aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 20-21, 1982
Washington Hilton Hotel

WEDNESDAY, January 20, 1982

6:30pm	COTH Administrative Board Meeting	Hamilton Room
7:30pm	COTH Reception and Dinner	Independence Room/ Hamilton Room

THURSDAY, January 21, 1982

9:00am	COTH Administrative Board Meeting	Grant Room
12:30pm	Joint Administrative Boards Luncheon	Map Room
1:30pm	Executive Council Business Meeting	Conservatory Room

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

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 21, 1982
Washington Hilton Hotel
Grant Room
9:00-12:30pm

A G E N D A

Association of American Medical Colleges
COTH Administrative Board Meeting
November 2, 1981

PRESENT

Mitchell T. Rabkin, M.D., Chairman-Elect
John W. Colloton, Immediate Past Chairman
James W. Bartlett, M.D., Secretary
Dennis R. Barry
Spencer Foreman, M.D.
Earl J. Frederick
Robert K. Match, M.D.
John A. Reinertsen
John V. Sheehan
William A. Robinson, AHA Representative

ABSENT

Fred J. Cowell
Robert E. Frank
Mark S. Levitan
Stuart J. Marylander, Chairman
Haynes Rice

STAFF

James D. Bentley, Ph.D.
Peter W. Butler
Joseph C. Isaacs
Richard M. Knapp, Ph.D.
Ann Vengrofski
Melissa Wubbold

I. Call to Order

Dr. Rabkin chaired the meeting in Mr. Marylander's absence and called it to order at 6:45 p.m. in the State Room of the Washington Hilton Hotel.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of September 9, 1981 Administrative Board meeting without amendment.

III. Membership Applications

Dr. Bentley reviewed three membership applications. Based on staff recommendation and considerable Board discussion, the following actions were taken:

ACTION: It was moved, seconded and carried to approve

(1) Grant Hospital, Columbus, Ohio for full membership

(2) West Suburban Hospital, Oak Park, Illinois for corresponding membership

(3) Provident Hospital, Inc., Baltimore, Maryland for corresponding membership

IV. COTH Nominating Committee Report

Mr. Colloton, Chairman of the Nominating Committee, indicated that the other members of the committee are Mr. Marylander and Don Arnwine of the Charleston Area Medical Center in Charleston, West Virginia. He then presented a condensed Committee Report, leaving for the COTH General Session a review of the 21 COTH representatives nominated for the AAMC Assembly membership (see attachment A). He noted that Jeptha Dalston, Ph.D., Director of the University of Michigan Hospital, Irwin Goldberg, Executive Director of Montefiore Hospital in Pittsburgh, and Sheldon King, Executive Director of Stanford University Hospital were nominated for three-year terms on the COTH Administrative Board. He also reported the nomination of Mark Levitan, Executive Director of the Hospital of the University of Pennsylvania in Philadelphia as COTH Chairman Elect for 1981-1982.

V. Medicare Program Cuts

Dr. Bentley reviewed this item, which was not a scheduled agenda topic. He reviewed a handout which was a memo he sent to Dr. Cooper and members of the staff of the AAMC Department of Teaching Hospitals on the subject of Medicare program cuts expected to be proposed by the Administration (see Attachment B). The eight Medicare program changes listed have, according to the best available sources, been approved by HHS Secretary Schweiker, OMB Director Stockman and are being submitted to President Reagan.

Dr. Bentley explained that he had also learned that the 3 percent federal Medicaid reduction provision enacted in the "Omnibus Budget Reconciliation Act of 1981" (P.L. 97-35) is expected to result in an unanticipated "windfall" in federal cuts due to the effects of Amendments in the Aid to Families with Dependent Children (AFDC) and other programs. It is estimated that the windfall will produce an additional federal expenditure cut of $700 million in addition to the enacted $560 million cutback. Moreover, Dr. Bentley informed the Board that Senator Harrison Schmitt (R-N.M.) plans to introduce legislation that would cut an additional five percent, or $900 million, from the federal share of the Medicaid program. He noted, however, that approval of Sen. Schmitt's proposal was not likely to occur in Congress.

In reviewing the expected savings and effective dates for each of the Medicare program cuts, Dr. Bentley explained that the Administration is seeking total Medicare savings of $1 billion for fiscal year 1982--$800 million out of hospital reimbursement and $200 million out of physician reimbursement.

Dr. Knapp then reviewed the proceedings of a meeting held at the AHA's Washington offices, at which the proposed Medicare cuts were discussed by representatives of several of the national hospital associations. He stated that there was general agreement among those in attendance to mount a concerted effort to defeat, as priority concerns, the provisions dealing with treatment of funded depreciation as income in determining a hospital's costs and reducing the rate of return on equity for proprietary hospitals. Dr. Knapp felt that the program cuts were simply the result of pressure by OMB to meet a figure targeted as the amount necessary to meet newly found deficits. This approach, he feared, does not portend well for future reimbursement revisions should further deficits be discovered.

Mr. Robinson informed the Board that the AHA has learned that efforts by the Administration to eliminate or reduce tax-exempt bond financing for hospital construction will not be pursued. After further discussion of the Medicare issues, Dr. Rabkin closed by noting that this agenda item was for informational purposes only and did not require Board action.

VI. Other Information Items

Dr. Bentley provided an update on progress staff has made on the AAMC Teaching Hospitals Study. He described revisions which staff proposes to make in order to address concerns previously expressed by the Board.

Dr. Bentley was then asked to discuss the impact of the new Section 223 limits imposed by the recently enacted Budget Reconciliation Act. He reported that hospitals in the State of California still get hit hard by the limits. The percentage of COTH members impacted by the new limits is similar to the percentage of all U.S. hospitals affected.

VII. Discussion of Competition

The discussion on competition was a follow-up to the discussion at the September meeting of the COTH Administrative Board. A questionnaire on competition had been sent to the Board members, and Dr. Knapp began by summarizing the results of the ten responses he had received. He noted

summarizing the results of the ten responses he had received. He noted that the responses suggested general support for implementation of the consumer choice principles (mandatory choice of plans, fixed dollar contribution by employers, and limit on tax-free status of premium contribution). However, these views could be regarded as inconsistent with the results of another question which suggested legislation promoting price competition should not be supported unless provisions supporting the separate funding of costs associated with medical education in teaching hospitals were included.

Further discussion of the questionnaire and competition reconfirmed the fact that there is not a consensus among the Board members on this issue. Concern was expressed about an image problem the AAMC and teaching hospitals may be experiencing, particularly with response to a perception by some legislators that the teaching hospitals have not been helpful in suggesting solutions to the potential problems.

Consideration was given to state rate review as an alternative to competition. There was agreement that a regulatory approach had been reasonably successful in some situations. The Board also agreed that they should be better informed about the advantages and disadvantages of rate review. It was decided that Hal Cohen from the Maryland Health Services Cost Review Commission should be asked to attend the January meeting of the Board to share his perspectives on the Maryland experience with state rate review.

VIII. Adjournment

The meeting was adjourned at 9:30 P.M.

COTH NOMINATING COMMITTEE REPORT

JOHN W. COLLOTON, CHAIRMAN

NOVEMBER 2, 1981

BY TRADITION, THE NOMINATING COMMITTEE IS COMPOSED OF THE IMMEDIATE PAST CHAIRMAN OF THE COTH ADMINISTRATIVE BOARD WHO SERVES AS THE CHAIRMAN, THE CURRENT CHAIRMAN OF COTH, AND ONE MEMBER-AT-LARGE. THUS, YOUR COMMITTEE INCLUDES MYSELF AS CHAIRMAN, STUART MARYLANDER AND DON ARNWINE, PRESIDENT OF THE CHARLESTON AREA MEDICAL CENTER, WEST VIRGINIA.

I HAVE SEVERAL NOMINATIONS, AND I WILL PRESENT THE ENTIRE SLATE AND LET THE CHAIRMAN TAKE IT FROM THERE.

IN ACCORDANCE WITH THE AAMC BYLAWS, COTH IS ENTITLED TO 63 REPRESENTATIVES ON THE AAMC ASSEMBLY. THIS YEAR WE HAVE 21 THREE YEAR TERMS AVAILABLE, AND TWO ONE-YEAR-TERMS TO REPLACE INDIVIDUALS WHO HAVE LEFT COTH INSTITUTIONAL POSITIONS. I WILL BEGIN WITH THE TWO ONE-YEAR TERM POSITIONS:

2 NOMINATIONS FOR ONE YEAR TERM FOR THE AAMC ASSEMBLY, EXPIRING 1982

DAVID W. GITCH	ST. PAUL-RAMSEY MEDICAL CENTER ST. PAUL, MINNESOTA
JANICE B. WYATT	UNIVERSITY OF MASSACHUSETTS MEDICAL CENTER WORCESTER, MASSACHUSETTS

1 NOMINATION FOR A TWO YEAR TERM FOR THE AAMC ASSEMBLY, EXPIRING 1983

BOONE POWELL, JR.	BAYLOR UNIVERSITY MEDICAL CENTER DALLAS, TEXAS

NEXT, THE FOLLOWING 21 INDIVIDUALS ARE NOMINATED FOR A THREE-YEAR TERM ON THE ASSEMBLY:

21 NOMINATIONS FOR THREE YEAR TERM FOR AAMC ASSEMBLY, EXPIRING, 1984

JAMES W. BARTLETT, MD	STRONG MEMORIAL HOSPITAL ROCHESTER, NEW YORK
DONALD A. BRADLEY	MORRISTOWN MEMORIAL HOSPITAL MORRISTOWN, NEW JERSEY
A. SUE BROWN	CMDNJ - COLLEGE HOSPITAL NEWARK, NEW JERSEY
ROBERT B. BRUNER	THE MOUNT SINAI HOSPITAL HARTFORD CONNECTICUT
THOMAS J. CAMPBELL	STATE UNIVERSITY HOSPITAL, UPSTATE SYRACUSE, NEW YORK
JACK M. COOK	MEMORIAL MEDICAL CENTER SPRINGFIELD, ILLINOIS
JOSE R. CORONADO	AUDIE L. MURPHY MEMORIAL VETERANS ADMINISTRATION HOSPITAL SAN ANTONIO, TEXAS
FRED J. COWELL	JACKSON MEMORIAL HOSPITAL MIAMI, FLORIDA
JEPTHA W. DALSTON, PHD	UNIVERSITY OF MICHIGAN HOSPITAL ANN ARBOR, MICHIGAN
JAMES C. DENIRO	VETERANS ADMINISTRATION MEDICAL CENTER PALO ALTO, CALIFORNIA
WILLIAM J. DOWNER, JR.	BLODGETT MEMORIAL HOSPITAL CENTER GRAND RAPIDS, MICHIGAN
JOHN R. FEARS	VETERANS ADMINISTRATION MEDICAL CENTER HINES, ILLINOIS
SIDNEY M. FORD	VETERANS ADMINISTRATION MEDICAL CENTER ST. LOUIS, MISSOURI
IRWIN GOLDBERG	MONTEFIORE HOSPITAL PITTSBURGH, PENNSYLVANIA
WILLIAM I. JENKINS	WISHARD MEMORIAL HOSPITAL INDIANAPOLIS, INDIANA
SHELDON S. KING	STANFORD UNIVERSITY HOSPITAL STANFORD, CALIFORNIA
JAMES T. KRAJECK	VETERANS ADMINISTRATION MEDICAL CENTER ALBANY, NEW YORK
MARK S. LEVITAN	HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

GLENN R. MITCHELL	MEDICAL CENTER HOSPITALS NORFOLK, VIRGINIA
JOHN A. REINERTSEN	UNIVERSITY OF UTAH HOSPITAL SALT LAKE CITY, UTAH
VITO F. RALLO	UNIVERSITY OF CINCINNATI HOSPITAL CINCINNATI, OHIO

NEXT, I HAVE THREE NOMINATIONS FOR THREE THREE-YEAR-TERMS ON THE COTH ADMINISTRATIVE BOARD, EXPIRING 1984.

3 NOMINATIONS FOR THREE-YEAR-TERM ON COTH ADMINISTRATIVE BOARD, EXPIRING 1984:

JEPTHA W. DALSTON, PHD	UNIVERSITY OF MICHIGAN HOSPITAL ANN ARBOR, MICHIGAN
IRWIN GOLDBERG	MONTEFIORE HOSPITAL PITTSBURGH, PENNSYLVANIA
SHELDON S. KING	STANFORD UNIVERSITY HOSPITAL STANFORD, CALIFORNIA

IN ADDITION TO THESE APPOINTMENTS, WE HAVE THE IMMEDIATE PAST CHAIRMAN WHICH IS AUTOMATIC, STUART J. MARYLANDER.

THE CHAIRMANSHIP WHICH LIKEWISE IS AUTOMATIC SINCE YOU EXERCISED YOUR FRANCHISE LAST YEAR, DR. MITCHELL T. RABKIN.

CHAIRMAN-ELECT, MR. MARK S. LEVITAN, EXECUTIVE DIRECTOR, HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA.

MR. CHAIRMAN, I MOVE THE NOMINATIONS.

aamc association of american medical colleges

MEMORANDUM

TO: Dr. Cooper, Teaching Hospital Staff

FROM: Jim Bentley

SUBJECT: Medicare Program Cuts

According to the best available information, Secretary Schweiker, OMB Director Stockman, and President Reagan have all approved the following Medicare program changes for April 1 implementation:

1) Include interest earned on funded depreciation as income in determining a hospital's costs - presently such interest is excluded

2) Establish an all-inclusive, per admission limit on inpatient costs at 108% of the group mean - presently only applies to routine services on a per diem basis

3) Totally eliminate the nursing salary differential - presently 5%

4) Reduce rate of return for proprietary hospitals from 150% to 100% of Social Security Trust Fund interest rate

5) Exclude from allowable Medicare costs the incremental costs of private rooms

6) Reduce payment for "hospital-based physicians" from 100% of cost to 80% of cost

7) For physicians practicing in hospital outpatient settings, reduce prevailing fee limit from 75th percentile to 60th percentile

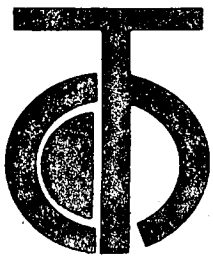
8) Delay the updating of physician fee profile from July 1 to October 1

There is one other change -- indirect capital costs -- which no one can explain to me.

MEMBERSHIP APPLICATIONS

Eight hospitals have applied for memberships in the Council of Teaching Hospitals. The applicants and the staff recommendations for type of membership are:

Hospital	Staff Recommendation	Agenda Page
Bellevue Hospital Center New York, New York	Teaching Hospital Membership	10
District of Columbia General Hosp. Washington, D.C.	Teaching Hospital Membership	15
Grant Hospital Columbus, Ohio	Teaching Hospital Membership Approved at Nov. Board Meeting	
Maimonides Medical Center Brooklyn New York	Teaching Hospital Membership	21
Ohio Valley Medical Center Wheeling, West Virginia	Teaching Hospital Membership	27
Provident Hospital Baltimore, Maryland	Corresponding Membership Approved at Nov. Board Meeting	
St. Mary's Medical Center Evansville, Indiana	Corresponding Membership	32
West Suburban Hospital Oak Park, Illinois	Corresponding Membership Approved at Nov. Board Meeting	



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: Bellevue Hospital Center

Hospital Address: (Street) 27th Street and First Avenue

(City) New York (State) New York (Zip) 10016

(Area Code)/Telephone Number: (212) 561-4132

Name of Hospital's Chief Executive Officer: Madeline A. Bohman

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	1200	Admissions:	26406
Average Daily Census:	980.7	Visits: Emergency Room:	106504
Total Live Births:	1778	Visits: Outpatient or Clinic:	391145

B. Financial Data

Total Operating Expenses: $ 154,244,083 (FY 80)

Total Payroll Expenses: $ 85,853,510 (FY 80)

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 26,816,721 (FY 80)
Supervising Faculty: $ 8,812,307 (FY 80)

C. Staffing Data

Number of Personnel: Full-Time: 4780
Part-Time: 139

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 852
With Medical School Faculty Appointments: 320

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

Medicine	OB/GYN	Neurology	Pediatrics
Surgery	Radiology	Ambulatory Care	Anesthesiology
Dermatology	Psychiatry	Neurosurgery	Orthopedics

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

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
Chest	No Specific No.Offered	36	Required
Medicine	No Specific No.Offered	180	Required
Anesthesia	No Specific No.Offered	18	Required
Surgery	No Specific No.Offered	186	Required
Dermatology	No Specific No.Offered	105	Required
Ob-Gyn	No Specific No.Offered	205	Required
Ophthalmology	No Specific No.Required	12	Required
Pediatrics	No Specific No.Required	181	Required
Orthopedics	No Specific No.Required	48	Required
Family Practice			
Otolaryngology	No Specific No.Required	48	Required
Psychiatry	No Specific No.Required	179	Required
Oral Surgery	No Specific No.Required	80	Required
Other: Neurology	No Specific No.Required	192	Required
Radiology	No Specific No.Offered	7	Required
Rehabilitation	No Specific No.Offered	11	Required
Urology	No Specific No.Offered	5	Required
Neurosurgery	No Specific No.Offered	0	

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	39	25	14	1937
Chest	13	12	1	1936
Medicine	99	99	0	1936
Surgery	84	82	2	1937
Ob-Gyn	35	32	3	1930
Pediatrics	61	50	11	1933
Family Practice				
Psychiatry	73	71	2	1934
Other:				
Dermatology	23	22	1	1932
Orthopedics	18	17	1	1934
Otolaryngology	12	10	2	1924
Neurology	17	16	1	1934
Neurosurgery	15	14	1	1940
Radiology	40	38	2	1934
Oral Surgery	10	10	0	1937
Urology	16	13	3	1935
Pathology	25	25	0	1936
Rehabilitation	6	1	5	1947
Plastic Surgery	15	15	0	1937

[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: New York University Medical Center

Dean of Affiliated Medical School: Ivan Bennett, M.D.

Information Submitted by: (Name) Madeline A. Bohman

(Title) Executive Director

Signature of Hospital's Chief Executive Officer:

Madeline A Bohman (Date) November 17, 1981

NEW YORK UNIVERSITY
MEDICAL CENTER
A private university in the public service

550 FIRST AVENUE, NEW YORK, N.Y. 10016
CABLE ADDRESS: NYUMEDIC
(212) 340-5372

**Provost of the Medical Center and
Dean of the School of Medicine**

October 10, 1981

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

Dear Dr. ~~Knapp~~ Ouch:

I am writing to recommend your favorable consideration of the application for membership in the Council of Teaching Hospitals submitted by Bellevue Hospital Center. Bellevue is a 1,200 bed teaching hospital affiliated with the New York University Medical School. Bellevue offers residency programs in all major specialties including internal medicine, surgery, obstetrics/gynecology, pediatrics and psychiatry.

Thank you for your consideration. If you have any questions, please do not hesitate to contact me.

Sincerely,

Ivan L. Bennett, M.D.
Dean

ILB:rl

SESQUICENTENNIAL CELEBRATION 1831 1981

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: DISTRICT OF COLUMBIA GENERAL HOSPITAL

Hospital Address: (Street) 19TH & MASSACHUSETTS AVE., S.E.

(City) WASHINGTON (State) D.C. (Zip) 20003

(Area Code)/Telephone Number: (202) 675-5000

Name of Hospital's Chief Executive Officer: Robert B. Johnson

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): (397 presently available) / 500

Average Daily Census: 335.5

Total Live Births: 1,449

Admissions: 10,726

Visits: Emergency Room: 77,299

Visits: Outpatient or Clinic: 106,879

B. Financial Data

Total Operating Expenses: $ 71,963,000

Total Payroll Expenses: $ 47,500,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $3,851,710
Supervising Faculty: $1,648,515

C. Staffing Data

Number of Personnel: Full-Time: 2,350
Part-Time: 48

Number of Physicians: (Med/Dental)

Appointed to the Hospital's Active Medical Staff: 176
With Medical School Faculty Appointments: 103

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

Amb. Svcs.	Dental	Neurology	Pediatrics	GT Surge
Anesthesiology	GT Medicine	OB/GYN	Phy.Medicine	HU Surge
Crippled Child.	HU Medicine	Pathology	Radiology	Urolog

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

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	36	35	Required
Surgery	10	6	"
Ob-Gyn	16	16	"
Pediatrics	12	11	"
Family Practice	-	-	-
Psychiatry	-	-	-
Other: Dental	4	4	Required
Radiology	3	3	"

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	8	4	4	
Medicine	38	15	23	
Surgery	10	6	4	
Ob-Gyn	13	13	0	
Pediatrics	12	7	5	
Family Practice	-	-	-	
Psychiatry				
Other: Dental	2	2	0	
Neurology	3	1	2	
Ophthalmology	6	6	0	
Radiology	3	2	1	
Urology	4	4	0	

[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: Georgetown University School of Medicin

Dean of Affiliated Medical School: John Bernard Henry, M.D.

Name of Affiliated Med. Sch.: Howard University School of Medicine

Dean of Affiliated Med. Sch.: Russell Miller, M.D.

Information Submitted by: (Name) Lewis N. Kuntz, MD

(Title) Acting Medical Director

Signature of Hospital's Chief Executive Officer:

(Date) 10/26/81

HOWARD UNIVERSITY
WASHINGTON, D.C. 20059

COLLEGE OF MEDICINE
OFFICE OF THE DEAN

October 29, 1981

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

Dear Doctor ~~Knapp~~ Dick:

The Office of the Dean of the Howard University College of Medicine is pleased to support the application of the District of Columbia General Hospital in Washington, D.C. for membership in the Council of Teaching Hospitals. The District of Columbia General Hospital is a major teaching facility for both medical students and postgraduate trainees from Howard and Georgetown Universities.

The Hospital has a long history of affiliation with the medical colleges in Washington, D.C., and is committed to medical education as part of its responsibility; it is also responsible for providing primary health care for a large number of Washington, D.C. residents. At the present time most of the Hospital's clinical departments are affiliated with the medical colleges; and it is the intent of both the Hospital and the medical colleges for all clinical departments to be affiliated with the medical colleges.

I am pleased to recommend the District of Columbia General Hospital to you, and request your favorable consideration on its application for membership.

Thank you for your consideration in this matter.

Sincerely,

Russell

Russell L. Miller, M.D.
Dean

RLM/pba

cc: Mr. Robert Johnson

GEORGETOWN UNIVERSITY
SCHOOL OF MEDICINE
3900 RESERVOIR ROAD, N.W.
WASHINGTON, D.C. 20007
(202) 625-7633

OFFICE OF THE DEAN

November 17, 1981

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

Dear Dr. Knapp:

Georgetown University Medical Center formally entered into an affiliation agreement with D.C. General Hospital and Howard University on December 19, 1980. Georgetown desired to be affiliated with a hospital where patient care services, teaching and demonstration could be conducted. This affiliation aids in training and increasing the supply of health care personnel as well as improving the quality and standards of medical science and education in a metropolitan public hospital.

As part of our recent LCME accrediatation visit, D.C. General Hospital was visited by the accreditation team. These individuals reviewed and assessed our undergraduate and graduate medical education programs in Medicine, Obstetrics and Gynecology, Ophthalmology and Surgery. These four departments currently have approved, active residency programs. Georgetown also has several faculty members at D.C. General Hospital who have both patient care and teaching responsibilities. These faculty members on site have been key to the success of our affiliation programs.

On behalf of Georgetown University School of Medicine, I wish to recommend that D.C. General Hospital be a member of the AAMC Council of Teaching Hospitals. As a member of the D.C. General Hospital Commission I have become knowledgeable of D.C. General's growing pains and triumphs. I am most encouraged that the Hospital will continue to improve and strive for excellence. It would be most valuable and beneficial to the Hospital to be a member of C.O.T.H. This would provide the Hospital with access to the expertise of the C.O.T.H. members. They would in turn be able to contribute to the Council as well.

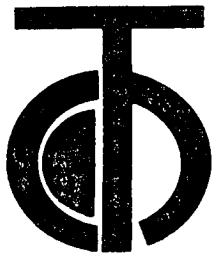
I would appreciate your consideration of D.C. General for C.O.T.H. membership. Please do not hesitate to call me for any further information or recommendations. Thank you.

Sincerely,

John Bernard Henry, M.D.
Dean

JBH:rgp

cc: Robert Johnson



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: MAIMONIDES MEDICAL CENTER

Hospital Address: (Street) 4802 TENTH AVENUE

(City) BROOKLYN (State) NEW YORK (Zip) 11219

(Area Code)/Telephone Number: (212) 270 - 7071

Name of Hospital's Chief Executive Officer: MR. LEE W. SCHWENN

Title of Hospital's Chief Executive Officer: EXECUTIVE VICE PRESIDENT

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	670	Admissions:	22,707
Average Daily Census:	597	Visits: Emergency Room:	56,755
Total Live Births:	4,627	Visits: Outpatient or Clinic:	118,303

B. Financial Data

Total Operating Expenses: $ 93,558.806.

Total Payroll Expenses: $ 51,331.807.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 4,828,138.
Supervising Faculty: $ 3,946.531.

C. Staffing Data

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

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 475
With Medical School Faculty Appointments: 276

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

Anesthesiology	General Surgery	Med. Onology	OTHERS:=
Internal Medicine	Neurology	Nephrology	Diag. Radiology
Obs/Gyn	Med. Sub-Spec.	Pulmonary	Clin. Pathology
Pediatrics	Cardiology	Infect. Disease	Emergency Medicine
	Hematology		

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	40	40	Required
Surgery	47	47	Required
Ob-Gyn	24	24	Required
Pediatrics	18	18	Required
Family Practice			
Psychiatry	30	30	Required
Other:			
Medical Sub-specialties		33	Elective
Surgical sub-specialties		8	Elective

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	Most Recent Date of Accreditation of the Program[2]
First Year Flexible				
Medicine	62	40	22	1979
Surgery	60	16	44	1979
Ob-Gyn	20	8	12	1981
Pediatrics	31	3	28	1979
Family Practice				
Psychiatry	16	3	13	1981
Other: Anesthes.	9	1	8	1979
Pathology	4	1	3	1979
Radiology	6	2	4	1980
Orthopedics	8	6	2	1981
Urology	6	1	5	1979
Fellows(Clin) Med. Sub. Spec.	12	5	7	

[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.

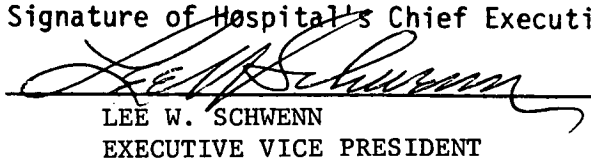
Name of Affiliated Medical School: STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER

Dean of Affiliated Medical School: STANLEY L. LEE, M.D.

Information Submitted by: (Name) DAVID GROB, M.D.

(Title) DIRECTOR MEDICAL EDUCATION

Signature of Hospital's Chief Executive Officer:



(Date) 10/29/81

LEE W. SCHWENN
EXECUTIVE VICE PRESIDENT

STATE UNIVERSITY
OF NEW YORK

DOWNSTATE MEDICAL CENTER

• COLLEGE OF MEDICINE
Office of the Dean

October 23, 1981

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

Gentlemen:

Maimonides Medical Center has been a major affiliate of this college since the beginning of Maimonides in 1947, before the Long Island College of Medicine became the State University Downstate Medical Center. Directors of the major services at Maimonides hold professorial rank here, and the Dean and faculty of the College participate in their selection. Over 200 staff members of Maimonides Medical Center hold simultaneous faculty appointments here.

Third year medical students are regularly assigned to Maimonides in all five clerkship disciplines:- Medicine, Obstetrics/Gynecology, Pediatrics, Psychiatry, Surgery. Approximately nine percent of the entire third year teaching load is carried out at Maimonides. In addition, significant numbers of fourth year students select clerkships at Maimonides.

Maimonides Medical Center is a highly valued and essential affiliate of the College of Medicine and entirely worthy of being admitted to membership in the Council of Teaching Hospitals.

Sincerely,

Stanley L. Lee, M.D.
Dean and Vice President
for Academic Affairs

c.c.: Dr. Donald J. Scherl
Dr. David Grob
Mr. Lee J. Schwenn

Maimonides medical center

DAVID GROB, M. D., DIRECTOR
DEPARTMENTS OF MEDICINE & MEDICAL EDUCATION
MAIMONIDES MEDICAL CENTER
PROFESSOR OF MEDICINE
STATE UNIVERSITY OF NEW YORK

MAIMONIDES HOSPITAL
4802 TENTH AVENUE
BROOKLYN, N. Y. 11219
270-7074

October 29, 1981

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

Gentlemen:

RE: IV SUPPLEMENTARY INFORMATION

Maimonides Medical Center has approved training programs in internal medicine, and its subspecialties, surgery and its subspecialties, pediatrics, obstetrics/gynecology, psychiatry, anesthesiology, radiology and pathology. With its broad clinical and academic scope, Maimonides Medical Center is well equipped to carry out its objectives of providing community health services, medical education and biochemical research. The house officer and the medical student benefit from the diverse programs of a teaching medical center that care for both private and non-private patients in an academic environment in which they have the opportunity and the challenge for professional growth.

Third year medical students are regularly assigned to Maimonides Medical Center in all five clerkship disciplines: medicine, obstetrics/gynecology, pediatrics, psychiatry and surgery. In addition, a significant number of fourth year students select electives at Maimonides.

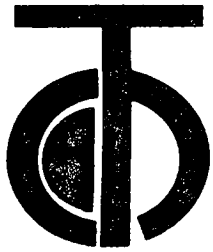
As an affiliate of State University of New York, Downstate Medical Center, Maimonides is assigned twelve "fifth pathway students" and clinical clerks for clinical rotations each academic year (these are American citizens who attend foreign medical schools) and provide the medical education and clinical experience required as a pre-requisite to their first postgraduate year of training.

Maimonides Medical Center has 670 beds. One-third of all beds are for non-private patients who are under the care of the resident/student staff supervised by attending physicians.

Sincerely yours,

David Grob, M.D.
Director, Medical Education

DG/lv



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: Ohio Valley Medical Center, Inc.

Hospital Address: (Street) 2000 Eoff St.

(City) Wheeling (State) West Virginia (Zip) 26003

(Area Code)/Telephone Number: (304) 234/8765

Name of Hospital's Chief Executive Officer: F.E. Blair

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	453	Admissions:	15,709
Average Daily Census:	355	Visits: Emergency Room:	26,864
Total Live Births:	1,397	Visits: Outpatient or Clinic:	9,285

B. Financial Data

Total Operating Expenses: $45,589,000.00

Total Payroll Expenses: $22,983,000.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 731,000.00
Supervising Faculty: $ 363,000.00

C. Staffing Data

Number of Personnel: Full-Time: 1,618
Part-Time: 522

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 99
With Medical School Faculty Appointments: 54 (F. T. and Clinical)

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

Internal Medicine	Pathology	Anesthesiology	
Ob/Gyn	Radiology		

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

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	68	4	Elective
Surgery	42	5	"
Ob-Gyn	16	4	"
Pediatrics	12	2	"
Family Practice	-	-	-
Psychiatry	24	0	"
Other: Radiology	8	3	"
Emergency Medicine	16	6	"

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	18	4	6	April 1969
Surgery	14	3	6	July 1955
Ob-Gyn	8	2	5	July 1964
Pediatrics				
Family Practice				
Psychiatry				
Other:				
Diagnostic Radiology	4	2	2	July 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: West Virginia University

Dean of Affiliated Medical School: John E. Jones, M.D.

Information Submitted by: (Name) F. E. Blair

(Title) Executive Director

Signature of Hospital's Chief Executive Officer:

F. E. Blair (Date) 10/30/81

School of Medicine

Medical Center
Morgantown, West Virginia
26506

West Virginia
University

October 31, 1981

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

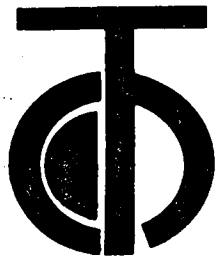
Gentlemen:

I am pleased to recommend for membership in the Council of Teaching Hospitals, Ohio Valley Medical Center, Inc., of 2000 Eoff Street in Wheeling, West Virginia 26003. Ohio Valley Medical Center, Inc., is one of two hospitals affiliated with the School of Medicine that makes up our "Wheeling Division". Indeed, we have four and a half full-time faculty positions at Ohio Valley Medical Center at this time involved with overseeing medical student education. The hospital has further been involved with graduate medical education for a number of years and is deserving of membership in the Council of Teaching Hospitals.

Sincerely yours,

John E. Jones, M.D.
Dean, School of Medicine

JEJ/kjb



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: St. Mary's Medical Center

Hospital Address: (Street) 3700 Washington Avenue

(City) Evansville, (State) Indiana (Zip) 47750

(Area Code)/Telephone Number: (812) 479-4000

Name of Hospital's Chief Executive Officer: Mr. William D. Harkins

Title of Hospital's Chief Executive Officer: Administrator

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	482	Admissions:	19,982
Average Daily Census:	413	Visits: Emergency Room:	35,625
Total Live Births:	2,346	Visits: Outpatient Clinic:	47,931 19,966

B. Financial Data

Total Operating Expenses: $45,916,162.00

Total Payroll Expenses: $23,108,639.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $493,349.00
Supervising Faculty: $378,968.00

C. Staffing Data

Number of Personnel: Full-Time: 1,362
Part-Time: 362

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 190
With Medical School Faculty Appointments: 48

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

Anesthesiology, Diagnostic Radiology
Pathology, Radiation Oncology

Does the hospital have a full-time salaried Director of Medical Education?: Yes (Since 1962)

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	6	7	Elective
Surgery	10	2	Elective
Ob-Gyn	1	2	Elective
Pediatrics	1	1	Elective
Family Practice	1	2	Elective
Psychiatry	1	1	Elective
Other: Radiology	2	2	Elective
Emergency Medicine	1	4	Elective

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	4	4	0	1956
Medicine	0			
Surgery	0			
Ob-Gyn	7	7	0	1971
Pediatrics	0			
Family Practice	12	12	0	1971
Psychiatry	0			
Other:	0			

[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: Indiana University School of Medicine

Dean of Affiliated Medical School: Steven C. Beering, M. D.

Information Submitted by: (Name) W. Thomas Spain, M. D., Ph.D.

(Title) Director of Continuing Medical Education

Signature of Hospital's Chief Executive Officer:

William D. Harkins (Date) 11/30/81

William D. Harkins

SUPPLEMENTARY INFORMATION

Section IV Application For Membership

Council of Teaching Hospitals

Corresponding Membership

St. Mary's Medical Center

Evansville, Indiana

The St. Mary's Medical Center of Evansville, Indiana, is a non-profit, private, acute care facility owned and operated by the Daughters of Charity of St. Vincent de Paul. It was established in 1872 and has been in continuous operation since its founding. It is the oldest medical facility in this community.

The need for, the stimulatory effect of and resultant patient care benefits of postgraduate medical education was recognized early by the Administrators of St. Mary's Hospital. The first intern arrived in July 1910, for a two year period of training following graduation from the University of Louisville School of Medicine. House officers have been a part of the postgraduate education program ever since.

In 1956, the Internship of this hospital received full approval by the Council on Medical Education. It has maintained approval throughout the many changes that have taken place. It still functions and is viable, never eliminated during the seventies when the trend was to proceed directly into specialty training following medical school graduation.

In January 1971 and July 1971 the Obstetrics and Gynecology and Family Practice Residencies, respectively, became operational after prior Council of Medical Education approval.

The Internship (now known as the Transitional Year) has had full-time leadership since 1962. The Family Practice Residency has had full-time leadership since 1975. The Obstetrical and Gynecology Residency has had full-time leadership since 1979. All residency directors are board certified.

All of our Intern and Residency Programs have been filled with U. S. Citizens. Our one exception was a Swiss Intern who had done a summer exchange when a senior at the University of Zurich.

We believe our graduate educational progress may be displayed in tabular form. Detailed records are available since 1956 when the accreditation of medical education became a function of the Council of Medical Education. Although our activities are requested for the 1980-81 academic year, we trust this historical display in Exhibit A will be reflective of our medical education committment by the Administration, the Medical Staff and the Faculty.

To complement the training programs, a clinical faculty has been developed. This faculty may be seen in Exhibit B.

This Medical Center was one of the early participants in the Indiana Plan for Statewide Medical Education. Our initial participation was in the Visiting Professor Program. This began in 1966. In 1969, we offered our first Senior Medical Student electives. From a humble four disciplines, we graduated to thirty-one electives during the 1980-81 academic year.

Because of our geographic location we have had not only Indiana University students but senior medical students from the Universities of Illinois, Missouri, Michigan, Kentucky, Cincinnati, St. Louis University, Bowman Gray, Medical College of Georgia and University of Louisville. A program of the electives may be seen in Exhibit C. All electives are approved by the respective departments at Indiana University School of Medicine, annually.

In 1972, two significant events took place regarding our education programing. An Association Agreement between this Medical Center and the Indiana University School of Medicine was signed. It was renewed in 1977 for a second five year period (Exhibit D).

The second event was the establishment of the first year of medical school with the community as a part of Indiana University. It was and continues to be known as the Evansville Center For Medical Education. The use of clinical faculty to supplement the basic sciences was provided in part by the postgraduate faculty of this Medical Center.

In 1980, the Evansville Center expanded to include the second year of medical school. Again the graduate faculty participated in the physical diagnostic portions of the second year.

Following World War II with the return of physicians to private practice, the Medical Staff of this hospital elected to have a weekly Grand Rounds for their benefit. This fundamental practice has continued to this date. From self-generated programs there has been added the Visiting Professor programs (previously mentioned), guest speakers and selected seminars. A summary of

these activities may be seen in Exhibit E and F. These programs have been under the supervision of a full-time director since 1962.

All of these programs are appropriately accredited for the Physician's Recognition Award, by the American Academy of Family Practice and the American College of Obstetricians and Gynecologists. This Medical Center has been approved to determine Category I credits, first in 1976 and again in 1980 for four years.

Our research activities have included a ten year prospective study of Iron Deficiency Anemia of Obstetrical Patients on Initial Visit by Parity, Uterine Relaxant Properties of Isoxsuprine HCL in Threatened Premature Labor, Hand Held Obstetrical Analgesia Device, Cervical Mucolytic Properties of Cysteine, Adrenal Cortisol Suppression of Synthetic Estrogenic Steroids, Effect on Stools Of Infants when Casein is Substituted for Lactose, Computer Assisted Medical Diagnosis and Decision Making, Intra-Articular Cement For Total Hip Prosthesis, Family Practice as a Specialty - Decision Making by Indiana Residents, and a new project Physician-Patient Satisfaction.

We feel the unique features of these educational efforts are the number of voluntary physicians who eagerly participate in the above indicated activities.

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

OFFICE OF THE DEAN
Fesler Hall 302
1100 West Michigan Street
Indianapolis, Indiana 46223
(317) 264-8157

November 23, 1981

Dr. Thomas Spain
St. Mary's Medical Center
3700 Wshington Avenue
Evansville, Indiana 47750

Dear Tom:

I am delighted that you are applying for corresponding membership in the Council of Teaching Hospitals. The St. Mary's Medical Center has indeed been one of the key institutions in our Statewide Medical Education System. Without the active support and cooperation of the St. Mary's staff, we would have been unable to have a distinguished program of continuing medical education as well as senior electives during the early sixties. Furthermore, during the last decade, your leadership has provided us with the opportunity to establish the Evansville Center for Medical Education with the development of the full first-year and second-year medical curriculum in Evansville.

Your contributions to graduate medical education in regard to family medicine and obstetrics are well known. In addition, you have been in the forefront in the appointment of full-time physicians to senior administrative posts in the hospital structure.

I am delighted that you are seeking this affiliation with the COTH and am pleased to lend my full support to it.

With warmest personal regards.

Yours,

Steven C. Beering

Steven C. Beering, M.D.
Dean and Director
Indiana Statewide Medical
Education System

SCB/cm

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-280-6000

November 1981

TO: Regional Advisory Boards

SUBJECT: Medicare Differential Pricing

Origin of Document

In July, 1981, Regional Advisory Board (RAB) 5 voted to recommend:

> To request the Board of Trustees to seek regulatory changes that will result in hospitals being able to initiate differential pricing without being penalized by mandated cost allocation mechanisms.

The attached report was presented to the Board of Trustees at its November 18-19, 1981 meeting. Following discussion of the issue, the Board requested that this report be distributed to the RABs.

Issues Involved

Since its inception, Medicare has mandated methods for cost finding. Over time, various statutory amendments and revised regulations also have been implemented which further limit Medicare's liability for payments, such as the Section 223 routine cost limitations and the "lower-of-costs-or-charges" rule. Additionally, Medicare providers are required as a condition of participation to apply their charges for services uniformly without discrimination to a class of patient or payer. The combined effect of these accounting, payment, and participation requirements is to limit the ability of hospitals to price outpatient and other services competitively.

The 1981 Omnibus Budget Reconciliation Act continues this trend. In particularly, the Act seeks to limit payment for most hospitals outpatient services to the prices charged by private practitioners in the community for similar services. If implemented, this provision will compound existing problems and increase payment shortfalls.

Approval Process

No approval is required. The material is presented for the purpose of information and comment.

Recommended Action

As noted in the attached report, staff has undertaken, and will continue to undertake, a number of actions on these issues. It is recommended that the RABs receive this report.

Howard J. Berman
Group Vice President

Staff Discussion Paper:
Medicare Differential Pricing:

Since the establishment of the Medicare program in 1966, the AHA has objected to various payment policies and procedural requirements that impede the ability of hospitals to determine costs and prices for ambulatory care and other services realistically. The purpose of this paper is threefold: (1) to describe these historical problems; (2) to discuss recent amendments contained in the 1981 Budget Reconciliation Act which may exacerbate these historical problems; and (3) to outline recent and planned AHA activities to address these issues.

Historical Problems

Theoretically, cost allocation can be accomplished through one of two techniques: marginal costing or full absorption costing. Marginal costing involves the assignment of only marginal or incremental variable costs to an activity or department. Full absorption costing involves the assignment of average costs, wherein the total amount of an overhead cost (depreciation, utilities, and so forth) is allocated to an activity or department based on its proportion of a specific unit of measure (square feet, manhours, and so forth). As a general rule, the Medicare program requires hospitals to use the full absorption cost allocation technique.*

Under full absorption costing, the calculated costs of producing outpatient and ancillary services typically are overstated as a result of two phenomena. First, because average costs rather than marginal costs are assigned, certain overhead expenses that have little or no bearing or relationship to a particular department or activity are allocated to it on some proportionate basis. For example, under Medicare, even though a hospital's outpatient clinic is located in a wing of the hospital specifically constructed for the clinic, the outpatient clinic must absorb a proportionate share of the hospital's total depreciation expense, rather than merely the outpatient wing's depreciation expense.

Second, while certain overhead costs may have a relationship to a particular department or activity, the statistical basis used to allocate those costs may be unrealistic. For instance, under Medicare, utility expenses are averaged and distributed on a square footage basis in hospitals regardless of a given department's activities or hours of operation. Thus, if a hospital's operating rooms and outpatient clinic each occupy 5% of the facility's total space, and the total utility expense equals $500,000, the utility cost allocated to each department will be $25,000. This occurs despite the fact that operating rooms are more intense consumers of utilities than outpatient clinics.

*Providers are permitted to use alternative allocation methods, provided an individual hospital can demonstrate its method is more appropriate and it has the written approval of its intermediary to do so. Alternative methods, however, require a complete and accurate cost accounting system which is expensive and time-consuming to establish and to maintain. Further, if applied alternatives shift more costs to inpatient care areas, the hospital runs the risk of exceeding its Section 223 inpatient routine cost limits.

The Medicare program's required cost allocation methods create financial problems for hospitals when combined with the following payment and participation policies:

- payment of the lesser of costs or charges
- inadequate recognition in payment for certain elements of cost (e.g., charity care)
- the requirement that all charges be applied uniformly to all patients (this requirement is necessary for cost apportionment purposes since Medicare's payment for ancillary services is determined by the application of the RCCAC formula*)

As a result, if financial shortfalls are to be minimized, a hospital must set its charges for outpatient services at least equal to their costs as determined by Medicare. Because full absorption costing overstates the costs of outpatient services, the charges thus set unavoidably will be higher than charges for similar services delivered by providers not compelled to use full absorption costing or to charge the same prices to all patients.

Currently, the Medicare program has no incentive to correct this problem. More precise cost allocation procedures would result in greater allocation of overhead costs to inpatient activities. Because "allowable" inpatient care costs are fully reimbursed under Part A and "allowable" outpatient costs are reimbursed only at the 80% level under Part B,** cost allocation reforms would result in increased federal expenditures.

New Potential Problems

Two important amendments included in the Omnibus Reconciliation Act of 1981 (P.L. 97-35) may compound the above problems.

First, Section 2143 lowers the current "223 limits" from 112 percent of the mean of each grouping to 108 percent. For hospitals obtaining approval for alternative methods of allocating costs to areas providing services to outpatients, this change increases the likelihood that those institutions will exceed the inpatient cost limits.

Secondly, Section 2142 generally calls for the establishment, to the extent feasible, of a system to limit payment for the costs and charges of hospital outpatient services to the charges of private practitioners in the community for similar services. More specifically, this Section states:

> The Secretary shall issue regulations that provide, to the extent feasible, for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals.

*Reimbursement for ancillary service costs is determined by calculating the ratio-of-beneficiary-charges-to-total-charges-applied-to-costs of the department (RCCAC)

**42 U.S.C. 1395, Sec. 1833(a)(1).

(other than bona fide emergency services provided in an emergency room) or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost-related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be reasonably related to the charges in the same area for similar services provided in physicians' offices. Such regulations shall provide for exceptions to such limitations in cases where similar services are not generally available in physicians' offices in the area to individuals entitled to benefits under this title.

HCFA recently signed a contract with the Center for Health Policy, a Columbia, Maryland consulting firm, to help develop a feasible approach to implementing this provision. Implementation issues include, but are not limited to: how to define and evaluate "bona fide emergency services provided in an emergency room"; how to gather actual charge data from physicians' offices and distinguish between professional fee versus general service fee components; and how to account for potential differences in the mix of outpatients and/or outpatient services provided in hospitals and physicians' offices.

Recent and Planned AHA Efforts to Address These Problems

The AHA has consistently advocated changes in various Medicare policies and procedures (e.g., cost allocation, lower-of-cost-or-charges, differential pricing, and others) to resolve these problems. Most recently, these concerns were presented to the Presidential and HCFA task forces on regulatory reform as priority issues. Also, staff will be monitoring the progress of the HCFA contract to help develop a feasible implementation of Section 2142 of the 1981 Reconciliation Act.

Given the current economic environment and the previous record on these issues, it is highly unlikely that regulatory relief holds much promise. Therefore, it is increasingly important as one approach to resolving this and other payment issues, that the field thoroughly discuss the conclusions and recommendations of the Report on Hospital Payment Systems Shortfalls which is being presented to the Board of Trustees as a separate agenda item at its November, 1981 meeting.

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-280-6000

November, 1981

TO: Regional Advisory Boards

SUBJECT: Report on Hospital Payment Systems Shortfalls

Origin of Document

In July, 1980 the House of Delegates voted to rescind the Guidelines on State-Level Review and Approval of Budgets for Health Care Institutions. Simultaneously, the House requested that the Board of Trustees develop a timely strategy aimed at securing for hospitals their full financial requirements. The Board of Trustees directed the Council on Finance to develop such a strategy.

After careful consideration, the Council on Finance determined that the appropriate process was to identify existing shortfalls in payment, underlying causes of those shortfalls, and general directions and strategies for their resolution. Accordingly, as a first step toward meeting the Board's request, the Council appointed a working party and charged it:

> to investigate existing shortfalls in hospital payment systems, to recommend methods of assuring full financial requirements for the provision of hospital services with equity among all payers, and to review existing hospital payment experiments and studies.

In September, 1981 the Council on Finance voted to accept the report of the working party. Further, they voted to recommend that the AHA immediately undertake a major initiative to create awareness throughout the field of the emerging health services financing environment and its implications as described in the Report on Hospital Payment Systems Shortfalls prepared by the working party.

As a second step toward meeting the Board's request, the Council on Finance also voted to ask staff, with Council assistance, to develop workable, non-quantitative principles and guidelines for the design and operation of payment systems which will serve the operating needs of hospitals in an increasingly competitive, fiscally austere environment and to present those findings at the next meeting of the Council.

At its October, 1981 meeting, the General Council reviewed the Report on Hospital Payment Systems Shortfalls. It was the General Council's belief that the nature and timeliness of the Report dictated its wide distribution and discussion in the field. At its November, 1981 meeting, the Board of Trustees accepted the Report and referred it to the Regional Advisory Boards for in-depth discussion at their Winter meetings.

Issues Involved

The working party of the Council on Finance reviewed various studies which attempt to document the existence of payment shortfalls. Analysis of these studies show varying conclusions, reflecting the differences in perspectives and philosophies between hospitals and payers on such issues as adequacy of payment, equity of payment, and the role of the payment mechanism as a vehicle to promote hospital efficiency and effectiveness.

The attached Report recognizes these differences in perspective and philosophy. Beyond that, it attempts to set a new direction for developing lasting and effective solutions to payment shortfalls and to ensuring access to needed health care services, particularly for the poor, within the realities of the current economic environment.

The Report concludes that in an increasingly competitive environment with limited resources available from the major payers, shortfalls cannot be eliminated through traditional payment mechanisms, in particular retrospective cost-based approaches. Given limitations on their overall pools of resources, major payers will be neither willing nor able to pay more in the aggregate to hospitals, such that every institution is assured that its full financial requirements are met. Accordingly, the Report indicates that the only viable, lasting strategy to resolve shortfalls is for the hospital field to join with major payers in developing and implementing new, innovative prospective payment approaches which balance financial risks and rewards such that hospitals are adequately paid for efficient and effective management and are penalized for poor performance.

In reviewing the document, the key questions which should be addressed are:

1. Is the Report correct in the conclusion that shortfalls in payment cannot be resolved within the context of retrospective, cost-based systems?

2. Are hospitals willing to develop and implement innovative prospective payment approaches which balance financial risks and rewards such that hospitals are adequately paid for efficient and effective management and are penalized for poor performance?

3. What are the key characteristics of payment systems that will eliminate shortfalls for the well-managed hospital?

Approval Process

This Report is presented for review and discussion. It is not a policy document requiring approval.

Recommended Disposition

It is recommended that the Regional Advisory Boards discuss this Report in-depth and communicate their reactions and any recommendations for appropriate follow-up action to the Board of Trustees.

Howard Berman
Group Vice President

REPORT ON HOSPITAL PAYMENT SYSTEMS SHORTFALLS*

November, 1981

*This report, developed by a working party of the AHA Council on Finance, was reviewed, discussed, and accepted by the Council on Finance at its September 9-10, 1981 meeting, by the AHA General Council at its October 6, 1981 meeting and by the AHA Board of Trustees at its November 18, 1981 meeting.

INTRODUCTION

In September, 1980, the American Hospital Association's (AHA) Council on Finance appointed a working party on Hospital Payment Systems Shortfalls. The working party was charged:

> to investigate existing shortfalls in hospital payment systems, to recommend methods of assuring full financial requirements for the provision of hospital services with equity among all payers, and to review existing hospital payment experiments and studies.

In its study of shortfalls, the working party reviewed a number of research studies and believes that, from the hospital's perspective, the studies support the existence of payment shortfalls and provide adequate methodology for their documentation. More importantly, the review of these studies highlighted the differences in perspective and philosophy between hospitals and payers, as well as the operational implications of those differences including:

- differing views of the adequacy of payment from the hospital's and payer's perspective;
- differing views on the equity of payment between payers; and
- differing views on the role of the payment mechanism as a vehicle for promoting hospital efficiency and effectiveness.

This report presents the working party's conclusions and recommendations. It is intended, by clarifying the issues and economic realities, to help the hospital field move forward in developing:

- a realistic understanding of the increasingly competitive and fiscally austere environment facing hospitals, and the implications of that environment; and
- pragmatic and effective policies and programs for the future financing of and payment for health services within that environment.

SHORTFALLS - DEFINED AND DESCRIBED

For purposes of its study, the working party defined shortfalls as a lack of recognition in payment by any payer of its fair share of the financial requirements that hospitals consider necessary for efficient and effective delivery of hospital services. Differences in philosophy and perspective between hospitals and payers as to what represents adequate and equitable payment have created a mismatch between payment levels and financial needs. Not only does this mismatch lead to inappropriate subsidization by others of certain payers' financial responsibilities, but it also threatens the ability of individual hospitals to effectively meet community needs.

Various studies have attempted to document the kind and quantity of payment shortfalls. These studies however, demonstrate that the perspective and philosophy of the parties performing the studies influence the results.

From the hospital's perspective, there are four general types of payment shortfalls: inadequate recognition of certain operating costs, inadequate recognition of certain capital costs, different payer methods of apportioning costs, and inequitable limitations on cost levels.

Inadequate Recognition of Certain Operating Costs

In many cases, the operating costs identified by the Policy on Financial Requirements are not adequately recognized by payers. This lack of adequate recognition takes several forms and is defended by payers with a variety of arguments.

- Charity Care. Charity care is a societal cost that hospitals believe must be borne proportionately by all payers, including government. Contrary to this principle, it is the policy of the Medicare and Medicaid programs to limit their payments to the hospital's direct costs of providing services to their beneficiaries only.

- Bad Debts. Hospitals believe that all payers must share in bad debts in accordance with their use of the institution. The Medicare program believes that it should pay only for the bad debts of its beneficiaries rather than pay a proportionate share of all bad debts. Blue Cross Plans vary widely on this issue. Some pay a proportionate share of bad debts, some pay for no bad debts, and others pay only for the bad debts of their subscribers. Plans in the last category argue that their benefit coverage is comprehensive and it would be inequitable for them to pay for the generally higher bad debts of other patients who have less comprehensive benefit coverage. Medicaid programs do not believe that they should pay for any bad debts and argue that their indigent beneficiaries, by definition, are unable rather than unwilling to pay.

Hospitals believe that these restrictive policies, if fully carried out, represent a shortfall wherein only those patients who create bad debts should pay for the bad debts.

- Nursing Costs. In recognition of the more intensive nursing service required by older patients, hospitals believe that Medicare should pay a larger than average share of nursing costs. Congressional actions to reduce nursing service differential payments, taken without empirical justification, create new shortfalls.

- Certain Administrative Costs. Hospitals believe that one payer's share of certain administrative costs should differ from other payers' shares only when there is clear demonstration of: (a) promptness of payment that reduces working capital costs; and (b) payer underwriting and administrative practices that reduce costs of admitting, billing, credit and collections activities, or verification of coverage. Certain Blue Cross Plans have differentials that do not appear to be based on these factors.

Other examples of operating costs believed by hosptials to be inadequately recognized by certain payers include costs of shared educational programs, malpractice insurance, and telephone and television services.

Inadequate Recognition of Certain Capital Costs

Payers generally concur that investor-owned hospitals require a rate of return on equity in order to attract and maintain capital. Hospitals

believe that all payers should include amounts in their payments that will enable not-for-profit hospitals to generate revenues sufficient to meet current and future capital needs. In practice, the Medicare and Medicaid programs and some Blue Cross Plans do not agree that their payments should contribute toward a rate of return or an operating margin for not-for-profit hospitals.

Different Payer Methods of Apportioning Costs

Even though the hospital and the payer may agree that a particular cost is appropriate and reasonable, there may be differing views on how to apportion that cost in accordance with each purchaser's use and its measurable impact on the operations of the hospital.

Hospitals believe that different bases for apportioning costs, such as charges or patient days, can result in aggregate cost-based payments that are less than aggregate actual costs. Although cost-based payers in general acknowledge this possibility, they also defend their chosen methods of apportionment as the most appropriate.

Hospitals also believe that Medicare's lack of recognition of more detailed special cost centers and its requirement that labor room statistics, but not related costs, be included in the Medicare apportionment calculation, cause shortfalls.

Inequitable Limitations on Cost Levels

Some payers apply a variety of limitations on costs they will pay for individual items and services, or on their shares of total costs. In general, hospitals believe that the Medicare "reasonable cost" limits, as well as similar types of limits applied in some locales by Medicaid programs and Blue Cross Plans, are arbitrary, simplistic, and create unjustified shortfalls in payment for well-managed hospitals.

Hospitals also believe that the practice of some payers which place limitations on individual costs in a capricious manner, such as including limits on salaries of selected employees, fees to contractors, or the prices paid for drugs and other supplies, creates shortfalls.

CONCLUSIONS AND RECOMMENDATIONS

Recognizing these differences in philosophy and perspective, as well as the realities of the current economic and hospital operating environments, the Working Party reached the following conclusions and recommendations.

1. WITHIN THE CONSTRAINTS OF THE CURRENT ECONOMIC AND POLITICAL ENVIRONMENT AND THE LIMITATIONS OF RETROSPECTIVE COST-BASED PAYMENT SYSTEMS, THE DIFFERENCES IN PERSPECTIVE BETWEEN PAYERS AND HOSPITALS CANNOT BE RESOLVED.

Resolution of payment shortfalls is not primarily a technical or quantifiable matter. The overall budgetary and market pressures confronting various payers either create pragmatic obstacles to or prohibit changes in their payment philosophies, policies, and practices.

In the current environment, the major payers view their overall pools of resources for paying hospitals and other health care providers as limited. Federal and state government budgetary constraints represent the underlying problem for the Medicare and Medicaid programs. For the Blue Cross and Blue Shield Plans, commercial health insurers, and other private insurers and payers, the impetus for payment restraint derives from several sources including, but not limited to, pressures from state insurance regulatory bodies, limitations on employer resources, and price competition in the marketplace for individual and group business.

Hospital litigation on shortfall issues, even when successful, will not by itself result in lasting levels of adequate payment. Given their overall economic constraints and without better alternatives, major payers confronted with litigation decisions favorable to hospitals will tend to employ other means of containing their payments to hospitals. An example of this would be the Medicare program lowering the ceiling or expanding the scope of reasonasle cost limits to make up any "losses" incurred in hospital litigation.

2. LASTING AND EFFECTIVE SOLUTIONS TO THE SHORTFALL ISSUE -- AND TO ENSURING ACCESS TO NEEDED HEALTH CARE SERVICES, PARTICULARLY THE POOR -- LIE NOT IN ADDITIONAL RESEARCH OR ECONOMIC ANALYSIS. RATHER, SUCH SOLUTIONS LIE IN NEW UNDERSTANDING OF THE POLITICAL AND ECONOMIC ENVIRONMENT, AND IN INNOVATIVE, PLURALISTIC APPROACHES TO HEALTH CARE FINANCING AND HOSPITAL PAYMENT WHICH REFLECT THE REALITIES OF THAT ENVIRONMENT.*

*It is realistic to expect, and appropriate from the standpoint of innovation, that major payers will negotiate different payment approaches with hospitals within a region, as well as across regions.

3. WHILE THE HOSPITAL FIELD CONTINUES TO IDENTIFY, STUDY AND LITIGATE SPECIFIC SHORTFALL ISSUES, IT SHOULD JOIN SIMULTANEOUSLY WITH MAJOR PAYERS IN DEVELOPING AND IMPLEMENTING INNOVATIVE, PROSPECTIVE PAYMENT APPROACHES. THESE APPROACHES SHOULD BALANCE FINANCIAL RISKS AND REWARDS SUCH THAT HOSPITALS ARE ADEQUATELY PAID FOR EFFICIENT AND EFFECTIVE MANAGEMENT AND ARE PENALIZED FOR POOR PERFORMANCE.*

In developing such approaches to hospital payment, it is critical that:

- Hospitals with education, research, and major medical technology testing programs be treated fairly, and that performance incentives recognize these unique factors;

- Hospitals with other special needs and circumstances, such as high levels of charity care and bad debts, isolated location, special mix of services, and so forth, be treated fairly in terms of performance incentives; and,

*For purposes of this document, the term "prospective" is used in the broadest sense to refer to systems where rates or amounts of payments are determined in advance of delivery of service. Prospective approaches can include cost-based systems, as well as charge or other price-based approaches that either involve or forego negotiation or consideration of specific elements of cost or financial requirements.

- The payment system's incentives promote a cost-effective, coordinated mix of government regulatory, voluntary, and market forces at the national, state, and local levels, and be compatible with and reinforce the incentives in payer arrangements with other types of health care providers.

4. IN ADDITION TO NEW PAYMENT INITIATIVES, THE HOSPITAL FIELD SHOULD EXPLORE APPROPRIATE MEANS OF SUPPLEMENTING THE INCREASINGLY FIXED POOL OF FINANCIAL RESOURCES AVAILABLE FROM THE MAJOR PAYERS.

Examples of possible initiatives, include, but are not limited to:

- Private or public risk pools for the uninsurable; and
- Increased awareness by consumers of their influence on health service demands and costs, as well as increased consumer knowledge and financial involvement in purchasing health benefit plans and in using individual health services.

Hospital Payments For Physicians' Services

Across the past ten years, Department of Teaching Hospitals' staff have repeatedly received calls from member hospitals interested in obtaining information on hospital payments to physicians for various functions. These calls have generally sought to identify hospital payments in one or more of four areas: 1) financial arrangements with the specialties of radiology, pathology, and anesthesiology; 2) cost sharing arrangements with medical schools for physicians who are both school chairmen and hospital chiefs; 3) costs incurred for physician supervision in graduate medical education programs; and 4) financial arrangements with physicians supervising specialized care units (e.g., CCU, ICU). The staff has had little or no data to share with member hospitals in any of these areas.

In the past year, as federal and state support for some programs has declined, as medical schools have sought additional revenue sources, and as third-party payers have conducted more strenuous audits, staff have received more calls concerning hospital costs for physicians. One member, North Carolina Baptist Hospital, is interested in joining with the AAMC to develop and conduct a survey on cost sharing relationships between medical schools and teaching hospitals. Their initial draft of a questionnaire is attachment A. Two years ago, the University of Wisconsin conducted a somewhat similar survey, attachment B.

In light of the apparently growing member interest in hospital costs and arrangements for physicians, the Administrative Board is requested to assess the following questions:

- can the financial and organization relationships between hospitals and physicians be adequately described using a questionnaire? and
- should the staff, working with members and/or consultants, develop a questionnaire and survey the membership on hospital payments for physicians' services?

Attachment A

SURVEY FOR TEACHING HOSPITALS

Name of Hospital _____

I. Is there a formal affiliation agreement between the hospital and the medical school? If yes, please provide a copy of agreement OR specify components and issues addressed. _____

II. Clinical Director

A. Does the hospital reimburse salaries in part or in full for clinical directors? _____

If yes, what clinical areas and percent of support exist for each? _____

B. Are there written agreements for these relationships (contracts, memorandums of understanding, etc)? _____

If yes, please provide copies OR specify responsibilities or issues addressed. _____

III. Faculty Support

A. Does the hospital reimburse the medical school for faculty administrative services? _____

If yes, what areas and percent of salaries exist for each? _____

B. Does the hospital reimburse the medical school for educational effort to house staff? _____

C. Is there a central administration for the medical center? _____

If yes, how are costs shared? _____

D. If any of the above costs are not supported directly by the hospital, does the hospital receive government program reimbursement for these costs? _____

If yes, how are these funds used? _____

IV. Hospital-Based Physicians

A. Does your hospital have hospital-based physicians? _____

B. What areas of service are included?

C. What is the annual cost of each agreement?

D. Please provide copies of agreements OR specify responsibilities and issues addressed in each.

V. Does the medical school reimburse the hospital for any support provided to undergraduate education?

If yes, what is the basis for support and approximate annual cost?

VI. Does the medical staff use physician assistants to a significant degree in clinical activities?

If yes, who supports this cost, hospital charges or medical fees?

VII. House Staff

A. What number of house staff is supported by hospital?

B. What is the dollar value of salaries supported by the hospital for these positions?

C. What number of house staff is supported by other sources?

D. What are these other sources of support and approximate proportion for each? (by general categories)

VIII. Grants

Does the hospital receive funds from grants?

If yes, what are the types of services and approximate value of grant funds received? Example: tumor registry

IX. Facilities

A. Does the hospital provide any facilities for clinical or academic use by the medical staff?

B. Is there cost-sharing to support this space? _____

If yes, what is the basis for cost sharing? _____

C. Does the medical school provide any facilities for use by the hospital? _____

If yes, is there cost sharing to support this space? Basis for cost sharing? _____

X. Medical Library

A. What is the annual direct cost to the hospital for medical library use? _____

B. What is the percent of total library supported by hospital? _____

C. If cost is shared, what is the basis for cost sharing? _____

D. Does medical school have a separate medical library? _____

XI. Medical Records

A. Is there a central medical record department for the hospital and private outpatient services? _____

B. Is the cost of this service shared between hospital and medical staff? _____

C. What is the total direct cost of the department and the percent supported by medical school and/or med. staff? _____

XII. Do any areas of the medical staff contribute to purchases or directly make purchases of clinical capital equipment for hospital services (particularly in areas of hospital-based physicians)? _____

XIII. Please list other significant areas of cost sharing with the medical school, approximate annual cost to each and a brief description of the basis for cost sharing. _____

_____

_____

_____

_____

XIV. General Information

A. Number of beds available (excluding newborn nursery). _____

B. Prior year actual and current year budgeted patient days (excluding newborn nursery).

_____ 19
_____ 19

C. Prior year actual and current year budgeted percent occupancy.

_____ % 19
_____ % 19

D. Prior year actual and current year budgeted gross patient charges (before write-offs).

$ _____
$ _____

E. Prior year actual and current year budgeted net patient charges (after bad debts and contractual adjustments).

$ _____
$ _____

F. Prior year actual and current year budgeted total operational expenses (net of cost recoveries and other operating income, i.e. cafeteria revenue, gift shop revenue, etc.).

$ _____
$ _____

G. Total of nonoperating income (interest earnings, donations, state allocations, etc.) _____

Name of person completing form _____. Phone no. _____

Attachment B

CONFIDENTIAL SURVEY OF UNIVERSITY HOSPITAL
FINANCIAL SUPPORT TO MEDICAL SCHOOL FACULTY

1) Total Hospital Operating Budget - Current Fiscal Year

Gross Total Revenues 80,191,000

Total Operating Expenses 80,131,000

2) Does your hospital receive a subsidy or appropriation from a parent organization (e.g., university, county government, state government)? YES X NO ____

Is it required that the subsidy or portion thereof be allocated for any specific activity (e.g., education)?

YES ____ NO X

If yes, please complete the following:

Specify the dollar amount per annum of the appropriation (do not include amounts earmarked for indigent patient care).

$ 11.5 million per annum
(primarily salary support)

Please provide a breakdown by dollar expenditure by category if required:

____

____

____

____

3) House Staff:

Total Annual House Staff Salaries	$ 4,956,000
Fringe Benefits	$ 130,000
Total*	$ 5,086,000

*Net of any revenue charged to other institutions for affiliation arrangements.

4) Total financial support (including fringe benefits) provided for medical school faculty for administrative, educational, and research activities. No support from the Hospital.

Department	Amount For Administration	Education	Research	Total
Anesthesiology				
Family Practice				
Medicine				
Obstetrics/Gynecology				
Oncology				
Pathology				
Clinical Laboratories				
Autopsy				
Surgical Pathology				
Pediatrics				
Psychiatry				
Radiology				
Surgery				
_____				
_____				
_____				
_____				
_____				

****

Return completed survey to: Gordon M. Derzon, Superintendent
University of Wisconsin Hospital
and Clinics
600 Highland Avenue
Madison, Wisconsin 53792

Marsh & McLennan

Marsh & McLennan, Incorporated
1221 Avenue of the Americas
New York, New York 10020
Telephone 212 997-7255

January 11, 1982

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

Thomas S. Chittenden
Senior Vice President

Dear Dick:

On September 30, 1981, I wrote to John Sherman outlining a number of ways in which AAMC might be helpful to its members with respect to risk management and the purchase of insurance. I also offered Marsh & McLennan's services in any way that might be helpful. At a follow-up meeting in October in Dr. Cooper's office, it was suggested that the Council of Teaching Hospitals was the appropriate group within AAMC to review proposals and that they should be submitted through you as the cognizant staff director. It was also intimated that Marsh & McLennan focus on practical suggestions that could lead to more cost-effective funding of the professional liability exposures of non-government teaching hospitals and their employed or affiliated medical staffs.

The specific proposals outlined hereafter are based on four assumptions:

1. Exposures for hospitals and hospital-based physicians are continually growing due in part to the increasing number and complexity of treatments and procedures. The society is also more litigious than ever; the plaintiff's bar has never been so numerous, skilled and aggressive; and the prospects of meaningful reforms in the tort law are dim for the foreseeable future.

2. While liability insurance is now easily available at relatively low prices, the exposures being created by physicians and hospitals are probably being underfunded at the present time. Historically, underfunding has resulted in a market shake-out which in its most severe form results in sudden and steep increases in costs and, at least for some buyers, a total lack of insurance options. It is unlikely that any shake-out in medical malpractice insurance markets will be as severe and traumatic as the 1974-1976 crisis, but the underlying conditions are not dissimilar to the early 1970's.

3. Physicians and hospitals require continuous availability of insurance capacity at prices that do not wildly fluctuate from year to year. Physicans and hospital administrators also need credible assurances that they are not being unfairly charged for their protection.

4. In this terribly imperfect world, health care providers cannot afford to leave the important needs outlined just above totally to the insurance industry. In the insurance business, when capital is not overabundant, it tends to flow toward risks that are relatively predictible, and most underwriters are profoundly convinced that medical malpractice risks are among the least predictible in the casualty field. In this context, it behooves the health care industry, in its various segments and with the active leadership of its trade and professional associations, to maximize the likelihood that the needs suggested above will be met. Much has already been done through the formation of provider-owned insurance companies by many medical and hospital associations, and by the recent cooperative effort of the National Association of Insurance Commissioners and the Council of Medical Specialty Societies to collect, analyze and publish data on over 70,000 claims closed between July, 1975 and December, 1978. These efforts have developed considerable expertise and information in the health care industry which helps to assure physicians and

hospitals that liability insurance will continue to be available at fair prices. However, it is submitted that AAMC could play an important information-gathering and advisory role which would be very helpful to teaching hospitals and their medical staffs in meeting their particular risk management needs.

* * *

My proposals to the Council are two:

1. That the Council explore the feasibility of becoming a vehicle for the collection, analysis and dissemination of claims information, on an on-going basis and for the benefit of its members in defining and funding for malpractice liabilities arising out of activities of teaching hospitals.

2. That the Council explore the feasibility of creating a capability to advise members as to effective risk management and claims control techniques, especially with respect to large claims.

INFORMATION PROPOSAL

In order to determine whether to write a class of business and, if so, at what rates and on what terms, underwriters rely principally on information as to the frequency and severity of losses within that class. The more complete the data over time, the more comfort an underwriter has that he can price his product correctly. Traditionally, loss information has come from insurance company files and pooled data available through the Insurance Services Office, an industry data collection and rating office. ISO data form a valuable historical base in the medical malpractice area, but the files are increasingly incomplete in recent years due to failures of some insurance companies to submit loss information and the prevalence of provider-owned companies that do not report data to ISO. More importantly, however, ISO information is only available to participating insurers

and even if it were available to AAMC, it would not provide a break-out of loss information as between teaching hospitals and hospitals in general.

The N.A.I.C. study referred to above is a comprehensive study of claims against physicians and hospitals closed during a three and one-half year period ending in December, 1978. While the N.A.I.C. data files are being further refined to provide break-outs of claims by the medical specialty involved, there are no current plans to collect data for more recent years or to provide additional analyses. However, the data is available to permit a break-out of all hospital-related tables by type of hospital and by location. Thus, it would be possible to generate a discrete data base relating to teaching hospitals, or sub-categories of teaching hospitals, and to compare the results with all hospitals or other sub-sets of hospitals.

The benefits of collecting loss information on a comprehensive on-going basis are obvious. Individual teaching hospitals would have a better basis for projecting self-insurance funding requirements; groups of hospitals engaged in or interested in collective self insurance would be better able to project expected losses; and opportunities would be enhanced for the establishment of regional or national excess insurance of re-insurance pools on favorable terms.

Nonetheless, such a project is ambitious and would require not only significant funding but the informed cooperation of most, if not all, teaching hospitals. As a first step, I suggest that the Council explore with the N.A.I.C. and the Council of Medical Specialty Societies the cost of obtaining break-outs of hospital-related data by type of hospital. This would not seem to be a very difficult task, and would perhaps be done as an extension of the follow-up study of medical specialties being conducted by the Council of Medical Specialty Societies. Our preliminary inquiries suggest that most of the cost could be defrayed from foundation sources. If it turned out that teaching hospitals have less than their proportionate share of losses (either on a frequency or a

severity basis, or both), then this would be a large impetus towards a broader data collection project, since the probabilities of more favorable insurance arrangements for teaching hospitals would be enhanced. Even if the results were less favorable, such a study would be valuable of itself and would point the Council in its thinking towards areas of greatest concern.

CLAIMS CONTROL PROPOSAL

The N.A.I.C. study demonstrates that a very high percentage of indemnity dollars are paid out in relatively few serious cases. (Overall, 64% of all indemnity dollars were paid out in the 11% of all claims where the amount of indemnity exceeded $100,000). Also, there was a major increase in claims disposed of for more than $1,000,000 during the period of the study (23 in 1978 as opposed to five in 1975). Large claims also tend to take the longest to close and involve the most defendants. (Typically, a major case involves at least one surgeon, an anesthesiologist, the hospital, and sometimes a product manufacturer). An astute plaintiff's attorney will do all he can to sow discord between the hospital and the defendant physicians, sometimes offering to settle with one or more parties at the expense of the others. Whatever the outcome (and cases involving severe patient injury are more often than not won by the defendants), such cases produce grave strains and conflicts in a hospital.

In general, teaching hospitals have very sophisticated formal and informal peer review mechanisms and administrative controls. Some of the largest teaching hospitals have employed risk managers and/or house attorneys in recent years whose duties include controlling potential and actual malpractice claims. Also, many teaching hospitals have established patient representative positions in order to head off complaints or claims at an early stage. However, the degree of sophistication in handling claims, even among teaching hospitals, varies greatly, and I believe that the Council could serve a very useful

purpose by providing focused educational efforts and technical assistance to member hospitals in creating and maintaining state of the art claims management systems.

Again, implementing such a notion fully would require a planning effort and time and expense. As a practical suggestion for assessing the desirability and feasibility of AAMC involvement, I suggest that the Council undertake a detailed examination into 10 to 12 serious malpractice claims closed within the past three years. Probably it would be best if all the cases involved the same medical specialty (e.g., ob-gyn, neurosurgery). Also, the cases should involve an allegation or an indemnity payment of at least $300,000 and multiple defendants (the hospital and at least one physician sued separately). Finally, the cases should be split evenly between "wins" and "losses". The study should, of course, be carried out so as to protect completely the identities of all persons and institutions. For the sake of convenience, the claims could all be from one region of the country.

Members of the Council would serve as an informal mechanism for identifying claims to be studied. Basic factual information would be collected about each claim, and then a team of investigators consisting (at a minimum) of a hospital administrator, a physician of the same specialty as involved in the selected cases, and an experienced malpractice defense attorney, would conduct interviews with as many interested parties as possible (including the patient and his or her attorney) to determine whether the underlying injury could have been prevented; how the patient was handled (medically and otherwise) after the injury; how the claim was investigated, monitored and settled (or tried); and the extent to which the claim disrupted relationships within the hospital.

Such a study could reveal a wealth of insights into claims techniques, mistakes and alternatives. It could also provide a basis for a decision by the Council as

to whether to become further involved with education and technical assistance.

* * *

My two proposals are, I believe, a practicable way for the Council to become sufficiently involved in questions of risk management to make an intelligent determination whether a fuller involvement is warranted. I am convinced that AAMC could have a significant long-term impact on the availability and price of liability insurance through programs developed out of these pilot efforts. And the break-out of the N.A.I.C. data could have a near-term beneficial effect on pricing for hospitals if it establishes that teaching hospitals have been cross-subsidizing other hospitals in the rates currently being charged.

Marsh & McLennan will be pleased to work with the Council in developing and implementing these proposals. Perhaps the first step would be to form a small ad hoc committee from the Council to explore the proposals further with you and me.

I appreciate the opportunity to communicate with the Council in this way and look forward to hearing from you after the meeting.

Sincerely yours,

Tom Chittenden

Thomas S. Chittenden

TSC/jmf

Comparing Bad Debt and Charity Deductions for COTH and Non-COTH Community Hospitals, FY 1980

	Community Hospitals		
	COTH Members	Non-COTH	Total
Number of Hospitals	327	5,503	5,830
Deductions for Bad Debts	$ 1,176,457,285	$ 2,147,076,975	$ 3,323,534,260
Deductions for Charity	600,830,737	673,420,989	1,274,251,726
Total Net Patient Revenue	18,935,681,665	54,883,157,724	73,818,839,389
Percent of Hospitals	5.6%	94.4%	100.0%
Percent of Bad Debts	35.4	64.6	100.0
Percent of Charity	47.2	52.8	100.0
Percent of Net Patient Revenue	25.7	74.3	100.0
Bad Debt and Charity as a Percent of Net Patient Revenue	9.4%	5.1%	6.2%

Source: American Hospital Association's Annual Survey of Hospitals

Prepared by Department of Teaching Hospitals
Association of American Medical Colleges
December 21, 1981

Estimated Stipends and Benefits for Housestaff

	Resident Training Site				
	All Residents[1]	Federal Hospitals[1]	Community Hospitals Total[1]	Community Hospitals Affiliated[2]	Long Term/ Other Hospitals[1]
Number of Residents	66,771	10,090	55,576	50,386	1,105
Mean 2nd Year Stipend[3] (in 000's)	$18.7	$18.7	$18.7	$18.7	$18.7
Total Stipends (in millions)	$1,251	$189	$1,042	$942	$21
Benefits 15%[4] (in millions)	$188	$28	$156	$141	$3
TOTAL STIPENDS AND BENEFITS (in millions)	$1,439	$217	$1,198	$1,083	$24

Medical School Affiliated Hospitals=
75% of total national residency stipends and benefits
90.4% of total community hospital stipends and benefits

NOTE: These estimates exclude costs for both program operation (e.g., supervising faculty, clerical personnel, supplies) and allocated hospital overhead.

Sources:

[1]Table 5A. Hospital Statistics: 1981 Edition published by the American Hospital Association

[2]Table 8. Hospital Statistics: 1981 Edition published by the American Hospital Association.

[3]Table 1. COTH Survey of Housestaff Stipends, Benefits, and Funding: 1981 Edition published by the Association of American Medical Colleges.

[4]Unpublished Data. COTH Survey of Housestaff Stipends, Benefits, and Funding, 1981.

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