate Medical Education

The University of Michigan established a senior Obstetrical clerkship at Saint Mary's Hospital in the mid 1950's which continued in effect until 1968. After World War II through the 1960's, externships were common and abundant. From 1964 on, these were offered only as approved elective clerkships from the Dean's Office of the student's medical school. The responsibility for these were transfered to GRAMEC in 1972 so they could be coordinated with the MSU-CHM program in Grand Rapids.

In March of 1971, 12 medical students, who would graduate as the first MSU-CHM class in June, 1972 came to Grand Rapids for their final year and a quarter. In the Fall of 1971, a similar number came to spend their final two years of clinical medical education in Grand Rapids. Saint Mary's Hospital along with Blodgett Memorial Medical Center and Butterworth Hospital (both members of the Council of Teaching Hospitals) are the major members of GRAMEC and provide all of the basic clerkships except Psychiatry for GRAMEC. During 1979 - 1980 (Fall through Summer), five students rotated on the basic Medicine Clerkship on one of three twelve week clerkships; three students rotated on Obstetrics on one of two six week clerkships; four students rotated on the basic Surgery Clerkship on one of two twelve week clerkships; thirty students rotated on Fundamentals of Patient Care on one of three seven week clerkships. An additional twelve electives each attracted one to thirteen students. Except for Fundamentals of Patient Care, the students are assigned to a teaching service (see Appendix A), in which there are house staff and faculty members.

A capacity study done by MSU-CHM showed Saint Mary's Hospital to be able to take three students per quarter in both Medicine and Surgery for three quarters a year (nine each year) and to take two students per six week clerkship at five a year (10 each year) in Obstetrics and Gynecology. Because of budgetary reductions in other communities, we anticipate coming close to capacity.

Continuing Medical Education

Since the beginning of the University of Michigan Affiliated Hospitals Program, a visiting professor program has been an integral part of the Continuing Medical Education program in each of the specialties. With the evolution of GRAMEC, these have become city-wide and faculty from throughout the country come to Grand Rapids. In 1976, with the advent of mandatory continuing medical education for relicensure in the State of Michigan, Saint Mary's Hospital became accredited for Category I Programs.

IV. Supplementary Information - cont. Page 3

Unique Features of Saint Mary's Hospital

1. Saint Mary's has the largest ambulatory care experience in the city, the core of which is the Family Health Center - the model Family Practice Unit.

2. Saint Mary's has the regional Kidney Disease Center, doing transplants for a catchment area of 1.5 - 2.0 million people (twenty to twenty-five per year) and having an active home dialysis as well as in-center program.

3. An exciting and intellectually stimulating mix of family practitioners, specialists and sub-specialists exist which never fails to provide tension and conflict - the working through of which is an unique educational experience.

V. SUPPORTING DOCUMENTS - Nature of Affiliation with Michigan State University College of Human Medicine

In 1970, when Dean Andrew Hunt developed the plan for community based undergraduate medication education, he established the principle that the College of Human Medicine would deal with a non-profit medical education corporation in which all of the hospitals who would participate in the undergraduate medical education in an area would be part of that corporation, rather than dealing with each hospital individually. The purpose of this was to promote effective health care and health education on an area-wide basis rather than in isolated institutions in an area. This was a major stimulus for the formation of the Grand Rapids Area Medical Education Center, Inc., commonly refered to as GRAMEC. The Articles of Incorporation are included as Appendix C. Dr. W. Donald Weston, then Associate Dean for Community Affairs, presently Dean of the College of Human Medicine, was on the first Board of Directors, representing the College. On the same date that GRAMEC was incorporated, an agreement between three acute care hospitals; Blodgett Memorial Hospital (presently Blodgett Memorial Medical Center), Butterworth Hospital and Sisters of Mercy - Grand Rapids (also known as Saint Mary's Hospital), was struck (see Appendix D). In this, each of the hospitals delegate to GRAMEC the administration of the education program for medical students from Michigan State University College of Human Medicine (as well as other medical schools) (see p. 7:2a). The governance of GRAMEC, as originally developed, thus, has representatives of the three hospitals along with a representative of the College of Human Medicine on the Board of Directors.

In 1977, the position of Executive Vice President of GRAMEC was combined so that he/she is also Assistant Dean for the Grand Rapids' campus. Also in 1977 and 1978, specialty councils in Medicine, Surgery, Obstetrics and Gynecology, Family Practice, Pediatrics, Radiology, Pathology, Orthopaedic Surgery, Plastic Surgery and Psychiatry were established for the purpose of facilitating joint medical education efforts at all levels within each of the specialties and for the review and recommendation of faculty appointments in Grand Rapids. Membership on these councils include hospital chiefs of service, educational program directors and departmental chairmen at Michigan State University. Formal graduate medical education affiliation agreements have been made between GRAMEC and MSU-CHM in Psychiatry and Radiology. GRAMEC facilitated the affiliation in General Surgery between MSU-CHM and Butterworth Hospital. Active negotiations are presently going on between MSU-CHM and the Family Practice and Plastic Surgery Residencies (both city-wide, although no administered through GRAMEC). These have been largely stimulated and developed through the activities of the councils.

The affiliation is funded by a yearly agreement between GRAMEC and Michigan State University (see Appendix E).

MICHIGAN STATE UNIVERSITY

COLLEGE OF HUMAN MEDICINE · OFFICE OF THE DEAN EAST LANSING · MICHIGAN · 48824

October 10, 1980

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

Dear Dr. Knapp:

It is indeed a pleasure to support heartily Saint Mary's Hospital's (Grand Rapids) application for teaching hospital membership in the Council of Teaching Hospitals. Saint Mary's Hospital has played a major and very important role in the education of our students dating back to 1971 and is the last of the "big three" Grand Rapids hospitals to seek COTH membership.

The administrative and medical education leadership in this hospital has been outstanding and has fully participated in the instruction of our students taking required major clerkships and electives in Grand Rapids. The supplementary information, contained under Section IV of the application, very aptly states the importance of Saint Mary's Hospital within our educational system and I fully support those statements.

Its importance is further documented in our College Catalog (page 30), which is enclosed with the application.

The application from Saint Mary's Hospital for teaching hospital membership has my strong recommendation and support and I look forward to hearing that Saint Mary's has successfully joined both Butterworth Hospital and Blodgett Memorial Medical Center in the COTH membership.

Sincerely,

W. Donald Weston, M.D.
Dean

WDW/kcf

Enclosure

cc: Sister Margaret Straney, R.S.N.
John Peirce, M.D.

APPENDIX C

C-2208
FORM ~~39-110-67M~~

STATE C
DEPARTMENT OF [illegible]
CORPORATION DIVISION
LANSING, MICHIGAN

(THIS IS A PART OF THE ATTACHED CORPORATE DOCUMENT AND SHOULD NOT BE DETACHED)

DO NOT WRITE IN SPACES BELOW - FOR DEPARTMENT USE

DATE RECEIVED:
December 1, 1971

FILED
DEC 2 8 1971
[signature]
STATE TREASURER
Michigan Department of Treasury

TRUE COPY
MICHIGAN DEPARTMENT
OF TREASURY

NAME OF CORPORATION:
Grand Rapids Area Medical Education Center, Inc.

CORPORATE DOCUMENT:
Articles of Incorporation

ARTICLES OF INCORPORATION
NON-PROFIT

These Articles of Incorporation are signed and acknowledged by the incorporators for the purpose of forming a non-profit corporation under the provisions of Act. No. 327 of the Public Acts of 1931, as amended, as follows:

ARTICLE I.

The name of the Corporation is GRAND RAPIDS AREA MEDICAL EDUCATION CENTER, INC.

ARTICLE II.

The purpose or purposes for which the corporation is formed are as follows:

To institute, operate, manage, and conduct medical education training programs at the hospitals owned and operated by the members, and to coordinate, facilitate, and assist member institutions in the conduct of graduate medical education, continuing medical education, and the education of allied health personnel; to provide consulting services and other services in connection with medical educational and training programs operated and conducted by any other person, corporations, and institutions, but in no event to conduct a school, academy, seminary, college, or other institution of learning, or to grant academic credit hereto; to acquire, employ, build, maintain, lease, contract own and otherwise provide for such facilities, personnel, and equipment as shall be necessary to carry out the foregoing purposes; to sell, lease, or otherwise dispose of any property or facilities as the Board of Directors shall deem advisable; in general to do all things and perform all acts necessary to carry out such purposes; to exercise all powers granted to nonprofit corporations under the corporation laws of the State of Michigan; to solicit and accept gifts of money or property, real and personal, within such limitations of the law as may be applicable in order to carry out the purposes of the corporation; the corporation will not be operated for purposes other than one or more exempt purposes specified under Section 501 of the Internal Revenue Code of the United States, and no part of any net income of the corporation shall insure to the benefit of any private individual; and no part of the

activities of the Corporation shall be to carry on propaganda or to attempt to influence legislation or to participate in or to intervene in any political campaign on behalf of any candidate for public office.

ARTICLE III.

Location of the first registered office is:

201 Lafayette Avenue S.E., Grand Rapids, Kent, Michigan 49502

Postoffice address of the first registered office is:

201 Lafayette Avenue S.E., Grand Rapids, Michigan 49502

ARTICLE IV.

The name of the first resident agent is John L. Morrow.

ARTICLE V.

Said corporation is organized on a non-stock basis.

The amount of assets which said corporation possesses is:

Real property: none

Personal property: Office furniture and equipment with a value of $5,000.00

Said corporation is to be financed under the following general plan:

Contributions from the members to the corporation.

ARTICLE VI.

The names and places of residence, or business, of each of the Incorporators are as follows:

NAMES	RESIDENCE ADDRESS
David M. Amberg	1346 Cornell Dr., S.E., Grand Rapids, Michigan 49506
Henry Idema II	737 Cambridge Blvd., S.E., Grand Rapids, Michigan 49506
William K. McInerney	2000 SanLuRae Dr., S.E., Grand Rapids, Michigan 49506

ARTICLE VII.

The names and addresses of the first board of directors are as follows:

NAME	ADDRESS
William Downer	2234 Shawnee Dr., S.E., Grand Rapids, Michigan 49506

Article VII. (cont.)

NAME	ADDRESS
Henry Idema II	737 Cambridge Blvd., S.E., Grand Rapids, Michigan 49506
Craig E. Booher	3010 Okemos, S.E., Grand Rapids, Michigan 49506
Calvin J. Dykman	1037 Gladstone Ave., S.E., Grand Rapids, Michigan 49506
Norman M. Gervais	4333 Balfour Dr., S.E., Grand Rapids, Michigan 49506
Edward L. Moorhead	833 Lake Dr., S.E., Grand Rapids, Michigan 49506
Samuel M. Oates	2455 State S.E., Grand Rapids, Michigan 49502
David M. Amberg	1346 Cornell Dr., S.E., Grand Rapids, Michigan 49506
John L. Morrow	1932 Menominee Dr., S.E., Grand Rapids, Michigan 49506
William K. McInerney	2000 SanLuRae Dr., S.E., Grand Rapids, Michigan 49506
John C. Peirce	933 Princeton S.E., Grand Rapids, Michigan 49506
Robert S. Levine	1749 Alexander S.E., Grand Rapids, Michigan 49506
Neal A. Vanselow	The University of Michigan Medical Center, Ann Arbor, Michigan 48104
Donald W. Weston	College of Human Medicine of Michigan State University, East Lansing, Michigan

ARTICLE VIII.

The term of the corporate existence is perpetual.

ARTICLE IX.

On dissolution or liquidation of the Corporation, all of its assets remaining after payment of all claims against the Corporation shall not be distributed to the benefit of any individual, but shall be distributed to those members of the Corporation who are then qualified as exempt organizations under the provisions of Section 501 of the Internal Revenue Code, as then amended or any other provisions substituted therefore. Such distribution to each of such members, so qualifying as exempt

organizations, shall be in the same ratio as such members have contributed to the capital of the Corporation; and the decision of the last Board of Directors as to the proportionate share of such distributions to the members shall be final and binding.

We, the Incorporators, sign our names this 29th day of November, 1971.

David M. Amberg

Henry Idema II

William K. McInerney

STATE OF MICHIGAN)
) ss.
COUNTY OF KENT)

On this 29th day of November, 1971, before me personally appeared David M. Amberg, Henry Idema II and William K. McInerney to me known to be the persons described in and who executed the foregoing instrument, and acknowledged that they executed the same as their free act and deed.

Notary Public, Kent County, Michigan.
My Commission expires 11-5-74.

APPENDIX D

AGREEMENT

THIS AGREEMENT made this 23rd day of NOVEMBER, 1971, between BLODGETT MEMORIAL HOSPITAL, SISTERS OF MERCY-GRAND RAPIDS, and BUTTERWORTH HOSPITAL, all Michigan, nonprofit corporations, of Grand Rapids, Michigan, WITNESSETH:

RECITALS

The above named parties to this agreement constitute the three acute-care, medical hospitals situated in the City of Grand Rapids and serving the Grand Rapids area. Each of the three hospitals is a separate corporate entity and is governed by a separate Board of Trustees or Advisory Board.

It appears at the present time to the parties hereto that there are many proposals under formation and many studies and examinations underway of the methods and procedures for providing adequate medical education in the United States. In addition, there are various proposals for Federally supported programs in the field of medical education which are in various stages of the legislative process in the United States Congress. It is the opinion of the parties hereto that, at the present time, it is only possible to conclude that there may be substantial changes in the methods and procedures of medical education; and that in order to provide the best medical care for the residents of the Grand Rapids area, the parties hereto should be in a position to try new methods and procedures, to avail themselves of new programs and in general to adapt medical education in the area to any new methods and procedures as they are formulated.

In so far as forms of medical education are developed which entail the joint operation of such programs by the parties hereto with such programs taking place in the hospital owned and operated by the parties hereto, the parties hereto believe that it would be desirable to set up a proper entity and methods and procedures to plan, operate and manage such joint programs in the most effective way.

The parties hereto also desire to set up at this time an entity and methods and procedures which will allow the parties hereto to avail themselves of any Federally assisted medical education programs or other programs assisted by the State of Michigan.

In addition thereto, the College of Human Medicine of Michigan State University has instituted a program whereby undergraduate students attending such college will receive a portion of their education and training at the hospitals owned and operated by the parties in Grand Rapids, Michigan and such undergraduate medical students are already present at the hospitals owned by the parties hereto and such program is underway. The Medical School of the University of Michigan has also expressed a desire to institute a similar program for the education and training of its undergraduate medical students; and other medical schools in the State of Michigan or elsewhere may desire to institute such programs. It further appears that such programs for the training and education of students attending medical schools should be operated jointly by the parties hereto in order to provide the best possible program for such education and training.

It is, therefore, in consideration of the foregoing recitals and for the reasons and purposes set forth above that the parties hereto enter into this agreement in an effort to provide an entity and methods and procedures to operate education programs and in other ways to avail themselves of the developments in the field of medical education which will arise during the coming years. The parties hereto fully realize that the success of jointly operated programs in the medical education field will require in each case an agreement by the parties hereto as to the specific procedure for each such program and it is the intention of this agreement to provide for the methods or proper management of each programs; and also to provide that as each such program is developed

agreement of each of the parties hereto participating in such programs will be necessary before such program is placed in complete operation.

NOW, THEREFORE, the parties hereto agree as follows:

1. Formation of Nonprofit Corporation. The parties hereto agree to form nonprofit, membership, corporation under the general corporation laws of the State of Michigan in accordance with the following provisions:

(a) The name of the Corporation shall be Grand Rapids Area Medical Education Center, Inc.

(b) The purposes for which the Corporation is formed shall be as foll

To institute, operate, manage, and conduct medical education training programs at the hospitals owned and operated by the member and to coordinate, facilitate, and assist member institutions in the co duct of graduate medical education, continuing medical education, and the education of allied health personnel; to provide consulting services and other services in connection with medical educational and training programs operated and conducted by any other persons, corporations, and institutions; to acquire, employ, build, maintain, lease, contract own, and otherwise provide for such facilities, personnel, and equipment as shall be necessary to carry out the foregoing purposes; to sell, lease, or otherwise dispose of any property or facilities as the Board of Directors shall deem advisable; in general to do all things and perform all acts necessary to carry out such purposes; to exercis all powers granted to nonprofit corporations under the corporation law of the State of Michigan; to solicit and accept gifts of money or proper real and personal, within such limitations of the law as may be applicable in order to carry out the purposes of the corporation; the corpor tion will not be operated for purposes other than one or more exempt

purposes specified under Section 501 of the Internal Revenue Code of the United States, and no part of any net income of the corporation shall inure to the benefit of any private individual; and no part of the activities of the Corporation shall be to carry on propaganda or to attempt to influence legislation or to participate in or to intervene in any political campaign on behalf of any candidate for public office; on dissolution or liquidation of the Corporation, all of its assets remaining after payment of all claims against the Corporation shall not be distributed to the benc of any individual, but shall be distributed to those members of the Corporation who are then qualified as exempt organizations under the provi of Section 501 of the Internal Revenue Code, as then amended or any oth provisions substitued therefore. Such distribution to each of such mem so qualifying as exempt organizations, shall be in the same ratio as su members have contributed to the capital of the Corporation; and the decision of the last Board of Directors as to the proportionate share of such distributions to the members shall be final and binding.

(c) The location of the first registered office shall be 201 Lafayette Avenue S.E., Grand Rapids, Michigan 49502.

(d) The name of the first resident agent shall be John L. Morrow.

(e) The articles of incorporation and by-laws of the Corporation shall so drafted and amended, as required, as to permit the obtaining by the Cor tion of a tax exempt status under the provisions of Section 501 of the Interna Revenue Code of the United States.

(f) The parties hereto agree that the Board of Directors of the new Corporation shall consist of the following members to be elected as herein provided. The parties hereto specifically agree that, in the original artic of incorporation and at each subsequent annual meeting of the members of Corporation, they shall each cause to be designated or elected, as directo four (4) persons who will be representatives from each of the parties here Said four (4) directors who shall act as such representatives on the Board

Directors of the new Corporation for each of the parties hereto shall consist of one person selected as determined by each party with respect to its representative from each of the four following classifications;

(i) The director or administrator of the hospital owned and operated by the party or any assistant director or administrator.

(ii) The Director of medical education employed by a party hereto or any assistant director of medical education or any other member of the Medical Staff of a member hospital who acts in the capacity of a director of an educational program as determined by the member hospital.

(iii) The chairman of the professional education committee of the Medical Staff of a party hereto or any member of the medical staff of a party hereto.

(iiii) Any member of the governing body or advisory board of a party hereto.

In addition to the foregoing directors who shall act as representatives of the members, there shall be elected to the Board of Directors one representative from each medical school or college of medicine with which the Corporation enters into an agreement or arrangement for medical education. Such representatives shall be designated by the Dean or other administrative head of the medical school or college of medicine concerned. Upon such designation, the members shall elect such representative to the Board of Directors, and such representative shall be a full-voting member of the Board of Directors; provided that, if such nomination occurs between the annual meetings of the members of the Corporation, then the Board of Directors may elect such nominee for a term expiring at the next annual meeting of the members of the Corporation. In the event that the Corporation enters into agreements or arrangements for medical education or training of allied health personnel with organizations other than said medical schools or colleges of medicine, then the members of the Corporation shall have the power either to elect a representative from each

such other institution or organization to the Board of Directors as a full-vot member thereof or to appoint such representative to the position of associat director. Associate directors shall have a term of one year from each annu meeting of the members of the Corporation to the next; shall be entitled to attend all meetings of the Board of Directors and receive notice thereof; but shall not be entitled to vote at such meetings. The Board of Directors shall have the power to elect such representatives to full membership on the Boar of Directors and to appoint associate directors, in both cases for terms exp at the next annual meeting of the members of the Corporation.

(g) The initial membership of the new Corporation shall consist of the parties hereto. Membership in the Corporation shall be open to other hospi or organizations in the Grand Rapids area, and such other hospitals or orga zations shall be admitted to membership upon obtaining a two-thirds vote of then existing members. It is specifically understood and agreed by the part hereto, that it shall be a part of the consideration of the acceptance of new members of the Corporation that there shall be a determination of the ques as to the number and qualifications and their voting or non-voting status of the representatives, if any, on the Board of Directors of the Corporation wi each new member shall have. It is also specifically agreed and understood that it shall be expressly set forth as a part of the conditions of membershi in the Corporation for a new organization or institution, that such new mem shall agree to be bound by the provisions of this agreement and the conditio as to its representation on the Board of Directors and by any other agreeme covering the election of or appointment of representatives of members to th Board of Directors of the Corporation.

(h) The fiscal year of the Corporation shall be determined by the Boar of Directors.

3. Scope of Agreement; Operation of Educational Programs by the new Corporation. It is specifically agreed by the parties hereto that the operation and

management of an educational program in which a party hereto is participating by the new Corporation shall be only in accordance with the express delegation of such powers to the new Corporation by each party hereto participating in such program in accordance with the following provisions of this agreement.

(a) Education and Training of Medical School Students. The parties hereto delegate to the new Corporation the operation and mana gement of the program now started for the education and training of students attending the College of Human Medicine of Michigan State University and in addition they delegate to the new Corporation the powers and duties of negotiating and entering into those contracts or agreements with the said College of Human Medicine of Michigan State University necessary for the proper operation an management of such program. In addition, the parties hereto specifically delegate to the new Corporation the powers and duties for planning and negot ting a program for the education and training at the hospitals owned by the pa hereto of students attending the Medical School of the University of Michigan and upon the completion of such negotiations, the parties hereto delegate the operation and management of such a program with respect to students attending the Medical School of the University of Michigan to the new Corpor The parties also delegate to the new Corporation the powers and duties of planning and negotiating similar programs for the education and training of s dents attending other medical schools in the Stat e of Michigan and elsewhere.

With respect to the programs at the hospitals owned and operated by the parties hereto for the education and training of undergraduate medical studer of the College of Human Medicine of Michigan State University and at the Me cal School of the University of Michigan (when such program is adopted), the parties hereto agree that such programs shall continue in full force in effect a period of two years from and after the date of the institution of each such program. The parties hereto also agree that prior to the termination of said

two-year period that said programs and all of the terms and provisions of th agreement and the by-laws and other operating procedures of the new Corpo tion shall be thoroughly reviewed by the parties hereto and representatives from the Medical School of the University of Michigan and the College of Hur Medicine of Michigan State University in an effort to determine whether any changes, modifications or other alterations in the terms and conditions of th agreement and of the operating procedures of the new Corporation would be desirable for the purpose of improving said programs. In the event that the are no changes, additions or alterations to this agreement or to the by-laws operating procedures of the new Corporation then with respect to such progr this agreement shall continue in full force and effect subject to the right of e party hereto to withdraw from an educational program in accordance with th provisions hereinafter set forth.

(b) Existing Medical Education Programs. Existing medical education programs shall be deemed to include all of the educational programs operate by each party nereto at the date of this agreement or operated jointly by two or more of the parties hereto at the date of this agreement. Said existing m cal education programs shall include by way of illustration and not for the pu poses of limitation programs for the training of interns and residents, progr of continuing education, and programs for the training of allied health perso such as schools of nursing and training programs for various types of medic technicians. It is expressly agreed that no such existing program of medica education operated and managed by one party hereto shall be delegated to the new Corporation for operation and management except upon the express agreement of each party hereto operating such program and in the cases of existing programs operated jointly by two or more of the parties hereto with out the express agreement of each such party jointly operating such program The foregoing provisions shall apply to all extentions, mergers and modifica

tions of such existing educational programs. In addition, the acceptance of management and operation of any such program by the new Corporation shal only by a vote of two-thirds (2/3) of the entire membership of the Board of Directors of the new Corporation.

(c) New Educational Programs and Programs Not Involving All Parties hereto. Any party hereto either alone or jointly with one or more of the oth parties hereto may institute and set up a new educational program which has been operated in the Grand Rapids area prior to the date of this agreement c institute and set up a new educational program which has not been operated by the party or parties instituting such program, prior to the date of this agreement; and such programs may be delegated to the new Corporation for operation and management upon agreement as to the terms of such delegatio between the parties hereto who agree to participate in such program and the Corporation. The fact that a party to this agreement shall have in operation a similar program shall not prevent the setting up of such new program in w such party may decide not to participate. The acceptance by the new Corpor of the management and operation of any such new program shall by only by a vote of two-thirds (2/3) of the entire membership of the Board of Directors c the new Corporation.

(d) Agreement for Delegation to the New Corporation. It is understood and agreed that when a new or existing educational program is delegated to t new Corporation for operation and management, that such delegation shall be way of an agreement of delegation between the parties hereto participating in such program and the new Corporation. It is the consensus of the parties he that each such agreement of delegation should contain at the minimum provis covering the following matters:

(1) The medical and educational standards to be applied to the program and the methods and procedures for maintaining such standards

(2) The designation of the Director or Chief of such program and his assistants and the method for their replacement.

(3) The facilities of each participating hospital or party hereto or member of the new Corporation which will be used in the program.

(4) The employees, who will participate in the program, of each hospital or of each party hereto or each member who will be engaged in educational program and the procedures for compensation of such employees and for the handling of personnel policies.

(5) The members of the medical staff of each hospital participatir in such program who will be involved in such program and the services which they will perform together with provisions for their compensation if any.

(6) The financing of the program and the method of determining the respective shares in such financing by each participating hospital or party or member of the Corporation in such program.

(7) Provisions covering any time period for which the parties hereto or members of the Corporation or others agree to continue the program without the right of withdrawal therefrom.

(e) Withdrawal from Participation in an Educational Program. Subject to the provisions of Subparagraph 2 (a) above, and subject to the provisions o any agreements of delegation of educational programs pursuant to the provisi of Subparagraph 2 (d) (7) above, any party hereto shall have the right to withdraw from any educational program which has been delegated to the new Corp tion for its operation and management and to revoke such delegation on its pa: Such withdrawal shall only be upon six (6) months notice in writing to the othe parties hereto participating in the program and to the new Corporation and su withdrawal shall become effective six (6) months after the giving of such writ notice. Notwithstanding the foregoing provisions with respect to revocation

of delegation and withdrawal from a program operated and managed by the ne Corporation, no party by such withdrawal shall be released from any obligations applicable to it under any such educational or training program which w validly adopted by the new Corporation prior to the giving of notice of such withdrawal; and even though withdrawal shall have been accomplished as here inabove provided; the party so withdrawing shall continue to be bound by all t obligations under such an educational or training program in accordance with its terms and conditions until the termination of the agreements or arrangements covering such program between the new Corporation and the parties hereto and third parties; specifically excluding any periods of automatic rene or periods of renewal accomplished by the new Corporation after the giving o such notice of withdrawal and revocation of delegation. A party who has with drawn from a given education program shall still remain a member of the Corporation and its qualifications for membership shall not be affected there A party hereto who has withdrawn from an educational program operated and managed by the new Corporation shall have the full right and power to institu by itself any educational and training program to replace the program from which it has withdrawn.

3. Withdrawal from Membership in the Corporation and Termination of this Agreement. Subject to the provisions of this agreement and any other agreement of delegation with respect to agreed upon terms of continuation of education and training programs, any party hereto shall have the right to withdraw from membership in the Corporation and thereby to be released from all the obligations and terms of this agreement upon such withdrawal subject to the conditions hereinafter set forth, and only upon six (6) months notice in writing to the other members of the Corporation and the parties to this agreement, and such withdrawal shall become effective six (6) months after the giving of such written notice. Notwithstanding the foregoing provisions that such withdrawal from membership in the Corporation

may be made as hereinabove provided, no member by such withdrawal shall be released from any obligations applicable to it under any education or training programs validly adopted by the new Corporation prior to the giving of such notice of withdrawal; and, even though such withdrawal shall have been accomplished as her inabove provided, the withdrawing member shall continue to be bound by all the obligations under such educational and training programs in accordance with the terms and conditions of any agreements and arrangements covering such program between the new Corporation and the parties hereto and third parties until the term nation of such agreements or arrangements in accordance with their terms; specifi cally excluding any periods of automatice renewal or periods of renewal accomplis: by the new Corporation after the giving of such notice of withdrawal from members by a party hereto.

4. Financing. The parties hereto agree to provide the new Corporation wit sufficient financing to carry out its purposes with respect to its administrative expenses (it being the intention of the parties hereto to include in the terms "administrative expenses" all those expenses of the new Corporation which under contractual arrangements, statutory provisions and administrative rules and regulations, in existance from time to time, are not reimburseable by various third party payor Each party hereto agrees to contribute one-third of such unreimburseable or unallo cated administrative expenses. The initial contributions of the new Corporation for the first two years of its operation shall not exceed the sum of $10,000 annually for each party hereto. The financing of the direct expenses of each educational and training program which is delegated to the new Corporation for the operation and management thereof shall be in accordance with the provisions of the agreement del gating the operation and management of such a program to the new Corporation; and the respective shares of the parties hereto in such financing and the obligations of each party shall be in accordance with the terms and provisions of such agreement of delegation.

IN WITNESS WHEREOF, the parties hereto have caused this agreement to be executed in triplicate as of the day and year first above written.

BLODGETT MEMORIAL HOSPITAL

By _____

Its Chairman

BUTTERWORTH HOSPITAL

By _____

Its _____

SISTERS OF MERCY-GRAND RAPIDS

By _____

Its Trust

AGREEMENT

Michigan State University hereby agrees to reimburse Grand Rapids Area Medical Education Center, Inc., Grand Rapids, Michigan, for their share of the administrative and coordination costs of the Undergraduate Medical Education programs for Michigan State University medical students in the Grand Rapids area for the period July 1, 1980 through June 30, 1981 in an amount not to exceed $705,882 as shown by the attached budget.

Invoices covering actual expenditures for each budgetary line item should be submitted to Michigan State University as of the end of each month or quarter. Invoices should be addressed to Winifred H. Rome, College of Human Medicine, A128 East Fee Hall, Michigan State University, East Lansing, Michigan 48824.

Robert K. Richards

GRAND RAPIDS AREA MEDICAL EDUCATION CENTER, INC.
Robert K. Richards, Ph.D.
Executive Vice President

MICHIGAN STATE UNIVERSITY
Stephen H. Terry
Assistant Vice President

COLLEGE OF HUMAN MEDICINE
W. Donald Weston, M.D.
Dean

COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES

Background

The Commission on Professional and Hospital Activities of Ann Arbor, Michigan is a non-profit organization established by the American College of Physicians, American College of Surgeons, American Hospital Association, and the Southwestern Michigan Hospital Council to provide a centralized, national information system for medical abstracts. The Commission's most widely known product is the Professional Activity Study (PAS), a medical abstract service to which approximately 95 COTH members subscribed as of September, 1979. A substantial decline has subsequently occurred and now about 50 members subscribe.

In 1979, the Commission encountered serious financial problems threatening its viability. The American Hospital Association entered into a management contract to operate and try to rescue the Commission. The AHA's activities were described to the COTH Administrative Board at its January, 1980 meeting by Gail Warden, AHA Executive Vice President, and Howard Berman, AHA Group Vice President. In the spring of 1980, the AHA named John Bassett, formerly of the Hospital Association of New York State, as the Commission's new chief executive officer.

Two of Mr. Bassett's objectives are to obtain new subscribers for the Commission's services and to develop the Commission into a permanent repository for medical abstract data. In July, 1980, Dick Knapp and Jim Bentley met with Mr. Bassett during the AHA convention to discuss COTH member participation in PAS. As a result of that meeting, Mr. Bassett met with the COTH Administrative Board at its September, 1980 meeting. Mr. Bassett proposed that the Commission develop a separate data base for U.S. teaching hospitals as a joint COTH-Commission project. After discussion, the Board concluded that a group of COTH members and staff should visit the Commission to review its capabilities and to obtain a more detailed project proposal before making a decision.

Site Visit of COTH Members

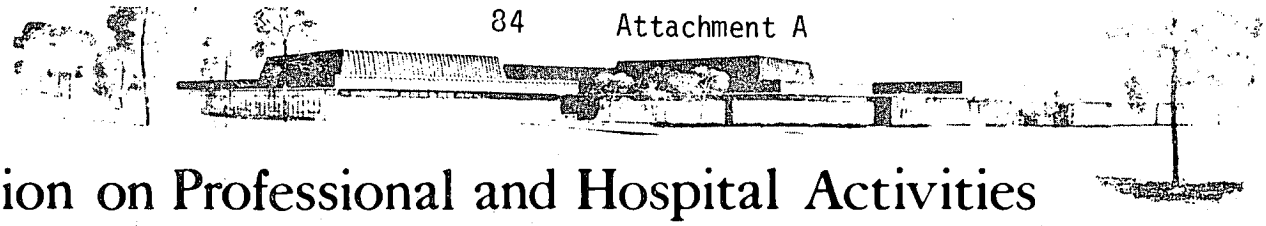
On November 25, 1980, John Colloton, Director of the University of Iowa Hospitals and Clinics; Mark Levitan, Executive Director, Hospital of the University of Pennsylvania; Irvin Kues, Vice President for Finance, the Johns Hopkins Hospital; Dick Knapp; and Jim Bentley met with Mr. Bassett and his staff at the Commission's Ann Arbor offices. Earl Frederick, President, Children's Memorial Hospital of Chicago was also invited to visit the Commission but a last-minute conflict required him to remain in Chicago. The first half of the meeting was a demonstration of the on-line, data processing capabilities which the Commission can use at the University of Michigan. After the demonstration, Mr. Bassett reiterated his interest in establishing a COTH-Commission medical abstract data base for teaching hospitals. Unfortunately, the proposal was no more advanced than in September. No minimum data set was proposed, no cost estimates were available, and no procedure had been developed for obtaining data from other commercial or association operated medical abstract services.

Mr. Colloton asked Mr. Bassett to review the present operating conditions at the Commission. Mr. Bassett noted that the Commission has 300 employees with an additional 83 Electronic Data System (EDS) employees who are responsible under a long-term contract for computer programming and operations. Forty-five employees were terminated in the previous year. Annual revenues are presently $16.5 million, reserves total $3.8 million, and $750,000 in financial support is available from the American Hospital Association. Present research contract revenues do not cover the full costs of the contracts. In September and October, 1980, the Commission operated in the black.

At Mr. Levitan's request, Mr. Bassett then reviewed the composition and activity of the Commission's governing board and its six-member Executive Committee. The Board and its Exeuctive Committee each meet four times annually. Board Members are listed in Attachment A.

In response to a question about planned changes in the Commission, Mr. Bassett noted a marketing department would be established in January, 1981, a series of advisory groups would be appointed in 1981, and a new microcomputer system for entering data would be introduced in 1981.

At the conclusion of the site visit, three questions remained: (1) should COTH seek to establish a national data base for teaching hospitals, (2) is the Commission of Professional and Hospital Activities a viable organization and to what extent is the AHA committed to supporting and sustaining it, and (3) if COTH wants a data base, what are the advantages of establishing it at the Commission. The staff have no firm recommendations to make on a possible COTH-Commission data base for teaching hospitals; however, a full discussion of the topic is needed at the January, 1981 COTH Administrative Board meeting.



Commission on Professional and Hospital Activities

1968 Green Road, Ann Arbor, Michigan 48105 313 769-6511 800 521-6210 (toll-free number for continental US except Michigan)

Professional Activity Study (PAS)

SUMMARY OF AAMC PROJECT TO SUPPORT LONG TERM CARE GERONTOLOGY CENTERS

In FY 1979, the Administration on Aging (AoA) awarded grants to 22 institutions for the planning and development of Long Term Care Gerontology Centers authorized by Title IV, Part E, of the Older Americans Act. These grants were to support planning activities in the areas of education and training, research, model service development, technical assistance, and information dissemination for multidisciplinary long term care. In FY 1980, those institutions that had received the original grants competed again for awards: five were awarded funds as operational Long Term Care Gerontology Centers and four received funds to support advanced planning. Funds were also awarded to seven additional institutions to support initial planning activities.

In order to provide support to these institutions in their efforts to become comprehensive long term care gerontology centers that will function as a national resource for improving the planning, management and delivery of health care and social services to the chronically ill and functionally impaired elderly, AoA has funded a two-year project to be conducted by the Association of American Medical Colleges. Under the terms of a cooperative agreement with AoA, the Association will provide support to the funded centers in the areas of information exchange and information systems development and will act as a link between nationally known consultants and the funded centers.

During the two-year project, the AAMC will carry out the following tasks in order to meet the project goals and objectives.

- A Project Advisory Committee, composed of representatives from the various disciplines involved in long term care issues, will be established. This committee will meet twice during the two-year period and will review AAMC project activities throughout the life of the project.
- The AAMC will work with representatives from the operational

centers through an Information Systems Advisory Group to identify data elements for use in collecting operational and programmatic information. This group will meet five times over the two-year period to develop a list of data elements to be utilized in surveys and questionnaires intended for collecting aggregate information on activities for their own use and for public reporting, will assist AAMC in preparing the annual reports, and will review the final products of the information systems development component of this project.

- Three workshops will be conducted for Center Directors and their staff over this two year period. The purpose of these workshops is to promote an exchange of information on developments in long term care among the LTCGCs and to provide a forum for discussion of organizational and programmatic issues associated with Center development and implementation.

- Consultants from the areas of organizational development, interdisciplinary education and training, research, and development of model services will be identified as will experts in long term care. Provisions will be made for their consultants to visit new and continued planning centers during the first fifteen months of the project.

- The AAMC will prepare a newsletter, similar to the COTH Report prepared by the Department of Teaching Hospitals, which will be circulated to the centers, deans of medical schools, hospital administrators and members of the Project Advisory Committee. It is anticipated that this newsletter will contain information on activities at the funded centers, identify potential sources of funding for center activities, report on Congressional committees whose decisions affect the future of long term care, and provide other information of interest to Long Term Care Gerontology Centers.

- Ad hoc reports of workshops and meetings of the various project committees will also be disseminated to the LTCGCs by the AAMC.

The proposed timeframe for these activities is as follows:

- Review of funded proposals and project start-up - October, 1980-January, 1981

- Project Advisory Committee Meeting - January 9, 1981
  October, 1981

- Information Systems Advisory Group Meetings - December 15, 1980
  March, 1981
  July, 1981
  November, 1981
  May, 1982

- Consultant Visits - Ad hoc throughout first 15 months of project.

- Workshops - January 12-13, 1981
  May, 1981
  TBA, 1982

- Reports

  Postworkshop - March and July, 1981
  TBA, 1982

  Annual Reports of Information
  Systems Development Group - September, 1981 and 1982

  Yearbook to AoA - March, 1982

- Newsletter - March, June, September, 1981
  January, April, August, 1982