aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 23-24, 1982
Washington Hilton Hotel

WEDNESDAY, June 23, 1982

6:30pm	COTH ADMINISTRATIVE BOARD Meeting	Hamilton Room
7:30pm	COTH Reception and Dinner	Indepdence Room Hamilton Room

THURSDAY, June 24, 1982

9:00am	COTH ADMINISTRATIVE BOARD Meeting	Jackson Room
12:30pm	Joint Administrative Boards Luncheon	Military Room
1:30pm	Executive Council Business Meeting	Hemisphere Room

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

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 24, 1982
Washington Hilton Hotel

9:00-12:30pm

A G E N D A

I.	Call to order	
II.	Consideration of Minutes	Page 1
III.	Membership Applications	Page 7
IV.	COTH Sponsorship of Capital Purchasing Program	Page 34
V.	AAMC Study of Teaching Hospital Characteristics	Page 35
VI.	Relationships with JCAH	Dr. Rabkin
VII.	National Commission on Nursing: Initial Report and Preliminary Recommendations	Page 56 Enclosure
VIII.	American Hospital Association's Proposed Medicare Prospective Payment System	Executive Council Agenda - page 29
IX.	Graduate Medical Education Positions	Executive Council Agenda - page 50
X.	Town Gown Issues	Executive Council Agenda - page 53
XI.	ACCME Essentials	Executive Council Agenda - page 16
XII.	Management of Academic Information	Executive Council Agenda - page 25 Enclosure
XIII.	ACGME General Essentials	Executive Council Agenda - page 27
XIV.	Other Business	
XV.	Adjournment	

Association of American Medical Colleges
COTH Administrative Board Meeting
April 13, 1982

PRESENT

Mitchell T. Rabkin, MD, Chairman
Mark S. Levitan, Chairman-Elect
Stuart J. Marylander, Immediate Past Chairman
James W. Bartlett, MD, Secretary
Fred J. Cowell
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
John A. Reinertsen
Haynes Rice
John V. Sheehan
William T. Robinson, AHA Representative

GUEST

Ed Smith

STAFF

James D. Bentley, PhD
Melinda Hatton
Joseph C. Isaacs
Richard M. Knapp, PhD
Melissa H. Wubbold

CONSIDERATION OF MINUTES

I. Call to Order

Dr. Rabkin called the meeting to order at 9:00am in the Jackson Room of the Washington Hilton Hotel. Before moving directly to the Agenda, Dr. Rabkin noted that Dr. Knapp wished to report on several matters of interest.

Dr. Knapp introduced Ed Smith who is a resident at Fairfax Hospital and who had specifically asked if it would be possible for him to attend a Board meeting and learn more about the AAMC. Following this introduction, Dr. Knapp indicated that in response to advertisements in the Washington Post and Hospitals magazine, 170 applications had been received for the staff associate position that became available when Peter Butler left the Association. The number of applicants has been screened and a group of 30 are now being reviewed by the staff in an effort to decide how many of these individuals should be interviewed for the position. Dr. Knapp reported his hope that the position would be filled by the time of the next Board meeting.

At this point Dr. Knapp distributed the letter addressed to the HCFA Administrator in response to the proposed rule implementing prospective reimbursement for dialysis services. He indicated that it had become apparent as work progressed on this subject that it is difficult to support the position that all 537 hospital-based facilities have a distinctive and more complex patient case mix. There does seem to be a distinction with respect to cost and other problems between hospital-based facilities and independent free-standing programs, but there is also a distinction that needs to be made within the 537 hospital-based services with respect to the case mix issue. A discussion based on this matter then ensued, following which it was agreed that Dr. Rabkin should ask that the AAMC Executive Council consider the possibility of appointing a small group of nephrologists to look into this matter more carefully. Dr. Rabkin indicated that he would do so. Before leaving the subject, Dr. Knapp stated that the group should be aware that most of the work done on this letter was accomplished by Dr. Roger Acheatel, a chief resident in medicine at Cedars-Sinai Medical Center who spent four weeks with the Department of Teaching Hospitals learning how the AAMC is organized, what the priorities are and contributing to the workload whenever possible.

Dr. Knapp then distributed an editorial from the April issue of Modern Health Care Magazine which indicated

that, "University hospital executives prefer regulations to upfront deductibles and copayments in the taxation of employee health insurance benefits." Following a brief discussion of the matter it was agreed that irrespective of whether the editorial was inaccurate, it would be unwise to call attention to the matter by any letter writing campaign.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the January 21, 1982 Administrative Board Meeting without amendment.

III. Membership Applications

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

ACTION(S): It was moved, seconded and carried to approve:

(1) St. Joseph's Hospital and Medical Center, Paterson, New Jersey for FULL TEACHING HOSPITAL MEMBERSHIP;

(2) Providence Medical Center, Portland Oregon for CORRESPONDING MEMBERSHIP.

IV. Upcoming Meetings

A. Location of 1984 COTH Spring Meeting

Before discussing this matter, Dr. Knapp reported that registration numbers for the 1982 Spring Meeting were running very high and ahead of schedule. Previous meetings, after two mailings and including on the spot registration, have attracted 162 fully paid attendees. Already this year in a single mailing the paid registration number is over 180. All the sleeping rooms at the Colonnade Hotel have been sold and the Boston Sheraton across the street is handling the overflow.

The discussion centered around the question of whether Philadelphia or Baltimore would be the most desirable location for the 1984 Spring Meeting. It was pointed out that the American Hospital Association held its Annual Meeting in Philadelphia two years ago.

Following this discussion it was agreed that if the Hyatt Regency Hotel or a newly built hotel adjacent to the Baltimore Harbor could be the site of the meeting, Baltimore would be the first choice. In the absence of a harborside hotel in Baltimore, arrangements would be made to have the meeting in Philadelphia.

B. COTH 1982 Annual Meeting Program

A number of program suggestions were discussed, many of which were centered around the changing fiscal environment of the medical school. Some of those suggested included:

- o University tenure as it relates to hospital services;
- o The changing sociology of running academic departments;
- o Relationship of hospital to faculty medical practice plans;
- o The growing sensitivity surrounding the town/gown issue.

After a discussion of these items it was generally agreed that many of these topics were appropriate, but would more likely be a series of program items that might better serve under the general heading of a larger program title for the 1983 COTH Spring Meeting.

It was then suggested that it might be more appropriate to identify two or three speakers who could describe the growing emergence of business coalitions. It was agreed that the staff should pursue this subject and consider the possibility of identifying someone who could give an overall view of the business coalition development and also locate both a business leader who has chaired one of these coalitions and an executive director who is the chief staff person for a business coalition.

V. Teaching Hospital Study

Mr. Levitan opened the Board's discussion of the draft of the final report of the Association's study of teaching hospitals by briefly reviewing the study's purposes, its data limitations, and its understated advocacy stance. The Board was then asked to evaluate and comment upon the draft. This led to an extensive discussion which focused upon five areas: the intended audience(s) for the report, the appropriateness of the report's tone for its audience(s),

the diversity of the hospitals included in the study, the general absence of comparative data with non-teaching hospitals, and the failure of the report to clearly and concisely differentiate teaching from non-teaching hospitals. Following a recommendation by several board members that the report not be published in its current form, it was agreed that the Board would establish a small subcommittee to address two issues: to whom is the report directed; and, what tone and format are appropriate for the audiences? The subcommittee is also to discuss what next steps, if any, should be taken, to follow up on the study. At the June Board Meeting, a revised draft report and proposal for future staff activities will be presented to the Board.

VI. Hospital Payments and Patient Case Mix

Dr. Knapp introduced this topic by discussing the Federation of American Hospital's recently adopted policy position that prospective payment systems should "avoid complex formulas which rely on diagnostic related groupings and which result in a large number of exception requests." In light of various state payment systems which use case mix and the findings of the Association's study which suggest that the relative complexity of cases varies between teaching hospitals, Dr. Knapp asked the Board if they believed the AAMC should have a policy position on the use of case mix in hospital payment systems. Following discussion the following action was taken.

ACTION: It was moved, seconded and carried that the AAMC actively pursue explicit recognition of hospital patient mix (including difference in diagnosis, intensity of illness, and type of patient) in all hospital payment limitations and prospective payment systems.

VII. AHA Discussion Papers

Mr. Robinson opened the discussion of ongoing AHA efforts to develop position statements on paying for hospital services by distributing a three-page concept paper being used by the AHA to develop a prospective payment system for Medicare inpatients. After briefly summarizing the main points, he invited Mr. Levitan, Mr. Frank and Dr. Bentley, each of whom participated in its development, to offer any observations on the plan that they had. Following a discussion of the concept paper and recognizing that a detailed proposal might identify areas of controversy, the following action was taken.

ACTION: It was moved, seconded and carried that the COTH Administrative Board encourage the AHA to continue developing and evaluating its prospective payment proposal for Medicare patients.

In addition, the Board expressed its concern that the concept paper did not include a specific adjustment for case mix and its reservations about advocating competitive bidding as a payment system for patient services.

VIII. Report of the Ad Hoc Committee on Health Planning

Mr. Goldberg who served as a member of the Association's ad hoc Committee on Health Planning which developed the proposed position, reviewed the statement for the Board and the rationale behind various provisions in it. Mr. Levitan expressed concern that the mandatory certificate of need (CON) review requirement would leave the revised planning program again open to extensive federal regulation.

Mr. Goldberg explained that the existing federal CON regulations would not be so onerous if, as the ad hoc Committee has recommended, adequate provision was made for expeditious review, indexing the dollar value of proposed projects to inflation, and due process protection for applicants. In addition, he stated that the Committee felt CON should be mandatory because without it reimbursement of capital expenditures would not be franchised and a buffer from new forms of competition to our hospitals would be lost. Besides, he noted, academic medical centers have fared very well under the CON process.

Mr. Rice indicated that delays in the CON review process have been a major problem in the Washington, DC area and that the proposed expeditious review provision should stipulate the exact number of days that would be involved. He also thought that the proposed limitation on federal funding for the CON component of no more than one-third of the state's program costs was still too high and he suggested a 10% limit.

Dr. Foreman felt that continuation of mandatory CON programs would require clear minimum federal standards for the states to meet. Without such, he feared that certain states could be very lenient and approve almost every project proposed and thereby siphon off capital funds and reimbursement dollars from providers in states where CON review is very stringent. He then recommended that the proposed CON dollar threshold of the greater

of one percent of the applicant total annual operating expenses or $600,000 be limited to just a specific dollar figure because the "one percent" threshold would be impossible to apply uniformly.

Mr. Goldberg admitted that the "one percent" threshold was proposed as a self-interest feature, believing that it would serve the larger, higher cost teaching institutions well in the CON process. Mr. Marylander supported inclusion of this provision and declared that maybe it was time to start "protecting the big guy (teaching hospital) on the block." Dr. Rabkin noted that CON guarantees a hospital a return on its investment and that the "one percent" threshold could permit bigger hospitals to monopolize capital expenditures and major medical equipment purchases without being subject to CON review.

The Board then voted nine yeas to five nays in favor of a fixed dollar threshold for CON review coverage, nine yeas to five nays in favor of uniform minimum federal requirements for state CON programs, and 13 yeas to one nay in favor of expanding CON review coverage to all providers.

ACTION: By a vote of seven yeas, six nays and one abstention, the COTH Administrative Board recommended that the Executive Council approve the proposed AAMC position statement on health planning amended by deleting the "one percent" CON dollar threshold alternative and calling for uniform minimum federal requirements for the mandatory state CON programs.

IX. Adjournment

The meeting was adjourned at 12:30pm.

MEMBERSHIP APPLICATIONS

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

HOSPITAL	STAFF RECOMMENDATION	PAGE
East Suburban Health Center Monroeville, Pennsylvania	Corresponding Membership	
Franklin Square Hospital Baltimore, Maryland	Request careful review of affiliation agreement	

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: East Suburban Health Center

Hospital Address: (Street) 2570 Haymaker Road

(City) Monroeville (State) PA (Zip) 15146

(Area Code)/Telephone Number: (412) 273-2434

Name of Hospital's Chief Executive Officer: George H. Schmitt

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

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	292	Admissions:	12,126
Average Daily Census:	249.7	Visits: Emergency Room:	36,224
Total Live Births:	890	Visits: Outpatient or Clinic:	10,395

B. Financial Data

Total Operating Expenses: $ 14,916,000

Total Payroll Expenses: $ 12,008,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 282,903
Supervising Faculty: $ 248,005

C. Staffing Data

Number of Personnel: Full-Time: 618
Part-Time: 289

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 275
With Medical School Faculty Appointments: 30

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

Emergency Medicine	Laboratory	Radiology	Family Practice
Pediatrics	Nuclear Medicine	Anesthesia	

Does the hospital have a full-time salaried Director of Medical Education?: Part-time Director of Continuing and Graduate Medical Education

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	0		
Surgery	0		
Ob-Gyn	0		
Pediatrics	2		Required
Family Practice	2		Dependent upon medical school
Psychiatry	0		
Other:			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine				
Surgery				
Ob-Gyn	2.0	1.0	1.0	July 16, 1979
Pediatrics	1.0	0.0	0.1	October 1, 1979
Family Practice	18.0	12.0	0.0	May 1, 1981
Psychiatry				
Other:				
Radiology	5.0	3.0	2.0	July 1, 1980

[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: The Medical College of Pennsylvania

Dean of Affiliated Medical School: Dr. Alton Sutnick

Information Submitted by: (Name) Elizabeth L. Surma

(Title) Assistant to the Executive Vice President

Signature of Hospital's Chief Executive Officer: _____ (Date) _____

SUPPLEMENTARY INFORMATION
MEDICAL EDUCATION & RESEARCH PROGRAMS

The Forbes Health System was formed in 1972 from the consolidation of two well respected institutions in Pittsburgh: the Columbia Hospital in Wilkinsburg and the Pittsburgh Hospital in the East End. Soon after, the Forbes Hospital System, as it was then called, merged with the East Suburban Hospital Group, Inc. to build an acute care hospital which would provide service for the communities of the eastern suburbs of Pittsburgh. The Pittsburgh Hospital was converted into the Pittsburgh Skilled Nursing Center in 1977, and in 1979, the Forbes Hospice, also located in this facility, was opened. In July, 1975, the Forbes' Board of Directors voted to change the names of the hospitals to "Health Centers" to better represent their role in both preventive and acute health care for the community.

Today, the Health Centers are legally joined as the Forbes Health System, one corporate organization with a single Board of Directors and Medical Staff. The results of this consolidation include: specialized health care programs, cost and containment to increase purchasing power and service centralization, standardized procedures for improving health services, elimination of duplicated services, and improved and expanded health education and outreach programs.

There are four active graduate training programs within the Forbes Health System. The System has a free-standing residency program in Family Practice. At present, it has been in existence for five years and is actively functioning with seventeen (17) residents currently enrolled. Within the past year, the System has concluded a formal affiliation agreement with the Medical College of Pennsylvania in Philadelphia. This arrangement includes the elective rotations of medical students in the Family Practice Program at the Forbes Health System.

The Forbes Health System also participates in an accredited residency program in Diagnostic Radiology in concert with St. Francis General Hospital of Pittsburgh. Radiology residents spend approximately one-third of their time within the Forbes Health System; the remaining time is spent at St. Francis General Hospital.

The Mercy Hospital of Pittsburgh and the Forbes Health System participate jointly in an accredited residency in Obstetrics/Gynecology. The OB/GYN residents rotate through the Forbes Health System as part of their training. Both the Diagnostic Radiology and OB/GYN Residency Programs are listed in the American Medical Association's Directory of Residency Training Programs.

The Forbes Health System has a less formal relationship with the hospitals of the University Health Center of Pittsburgh, specifically, the Children's Hospital of Pittsburgh, in Pediatrics. Senior Pediatric residents from the Children's Hospital of Pittsburgh may rotate through the East Suburban Health Center facility as part of their Pediatric training. In addition, medical students from the University of Pittsburgh School of Medicine may electively rotate through the East Suburban Health Center in Pediatrics. Thus, the System has undergraduate students at a regular basis in both Family Practice and Pediatrics.

RESEARCH PROGRAMS

The Family Practice Residency Program received a training grant from the United States Public Health Service at its inception. This grant was approved and funded for a period of three (3) years. More recently, the Family Practice Residency Program applied for a second Public Health Service Training Grant for the purpose of expanding its facilities in studying the role of nurse practitioners in resident education. This grant was approved by the Public Health Service, however, due to budgetary constraints, was not funded. Dr. Laurel Milberg, a clinical psychologist, a member of the Family Practice Residency Program Faculty, is actively participating in a research program involving the utilization of patient simulators for the training of Family Practice residents. Her work is funded through a grant from the Allegheny Area Health Education Council.

Additional research efforts within the Forbes Health System are conducted through the Forbes Hospice. A particular research program is designed to develop standards for the recruitment of "terminal care specialists". The expected need for an estimated 500 hospices in the United States and the concurrent need for "terminal care specialists" was the impetus for the inception of this research program. The hospice modality of care demands a unique educational process for participating health care professionals which has yet to be defined and tested. Presently, a formal, systematic curriculum for hospice workers has not been developed in the United States. The hospice research program has been funded by the Health Research and Services Foundation of Pittsburgh, Pennsylvania.

The Forbes Health System is entering into a joint demonstration project with the University of Pittsburgh School of Medicine which will involve the Pittsburgh Skilled Nursing Center. Resident physicians in Geriatrics and Psychiatry from the University of Pittsburgh will be afforded clinical experience in the Pittsburgh Skilled Nursing Center. The major objectives of the demonstration project is to engage in clinical research programs that will enhance the quality of long-term care. Funding for this project is provided by the Benedum Foundation.

In addition, a second research program associated with the Pittsburgh Skilled Nursing Center is in the planning process. This program will involve a study of the relocation of fifty (50) individuals who were recently transferred from one long-term care facility to the Pittsburgh Skilled Nursing Facility. This study will address the effects of this relocation and describe the preparation for the relocation of this group by the staff of the receiving facility. Funding for this program will be sought from the Health Research and Services Foundation of Pittsburgh, Pennsylvania.

THE MEDICAL COLLEGE OF PENNSYLVANIA

3300 HENRY AVENUE PHILADELPHIA, PA. 19129 215-842-7007

SENIOR VICE PRESIDENT FOR HEALTH AFFAIRS AND DEAN

May 19, 1982

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

Dear Sir:

I am pleased to recommend for membership in the Council of Teaching Hospitals the East Suburban Health Center in Monroeville, Pennsylvania. The East Suburban Health Center has been an affiliate of The Medical College of Pennsylvania for the past year. Under the direction of Dr. Nicholas Toronto, this institution has developed a fine program in Family Practice and Primary Care. Our own institution has a required fourth-year elective course in Primary Care and the East Suburban Health Center has been active in providing four-week electives for such students. They assume responsibility for approximately 20 students per year in this course. This affiliation is off to a good start and I am certain that more and more of our students will be electing the East Suburban Health Center in the future.

In addition to the above, the staff from the East Suburban Health Center flies to Philadelphia during the year and participates in the advising of our senior students in matters involving Family Practice as a career. These sessions have proven very helpful to our students and are becoming popular.

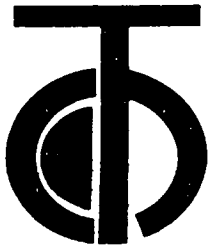
I am pleased to recommend East Suburban Health Center for the Council of Teaching Hospitals and am sure that if elected they will be active participants.

Sincerely yours,

Alton I. Sutnick, M.D.

AIS:sch

1850 The Female Medical College of Pennsylvania
1867 The Woman's Medical College of Pennsylvania
1970 The Medical College of Pennsylvania



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: Franklin Square Hospital

Hospital Address: (Street) 9000 Franklin Square Drive

(City) Baltimore (State) Maryland (Zip) 21237

(Area Code)/Telephone Number: (301) 391-3900

Name of Hospital's Chief Executive Officer: Mr. Michael Merson

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 465*

Average Daily Census: 372 (86%)

Total Live Births: 2,291

Admissions: 16,966

Visits: Emergency Room: 36,757

Visits: Outpatient or Clinic: 33,837

B. Financial Data

Total Operating Expenses: $ 45,126,944.00

Total Payroll Expenses: $ 25,927,899.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,418,461.00
Supervising Faculty: $ 1,795,897.00**

**includes $524,273.00 professional component

C. Staffing Data

Number of Personnel: Full-Time: 1,363
Part-Time: 676

Number of Physicians: 187 active, 73 associate, 108 visiting

Appointed to the Hospital's Active Medical Staff: 368
With Medical School Faculty Appointments: 104

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

Surgery	Pediatrics	Family Practice	Emergency Medicine
Medicine	Ob/Gyn	Psychiatry	Pathology & Radiology

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	4	14	elective
Surgery	4	--	elective
Ob-Gyn	1	4	elective
Pediatrics	1	--	elective
Family Practice	1	4	elective
Psychiatry			
Other:			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads		Positions Filled by Foreign Medical Graduates		Date of Initial Accreditation of the Program[2]
		1981	1982	1981	1982	
First Year Flexible						
Medicine	31	4	5	27	26(2)	1974
Surgery	23	6	10	17	13(3)	1948
Ob-Gyn	14	10	14	3	0	1952
Pediatrics						
Family Practice	27	23(1)	23	0	0	1972
Psychiatry						
Other:						
	95	43	52	47	39	
% filled	94.7%	47.7%	57.7%	52.3%	43.3%	

86 out of 90 filled positions are by graduates of American schools and/or American citizens.

[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.

(1) Family Practice residents transferring to other residencies after 1 or 2 years are not routinely replaced.

(2) 23 of 26 FMG's are American citizens

(3) 11 of 13 FMG's are American citizens

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: Richard S. Ross, M.D.

Dean of Affiliated Medical School: The Johns Hopkins University

Information Submitted by: (Name) Thomas Crawford M.D.

(Title) Medical Director

Signature of Hospital's Chief Executive Officer: Robert Mason

(Date) May 28, 1982

Supplementary Statement
Sections I-III

Franklin Square Hospital in association with the Maryland Medical College began in downtown Baltimore in 1898. Following the Flexner review, the medical college was terminated and/or merged with the University of Maryland in 1912. In 1914, internship programs were initiated which continued until 1975. Residency programs were initiated in 1948 and have continued to the present.

In 1969, Franklin Square Hospital relocated to Eastern Baltimore County. At the same time the institution abandoned the policy of voluntary departmental chairmen and began to recruit geographical, full-time departmental directors appointed by the Board of Trustees. A Director of Medical Education was appointed in 1966. Subsequently the DME was also made Medical Director. From only one full-time physician in 1968, Franklin Square now has 30 geographical departmental chairmen and section chiefs. This does not include more than 30 full-time radiologists, anesthesiologists, and emergency medicine specialists.

The Medical Executive Committee (MEC) was entirely elected by the medical staff prior to 1969. The MEC is now composed of the Medical Director and ten Departmental Chairmen who are permanent members; and, seven members of the active attending staff who are elected for one to four years. This assures not only a voice, but also continuity in the development of educational programs, quality assurance, staff development, etc., while at the same time giving representation to the attending staff.

Franklin Square Hospital is a non-sectarian, non-governmental, not-for-profit [IRS 501 (C) (3)] institution governed by 30 Trustees who are community leaders, a list of whom is attached (A). The Hospital is located on a joint 215 acre campus with the Eastern Regional Division of the Baltimore County Health Department and Essex Community College. The Latter (ECC), with a student body of over 10,000, specializes in allied health professions, many of which obtain clinical training at Franklin Square Hospital. Franklin Square Hospital also provides clinical training for nursing students from Towson State University, Harford Community College, Eastern Vocational-Technical School and Notre Dame College in addition to the nursing school at Essex.

To meet the demands of a rapidly growing community of over 300,000, Franklin Square Hospital completed, in 1981, a 26 million dollar expansion of the 1969 building. In October, 1982, the last 22 beds will be opened bringing the total to 465. The rate of ancillary support space to bed space is approxiamtely 2:1. All patients are treated as teaching patients irrespective of race, color, creed or capacity to pay.

The medical staff has grown from less than 80 in 1969, to approximately 450 at present, virtually all of whom are board certified. The average age of the medical staff has declined from near 60 to 42 years of age in the past decade. Approximately 200 of the attending staff participate annually in the teaching programs.

In 1968, the medical staff created the Franklin Square Medical Foundation (IRS approved) to support education, research and innovation in addition to what the Hospital could fund. As of December, 1981, the medical staff had donated over 1.2 million dollars. The Foundation actively seeks to support individual and institutional basic and clinical research. The most recent annual report is attached (B).

The budget of the Hospital has grown from less than four million dollars, a decade ago, to sixty (60) million projected for next year. The housestaff has grown from less than 25 to nearly 100. The housestaff stipends comprise over three percent (3%) of last years operating budget. When combined with the faculty support and other indirect costs, over seven percent (7%) is dedicated to graduate and undergraduate medical education. This equals or exceeds the average hospital expenditures of COTH member hospitals as reported in the 1978-79 reports. In addition, all residents above PG-I are encouraged to attend at least one national medical meeting. Copies of resident meetings for the past two years are attached (C).

Franklin Square Hospital is also approved by the Medical and Chirurgical Faculty of Maryland and the American Medical Association for over 1300 hours annually of Continuing Medical Education. There are 14 conference rooms comprising over 7000 square feet dedicated to undergraduate, graduate and postgraduate education.

Clinical clerkships were initiated in 1975, for students from Johns Hopkins and the University of Maryland. Several out-of-state students have also participated. More formal clerkships from Johns Hopkins were initiated May 1, 1982, with our Ob/Gyn Department. We are looking forward to more student rotations in the future and can accommodate about 20 at any one time.

The graduate program consists of four residencies as outlined in Section III-B. It is our immediate goal to accept only graduates of American medical schools into PG-I positions as of 1983. We have made considerable progress in that direction in the past two years. We feel that this can definitely be accomplished in Surgery. Our new Chairman of Medicine (Arthur Leonard, M.D. - former Chair of Medicine and Associate Dean of Clinical Affairs, School of Clinical Medicine, University of Illinois, Urbana-Champaign, Illinois) is exploring the possibility of a medical affiliation with Johns Hopkins. Dr. Leonard feels that all American medical school graduates is a real probability for 1983, PG-I positions.

The pass rate for all graduates from our four residencies in the past five years is as follows:

	Attempted	Passed
Family Practice	30	30
Medicine	28	19
Ob/Gyn	13	13
Surgery	15	15-Part I; 13-Part II

We feel this speaks well for the quality of the programs, which can now be best improved by graduates of AAMC approved medical schools.

To Summarize briefly:

1. Franklin Square Hospital has a long tradition of medical education.

2. The Trustees, Administration and Medical Staff strongly support educational endeavors at all levels.

3. The By-laws of the Hospital and composition of the Medical Executive Committee reflect the importance of medical education.

4. Meaningful institutional relationships with Johns Hopkins University Medical School have been initiated and are prospering.

5. A significant portion of revenues and facility space are dedicated to graduate education.

6. Recent graduates of our programs have done well scholastically and professionally.

7. The Medical Staff has generously supported education and research through contributions of both time and money.

8. A significant geographical faculty has been assembled and funded for providing excellence in medical education.

9. Recruitment of graduates from American medical schools has been increasingly successful and appears very favorable in the near future.

None of these achievements has been easy. In the past decade, our expansion programs, buildings and people, were hampered by Federal price freezes under the Economic Stabilization Program; bed moritoriums, decreed by the HSA's; and, price regulation by the Maryland Health Services Cost Review Commission. The easiest course of action, when confronted with these obstacles, would have been to abandon our committment to education as many institutions have. These accomplishments are a reflection of our capacity and will to contribute

meaningfully to excellance in patient care and medical education.

This brief statement, along with the formal application, provides a thumb nail description of our facilities, governance, organization, finances and educational endeavors.

Thomas Crawford M.D.

Thomas Crawford, M.D.
Medical Director

TC/gab

The Johns Hopkins University School of Medicine / 720 Rutland Avenue / Baltimore, Maryland 21205

Richard S. Ross, M.D.
Vice President for Medicine
Dean of the Medical Faculty
(301) 955-3180

April 22, 1982

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

Gentlemen:

The Franklin Square Hospital, Inc. is an acute care general hospital in Baltimore County which has free standing accredited postdoctoral programs in medical training. The areas of interchange between the Franklin Square Hospital and the Johns Hopkins School of Medicine include an affiliation between our Departments of Obstetrics and Gynecology, in which one Franklin Square resident per year rotates through the Hopkins program. There is also an affiliation with general surgery in which plans have been outlined to develop at some time in the future a clinical rotation in surgery for students in the School of Medicine and possibly for residents in surgery. Additionally, an elective rotation for Johns Hopkins medical students to the Division of Cardiology at Franklin Square is ongoing between the two institutions and involves up to four students per year for 4 1/2 week rotations.

Insofar as Franklin Square has independent training programs predominantly at the postdoctoral levels, it has a limited role in the educational programs of the Johns Hopkins School of Medicine. It is my understanding, however, that the educational efforts of this hospital are good and that our limited contacts at the pre- and postdoctoral level have been and continue to be favorable.

Sincerely yours,

Richard S. Ross

Richard S. Ross, M.D.

RSR/lah

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE

GARDNER W. SMITH, M.D.
Deputy Director, Department of Surgery
Professor of Surgery

Please address reply to:
THE JOHNS HOPKINS HOSPITAL
601 N. BROADWAY
BALTIMORE, MARYLAND 21205
Telephone: (301) 955-3822

15 April 1981

D. Thomas Crawford, M. D.
Medical Director, Franklin Square Hospital
9000 Franklin Square Drive
Baltimore, Maryland 21237

Dear Tom,

I enclose with this letter the completed and signed Affiliation Agreement between the Franklin Square Hospital and The Johns Hopkins University and The Johns Hopkins Hospital. As you know, this agreement was approved by the Advisory Board of the Medical Faculty of The Johns Hopkins University School of Medicine on 27 February 1981. All of the appropriate signatures have now been affixed and the enclosed is returned for your files.

With best regards, I remain

Sincerely yours,

Gardner W. Smith, M. D.

GWSmth
Enclosure
cc: Bernadine H. Bulkley, M. D.
George D. Zuidema, M. D.
Mr. Charles C. Burch, Jr.

THIS AGREEMENT made this 17th day of December 1980, between THE FRANKLIN SQUARE HOSPITAL, INC., 9000 Franklin Square Drive, Baltimore, Maryland (Franklin Square) and THE JOHNS HOPKINS UNIVERSITY, 720 Rutland Avenue, Baltimore, Maryland and THE JOHNS HOPKINS HOSPITAL, 600 North Wolfe Street, Baltimore, Maryland (Hopkins).

Prefatory Statement

Franklin Square is an acute-care general hospital in Baltimore County, Maryland. It has offered an accredited, postdoctoral residency in surgery for more than three decades to train surgeons for general surgery in a community hospital setting.

Hopkins is a university-teaching hospital with an accredited School of Medicine providing doctoral and postdoctoral programs. It has a surgical residency program training surgeons for university positions and surgical specialties.

Franklin Square and Hopkins have an informal and cordial relationship in the surgical residency programs and in a number of other medical and educational programs. They now believe that a more formalized relationship between the surgical programs would permit each program to benefit from the complementary aspects of the other with the end result of a better educational environment.

Franklin Square and Hopkins enter into this Agreement to formalize their present cooperative relationship and to establish a framework for their mutual benefit.

Principles of Affiliation

The parties agree that these general principles will govern the affiliation of the surgical residency programs:

I. FACULTY AND STAFF APPOINTMENTS

A. Franklin Square Based

1. Appointments

a. Franklin Square will maintain the appointment of a geographical full-time Chairman of the Department of Surgery (Surgeon-in-Chief) with advice and consent of the Hopkins Director of Surgery.

b. The Hopkins Director of Surgery will nominate the Franklin Square Surgeon-in-Chief for appropriate academic appointments to the faculty of Hopkins. Appointments will be subject to the usual established process of Hopkins.

c. Hopkins Director of Surgery will nominate the Franklin Square Surgeon-in-Chief for appropriate appointments to the Medical Staff of The Johns Hopkins Hospital where such appointments will further the aims of the programs subject to this affiliation. Appointments will be subject to the usual established process of The Johns Hopkins Hospital. Professional liability coverage will be the responsibility of the Franklin Square Hospital, and not that of The Johns Hopkins Hospital or University.

d. The clinical appointment of sub-specialty chiefs shall remain the discretion of the Surgeon-in-Chief at Franklin Square and the nomination for academic appointment to the faculty of Hopkins will remain the discretion of the Hopkins Director of Surgery.

II. STUDENTS

A. Program

1. Elective Rotation

a. The Franklin Square staff members who are faculty members of The Johns Hopkins School of Medicine will develop a clinical elective rotation under the general policies of

Hopkins to be administered by Franklin Square.

b. Students on rotation will be supervised and evaluated by Franklin Square based members of The Johns Hopkins faculty.

c. If and when it is mutually advantageous, a core curriculum may be implemented at Franklin Square with the advice and consent of the Hopkins Director of Surgery and of the Associate Dean for Academic Affairs of Hopkins.

d. The core curriculum would be conducted by the Franklin Square based faculty of Hopkins.

III. POSTDOCTORAL TRAINING PROGRAMS

1. Franklin Square and Hopkins will maintain independent but educationally affiliated postdoctoral training programs.

2. Residents will be appointed independently by the parties, but cross-consultation between the departments may occur.

3. Any future rotation of Hopkins Surgical House Staff to the Franklin Square Hospital will be negotiated by a separate contract which must be approved by the Joint Committee on House Staff Policy and the Advisory Board of the Medical Faculty.

4. Each party will evaluate the structure and form of its program and mutually make whatever changes are deemed to be beneficial to maximize opportunities for interchange of surgical residents between the respective departments.

IV. PROGRAM PLANNING AND EVALUATION

A joint Liaison Committee shall be appointed by the Hopkins Director of Surgery and the Franklin Square Departmental Chairman to evaluate the existing program on an annual basis, and to recommend modifications when and where indicated.

V. TERMINATION

This Agreement shall remain in effect until termination at the instance of either party by the giving of written notice at least six (6) months prior to the beginning of a new fiscal year. The termination of this Agreement shall be effective as of July 1 of the year following the giving of timely notice. Written notice shall be addressed, as the case may be.

FOR THE JOHNS HOPKINS UNIVERSITY
AND THE JOHNS HOPKINS HOSPITAL

Steven Muller
President
The Johns Hopkins University and
The Johns Hopkins Hospital

3/30/81
Date

Richard S. Ross, M. D.
Dean of the Medical Faculty

5/24/81
Date

Robert M. Heyssel, M. D.
Executive Vice President & Director
The Johns Hopkins Hospital

3/18/81
Date

Bernadine H. Bulkley, M. D.
Assistant Dean-Postdoctoral
Programs and Faculty Development

3/11/81
Date

George D. Zuidema, M.D.
Director
Section of Surgical Sciences

5 March, 1981
Date

FOR FRANKLIN SQUARE HOSPITAL

President, Board of Trustees

Jan. 22, 1981
Date

Executive Director

Jan. 16, 1981
Date

President, Medical Staff

Jan 13, 1981
Date

Medical Director

13 Jan 81
Date

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
BALTIMORE, MARYLAND 21205

OFFICE OF THE DEAN
720 RUTLAND AVENUE

CABLE ADDRESS
HOPMED

April 1, 1981

D. Thomas Crawford, M.D.
Medical Director
The Franklin Square Hospital
9000 Franklin Square Drive
Baltimore, Maryland 21237

Dear Dr. Crawford:

Re: Affiliation Agreement between the Departments of Ob/Gyn of The Franklin Square Hospital and The Johns Hopkins University and Hosptial

Attached please find a copy of the finalized affiliation agreement indicated above. If there are any questions concerning this agreement, please contact the Postdoctoral Office at 955-3191 or the Director of the Department of Obstetrics/ Gynecology at Hopkins.

Alice H. Kessler
Administrative Assistant
Postdoctoral Office

CC: Mr. W. Appelbaum
Miss L. Cavagnaro
Mrs. C. Ponticas
Mr. M. Ventura
Dr. T. King
Dr. N. Rosenshein

POSTDOCTORAL TRAINING IN GYN-OB

THIS AGREEMENT made as of March 23, 1981 between the Franklin Square Hospital and THE JOHNS HOPKINS UNIVERSITY 720 Rutland Avenue, Baltimore, Maryland and THE JOHNS HOPKINS HOSPITAL, 600 North Wolfe Street, Baltimore, Maryland (Hopkins)

WHEREAS the parties desire to cooperate in the training of residents in GYN-OB in order to promote their professional growth, enlarge their professional experience, and contribute to excellence in patient care.

THEREFORE, the parties agree as follows:

1. Rotations

Effective July 1, 1980, each year, the Franklin Square Hospital will rotate the equivalent of one full time Resident to Hopkins. The duration of each rotation will be jointly determined by the parties and may be changed from time to time, but experience will be in Gynecologic Oncology.

2. Selection

The selection of the house officers to be assigned rotations under this agreement shall be made by the Franklin Square Hospital with the concurrence of Hopkins. Only those house officers who previously have performed their duties in a satisfactory manner shall be selected from this rotation. Both parties agree that selection of house officers shall be without regard to race, religion, sex, handicap, veteran status, or national origin, or age.

A house officer on rotation at Hopkins shall be under the supervision and control of the Hopkins GYN-OB Program Director and shall abide by all the rules and regulations of Hopkins.

Hopkins reserves the right to request the recall, prior to expiration of a rotation, of any resident if his/her performance has not been satisfactory.

3. Salary

Franklin Square Hospital will continue to be responsible for payment of full salary and all benefits of those Franklin Square Hospital house officers on rotation to Hopkins.

4. Uniforms and Laundry of Uniforms

House officers will be expected to wear the uniforms provided by the Franklin Square Hospital. Hopkins will provide laundry service of said uniforms during the rotation.

5. Liability for Malpractice

Hopkins will provide medical professional liability insurance for each rotating resident for claims and judgments arising out of the performance of professional services at Hopkins in the same amount and subject to the same conditions as applied to its House Staff. Certification of such insurance will be provided to the Franklin Square Hospital at the beginning of each year beginning July 1, 1980 and thereafter.

6. Medical Insurance

The Franklin Square Hospital will continue to be responsible for retaining the rotating house officer on its own medical insurance plan and for supporting the cost thereof.

7. Amendments

This Agreement may be altered, revised or amended from time to time by written agreement of the parties.

8. Termination

This agreement shall remain in effect until terminated at the instance of either party by the giving of prior written notice of a least six (6) months.

FOR THE JOHNS HOPKINS UNIVERSITY AND THE JOHNS HOPKINS HOSPITAL

Steven Muller, Ph.D., President
The Johns Hopkins University and
The Johns Hopkins Hospital

3/23/81
Date

Richard S. Ross, M.D., Dean
Medical Faculty
The Johns Hopkins University

Bernadine H. Bulkley, M.D.
Assistant Dean for Postdoctoral Programs
The Johns Hopkins University

Robert M. Heyssel, M.D.
Executive Vice President and Director
The Johns Hopkins Hospital

FOR FRANKLIN SQUARE HOSPITAL

George B. Hankins, President
Board of Trustees
The Franklin Square Hospital, Inc.

December 11, 1980
Date

D. Thomas Crawford, M.D.
Medical Director
The Franklin Square Hospital, Inc.

December 12, 1980
Date

Sanford Kotzen, Executive Director
The Franklin Square Hospital, Inc.

December 12, 1980
Date

FOR THE JOHNS HOPKINS UNIVERSITY
AND THE JOHNS HOPKINS HOSPITAL

Theodore M. King, M.D.
Director
Department of Gynecology and Obstetrics

Office Memorandum • GEORGETOWN UNIVERSITY HOSPITAL

To: Dick Knapp **Date:** April 29, 1982

From: Charles M. O'Brien, Jr.
Hospital Administrator

Subject: COTH Sponsorship of Capital Purchasing Program

At the spring meeting of the Appalachian Council of University Teaching Hospitals, the Appalachian group discussed and expressed its support for the concept of the exploration of capital purchasing section by a larger group, either an independently organized consortium of teaching hospitals possibly under the COTH. One of the major discussion points has been the impact of both proprietary and not for profit groups and their ability to capitalize on their bulk purchasing power for equipment. As centers which over the next several years will be purchasing substantial amounts of high cost technological equipment it appeared to the Appalachian Council that there is an opportunity which should be fully explored. For example, it was pointed out that recently the Sun Alliance had issued an order for 15 CAT scanners. The best price for the top of the line General Electric scanner is approximately $1.2 million and they purportedly received bids from General Electric for $800,000 per unit. Multiplying the number of institutions in the COTH who will be purchasing CAT scanners, nuclearmagnetic equipment, cath labs, etc., it would seem that within the group of the Council of Teaching Hospitals a very substantial opportunity exists to capitalize on that part of the market sharing which the Council of Teaching Hospitals institutions singularly represent.

Such a program could be easily implemented without substantial staff costs and could serve as a method or mechanism, at least at the subregional area, to develop more joint programs that could assist the teaching hospitals in their increasingly competitive environment.

The group had asked me to convey their sentiments to the Council of Teaching Hospitals to see if there is an interest, and if there is to start discussions on how such programs could be implemented. I would be pleased to discuss it further.

cc: Members of the Appalachian Council

AAMC Study of
Teaching Hospital Characteristics

At the last meeting of the COTH Administrative Board, it was agreed that a subcommittee of the Board would be established to review the draft final report for the study of teaching hospital characteristics. The subcommittee was to address to whom the report should be primarily directed and what tone and format are most appropriate for such audiences. Shortly after the Board meeting, Dr. Rabkin appointed Drs. Foreman and Rabkin and Messrs. Goldberg, King, and Reinertsen to the subcommittee with Mr. King as chairman.

On May 12th, the subcommittee met in Boston and discussed the draft report. The subcommittee concluded the original draft report suffered from a series of limitations (e.g., small number of hospitals, four year old data, incomplete and limited data) and that no rewriting of the original draft would make it suitable for the multiple audiences and purposes a single report would have to serve. Therefore, the subcommittee recommends that the Board request the staff to develop two separate reports as follows:

Public Advocacy Report

purpose: To describe the characteristics of teaching hospitals to health policymakers and the general public so that the distinctive needs of teaching hospitals are not ignored when global, health policy positions are taken.

audiences: Federal executive and Congressional personnel
State and local government agencies
Third party payers
Hospital association and hospital boards
The interested general public

data: The American Hospital Association's 1980 Annual Survey of hospitals for all non-Federal, non-specialty, COTH members and for all community general hospitals. Where the AHA data does not include necessary data (e.g., case mix), findings from the 33 study hospitals would be used as tentative supplementary information.

tone: An advocacy document using limited data to support statements made in the text.

outline: See Attachment A for draft.

Membership Feedback Report

purpose: To provide AAMC members with selected historical data for their use in comparing the characteristics of their own hospital to those from a diverse group of the membership.

audiences: COTH hospitals
Medical school deans
General public, only upon request

data: Frequency distributions (low, 25th percentile, median, 75th percentile, high) for most data elements collected from the 33 hospitals participating in the original study.

tone: Straightforward description of data which assumes an informed reader and which describes limits and weaknesses of data.

outline: See Attachment B for draft.

If this two report alternative is approved by the Board, the following timing for preparation, review, and publication of both reports is envisioned:

	Membership Feedback Report	Public Advocacy Report
Draft to Board	September 1	August 1
Board Review	September 9 (Regular COTH Administrative Board Meeting)	September 9
Publication	AAMC Meeting Nov. 8, 1982	October 1

Case Mix for Teaching and Non-Teaching Hospitals

The DRG and disease staging analysis of hospitals participating in the AAMC study of teaching hospitals included no information on non-teaching hospitals. SysteMetrics, the data processing contractor for the AAMC case mix analysis, now has available medical abstract information on 80 non-teaching hospitals subscribing to the Commission of Professional and Hospital Activities. The non-teaching hospital data is for calendar year 1978 and is time comparable to the fiscal year 1978 data collected for COTH hospitals.

With the agreement of the Board subcommittee, Jim Bentley asked SysteMetrics to prepare a research design and firm price for an analysis comparing the 80 non-teaching hospitals to the 24 COTH hospitals. Attachment C is their proposal.

Strengths of the proposal

1. Would provide a national comparison of teaching and non-teaching hospital patient mix.

2. Uses two case mix measures, diagnosis related groups and disease staging.

3. Rank ordering of hospitals by expected length of stay for each case mix measure.

4. Comparisons, for each case mix category, of average length of stay by bed size and region.

Limitations of the proposal

1. Uses 1978 data.

2. Uses ICDA-8 and H-ICDA-2 coding conventions which have been replaced by ICD-9-CM.

3. Hospitals not selected to be statistically representative of all U.S. or COTH hospitals.

4. Uses the old DRG classification rather than the December, 1981 revision.

5. Identity of 80 non-teaching hospitals is confidential.

In light of these strengths and weaknesses, the Board is requested to evaluate the desirability of conducting the comparison. If the Board favors undertaking the analysis, $20,000 ($18,500 for SysteMetrics and $1,500 for staff travel) should be requested from AAMC reserves to fund the analysis.

Draft Chapter Outline

"A Description of Teaching Hospital Characteristics"

Section I:
The Similarities with General Community Hospitals

Chapter One: The Industry Setting

- A. Tax-exempt and governmental
- B. Primarily free-standing
- C. Half of expenses are salaries: significant employers
- D. General financial characteristics
  1. Primary source of revenue is patient revenues
  2. Non-operating revenues are small
  3. Unit costs of revenue centers involve major allocated costs
  4. Similar financial ratios

Section II:
Distinctive Operating Characteristics of Major Teaching Hospitals

Chapter Two: Full Service Clinical Education Programs

- A. Graduate medical education
  1. Structure of contemporary graduate training
  2. Relationships with schools and hospitals
  3. Number of programs sponsored
  4. Number of trainees
  5. Programs provided by at least half of hospitals
- B. Undergraduate medical education
  1. Site for the school's programs
  2. Residents generally a precondition
  3. Required and elective clerkships
  4. Number of clerkships, clerks
- C. Nursing education
  1. Sponsored and participating programs -- primarily participating
  2. Percent with programs

D. Allied health education
    1. Sponsored and participating programs -- primarily participating
    2. Number of programs
E. Educational costs
    1. Problems with calculating
        a. simultaneous activity
        b. education through service
    2. Accounting costs
        a. graduate medical
        b. nursing
    3. Non-accounting costs
        a. productivity impact
        b. use of services impact
        c. some non-accounting costs necessary for learning

Chapter Three: Clinical Research and Applied Technology
A. Clinical research
    1. Difficulty measuring
    2. Research beds and space
B. Applied technology
    1. Equipment: CT Scanners, electron microscopes
    2. Programs: joint replacement surgery, microsurgery
C. Research costs
    1. Accounting costs
        a. research supported costs
        b. patient care costs
    2. Economic costs - low utilization

Chapter Five: Patient Services
A. Teaching hospitals are large
    1. Number of beds
    2. Number of bed units
    3. Outpatient clinics and visits
    4. Emergency visits
    5. Number of operating rooms, cardiac cateterization laboratories, radiology rooms, blood bank volumes, dialysis stations

B. Teaching hospitals provide complex services
    1. Microsurgery
    2. Joint replacement
    3. Open heart procedures
    4. Pulmonary function studies
    5. Laboratory services
    6. Specialized blood banking
    7. Kidney transplant
    8. Specialized neurological services
    9. Specialized opthalmology services
    10. Most costly diagnosis related groups
    11. Percentage of patients in severity stage 3, 4, and 5
    12. Proportion of most severe patients with cardiovascular and neoplastic diseases

C. Teaching hospitals are full service institutions
    1. Proportion of births
    2. Most common DRGs
    3. Percentage of patients in severity stage 1
    4. Importance of routine cases
        a. for operational efficiency
        b. for medical education
    5. Adverse impact of cost averaging on routine cases

D. Teaching hospitals serve all patients
    1. Type of patient by sponsor
    2. Out of area patients
    3. Bad debt and charity impact of admissions policy

E. Teaching hospitals are diverse
    1. Not homogeneous - cite variation in previous tables
    2. Development a function of opportunities and constraints
        a. omitted services - ob, peds, blood bank
        b. community services - burn care, shock trauma, neonatal
    3. Variation in affiliation arrangement
        a. primary teaching site
        b. affiliated teaching site
        c. medical staff/faculty variations
    4. Diversity means it's necessary to compare actual teaching hospital with mission specific, case mix adjusted expected values rather than average values

F. Costs of patient care

1. Patient care costs

a. include specialized services often on an average cost basis

b. include charity care/bad debt costs

c. include educational costs

d. exclude research costs

2. Average cost comparisons disadvantage teaching hospitals

a. high cost services -- underpriced

b. low cost services -- overpriced

Section III

Chapter Five: Summary and Policy Recommendations

Draft Chapter Outline

"Selected Data on A Small Sample of Teaching Hospitals"

Introduction: Signed by COTH Chairman

- A. Statement summarizing the importance of teaching hospitals to patient care, health manpower education, biomedical research
- B. Examples of public policy questions confronting teaching hospitals in a period of limited resources
  1. Higher average costs
  2. Use by routine care patients
  3. Limitations on introduction of technology
  4. Subsidy of educational cost
- C. Purpose of the report
  1. To document the patient service and educational outputs of teaching hospitals
  2. To inform policy makers and policy analysts of the major, interdependent characteristics of teaching hospitals which must be accommodated in global health policies
  3. To describe the variability and diversity of teaching hospitals to help avoid simplistic accommodations in public policies

Preface: acknowledge hospital and staff support

Chapter One: Background and Methodology

- A. Origin of the effort
- B. Methodology
  1. Selection of hospitals
  2. Sources of data
- C. Limitations of study

Chapter Two: Hospital Facilities and Services

- A. Beds
- B. Patient services

C. Ambulatory services

D. Tables

Chapter Three: Hospital Staff

A. Aggregate hospital staff

B. Nursing staff

C. Social work staff

D. Medical staff

E. Tables

Chapter Four: Education and Research Programs

A. Graduate medical education

B. Undergraduate medical education

C. Continuing medical education

D. Nursing education

E. Allied health programs

F. Research and technology applications

G. Tables

Chapter Five: Patient Case Mix

A. Methodology

1. Hospital sample

2. Case mix measures

3. Assigning weights to disease categories

4. Problems with data and methodology

B. Empirical findings

1. Overall data summary

2. Most frequent and expensive cases

3. Expected values

4. Case mix index

5. Tables

SYSTEMETRICS, INC.
104 West Anapamu Street • Santa Barbara, CA 93101 • (805) 963-6589

June 2, 1982

Dr. James Bentley
American Association of
Medical Colleges
One Dupont Circle
Washington, D.C. 20036

Dear Jim:

Enclosed is a research design for the CPHA comparison study we discussed on the 23rd. I've included the analyses you specifically requested and a few additional comparisons I thought would be useful. I suggest that we stick closely to the formats already developed for the earlier reports--I've included an example of each of the formats for your review.

Our charge to AAMC for the work described herein will be $18,500. We expect the project to take roughly 60 days to complete. We propose to bill you for 40% of the above amount each month for two months and for the remaining 20% upon completion. We have not included a travel budget in this amount although we feel that a face to face meeting would be desirable to review draft results. If we hold this meeting in Washington, we'll bill you for actual travel expenses incurred.

If you have any questions or suggestions, please don't hesitate to call either me or Pete Lufkin.

Sincerely,

Daniel Z. Louis
Vice President

DZL/jw

Enclosures

PROPOSED RESEARCH DESIGN FOR THE AAMC TEACHING/ NON-TEACHING HOSPITALS COMPARISONS

This part of the AAMC "Describing the Teaching Hospital" study involves length of stay comparisons between the original sample of teaching hospitals and a new sample of non-teaching hospitals provided by the Commission on Professional and Hospital Activities (CPHA). Three tasks are required for the comparisons: create a comparison dataset of non-teaching hospitals compatible with the original teaching hospital dataset; generate an analysis dataset; and prepare a report including specific comparisons of the teaching and non-teaching datasets. These tasks are discussed in detail below.

- TASK 1 creates the CHPA comparison dataset. Raw patient records will be read into a SAS dataset and assigned DRG and Disease Staging variables. This dataset will include over 1 million records from 80 hospitals sampled in the following way:

CPHA SAMPLE OF NON-TEACHING HOSPITALS

Beds	1-99	100-299	300+
Northeast	10	5	5
Northcentral	10	5	5
South	10	5	5
West	10	5	5
			Σ 80

- TASK 2 generates the analysis dataset. The AAMC and CPHA datasets will be processed to produce hospital-specific average lengths of stay (LOS) by DRG and Staging levels. These averages will be collapsed to produce overall (weighted) means for the two datasets. Overall means by DRG and Stages will also be calculated for the combined datasets, to be used in the expected value equations.

- Patient records with LOS greater than or equal to 365 days will be dropped from the analysis dataset and a new variable added to identify regions for the AAMC hospitals to match the definition used for the CPHA hospitals.

- Expected length of stay (ELOS) will be calculated for each hospital using the same equation as in the previous "all hospital" reports:

$$ELOS_h = \Sigma\ (P_{hc}\ X\ ALOS_c)$$

  Where expected LOS for hospital h is the proportion of patients p in DRG or Stage level c multiplied by the combined datasets ALOS for c, summed across all c. ELOS calculations will be made using DRGs and Staging. Expected LOS using Staging will be calculated at the substage level.

- Two sets of ELOS calculations will be made, with and without newborn records, using the appropriate DRG codes to identify newborns.

- Hospital identifiers will be specified by AAMC. We suggest that the identifier include the hospital teaching status, region, and size, such as "NT 1-99 West".

• TASK 3 prepares the final report. Actual means and expected means calculated in the analysis dataset will be used to produce 7 comparison tables. The formats for these tables will correspond closely to the previous "all hospital" reports where possible.

- TABLE 1, SUMMARY OF COMPARISON DATA: shows counts and average LOS for both datasets, by region and size category.

- TABLE 2, RANK ORDERING OF HOSPITALS BY EXPECTED LOS, USING DRGS: lists hospital identifier, average LOS, and expected LOS.

- TABLE 3, AVERAGE LOS BY DRG: lists counts, proportions and average LOS by DRG, broken down by teaching/non-teaching and size category.

- TABLE 4, AVERAGE LOS BY DRG: lists counts, proportions and average LOS by DRG; broken down by teaching/non-teaching and region.

- TABLE 5, RANK ORDERING OF HOSPITALS BY EXPECTED LOS, USING DISEASE STAGING: lists hospital identifier, average LOS, and expected LOS. Expected LOS will be calculated at the substage level.

- TABLE 6, AVERAGE LENGTH OF STAY BY STAGING SUMMARY GROUPS: lists counts, proportions, and average LOS by summary group, broken down by teaching/non-teaching, size category, and Stages. A 25th summary group will be added for newborns in Table 6 and 7.

- TABLE 7, AVERAGE LENGTH OF STAY BY STAGING SUMMARY GROUPS: lists counts, proportions, and average LOS by summary group, broken down by teaching/non-teaching, region, and Stages.

TABLE 1

SUMMARY OF COMPARISON DATA

BEDS:	1-99		100-200		300+		TOTAL	
	N	ALOS	N	ALOS	N	ALOS	N	ALOS
TEACHING HOSPITALS								
Northeast								
Northcentral								
South								
West								
Total								
NON-TEACHING HOSPITALS								
Northeast								
Northcentral								
South								
West								
Total								

TABLE 2

RANK ORDERING OF HOSPITALS BY EXPECTED LOS, USING DRGS

RANK	HOSPITAL IDENTIFIER	AVERAGE LOS	EXPECTED LOS

TABLE 3

AVERAGE LENGTH OF STAY BY DRG

DRG 1

DRG Label _____

	Number of Discharges	Percent Discharges	Average LOS
TEACHING HOSPITALS			
Beds: 1-99			
100-299			
300+			
Total			
NON-TEACHING HOSPITALS			
Beds: 1-99			
100-299			
300+			
Total			

TABLE 4

AVERAGE LENGTH OF STAY BY DRG

DRG 1

DRG Label _____

	Number of Discharges	Percent Discharges	Average LOS
TEACHING HOSPITALS			
Northeast			
Northcentral			
South			
West			
Total			
NON-TEACHING HOSPITALS			
Northeast			
Northcentral			
South			
West			
Total			

TABLE 5

RANK ORDERING OF EXPECTED LOS, USING DISEASE STAGING

RANK	HOSPITAL IDENTIFIER	AVERAGE LOS	EXPECTED LOS

TABLE 6

AVERAGE LENGTH OF STAY BY STAGING SUMMARY GROUP

Summary Group 1
Label: _____

	Number of Discharges	Percent Discharges	Average LOS
TEACHING HOSPITALS			
Beds: 1-99			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Beds: 100-299			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Beds: 300+			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
All Beds			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
NON-TEACHING HOSPITALS			
Beds: 1-99			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Beds: 100-299			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Beds: 300+			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
All Beds			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			

TABLE 7

AVERAGE LENGTH OF STAY BY STAGING SUMMARY GROUP

Summary Group 1

Label: _____

	Number of Discharges	Percent Discharges	Average LOS
TEACHING HOSPITALS			
Northeast			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Northcentral			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
South			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
West			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
All Regions			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
NON-TEACHING HOSPITALS			
Northeast			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
Northcentral			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
South			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
West			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			
All Regions			
Stage 1			
Stage 2			
Stage 3			
Stage 4			
Total			

NATIONAL COMMISSION ON NURSING

It has been suggested that COTH/AAMC comment or take positions on the various recommendations in the "Initial Report and Preliminary Recommendations", National Commission on Nursing. The COTH Administrative Board needs to determine whether or not COTH/AAMC wishes to become engaged in the debates over any of the recommendations in this report, and if so, what is the most appropriate way to accomplish such a task.